FY2021

Community Behavioral Health Plan

Mid Shore Planning Collaborative (MSPC)

CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

DORCHESTER
water moves us
DORCHESTER COUNTY MARYLAND

THE COUNTY OF KENT
IN THE PROVINCE OF MARYLAND

MID SHORE
BEHAVIORAL HEALTH

QUEEN ANNE'S COUNTY
1706

TALBOT COUNTY HEALTH DEPARTMENT

ACKNOWLEDGEMENTS

The FY2021 mid-shore Community Behavioral Health Plan is the product of the work of many individuals and their commitment to the Mid Shore Planning Collaborative (MSPC). MSPC engaged with partners, persons in recovery, family members, natural supports, providers, and community leaders to develop the plan for FY2021. During the past year, MSPC has focused its work on the behavioral health integration process at a local level and has enhanced organizational relationships with community stakeholders to support and guide MSBH on the integration continuum and change process. MSPC prides itself on the inclusion and commitment of our partners in supporting the work that is done on behalf of our mid-shore community.

Persons Served by the Public Behavioral Health System
Persons in Recovery, Family Members, and Natural Supports
Mid-shore Health Officers
MSBH Board of Directors
Regional Behavioral Health Advisory Committee
Drug Free Caroline/Caroline County LDAAC
Dorchester County Criminal Justice Treatment Network/LDAAC
Kent County LDAAC
Queen Anne's LDAAC/OIT
Talbot County LDAAC
Consumer Council
Mid-Shore Roundtable on Homelessness
Eastern Shore Behavioral Health Coalition
Behavioral Health Services Network (BHSN) Workgroups
CIT Advisory Subcommittee
Behavioral and Rural Health Advocacy Groups
Treatment and Recovery Support Provider Agencies
Local Health Systems
Local Health Departments
Local Management Boards (LMB)
Local Departments of Social Services (DSS)
Local Coordinating Teams (LCT)
Eastern Shore Crisis Response System
Maryland's Department of Health and Behavioral Health Administration
Other interested stakeholders and citizens of the Eastern Shore of Maryland

MSPC is grateful to all who contributed to the development of the mid-shore Community Behavioral Health Plan and is enthusiastic about the continued collaboration as we proceed with our goals and future endeavors in its implementation.

ACRONYMS

ACA	–	Affordable Care Act
ACT	–	Assertive Community Treatment
AHAR	–	Annual Homeless Assessment Report
ASAM	–	American Society of Addiction Medicine
ASO	–	Administrative Services Organization
BHA	–	Behavioral Health Administration
BHSN	–	Behavioral Health Services Network
B-HIPP	–	Behavioral Health Integration in Pediatric Primary care
CAF	–	Community Alternatives Framework
CCO	–	Care Coordination Organization
CBHP	–	Community Behavioral Health Plan
CIT	–	Crisis Intervention Team
CME	–	Care Management Entity
COC	–	Continuum of Care (Mid-Shore Roundtable on Homelessness)
COMAR	–	Code of Maryland Regulations
CQT	–	Consumer Quality Team
CSA	–	Core Service Agency
CSR	–	Client Service Representative
CVI	–	Chesapeake Voyagers, Inc.
EBP	–	Evidence Based Practice
ESOC	–	Eastern Shore Operations Center
FFS	–	Fee for Service
FY	–	Fiscal Year
HSAM	–	Human Services Agreement Manual
HMIS	–	Homeless Management Information System
HUD	–	Housing and Urban Development
IAC	–	Inter-Agency Committee
IFPS	–	Interagency Family Preservation Services
IOP	–	Intensive Outpatient Program
LAA	–	Local Addiction Authority
LBHA	–	Local Behavioral Health Authority
LCT	–	Local Care Team
LDAAC	–	Local Drug and Alcohol Abuse Council
LMB	–	Local Management Board
MA	–	Medical Assistance or Medicaid
MABHA	–	Maryland Association of Behavioral Health Authorities
MAT	–	Medication-Assisted Treatment
MCCJTP	–	Maryland Community Criminal Justice Treatment Program
MCO	–	Managed Care Organization
MSPC	–	Mid Shore Planning Collaborative
MCSS	–	Mobile Crisis Stabilization Services
MCT	–	Mobile Crisis Teams

ACRONYMS FY2021

MDH	–	Maryland Department of Health
MHFA	–	Mental Health First Aid
MORR	–	Maryland Opioid Rapid Response
MSBH	–	Mid Shore Behavioral Health, Inc.
MTT/MTS	–	Mobile Treatment Team / Mobile Treatment Services
Multi-D	–	Multi-Disciplinary Team
NAMI	–	National Alliance on Mental Illness
OHCQ	–	Office of Health Care Quality
OIT	–	Opioid Intervention Team
OMHC	–	Outpatient Mental Health Clinic
OMPP	–	Opioid Misuse Prevention Program
OMS	–	Outcome Measurement System
OOCC	–	Opioid Operational Command Center
PASRR	–	Pre Admission Screening and Resident Review
PATH	–	Projects for Assistance in Transition from Homelessness
PBHS	–	Public Behavioral Health System
PHP	–	Partial Hospitalization Program
PIP	–	Performance Improvement Plan
PRP	–	Psychiatric Rehabilitation Program
RBHAC	–	Regional Behavioral Health Advisory Committee
RRP	–	Residential Rehabilitation Program
RTC	–	Residential Treatment Center
SAMHSA	–	Substance Abuse and Mental Health Services Administration
SEP	–	Supported Employment Program
SOAR	–	SSI/SSDI, Outreach, Access and Recovery
SOR	–	State Opioid Response Grant
SRD	–	Substance-Related Disorder
SSDI	–	Social Security Disability Insurance
SSI	–	Supplemental Security Income
TAY	–	Transitional Age Youth
TIC	–	Trauma-Informed Care
UCC	–	Urgent Care Clinic
WRC	–	Wellness and Recovery Center

ACRONYMS FY2021

CLINICAL SERVICES GUIDE

Level 0.5 – Early Intervention
A program that treats patients who may be at risk for developing substance-related problems and not yet diagnosed with a substance use disorder.

Level 1 – Outpatient Treatment
A program that provides outpatient services consisting of less than 9 hours weekly for adults and less than 6 hours weekly for adolescents to promote recovery and engage in motivational enhancement therapies and strategies.

Level 2.1 and 2.5 – Intensive Outpatient Treatment and Partial Hospitalization
A program used to treat multidimensional instability to meet the complex needs of patients with substance use disorders and co-occurring conditions. Level 2.1 Intensive Outpatient consists of 9 or more hours of programming weekly for adults and 6 or more hours of programming weekly for adolescents. Level 2.5 Partial Hospitalization provides 20 or more hours of programming weekly for multidimensional instability that does not require 24-hour care.

Level 3.1 – Clinically Managed Low-Intensity Residential Services
(Halfway/Transitional Housing) – A structured environment with 24 hour living support with at least 5 hours of programming provided each week and directed towards preventing relapse, applying recovery skills, promoting personal responsibility, and reintegration.

Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services
(Long Term Residential Care) – A structured environment with 24-hour care in combination with residential services and group treatment to support and promote recovery.

Level 3.5 – Clinically Managed High-Intensity Residential Services (Adults)
(Therapeutic Community) – A structured environment with 24-hour care in combination with a full active milieu to support and promote recovery and prepare for outpatient treatment.

Level 3.7 – Medically Monitored Intensive Inpatient Services (Adults)
(Intensive Inpatient/Residential) – A medically monitored intensive inpatient treatment program with 24-hour nursing care, 16-hour counseling and physician availability. Patients entering Level

3.7-WM require medication and have a recent history of withdrawal man FY20

A. INTRODUCTION

The FY2021 Community Behavioral Health Plan (CBHP), is representative of the collaborative and integrated work of the six local authorities responsible for managing Maryland's Public Behavioral Health System (PBHS) for the mid-shore counties of Maryland: Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. The FY2021 Community Behavioral Health Plan is a product of the following local authorities' partnership and dedication to completing the first regional behavioral health plan representative of the mid-shore:

Caroline County Local Addictions Authority (LAA)
Dorchester County Local Addictions Authority (LAA)
Kent County Local Addictions Authority (LAA)
Mid Shore Behavioral Health, Inc., Core Service Agency for the mid-shore counties (CSA)
Queen Anne's County Local Addictions Authority (LAA)
Talbot County Local Addictions Authority (LAA)

The decision to collaborate to complete the CBHP across local authorities representing the mid-shore counties, emerged out of the enhanced partnership that the mid-shore authorities have demonstrated since receiving guidance regarding the expectations for the integration of local authorities in the state of Maryland. The expectation for local integration stems from the Behavioral Health Plan released in FY2017 stating the expectation of "improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care". In addition, guidance from Maryland's State budget requesting that the Behavioral Health Administration (BHA) submit "a report on the feasibility, costs, and benefits of merging the core service agencies with the local addictions authorities." As part of that budget provision, the General Assembly reaffirmed the "policy imperative to fully integrate behavioral health services in the State." "In line with the policy imperative to fully integrate behavioral health in Maryland, BHA has been moving toward strategic integration of behavioral health, including state administrative functions, funding streams, and local systems management."

In the mid-shore, the six entities that represent and are responsible for the local systems management, initiated a collaborative process to assess the needs and priority areas for planning local integration in the region with the development of an integration workgroup in July 2018. The workgroup known as the Mid-Shore Counties Local Systems Management Integration Workgroup, determined in FY2019, that the first integrated activity that would be completed as a regional group was the Annual Community Behavioral Health Plan. As a result of this decision, the Workgroup convened in November 2019, to embark on the completion of the FY2021 CBHP.

An essential process for the Workgroup members, was determining a group name that would be respective of the collaboration that contributed to the development of the CBHP, while remaining respectful of the existing autonomy that each local authority has at this early stage of

local integration in the region. The Workgroup determined that the six entities represented would be called the "Mid Shore Planning Collaborative" or MSPC in FY2021. MSPC is representative of regional collaboration on each element of the CBHP and initiatives that will be universally endorsed, supported, reflected, and driving the work of the group. In the document, when MSPC is referenced, please note that this indicates a mid-shore region, not a single local authority. Additionally, with the FY2021 representing the first annual plan for the region, the partners recognize that there remains a need at times to note local authority-specific initiatives, experiences, or strategies that remain prescriptive to a county or to the regional CSA.

The FY2021 Annual Plan process has afforded the mid-shore region with the opportunity to address the needs of the region as a whole, evaluate the resources currently serving the jurisdiction and identify gaps, and assess the future planning required for a strategic plan and successful implementation of an integrated structure. The primary goal with the development of the CBHP is to address both the mental health and substance related disorder (SRD) needs and services throughout our region, as well as the gaps in our system, and opportunities for increased collaboration across systems. MSPC is committed to enhanced relationships to address our region's current capacity, disparities, and opportunities for growth for behavioral health.

Each aspect of the plan contributes to an overarching understanding of the mid-shore region's PBHS, offering the following: review of the previous year's accomplishments and analysis of FY2019 PBHS available data; description of the current FY2020 landscape of local authority implementation and integration, population needs, systems goals, objectives and strategies; and FY2021 projected budgets and established systems goals, objectives and strategies.

The five-county, mid-shore region spans 2,710 square miles; the population of this region is approximately 170,000. According to the 2017 study conducted by Maryland Health Care Commission (MHCC) contracted with the University of Maryland School of Public Health and the Walsh Center for Rural Health Analysis at NORC at the University of Chicago to address the public health needs of the mid-shore region, in an effort to improve health disparities and the healthcare delivery system, out of the areas identified to prioritize in the region were mental health and substance use. The number of emergency room visits for mental health in mid-shore counties exceeded the state's rate of 3,443 per 100,000 people in 2014. Substance abuse is a critical health issue in the mid-shore. Most, if not all mid-shore counites have higher drug- and alcohol-related intoxication deaths in comparison to the state averages. For the five-county region, "in 2016, the following drugs contributed to the corresponding number of deaths: fentanyl (20) heroin (18), prescription opioids (11), cocaine (9), oxycodone (8), methadone (4) and benzodiazepine (4). Fentanyl has a strong presence in Talbot County, while heroin, prescription opioids, cocaine and oxycodone are making a big impact in Caroline County."

Additional trends to note for the mid-shore are all five counties have more people over age 65 than the state average. The population in the mid-shore have lower incomes and a higher

percentage of residents living in poverty than the state average. The number of residents with a disability and the number of residents who are uninsured in this region are slightly higher than the state average. Transportation and access to health care and treatment services, as well as a dearth of behavioral health providers and workforce are major contributing factors to the wellness and health disparities in the region.

MSPC understands that behavioral health is essential to achieve overall health, and many domains of life contribute to one's behavioral health, especially having a home, purpose and community connection. As such, MSPC seeks to address the needs of the whole person and collaborates to improve the systems of care of the whole community throughout the region. Through the work of developing our FY2021 plan, MSPC seeks to address determinates of overall health and wellness in hopes of supporting resources that offer interventions and supports to our region in hopes of supporting improved quality of life and wellness of our community. This year, MSPC partners have worked to prioritize addressing trauma, cultural competency, access to supportive resources, integrated systems oversight, and emphasize collaboration across systems providers to include the primary care model in our planning and collaboration in our work in FY2021.

Priority populations for MSPC include: Young Children (0-3 years), Pregnant Women and Children, Transitional-Aged Youth, school-aged children, adolescents, overdose survivors and families, individuals with chronic diseases, the homeless, underserved populations, minorities with health disparities, intensive need consumers, consumers with and in need of entitlements (TCA, Medicaid, Medicare, SSI/SSDI), High Utilizers, Veterans, LGBT+, Seniors/Aging Population, farmers-agriculture workers, criminal justice system, forensic or incarcerated individuals, and high-risk individuals that have adverse childhood experiences (ACES).

MSPC prioritizes staying in touch with the changes, challenges, and opportunities that impact the delivery, system capacity, and accessibility of behavioral health services in the mid-shore region. MSPC has supported the integration processes on the state level and local level since FY2016. MSPC has supported the provider community with integration with the transition of substance related services to fee-for-service. MSPC guided our provider community with the infusion of information related to fee-for-service transition for substance related services. In FY2017, American Society of Addiction Medicine (ASAM) levels of care 0.5 to 2.1 transitioned from grant-based to fee-for-service, and as of January 1, 2017, all mid-shore counties were fee-for-service. MSPC supported the transition of residential treatment and withdrawal management providers (ASAM Level 3.3-3.7WM) to the fee-for-service structure effective July 1, 2017. MSPC supported the provider community with the transition of ASAM 3.1, clinically managed low-intensity residential services to fee-for-service. Currently, the mid-shore region has no 3.1 level of care recovery housing. MSPC has prioritized supporting the community with the certification and expansion of the mid-shore Recovery Housing community. Most recently, MSPC has supported the transition of Administrative Service Organizations from Beacon Health Options to Optum

Maryland. With this transition, the Recovery House community has been identified as a group that will be moving into the fee-for-service structure. With this change, MSPC has and will be working on an enhanced level with our Recovery House providers to ensure sustained services and any technical assistance needs.

MSPC has supported expanded funding and reimbursement structures for our providers and expansion of our grant-based services for the behavioral health community. MSBH endorsed Maryland General Assembly's passing of Maryland's Heroin and Opioid Prevention (HOPE) Act of 2017, which supports the expansion of treatment options for consumer access to mental health, substance related, and opioid specific needs. In support of the Keep the Door Open Act, the HOPE Act endorses fiscal supports expanded for providers. MSPC has worked collaboratively with the Eastern Shore Behavioral Health Coalition to advocate for full implementation of the HOPE Act support in the 2020 legislative session, with a focus on expanded funding to support behavioral health services.

MSPC continues to develop its focus on being an integral community partner and resource in an effort to combat the opioid crisis. MSPC is a regional leader with supporting solicitation of funding for our rural community to allow for access to, and support, the system of care. MSPC are members of the mid-shore Opioid Misuse Prevention Program (OMPP), and all mid-shore Local Drug and Alcohol Abuse Councils (LDAAC), has been an integral team member during the declaration of a state of emergency and Maryland's Opioid Operation Command Center (OOCC) and Opioid Intervention Team (OIT) and Shore Regional Health's mid-shore Opioid Task Force.

A priority focus for MSPC is eliminating the barriers for individuals seeking Medication Assisted Treatment (MAT), to support their recovery needs. The mid-shore region has a dearth of prescribers available in the PBHS to support the prescription of buprenorphine, Vivitrol, suboxone, and recovery sustaining medications. The provider network has been dependent on the use of a small group of current prescribers, and the use of telehealth, supported primarily by the University of Maryland, to assist with a significant portion of the buprenorphine prescribing in the region. MSPC will be enhancing its efforts to bring MAT to the mid-shore and eliminate barriers, such as transportation, with the use of newly launched mobile treatment units and expanded provider capacity in the Emergency Departments and primary care settings.

Crisis Services remains at the forefront of MSPC work as the mid-shore and Eastern Shore Crisis Response group work to implement the Crisis Strategic Plan of 2017. The primary goal for expansion of crisis services was the expansion of mobile crisis services to include 24/7 access to mobile crisis teams, enhancement of our Eastern Shore Crisis Response call center, and continued advocacy for our community stakeholders in our Wellness and Recovery Center and our Crisis Intervention Team programming for first responders. New initiatives to support the child and adolescent population and our overdose response groups are a focus for FY2021.

Peer support specialists and the peer model of care has been a service of major growth and positive community partner planning in the mid-shore region. Peers are now staffed to be on call 24/7 to support responding with EMS in the community or meet the individual in the emergency department for support and to respond to emergency room visits. This model of response and support has yielded positive outcomes for individuals seeking ongoing recovery supports, transition to inpatient care, and allowed for the resource of a peer to be made available as soon as the individual is ready to receive help.

The psychiatry and workforce crisis remain a concern for MSPC and the behavioral health provider network. The shortage of psychiatrists and behavioral health providers is not unique to the mid-shore region, but is a growing crisis facing Maryland as a whole. Our providers lack the capacity to support the current demands of individuals seeking behavioral health services, our primary care providers are currently not integrated to adequately serve behavioral health needs, and the efficiency with access is a barrier to ensuring community-based services. The mid-shore region has continued to support providers who are impacted by turnover of psychiatrists, nurse practitioners, and the credentialing issues with reimbursement outside of the PBHS system. The needs of the community are growing, and with advocacy for access, and work to combat stigma, providers need to be equipped to serve and allowed opportunities to operate and be supported as this workforce crisis evolves. MSPC will remain committed to supporting and addressing our network capacity with our work with BHA and our legislators, in addition to enhancing our regional collaboration across care models with partnership and *Warm Hand-off Initiative* work with our primary care, pediatric, and somatic provider partners.

MSPC has been working to remain involved with regional and state-led initiatives that are addressing the health and wellness of the region. Senate Bill 1056 created The Rural Health Collaborative for the five Mid-Shore counties (Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties) to operate as an independent unit under the Maryland Department of Health, reporting directly to the Secretary. The Rural Health Collaborative (RHC) representing the mid-shore to improve the access and delivery of health services in a rural area, is a group that MSPC is supporting and mindful of complementing with the FY2021 goals for the region. In the development of the FY2021 Goals, MSPC referenced the priority areas that have been identified by the RHC. MSPC identified that several elements of the RHC priorities attention to integrating healthcare delivery and efficiencies, coordination with clinical and proper access to community resources, as well as the universally noted barrier to access to and utilization of services, transportation.

In addition to the regional activities to evaluate behavioral health services, MSPC has participated and contribution to the Commission to Study Mental and Behavioral Health in Maryland. The commission, which is chaired by Lt. Governor Rutherford, has been tasked with studying mental health in Maryland, including access to mental health services and the link between mental

health concerns and substance use disorders. Several members of the MSPC team participated in the Upper Eastern Shore Meeting, that was held on Wednesday, December 11, 2019, at Chesapeake College. Members of the provider community, consumers, hospital representatives, school systems, Salisbury University's School of Social Work, and the Eastern Shore Crisis Response group were in attendance. Senator Addie Eckardt, representing District 37 (Caroline, Dorchester, Talbot, and Wicomico Counties), serves on the Commission, and has been an active member on the Eastern Shore Behavioral Health Coalition.

The FY2021 Community Behavioral Health Plan, demonstrates a tremendous dedication of the MSPC partnership and desire to serve the mid-shore community and commitment to progressing towards and integrated system. The planning and collaboration that contributed to the goals and objectives development for MSPC over the course of FY2021 and in the three to five years to follow, are priority areas that have been developed and endorsed by regional partners and leadership. The FY2021 Goals that reflect five priority themes: Community, Social Determinants, Services, Integration, and Workforce, have been received by the mid-shore local governing and advising bodies, but most importantly, and, universally agreed upon by MSPC group that will be supporting the implementation of the priorities with our mid-shore consumers, stakeholders, and community.

B. NEW DEVELOPMENTS AND CHALLENGES

The mid-shore region of Maryland's Eastern Shore: Caroline, Dorchester, Kent, Queen Anne's and Talbot counties, is rural and approximately 2710 sq. miles with a population of about 171,500 (MDRH Plan 2018). With a population density of 85 people per square mile, compared to 594 per square mile statewide, access to care is the primary health challenge in this rural region. Due to limited transportation options, compounded by the insufficient number of behavioral health providers, the county health departments play a key role in filling the healthcare delivery gaps in the region, where medical services are sparse. Telehealth, mobile community health initiatives, care coordination, community health outreach workers and peers are all critical efforts to overcome the isolating distances and chronic health issues. Many of the behavioral and somatic health deficits are chronic and link directly with the region's social determinants: poverty/lack of personal and community financial resources, lack of affordable housing and healthy food, as well as social supports for those in need and seeking health care. Addressing these social determinants constitute our biggest challenge and focus many of the new developments in the region.

Nature of a Rural System of Care

Transportation:

Transportation remains a significant barrier to accessing treatment. Limited public transportation does exist, but transit rides can take an entire day, given that the mid-shore spans more than 2,700 square miles. Some providers offer limited transportation for clients, as do wellness and recovery centers in both Dorchester and Talbot Counties. Queen Anne's County also offers limited transportation from its health department. MSBH continues to collaborate with providers to secure grant funding for vehicles and drivers; however, those requests have been unsuccessful. In some counties, Medical Assistance (MA) transportation will not retrieve children from school and will only transport one guardian per child. MSBH participates in regional groups tasked with addressing transportation issues. There are voluntary ride-sharing nonprofits, however, these are not available for individuals with behavioral health diagnoses. Peer-to-peer transport continues to be discussed but lack of funds to reimburse for mileage, gas, and repairs prohibit such an endeavor.

Residential and Acute Treatment; The Child and Adolescent Population:

Families with children with severe behavioral health needs have often exhausted their own financial, physical, and emotional resources and have access to very limited community resources to meet the needs of their child(ren). The lack of higher-level child and adolescent behavioral health treatment continues to be challenged in the mid-shore region and on the Eastern Shore. Since the closure of Adventist Healthcare in Cambridge, MD, in November 2016, there are no child and adolescent inpatient psychiatric hospital beds on the Shore to provide crisis stabilization. This development has added to the stress of families when attempting to meet the needs of their child(ren). The highest level of child and adolescent care, residential treatment,

continues to dwindle as more residential treatment centers across the state close, forcing children out of state for this level of treatment or back into their communities without adequate supports. Along with the lack of residential treatment, there are no non-public special education schooling options in the region to meet the intense behavioral needs of the children and adolescent population. This circumstance requires youth to travel to counties on the "Western Shore" to receive the needed level of care and schooling. As of September 24, 2019, Catoctin Summit Adolescent Program closed its doors to the youth of Maryland for substance abuse treatment services. With this closure, there now are no adolescent substance related treatment inpatient facilities remaining in the state. Thus, many of our children and adolescents with severe behavioral health needs are not receiving the services needed for effective treatment.

Telehealth:

Telehealth capability has enabled the mid-shore jurisdictions to have the ability to see more Mental Health and MAT-SUD clients, as a response to the provider desert that otherwise currently exists. Current contracted provider relationships with University of Maryland, Sheppard Pratt, and other inpatient facilities, have made it possible for behavioral health service delivery throughout the mid-shore.

Caroline County Behavioral Health (CCBH) has tele-MAT through a mobile treatment unit (MTU), and tele-MAT clinics in the outpatient office, through an arrangement with the University of Maryland School of Psychiatry. In addition, CCBH has a contract with Sheppard Pratt for four hours per week to provide tele-mental health prescribing as a supplement to the on-site Medical Directors' 20 hours per week. Most of the mental health clientele is seen on-site with all of the MAT clients being seen through our tele clinic services.

Telehealth services, especially for psychiatric care, remains an urgent need in the mid-shore region. Due to the lack of adequate services, and the multiple barriers to hiring and maintaining quality staff, telehealth is critical in providing well-rounded care for those who are served.
Dorchester County currently has a contract with a telehealth service provider, to enable Dorchester County Behavioral Health (DCBH) the ability to better provide psychiatric SUD services for its' residents. DCBH has two psychiatrists available via telehealth to prescribe medications to treat SUD. In FY20, these services will include psychiatric medications as well. Services will be available for the local detention center and Individuals receiving treatment through the Dorchester County Problem-Solving Court.

Telehealth is an expensive endeavor to undertake; cost of the equipment, fee for the secure web-based portal (between the originating site and distant site) and the cost of the Prescriber at the distant site, are daunting. Other barriers for telehealth services is the need for IT assistance, which is often unavailable or costly, and the need for using e-script (Prescribers may not be receptive of using). The telehealth services are an ideal resource for rural areas, in that it provides services from quality practitioners who prescribe indicated medications, as well as Data 2000

Waiver MAT Physicians, Physicians Assistants and Nurse Practitioner. Scheduling telehealth appointments must be shared remotely, therefore the program needs trained office staff. Time set aside for the prescriber must be filled as you are paying the telehealth prescriber by the hour. The prescriber also requires three vital signs to be documented (ie: height, weight, blood pressure, pulse, oxygen level, temperature). Although, telehealth is an ideal resource, there are many variables to take into consideration, which can make this service challenging to the providers.

Challenges of the Opioid Epidemic

Opioid Crisis:

Since March of 2017, when Governor Hogan declared a State of Emergency as a result of the Heroin, Opioid, and Fentanyl crisis, the shift in focus for the Maryland Department of Health and the Behavioral Health Administration has been on services and funding to combat the opioid crisis. Local authorities have responded the priority shift in the work that has been traditionally supported by local behavioral health systems managers, to dedicate a substantial amount of responsibility to concentrating on how to infuse new and enhance existing resources in our jurisdictions to combat the crisis.

The MSPC group has been impacted on the prioritization of administrative responsibilities to focus on the opioid crisis. All locals jurisdictions are required to participate and aid with the management of the Opioid Intervention Team (OIT) in their respective counties, report on local activities to combat the crisis, and solicit and manage funding from the Opioid Operational Command Center (OOCC) for local programming. In the mid-shore region, there are five distinct OIT groups, and varying implementation of programmatic enhancement, and staffing in each county to comply with the OOCC reporting and engagement expectations. Transition in leadership with the OOCC yielded visits from Director Steven Schuh over the Spring and Summer of 2019 to all the mid-shore counites. The county specific meetings were generally all-day visits with OIT Team Leadership, county tours, and provider specific introductions and site-visits. MSBH requested a special visit with OOCC leadership in October 2019 to orient the OOCC to the Crisis Response System on the Eastern Shore, engage with the MSBH team, and invite partners supporting the State Opioid Response Grant (S.O.R.); A.F. Whitsitt Center leadership and representation from Queen Anne's, Wicomico, and Worcester counties Health Departments.

The MSPC continues to work on enhancing our contribution to the mid-shore community on being an integral community partner and resource to combat the opioid crisis. Each agency in the MSPC solicited funding by way of the S.O.R. grant this year to add additional recovery housing in each mid-shore county, Safe Stations on the Eastern Shore, and expand and sustain the crisis beds at the A.F. Whitsitt Center. Collectively, MSPC strives to be a regional leader with supporting solicitation of funding for our rural community to allow for access to, and support, the system of care.

MSPC is represented with by regional mid-shore Opioid Misuse Prevention Program (OMPP), and the University of Maryland's Shore Regional Health's mid-shore Opioid Task Force. MSPC members are independently responsible for representation and leadership of their county's LDAAC and MSBH supports representation on all five mid-shore LDAACs. MSBH continues to provide the administrative management of the Caroline County LDAAC since FY2016. In 2019, each mid-shore county had the pleasure of collaborating with partners from the Johns Hopkins Bloomberg School of Public Health (JHU) and one at the University of Maryland, College Park (UMD) on the Statewide Ethnographic Assessment of Drug Use and Services (SEADS) Project. This project worked with each county in a statewide assessment in Maryland designed to characterize the experiences of people who use drugs. Reports and provider presentations were extended for each mid-shore county.

The opioid crisis has added to the administrative and community engagement responsibilities of the MSPC with limited additional funding for the added local systems management responsibilities. The substantial awards that have been granted to Maryland have supported services that have been essential to the treatment and resource expansion for our community members in need of immediate access to treatment through the need for recovery housing and coordination of care to support their recovery. This focus has presented its challenges to manage with the ongoing funding solicitation demands to sustain programs, complex data reporting requirements, and procurement and grant processing delays that have impacted providers capacity to initiate and maintain services. MSPC has been a cross-agency support network for funding solicitation. MSBH has supported several mid-shore counties with assisting with soliciting, monitoring, and management of the programs reporting requirements. Additionally, regional collaboratives have developed as a result of these initiatives, for example, the Eastern Shore Safe Station Collaborative. However, the growth and reach of these initiatives have been taxing on the responsibilities of the MSPC and at times has presented challenges with ensuring quality management of the breadth of the administrative oversight for all behavioral health programming.

Recovery Housing:

The mid-shore region welcomed several new recovery houses in FY19. The State Opioid Response (S.O.R) grant, assisted several new houses to become operational or to expand services. The S.O.R funding has supported the Gratitude House in Dorchester County, Oxford Houses in Queen Anne's and Talbot Counties and a sober living house in Caroline County. Over the past year, in addition to the S.O.R. supported homes, the mid-shore has welcomed three new recovery houses. One male house in Kent, one male and one female house in Talbot and a female house in Dorchester. These new Recovery Houses are an extremely needed and welcomed addition to the mid-shore region.

MSPC is assisting M-CORR (Maryland Certification of Recovery Residences) certified recovery houses with the new challenges associated with the funding and transition-related issues. The

M-CORR certified houses under contract with local addition authorities, will now be paid through the Administrative Service Organization. Many providers are struggling with this transition which has caused a delay in authorizing requests. MSPC is working closely with the owners of these recovery houses to assist in this transition.

Closure of MAT Providers:

Over the past two years, Queen Anne's County has experienced the unexpected closure of two of the three MAT Providers in the county. This not only impacted Queen Anne (QA) county residents, it greatly affected the mid-shore region. Unfortunately, the local health department was not notified prior to the closure/reduction of services by the MAT Providers. This did not allow the local health department to prepare local providers or clients to make other treatment arrangements. The concern is that each of these providers operated a general practice, a pain management clinic and provided MAT at the same facility. This resulted in hundreds of clients, who were difficult to contact, to ensure they did not run out of MAT and enter withdrawal needlessly. Once the local health department was made aware of the closures, the surrounding counties were contacted to notify providers about the influx of potential new clients. The QA County Health Department informed the local emergency services of potential withdrawal/overdose cases. In each case, the clients were offered services as quickly as possible. However, this illustrates the desperate need for additional providers on the Shore, as Queen Anne's County has only one MAT provider.

Additional Crisis Beds at the A.F. Whitsitt Center:

In FY20, the State Opioid Response Grant(S.O.R.) crisis opioid bed grant, a partnership with Kent County Health Department (KCHD), the A.F. Whitsitt Center and MSBH, admitted 271 consumers dealing with an opioid use disorder (OUD). This partnership allows for *on demand* admission into the crisis opioid beds (COB), located at the Whitsitt Center. Some of the afterhours referral sources include: University of Maryland Shore Regional Hospital of Chestertown (UMSRHC), University of Maryland Shore Regional Hospital of Easton (UMSRHE), Eastern Shore Crisis Response and Safe Stations located on the Shore. The S.O.R. COB program grant period began in May 2018, the admissions numbered 204 unique consumers. In FY19 there were 223 unique admissions to the S.O.R. COB program.

The Emergency Management System (EMS) responded to 32 overdose calls in FY 19. Thus far in FY20, the EMS have responded to 32 opioid related overdose calls. UMSRMC of Chestertown has documented over 60 OUD emergency department (ED) visits in FY20, with ten being fatal opioid overdoses, a four-hundred percent increase over FY19.

The A.F. Whitsitt Center, with help from MSBH, is seeking funding avenues to open a 12-bed crisis center in a vacant wing at the center. This would increase bed availability for mental health beds and to individuals with OUD. The funding request for the Center is $350,000, which would cover

renovations, start-up, and staffing. It is projected that COB would become a self-sustaining unit within twelve months.

Safe Stations:
Mid Shore Behavioral Health applied for and was awarded the S.O.R. grant in January 2019. In August 2019, two Safe Stations launched, one in Wicomico and the other in Worcester County. By the end of December 2019, the Wicomico County Safe Station (located in the Resource Recovery Housing in Salisbury, MD) had served 95 consumers. Worcester County Safe Station, located at the 15th Street Fire House in Ocean City, MD, has served 40 consumers. Both Safe Stations are primarily a Peer Led Program.

Identified challenges of the Safe Station program include transportation costs, the need for quick access to crisis and recovery beds, misunderstandings about what a Safe Station is, and stigma at the local hospital about individuals with SUD. Barriers include but are not limited to limited options for residential treatment on the Shore and Safe Stations being 24/7 but not having access to 24/7 admissions for crisis or recovery beds on the Shore.

The Queen Anne's County Health Department (QAHD) was a part of the original Safe Station program planning process in FY19. While the community and its leaders attempted to implement a successful program, the barriers proved too large to overcome at the time. The lack of inpatient/detox services available on the Shore, made it not feasible for QAHD to move forward with having Safe Station.

Often, peers need support for the important work that they provide in the community. The first Tri-County Peer Support meeting was held in November 2019 and was attended by peers from Wicomico, Worcester, and Somerset Counties. The meeting was organized by and had participation from the Worcester and Wicomico Safe Station Peers. The meeting is a platform designed for peers to meet and to provide networking opportunities. Topics of discussion included: local resources, barriers and challenges, accomplishments and determine where further work is needed to educate the public around substance use and reducing stigma.
On May 21st, 2020, there will be a *Holistic Health Conference* at the Convention Center in Ocean City, MD. This event will be recovery focused and encourages Safe Station Peer participation. This conference is geared towards the mind, body, and spirit with keynote speaker Chris Herren.

Mobile Treatment Unit (MTU):
In FY19 Kent County Health Department, applied for and received a Buprenorphine Initiative Grant, which allowed our jurisdiction to purchase a vehicle for the No Harm in Helping (HiH) Initiative. This MTU provides harm reduction services, anti-stigma education in the community, and serves as a vise to deliver MAT injections to consumers residing in recovery residences in the mid-shore region and Cecil County.

There are recovery houses in the jurisdiction that are not in support of welcoming residents who are on prescribed MAT. This appears to be influenced by: stigma related to those still on partial or full agonist therapy, the lack of recovery residence staff, complications of safe storage, oversight and providing consumers daily access to their prescriptions. The ability to bring the MAT monthly injectable medications to recovery residences will increase MAT referral acceptance in the mid-shore region and Cecil County. The monthly injectables, Vivitrol and SUBLOCADE, could bring resolution to these obstacles. This will also allow more time for the OUD consumer to gain stability, supports and recovery skills.

Caroline County, along with the University of Maryland School of Psychiatry, is working through a HRSA grant to fund mobile treatment tele-MAT services in the jurisdiction using a 35-foot RV. (It was formally called the University of Maryland/ Eastern Shore Health Collaborative). It is also part of a research study conducted by Dr. Weintraub of the University of Maryland, which studies the effectiveness of mobile treatment MAT delivery vs. the traditional clinic approach. The goal for the first year was to see 50 clients and in the first seven months, 55 clients were seen on the unit. To date, 74 clients have been seen so far which is 10 months into the first year of operation. Overdose data for the jurisdiction was used to determine the overdose hot spots where the mobile treatment unit would concentrate efforts first as a priority to take treatment to that community. Currently, the mobile treatment unit is out 4 days per week seeing MAT clients in four different locations throughout the county. It is staffed each day with a Peer Recovery Specialist and a nurse. Each client is assessed by the physician and given a urinalysis to determine substances present. Prescriptions for Suboxone are called in to local pharmacies by the Physician in order to make it convenient for the clients obtaining their medication. Clients subjectively report a high level of satisfaction being seen in their community for MAT treatment on the mobile unit which also addresses the transportation issues on the Mid-Shore as well as accessibility of services. Plans include the possibility of expanding services to include harm reduction initiatives on the mobile treatment unit.

START Across the Region:

The mid-shore has initiated the implementation of the Sobriety Treatment and Recovery Teams (START) model and its strategies in Caroline, Dorchester, Queen Anne's, Kent and Talbot Counties. This model is administered by the local Department of Social Services (DSS), in collaboration with the Local Health Departments (HD). The mission of this program is to *improve safety, permanency, well-being and recovery outcomes for children, parents and families affected by trauma, substance use and mental health disorders.* START is an evidence-based approach to serve families involved in the child welfare system, who are affected by parental substance abuse. Mothers of substance exposed newborns (SENS), agree to the intensive fast response assistance, which is provided through the START program. Families with children under the age of six are also eligible for START assistance.

START Family Mentors (individuals in long-term recovery) will be employed by the local HDs and co-located in the DSS offices, where they will share cases with DSS staff. Recruitment and hiring of the Family Mentor is difficult because the requirements are that the individual have at least 2 years of documented recovery and some history with the DSS Child Welfare System. Kent and Caroline Counties have hired their Family Mentor and are in the process of completing their training process. Queen Anne's County is reviewing applications and should be in the interview process soon. Dorchester Counties is preparing to repost the position as they have not yet found a qualified candidate. Talbot County has recently hired a full-time Family Mentor for the county START program. Caroline County Behavioral Health has a full time SUD Counselor and a Peer Recovery Specialist who are located within DSS to directly assess, provide case management, treatment, and peer support to the clients of DSS who have substance use disorders.

The Family Mentor hiring process was lengthy but extremely helpful in the selection of the best candidate for the position. Interview questions, grading scale and a joint interview panel which included the Peer Recovery Specialist Supervisor, the supervisor and the family investment case manager from Dept. of Social Services (DSS) created a teamwork bond between the involved agencies. Kent County's START Family Mentor was hired on August 21, 2019, the first START program to open on the Eastern Shore. With this program being a family centered practice, it has really been helpful having a family mentor with lived experience as well as previous exposure to the DSS. The Family Mentor has been able to reduce stigma associated with the Child Welfare System, by gaining the trust of the families through motivational interviewing techniques and positive motivation for change talk.

The START partnership formed between the Recovery in Motion (RIM) and DSS has shown exponential benefit as a united link to help move our START consumers towards family wellness and a greater insight of the internal workings within the agencies. With this dynamic now in place, child safety, treatment/recovery support, sober parenting, other available resources, family support and increased assistance results in a greater motivation for change and thus increased expectation for improved outcomes. Women in START have double the sobriety rate of their non-START counterparts, sixty-six percent vs thirty-seven percent. Children in START are about half as likely to enter foster care, twenty-one percent vs forty-two percent. At case closure, over seventy-five percent of START-served children remained with or were reunified with their parent(s).

The dynamic between the Local Health Department, Department of Social Services (DSS), the Family Mentor and the families enrolled into the START Program has been beneficial to all involved. With this dynamic now in place, child safety, treatment/recovery support, sober parenting, community resources, family support and motivation for change are all addressed and allow the families an opportunity for improved outcomes. Other benefits of the START program are the change in perception of family's involvement, after giving birth to a substance exposed newborn (SEN), or parent(s) who are using substances, that DSS is going to automatically remove

their children from their homes. This program allows the families the opportunity to address the substance use disorder and for the family to remain intact if possible. This new perception from the DSS involved consumers, as well as the teamwork and improved communications between DSS, behavioral health programs, has enhanced the outcomes while supporting family unity and healing.

Harm Reduction:
Harm reduction is designed to be a person-centered method, meeting consumers where they are without judgement. Because harm reduction is often misunderstood, it is sometimes difficult to get the mid-shore community to buy-in, to the benefits of utilizing harm reduction strategies. A community that has conservative views and stigma associated with substance use, make it difficult to move forward with implementing harm-reduction.

Due to the community's lack of knowledge and understanding, some believe that by offering Fentanyl test strips, "safe use sites" are right behind them in being implemented soon after. Therefore, education is going to be key in getting the community on board with harm reduction programs that will be on the Shore. Harm Reduction in Baltimore City or in Western MD, may not be received if implemented in the same manner on the Eastern Shore.

Education about Harm Reduction is also needed for medical providers, business owners, faith-based agencies, and the public is critical for both the acceptance of harm reduction strategies as well as successful implementation. The MSPC is dedicated in working to identify strategies that will be implemented on the Shore to save lives and help our communities recover.

Across the mid-shore region, MSPC has been working to bring Harm Reduction initiatives to the community. Most of the Local Addictions Authorities in the mid-shore have enhanced their distribution of Narcan, training of community members and stakeholders, in addition to welcoming new initiatives such as Fentanyl testing strips and mobile treatment units for the screening and prescribing of MAT to the region. The mid-shore region has been recognized for the Mobile Treatment Unit in Caroline County, that is working to expand their reach in the county for mobile MAT screening and treatment and is a partner for some new grant activities targeting at risk farming and agricultural workers. In Kent County, the implementation of the "No Harm In Helping" mobile unit is a new initiative to provide outreach, screening and prescribing, administration of MAT, as well as mobile Narcan training and Fentanyl distribution. Education of the mid-shore stakeholders remains a priority for the MSPC group. The buy-in of community partners and providers to move towards a system that embraces a harm-reduction philosophy, and desires to enhance harm-reduction and implement the harm-reduction priorities is a challenge in the mid-shore. Partners are often more conservative with services and initiatives, so education remains at the forefront of the work. In March of 2020, MSBH will be hosting an all-day Harm Reduction training presented by Maryland's Harm Reduction Training Institute. The

hope of this training is to educate partners and identify new harm-reduction priorities that can be introduced and advanced existing initiatives in the mid-shore.

Risk Fatality Review Board:
Queen Anne's County is in the early stages of developing an Overdose Fatality Review Board. Once established, the data obtained would be combined with the data provided from the "OD2A Grant" to ensure that our local leaders and partner providers are aware of the full scope of the issue, and develop strategic plans to perform community education, outreach, implement programs and support our residents. Across the mid-shore region, the need for fatality review committees is felt. The absence of the review committee has been a resource gap in the region, and MSPC partners are hopeful that the work to implement the Review Board in Queen Anne's, will be complemented throughout the region in FY2021.

Kent County and the Opioid Crisis:
Kent County's A.F. Whitsitt Center is expanding bed-capacity with the addition of a 12-bed opioid crisis unit. The current capacity of forty treatment beds for level 3.7 women and men, and four primary mental health diagnosis beds, bring the static capacity to fifty-six behavioral health and opioid crisis-beds. The focused area of referrals for the crisis-beds, include Caroline, Cecil, Dorchester, Kent, Queen Anne's, and Talbot Counties.

Kent County is fortunate to have the support of MSBH, the Kent County LDACC, Kent Provider Meeting, homeless coalition group and the Regional Behavioral Health Advisory Committee (RBHAC), for the opiate crisis-bed expansion. Kent County is also fortunate to have a great Prevention Program, Recovery in Motion (peer lead) Center, Opioid Intervention Team with ED overdose interventions, No Harm in Helping for MAT injection and harm reduction measures, and a strong peer community. Other programs include: Walk in Wednesday, Temporary Cash Assistance (TCA), Sobriety Treatment and Recovery Team (START), Health General 8-505 forensic assessments and detention-based referral services.

One of the gaps is continuum of care regarding referral sources after discharge from AFWC. The wait list to appointments is two weeks and the wait to start MAT can be up to 4-6 weeks after the initial appointment. Another program has less than a week wait for appointments and quick access to MAT but the consumers are restricted to daytime appointments only. This makes maintaining employment after a 21-day inpatient stay difficult. Two other MAT programs in Kent County offer prescriptions without counseling services and these programs are open 1-day per week with limited day-time appointment hours.

Other hindrances to continuing care referrals pertains to consumers seeking recovery housing combined with MAT continuation need. Despite conditions of award mandating acceptance of MAT many recovery residences on the Eastern Shore screen the MAT referrals out. This

complicates the consumers' recovery as they often are faced with decisions of staying local near family or relocating to the Western Shore area. Some consumers make the dangerous decision to forgo MAT recommendation to gain acceptance into a recovery residence.

Kent County AF Whitsitt Center (AFWC) is expanding bed-capacity with the addition of a 12-bed opioid crisis unit. Our current capacity of forty treatment beds for level 3.7 W/M, 3.7 and 3.5 and four primary mental health diagnosis beds, which will not bring out static capacity to fifty-six behavioral health and opioid crisis-beds for our focused area of referrals on the Eastern Shore: Cecil, Kent, Queen Anne's, Caroline, Talbot and Dorchester.

Kent County has not determined any significant factor to explain how our fatal opiate overdose increased 400 percent. The two overdoses in CY 17-18 seemed daunting enough, then in CY 18-19 there were ten. One possible explanation could be that fentanyl has increasingly been used to lace more substances then just heroin. Kent County being the smallest populated county in the State of Maryland, 19,383, would show an exponential increase if overdoses fatalities outnumbered the previous year. This year Kent's opioid fatalities increase four-fold.

Maintaining Programs and Services

Eastern Shore Hospital Center:

In collaboration with BHA, Local Behavioral Health Authorities and Core Service Agencies are working with the Social Work and Psychiatry Departments of the Eastern Shore Hospital Center to enhance communication and partnership with transition planning for individuals returning to the community on the Eastern Shore. On January 21, 2020, representatives from all LBHA/CSA entities on the Eastern Shore met with the team at the Eastern Shore Hospital Center with BHA to discuss the needs and possible supports for the staff of the hospital as well as the priority areas for individuals that are presenting as appropriate for discharge. MSBH supported the organization of this meeting out of the identified need to enhance communication with the State Hospital representing the Eastern Shore. The growing needs of discharge planning is an area that local authorities are sensitive to, and the complexity of discharge planning circumstances continue to grow. The limited availability of provider capacity, housing, and transportation resources in the region present as complicating elements to a population that can often be challenging to plan for transition to the community in resource-rich communities. The Eastern Shore local authorities have expressed that involvement in supporting the team at ESHC is best practice and is one that needs enhancement. The group identified that trial solutions to enhanced communication across agencies will include an exchange of information about established meetings for ESCH and local involvement, consider development of a bi-weekly discharge planning call across local authorities with the social work department at ESHC. In addition, the psychiatry department at ESCH has expressed a willingness to be available for a peer to peer medication review prior to a discharge with a community provider and following a community placement for consultation. The group has committed to meeting quarterly over the course of

the year to address progress with communication and discharge planning support. The first meeting to establish progress will be held in March 2020.

Workforce in a Rural Landscape:

There is an evident shortage in the behavioral health workforce, specifically in the field of psychiatry. The workforce crisis is not unique to the mid-shore region, as it overwhelming impacts the entire state of Maryland. However, accompanied by the challenges already presented in a rural region, the impacts have been truly detrimental to the mid-shore. Our providers lack the capacity to support the growing demands of individuals seeking behavioral health services, our primary care providers are not fully integrated to adequately serve behavioral health needs, and the efficiency with access is a barrier to ensuring community-based services. As a way to bridge one of the many gaps in services, the local Behavioral Health Coalition of the Eastern Shore worked tirelessly in its advocacy for Senate Bill 944, which now allows for a psychiatric nurse practitioner to serve as a medical director for outpatient mental health clinics (OMHCs), including telehealth services. The passage of SB944 has given not only our region, but the entire state of Maryland, an invaluable opportunity to widen its workforce and increase accessibility to behavioral health services.

Dorchester County Behavioral Health Services (DCBHS) plans to sponsor one American Society of Addiction Medicine (ASAM) and DSM-5 training on the mid-shore for clinical Staff. The goal of the training is to increase knowledge and strengthen the clinical skills of clinicians, regarding diagnosis and placements, with hopes for more appropriate placements and positive outcomes for clients in the mid-shore region. DCBHS plans to train twenty clinicians in ASAM and DSM-5, to improve the efficiency of public and private providers.

DCBHS also plans to sponsor two required trainings for Peer Recovery Specialists. This is to assist peers in obtaining their certification and to increase their ability of gaining employment as a Peer Recovery Specialist. The peers (20 total in the mid-shore region) will gain the knowledge to better provide the necessary supports that are needed in recovery.

In collaboration with the Upper Shore Workforce Investment Board (USWIB), DCBHS will provide job training for individuals in recovery. Working closely with USWIB, DCBHS will recruit recovering individuals for the program and provide the supports necessary to complete the program. Peer Recovery Specialists will receive training from USWIB, to offer consistent information and supports regarding job counseling. DCBHS will refer ten individuals in recovery to employment training with the hope that 50% will subsequently gain employment.

MSPC will continue to provide advocacy and support to current efforts in the mid-shore region—an area steadily facing limited provider access and capacity. In addressing the evolving workforce crisis, it is critical to not only have provider capacity but clinicians who are properly trained in a wide-range of areas including trauma-informed best practices, crisis management, and cultural

and linguistic competency. MSPC will continue to provide trainings that equip providers with the necessary tools to best deliver quality, behavioral health services across the region. MSPC remains committed to supporting and addressing our network capacity, working with BHA and legislators, in addition to strengthening regional collaboration across care models with partnership and Warm Hand-off work with somatic care provider.

Credentialing:

The mid-shore region has continued to support providers who are impacted by the turnover of health professionals, including psychiatrists and nurse practitioners, as well as the barriers that accompany credentialing with reimbursement outside of the Public Behavioral Health System (PBHS). Since there is no universal credentialing process across providers, as private insurance carriers are not subject to the same regulations as Medicaid providers, this results in delayed credentialing and limited service availability. Delayed credentialing has a direct impact on consumers of the PBHS and those seeking access to care, in addition to the many challenges already present in our rural region. Our local Behavioral Health Coalition continues partner with local providers, state legislators, and other community stakeholders to advocate for decreased barriers to credentialing and a less cumbersome process. In conclusion, MSPC hopes to advocate for increased provider availability and access to treatment, in the mid-shore region.

The Justice Reinvestment Act:

Challenges include the impact of the Justice Reinvestment Act and Detention Centers experiencing reduced periods of incarceration for individuals including those with SRD and co-occurring disorders. Since the JRA took effect in 2017, the mandatory minimum sentences for repeat drug dealing crimes have been eliminated. Moreover, inmates serving prison sentences on a mandatory minimum sentence became eligible to petition for sentence reduction. The JRA also aimed to reduce DOC populations and recidivism while also increasing supervision by placing caps on maximum sentences for nonviolent offenders who violate probation on a technicality. The law also emphasizes treatment over incarceration with more placements in residential levels of care and psychiatric beds across the state. Conversely, however, local DOC recognizes lack of continuity of care and degeneration in conditions of individuals leaving Detention Centers. The DOC is seeing shorter periods of confinement due to the JRA and may be unable to provide timely transitional services once an inmate is released without authority or legal obligation to do so. There are additional needs to reinvest savings to complement the JRA, improve public safety, and decrease crime and recidivism such as reinvesting money in housing, education, economic development, job training and treating substance use and mental health disorders.

During FY19, TCHD requested and received STOP funding for FY2020 to incorporate an integrated approach to community coordination and treatment within the local Detention Center using qualified and licensed providers and TCAP Peer Support Specialist that will enter the Detention Center and meet with male and female inmates. TCHD plans to utilize health and human service

providers to strengthen inmate connections to multiple resources, including self-help programs, behavioral health, vocation, complex social needs, chronic pain, infectious disease, medication management, harm-reduction strategies and relapse prevention, specialty and benefits programs, and other resource coordination during periods of confinement and upon release.

MAT in Detention Centers:

Maryland has initiated pilot programs for MAT in detention center settings, in the following jurisdictions: Howard, Prince Georges, Montgomery, St. Mary's Counties. According to an April 6, 2019 article in the Baltimore Sun, which cited research by Brown University during a similar Rhode Island detention center MAT project, MAT in the jail and prison system showed 70% of individuals who entered the penial system suffered from a substance use disorder (SUD). The study also showed a 61% decrease in overdose deaths of those who were part of the MAT program, after they were release from prison.

The Kent County Detention Center and KCBH have partnered with Friends Research Institute (FRI) to implement a three-year research project. This project will provide oversight and follow-up to twelve returning citizens, after their release, who agree to receive MAT in the form of Vivitrol or Brexbi. Brexbi is a weekly or monthly injectable form of buprenorphine, approved by the FDA for research purposes. This study will follow a minimum of six Vivitrol and six Brexbi MAT injected returning citizens per year, throughout the three-year study. This project is awaiting Secretary Robert Neall's approval.

The Caroline County Detention Center and CCBH have partnered to provide counseling and peer support services to the county's inmate population. Caroline County receives SOR funding that provides Vivitrol for injections and re-entry funds for the detention center population. A Peer Recovery Specialist visits the detention center two days per week to work closely with the on-site Substance Use Counselor in identifying clients who may need additional services and peer support. STOP funding also supports inmates being able to receive ID's, clothing, and other items in preparation for their re-entry into the community. Outpatient Mental Health and/or SUD treatment is also coordinated so they will have an appointment for these services when they are released.

DCBHS, Dorchester County Detention Center and the University of Maryland are partnering to provide MAT in the Detention Center in FY20. The MAT services will be funded through a grant obtained by the University of Maryland and treatment services are currently funded by the Governor's Office of Crime Control and Prevention. The program will offer Intensive Outpatient Treatment (IOP) and Level I treatment with peer recovery support services and telehealth.

MSBH will continue to serve as the contract monitor of the Maryland Community Criminal Justice Treatment Program (MCCJTP) which provides mental health screening, treatment and education throughout the state of Maryland's penial system. MSPC will jointly advocate for MAT in the

mid-shore region's detention centers, improving the overall behavioral health treatment and services in the mid-shore.

Long term care for "aging population":

"Long term care" is a continuum that can address chronic illness through long-term services and supports in the community and may culminate in institutional care. A 'nursing home level of care', which focuses on somatic needs, is required to access care, although a behavioral health diagnosis may validate the chronic need for service. As the overall population ages and somatic needs become primary, any individual may qualify for an increased level of care. Both community and institutional providers need cross-training, to address the behavioral health needs of the traditional long-term care population. Finding the best way to provide this training and on-going support to both management and front-line caregivers, is an ongoing challenge due to staffing shortages, staff turnover and stigma. Frequent contact will continue with the region's providers of long-term services and supports to provide person-specific consultations, information about Engage Training, Mental Health First Aide and facility-specific assistance, in compliance with Trauma-Informed Care and Pre-Admission Screening and Resident Review compliances.

Continuum of Care (CoC), Housing Solutions Programs:

MSBH, as the lead agency for the Mid Shore Roundtable on Homelessness, was tasked with program planning, community partnership, application completion and partner training, budget development, systems procedures development, and oversight for the homeless services program in the mid-shore region. This is the second year of the newly consolidated state grant program. MSBH was awarded the mid-shore funding and has contracted with local CoC providers to manage the funds that support emergency shelter services, rapid rehousing and homeless prevention, outreach services, and support for the Homeless Management Information Systems (HMIS). Administratively, these funds have allowed MSBH to expand the CoC program, to include an additional team member to assist with the oversight and management of the expanded programmatic responsibilities. In this year's funding application, our region was awarded funding for an Unaccompanied Homeless Youth Program, a critical population that has been identified as needing services by the Roundtable partners. This is the first year of youth specific homeless services in the mid-shore, and it is being provided by His Hope Ministries in Caroline County. This funding has allowed for more coordination and oversight of homeless services in the region and has strengthened the overall CoC program.

Cultural and Linguistic Competency Strategic Plan:

Over the past few years, the Community Behavioral Health Plan guidelines have included instructions that local authorities must speak to how they will address cultural competency. This year, the BHA guidelines provided a template for the Cultural and Linguistic (CLC) Strategic Plan. This was helpful in directing how the MSPC will address the CLAS Standards under each of the BHA CLC Goals. Along with this template, there've been several BHA sponsored trainings that offer technical assistance for constructing the CLC Strategic Plan. Having the CLC Strategic Plan

template, allowed for a formal structure to address improving cultural and linguistic competency and to execute the plan throughout FY21. This year, the challenge in constructing the plan with MSPC, was to consider the nuances of each county and the needs of the mid-shore region. Although the mid-shore local authority CLAS self-assessments were completed separately, we were able to agree on the CLAS Standards that will be addressed under each pf the BHA CLC Goal, and to create a combined FY21 CLC Strategic Plan.

Competitive Grants-Mobile Crisis Stabilization:

In recent years, there has been a trend with local funding for several programs transitioning to competitive grant cycles. While our local systems managers in the region have experience and success applying for competitive grants, funding that has been historically annualized in allocation transitioning to competitive in the State, presents several challenges. Planning and effective program implementation becomes difficult when you do not have a clear picture on the amount of funding that will be awarded, in addition to the need to anticipate reapplying for the funds annually. Competitive grants also are challenging for smaller rural jurisdictions were there may be a lack of services. Larger jurisdictions that are resource rich and showing positive outcomes more rapidly, often receive the largest amount of funding, leaving areas that are already struggling in cycle that can be hard to break. Funding may be limited due to under-performance of activity which impacts the ability to have an impact on positive outcomes due to lack of resources. Examples of awards that have presented as a challenge and have impacted the mid-shore region's delivery of services are the Substance Abuse Outcome Partnership Grant (STOP Grant) initiative as well as the Mobile Health Stabilization Services Grant.

Proposed Relocation of Inpatient Acute Psychiatric Beds:

In May of 2019, the University of Maryland's Shore Regional Health Hospital System (UM SRH), announced its intention to explore the relocation of the acute inpatient psychiatric treatment beds from their hospital in Cambridge, Maryland (Dorchester County) to Chestertown, Maryland (Kent County) in the summer of 2021. The proposed move stems from the planning and development that the UM SRH is in the process of executing with their regional hospital development planning. The Cambridge hospital is slated to close and move to a free-standing Emergency Department in 2021. The closure of the facility initiated the evaluation of the transition of the inpatient psychiatric beds withing the UM SRH system. A presentation from UM SRH Leadership regarding the proposed move was organized by MSBH on July 8, 2019 with community partners, MSBH Board of Directors, and the Regional Behavioral Health Advisory Committee.

The proposal to move the inpatient beds to the Chestertown Hospital location was endorsed by the UM SRH Board of Directors in August of 2019 to apply to the Maryland Health Care Commission (MHCC) for approval to relocate inpatient behavioral health beds and to add Intensive Outpatient Program and Bridge Clinic programs to Chestertown. As a result of this application to move the inpatient beds the mid-shore provider community has expressed

concerns as well as outreach to state leadership in hopes of reevaluating this application for the movement of the beds. There has been an expressed desire from several mid-shore providers to have the hospital and the Maryland Healthcare Commission review the placement of the beds in the Easton (Talbot County) hospital.

Providers have expressed concerns in the following areas if the application to relocate the inpatient beds is approved: Travel for staff and providers from their homes to work, transportation needs of patients and families, challenges in recruitment of additional staff, and the availability of community-based outpatient services to support discharged patients throughout the region.

As a result of the shift and provider support needs, MSBH has initiated local advisory groups, in particular MSBH Board of Directors and the Regional Behavioral Health Advisory Committee (RBHAC) to be a partner in forming a community forum group to focus on the needs that a transition in provider location and community impact may have in hopes of addressing the needs and gaps in services and community preparedness, prior to 2021. The formation of this group has been an inclusive process with UM SRH leadership to ensure the support of both the providers in the region and the hospital in planning for and addressing the needs of our behavioral health system. The Community Behavioral Health Partnership Committee is planning to convene its first meeting on March 11, 2020.

Transition of the ASO:
The transition of Maryland's Administrative Service Organization (ASO) is a change that the MSPC has been anticipating and supporting as the January 1, 2020 date approached from the change from Beacon Health Options to Optum Maryland. MSPC and systems managers in the state are peripheral supports and authorities for the ASO, with supporting the provider community, quality oversight and consumer access to the PBHS. The transition to Optum Maryland has presented several challenges on the local level with onboarding to the new system for reimbursement, enrollment, claims management, and consumer enrollment in the data platform. MSPC has extended support to both our provider community and Optum Leadership and MDH to assist with mitigating challenges that have presented as a result of the transition. This system change has impacted the work of the MSPC and the moral of our mid-shore behavioral health provider community.

The Whitsitt Center has begun to seek other funding resources for consumers being discharged without housing, and/or in need of a supportive recovery environment. During the transition from inpatient treatment to community housing, Care Coordinators and Peer Recovery Specialists (PRS) assist in the stabilization process. This includes housing funding for up to sixty-days, transportation and linkage to needed community services and treatment. MSPC will continue to prioritize supporting all entities with improving the transition to the new ASO and will continue to advocate for an ASO structure in our PBHS.

24/7 SRD Treatment Services, Withdrawal Management:
There are currently no providers who offer 24/7 detox or intake services for recovery clients. While the stages of change play into a person's choice to enter into recovery, due to the brain being altered due to substance consumption, when someone states they are ready to go to treatment, we, as providers need to offer these services at the time they are ready. Currently, the quickest someone can enter treatment is 24 hours. An entire day, which in the drug use landscape we find ourselves in currently, where Fentanyl is everywhere, and Carfentanil making an entrance, 24 hours is too long. The Whitsitt Center has the capability, however, lacks the capital to upgrade and improve their current building to accommodate the need on the Shore.

Integration:
The behavioral health integration continues to pose problems for the mid-shore LAA's as the number of reports, data requests and meetings increase. The LAA in each Jurisdiction realizes the importance of data collection and the need to analyze that data to identify gaps in the system and improve services. LAA's are not only providing behavioral health systems planning and reconstruction in the mid-shore jurisdictions, LAA's are assuming additional functions such as managing the Opioid Operations Command Center's OITs, forming collaborations with hospitals and primary care groups to name a few of the new function. These activities are happening as LAA's continue to provide treatment services and program oversight as necessary in jurisdictions where the private sector has not rushed in to address the opioid epidemic or the continuing increase of cocaine and alcohol abuse. The administrative structure of the jurisdictions did not change when these additional duties were passed down from the Behavioral Health Administration and there has been little change with the additional responsibilities. To meet the current needs of our behavioral health systems, the administrative structures of the LAA offices must evolve to a more robust and dynamic system management entity. This evolution requires staffing reconfigurations that will allow LAA offices the ability to collect, analyze, and implement system changes more efficiently and to maintain constant leadership.

Administration Concerns:
Barriers to program and contract implementations include delayed receipts of COA's which impact the jurisdictions ability to contract and implement programs according. The administrative oversight of the system is complex work in nature and when systems are delayed and communication is inhibited, this impacts quality of services for our community. MSPC is hopeful that with enhanced relationships of our mid-shore peers and with BHA enhanced processes, the mid-shore region will benefit

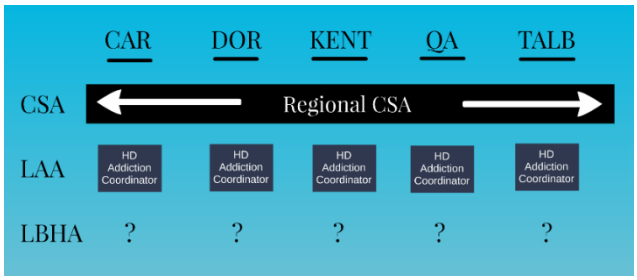
Faith-based Initiative:
Dorchester County Behavioral Health Services (DCBHS) plans to implement a faith-based initiative in Dorchester County, partnering with three Faith-based Organizations (FBO) to develop and implement community recovery support programs/services for those suffering from a

Substance Use Disorder. The goal of this initiative is to educate the FBOs about SUD and encourage them to develop a program or service in the community to support individuals in recovery. The LAA and Peer Recovery Specialists will act as a *support team*, providing SUD education and Narcan training. The support team will offer ideas regarding services that the FBO might offer in the community. The FBO will decide what type of service or support they want to develop, and DCBHS will assist in the development and implementation of that service. Once this is done, the Peer Recovery Specialist will act as a liaison between the FBO and DCBHS providing support, resources, and facilitating referrals to needed services and treatment. The Peer Recovery Specialist will also meet with the FBO, on a regular basis, for problem solving and as needed. MSPC will support efforts across the mid-shore, to boost involvement with the faith-based community.

C. ORGANIZATIONAL/ REORGNIZATIONAL STRUCTURE OF THE CSA, LAA, & LBHA IN THE MID-SHORE

Local Systems Management Integration

Historical Systems Management in the Mid-Shore:
In August 2014, the Health Officers and Local Addiction Authority (LAA) Directors of the mid-shore counties convened with MSBH leadership to discuss the impending legislation requiring revision of Health General Article §10–1201 to 1203, the statute defining the core service agency (CSA), expanded to include definitions for the local addictions authority and local behavioral health authority. At that time, the structure was as follows:



MSBH has served as the regional CSA to the mid-shore region since its inception as a private non-profit entity in 1992, with Letters of Agreement from all five county governments and support from all mid-shore county Health Officers. The region's Health Departments were providing Substance-Related Disorder (SRD) and addiction treatment services. While no decisions were made at this meeting, the questions for discernment were presented, and the potential for integration was offered for consideration.

In November 2014, BHA issued a letter to each county Health Department, allocating administrative funding for the first substance-related systems planning and management responsibilities of LAA for the second half of FY2015, beginning January 1, 2015. This letter clearly articulated the need to firewall systems planning and management functions from the provision of treatment and encouraged partnership with CSAs in doing so.

In the mid-shore region, each county instituted a Local Addictions Authority. Initially, all LAA were providing services to residents in their respective counties. As the fee-for-service structure and LAA responsibilities developed, Queen Anne's county as an early adopter, and Talbot county elected to discontinue their direct-service responsibilities and concentrate on local addiction authority systems management in their counites.

To support the LAA transition process and new systems management responsibilities, MSBH executed the following functions for all mid-shore county LAA(s)/Health Departments during FY2015 and FY2016:

1. Enhanced contract monitoring
2. Investigation of complaints about Public Behavioral Health System SRD treatment

3. Monitoring and correcting deficiencies of SRD treatment
4. Problem-solving difficult SRD patient situations
5. Assisting BHA and the ASO in placing individuals in need of SRD treatment

In January 2016, BHA issued an expanded definition of the role of the LAA that delineated 44 functions, adding 39 functions to the original five. MSBH was informed that during technical assistance sessions with BHA, the Health Departments were encouraged not to collaborate with the CSA, but instead retain the administrative funding in preparation for the treatment services grants ending, execute the LAA functions and determine another means of firewalling and resolving any conflict of interest concerns.

Two of the five counties, Talbot and Dorchester, contracted with MSBH in FY2017 for limited LBHA integrated functioning. Queen Anne's County moved all ambulatory substance-related treatment to the fee-for-service structure as of July 1, 2016, and no longer had any conflict of interest, therefore an independent LAA. Kent and Caroline counties collaborated to resolve conflict of interest concerns and retain full LAA functions. Caroline County contracted only for the leadership of the Local Drug and Alcohol Abuse Council (LDAAC) strategic planning process, planning, and meeting facilitation.

In FY2018, MSBH contracted with Dorchester and Queen Anne's counties to serve as the LAA for limited integrated functioning like the responsibilities in FY2017. Talbot County did not enter a contract with MSBH during FY2018 and supported the independent LAA systems management responsibility. MSBH entered a second contract with Caroline County Local Government during FY2018 to continue the role of LDAAC for strategic planning, regional provider meeting support, and meeting facilitation.

In FY2019 and FY2020, MSBH sustained contracted responsibilities with Dorchester County to serve as the partial LAA for systems management and oversight functions. MSBH continues to serve Caroline County Local Government and Caroline County Health Department with the role of LDAAC management and administrator for strategic planning, regional provider meeting support, and county awareness initiatives.

	FY2015 ***1/2015-6/2015***	**FY2016** ***7/2015-6/2016***	**FY2017** ***7/2016-6/2017***	**FY2018** ***7/2017-6/2018***	**FY2019** **7/2018-6/2019**	**FY2020** **7/2019-6/2020**
Caroline	5 functions	5 functions	LDAAC	LDAAC	LDAAC	LDDAC
Dorchester	5 functions	5 functions	24 Functions Partial LAA	24 Functions Partial LAA	24 Functions Partial LAA	24 Functions Partial LAA
Kent	5 functions	5 functions	No integrated Agreement	No integrated Agreement	No integrated Agreement	No integrated Agreement
Queen Anne's	5 functions	5 functions	No integrated Agreement	24 functions Partial LAA	No integrated Agreement	No integrated Agreement
Talbot	5 functions	5 functions	24 Functions Partial LAA	No integrated Agreement	No integrated Agreement	No integrated Agreement

MSBH has been honored to support the LAA integrated functioning in parts of our region, and in FY2021, MSPC will continue assess and plan for integrated responsibilities for the mid-shore region. MSPC aspires to support our region by enhancing oversight and collaborative systems managers, with the goal of working towards an integrated region/jurisdiction.

Mid-Shore Local Systems Management Planning:
MSPC strives to support the mid-shore community and is invested in working towards an enhanced and integrated systems management structure. The goal of MSPC is to engage the mid-shore region's Health Officers and local county governments to support the planning for an integrated local systems strategic plan that supports movement towards functional for formal integration in the future.

MSPC has identified that behavioral health systems management integration is a top priority and has been a focus over the last several years within our regional systems management group. The FY2021 Integrated Community Behavioral Health Plan supports goals and strategies to assist MSPC with moving towards an integrated systems management planning and implementation process. The mid-shore is a unique region with MSBH remaining as the last regional local authority in the State of Maryland. MSBH as the Core Service Agency (CSA), has prioritized the relationship with and respect for the responsibilities of each Local Addiction Authority (LAA) in the mid-shore. The relationship and partnership with our LAA peers is paramount in the work that we are currently doing to meet the needs of the community, with the aspiration that through integration, the person-centered experience and "no wrong door" philosophy of care will be enriched.

The 2017 Legislative Report on Integration Planning for Behavioral Health Plan has driven the work of MSPC over the last three years in particular. The directive of *"a policy imperative of fully integrated behavioral health services in the State"* has supported the need for local planning in the mid-shore region. MSBH served on the Behavioral Health Integration Advisory Group to support the development of the Behavioral Health Local Systems Management Plan that was released in July of 2018. MSPC leadership from MSBH and Queen Anne's County have served on the Behavioral Health Integration Advisory Council; MSBH since September 2018, Queen Anne's County since September 2019. This group will meet through the course of the state's integration transition through FY2022. MSBH has led the mid-shore Local Systems Integration Workgroup that has convened since July 2018. The work of our local group has and will continue to support our planning and strategic assessment of the elements of integration and systems management needed to integrate. MSPC hopes to support a structure in the mid-shore that is respectful of the local county level role, supported by a regional system management entity. MSPC is involving regional stakeholders, leadership, and advisory entities with plan development, implementation and assessment of the impact on the regional system of care.

In July 2018, the Mid-Shore Counties Local Systems Management Integration Workgroup was developed. The membership of this groups is as follows:

Caroline County Health Department:
Scott Leroy, MPH, MS, Health Officer
Terri Ross, LCSW-C, C-ASWCM, Caroline County Behavioral Health Director and LAA
Dorchester County Health Department:
Roger Harrell, MHA, Health Officer
Donald Hall, MHS, LCADC, Dorchester County Behavioral Health Program Director and LAA
Kent County Health Department:
William Webb, MPH, Health Officer
Joseph Jones, MHS, LCADC, LAA Director
Mid-Shore Counties Core Service Agency:
Kathryn Dilley, LCSW-C, Executive Director, Mid Shore Behavioral Health, Inc.
Patricia Doyle, Finance Director, Mid Shore Behavioral Health, Inc.
Queen Anne's County Health Department:
Dr. Joseph Ciotola, M.D., Health Officer and Medical Director
Maggie Thomas, MS, Director, Local Addictions Authority
Talbot County Health Department:
Dr. Fredia Wadley, M.D., Health Officer
Sarah Cloxton, LCADC, LGPC, RPS, Talbot County Addictions Program Director and LAA

The workgroup has met formally at a minimal quarterly, and has convened several times for local systems planning, integration self-assessment, and to complete the FY2021 Community Behavioral Health Plan. In February 2019, the group met and organized a group statement of purpose and integration plan intention to submit to the Behavioral Health Administration and Maryland Department of Health leadership.

In response to the Behavioral Health Administration's mandate for local systems management integration planning, the five mid-shore counties convened a local planning group to address the directive, and to take steps to plan accordingly.

The Local Systems Management Integration Workgroup formed in July of 2018 to begin the work of assessing the infrastructure of our unique rural and multi-county system. Workgroup activity is focused on the development of a successful systems management structure that is consumer and community focused.

To date, the workgroup has met nine times. The most recent meeting was a three-hour work session held on February 25, 2019.

Consensus

The workgroup members agree that it is our goal for the mid-shore counties' local authorities to work towards an integrated regional model of systems management. Further, members of the group agree that our vision of an integrated model will best serve the community if we

demonstrate a truly integrated model reflecting not just a fiscal integrated model, but a model that is representative of addressing programmatic, community need, and person-centered integrated systems management.

The integration plan for the mid-shore is complex. In order to successfully integrate, with the goal of a regional Local Behavioral Health Authority, we are developing a phase-in model of integration that can be achieved over a three- to five-year period.

Requirements for Success

The workgroup's agreement to work toward a fully integrated regional system comes with multiple risks and areas of concern. All members of the group concur that these issues must be mitigated in order to accomplish true integration—as opposed to a fiscal pass-through model. The essential elements for successful integration are the following:

- *Behavioral Health Administration endorsement of our vision and what is needed to successfully implement the phase-in integration plan*
- *Development of the regional integrated structure*
- *Development of the three-to five-year phase-in integration timeline*
- *Increase in Administrative funding to support the operation of a multi-county integrated local authority*
- *Members of the workgroup will have the opportunity to assist in determining the appropriate funding needed for quality systems management activities*
- *Current allocated funding to the local authorities; grant, programmatic, and administrative dollars, will to be held harmless*

Initial Joint Project *A significant integration milestone activity has been unanimously agreed upon by the members of the workgroup. For FY2021, the regional CSA and five county-based LAAs will collaborate on our annual plans as a group, with an end product of one integrated plan for the region. This activity will be an insightful process that allows our group to gain a greater understanding of the needs of our community, streamline our planning, and solicit resources to effectively and efficiently enhance the quality of services and supports for our consumers.*

The development of this group statement of intention with integration planning has served as a milestone of the work of the MSPC and workgroup. The workgroup has referenced this as guiding document to the plan to move towards a regional integrated system, and do so in a manner that is strategic, community and needs-focused, fiscally sensitive, and respective of our systems structure needs to serve the mid-shore.

In addition to the workgroup's development of the integration plan, the workgroup has convened and collaborated to complete the Local Systems Management Integration Self-Assessment Tool. The self-assessment tool has been required to be completed by all of Maryland's local authorities due to BHA first in October 2018, and most recently in October 2019. MSPC submitted individual self-assessments in 2018 (FY2019) and a combined response representative of all six local

authorities in 2019 (FY2020). Each jurisdiction was tasked with measuring progress on the seven domains of integration:

1. Leadership and Governance
2. Budgeting and Operations
3. Planning and Data-driven Decision Making
4. Quality
5. Public Outreach, Individual and Family Education
6. Stakeholder Collaboration
7. Workforce

Fiscal Year Response	Domain(s)	Leadership & Governance	Budgeting & Operations	Planning & Data Driven Decision Making	Quality	Public Outreach, Individual and Family Education	Stakeholder Collaboration	Workforce
FY2019	County/Entity							
FY2019	Caroline County LAA	1	1	1	1	1	1	1
FY2019	Dorchester County LAA	2	2	2	2	2	2	2
FY2019	Kent County LAA	2	1	1	1	2	1	1
FY2019	Queen Anne's County LAA	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response
FY2019	Talbot County LAA	1	1	1	1	1	1	1
FY2019	Mid Shore Behavioral Health, Inc. CSA	1	1	1	2	2	2	1
FY2020	Integrated Self-Assessment Response LAAs and MSBH	2	1	2	2	2	2	2

Integration Range:
Level 1: Coordinated Communication/Approaching
Level 2: Formal Collaboration/Capable
Level 3: Integrated/Enhanced

MSPC has shown movement across the integration domains over the course of the last two years. MSPC has made significant progress demonstrated by the capacity and support to complete the mid-shore self-assessment as one group, as well as progress in three domains, Leadership and Governance, Planning and Data-Driven Decision Making, and Workforce.

As a result of the demonstrated progress towards local systems management integration, MSPC has been asked by BHA to serve as a peer support to local jurisdictions for the following:

- Collective Experience with integrated crisis response systems
- Development of a regional annual behavioral health plan
- Contracting, contract monitoring, and regionalization of quality measure tool development

Organizational Structure: Mid-shore Counties Current Structure

Caroline County Local Addictions Authority Organizational Structure:

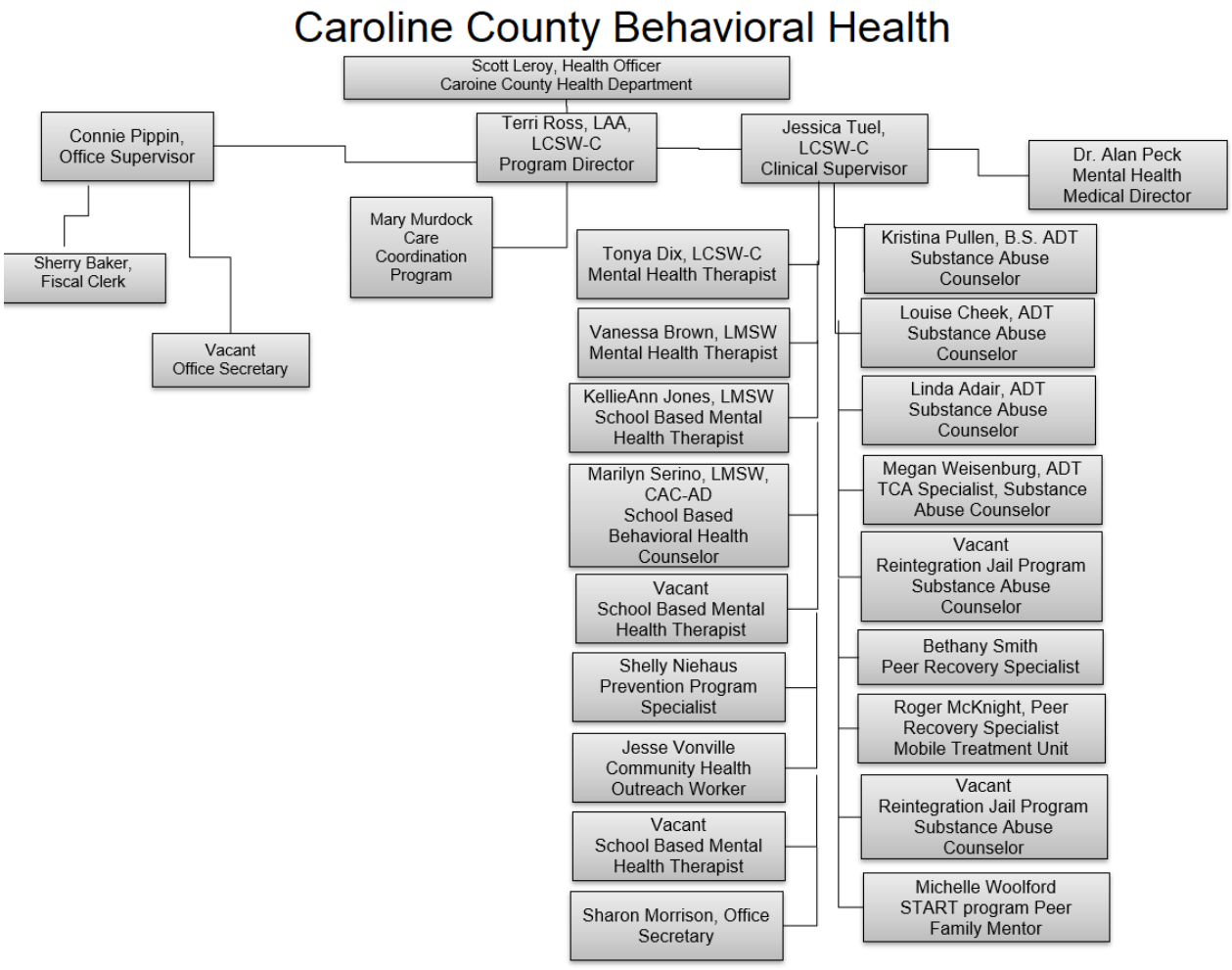
Caroline County's mission is to provide quality therapeutic, prevention, referral, community outreach and other related services to the residents of Caroline County. Qualified, trained professionals deliver these services to all residents impacted by substance use and mental health disorders. Caroline County Behavioral Health (CCBH) is dedicated to the community's wellness and recovery from behavioral health disorders while striving to gain the highest quality of life for all individuals and their families. CCBH plans to continue to provide and make available these desired services over the lifespan of its citizens.

Caroline County Behavioral Health (CCBH) resides within the Caroline County Health Department. Caroline County is a CARF-accredited direct service provider of outpatient Mental Health, Substance Use Disorders treatment as well as Prevention services. Caroline County provide services in the clinic setting, school-based treatment, the detention center, the Dept. of Social Services, and Mobile Treatment MAT in the community. CCBH received a three-year Commission on Accreditation Rehabilitation Facilities (CARF) accreditation on January 18, 2018. CCBH employs nine employees with a SUD focus and six employees for Mental Health services with one of them specializing in co-occurring disorders. Of the total employees who can render billable services, five is for SUD, and six for Mental Health as well as our on-site Psychiatrist who is available for the COMAR- mandated 20 hours per week. We also have some additional limited tele-psych hours available for our clients in Mental Health provided by a contract with a Sheppard Pratt provider. CCBH contracts with University of Maryland School of Psychiatry for our tele-buprenorphine clinics (including Mobile Treatment) to meet our consumers' needs for MAT-Suboxone. The CCBH system is challenged by rural features and low socio-economic development. These factors intensify SUD and MHD in our jurisdiction In addition, we continue to be challenged with the State of Maryland's Tort Law which impacts on our ability to apply as a provider of services with private insurance companies.

Caroline County's system program structure includes oversight of the following programs: Alcohol and other Drugs Prevention Program, outpatient Mental Health Disorders treatment, School-based Mental Health treatment and SUD Assessment services, outpatient Substance Use Disorders treatment, Mobile Treatment Unit services for mobile outpatient tele-MAT, DWI Education Program, Medication Assisted Treatment (MAT) for Vivitrol and Buprenorphine, Tele-buprenorphine, tele-psychiatry, SUD and MH Client Transportation Program, Caroline Detention Center Program for SUD assessment and Peer Recovery Specialist Re-entry Program, SUD Assessment, Treatment, and Court status reports for the Caroline County Drug Court Program, Temporary Cash Assistance and START Programs Counselor and Peer for Department of Social Services, Community Health Outreach worker, Peer Recovery Specialists and Care Coordination

for recovery housing. We also have the oversight of substance use disorder programs in our jurisdiction as the Local Addictions Authority (LAA).

Caroline County participates in the Local Drug and Alcohol Council, Drug Free Caroline Coalition, Opioid Misuse Prevention Program (OMPP), the Local Care Team, Caroline County Provider's Meeting, various spiritual-based community events, fairs, drug take back events, many other school prevention events, support internships within CCBH, Maryland Coalition of Families, ACES, and closely works with Mid Shore Behavioral Health, Inc. toward integration within the mid-shore.



Dorchester County Local Addictions Authority Organizational Structure:

In August 2014, the Dorchester County Health Officer, the Local Addictions Authority (LAA) /Director of Addiction Services (now known as Behavioral Health Services) and Mid Shore Behavioral Health (MSBH) leadership convened to discuss the impending legislation requiring revision of Health General Article §10–1201 to 1203, the statute defining the Core Service Agency

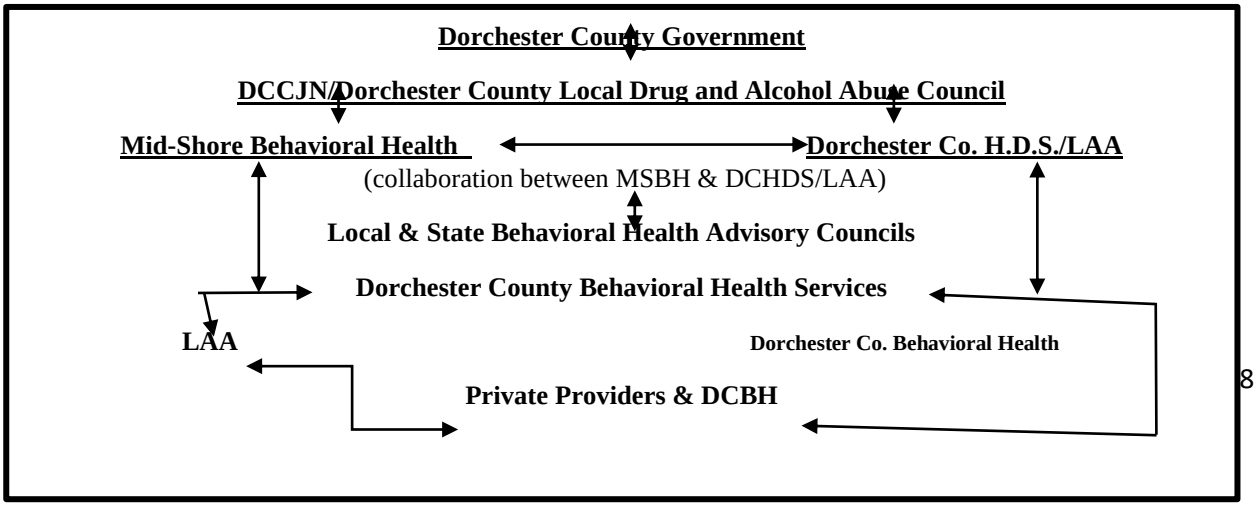
(CSA), expanding to include definitions for the local addictions authority, and local behavioral health authority. In November 2014, BHA issued a letter to each county health department, allocating administrative funding for the first Substance Use Disorder related systems planning and management responsibilities of Local Addictions Authorities, for the second half of FY2015, beginning January 1, 2015. This letter clearly articulated the need to firewall systems planning and management functions from the provision of treatment, and strongly encouraged a partnership with the CSA in doing so. The CSA is now known as Mid-Shore Behavioral Health (MSBH). For the second half of FY2015 to the present time, MSBH has executed the following functions for the Dorchester County Health Department:

1. Investigate complaints regarding Public Behavioral Health System SUD treatment.
2. Monitoring and overseeing the correction of deficiencies in SUD treatment.
3. Problem solving difficult SUD patient situations.
4. Assisting BHA and the ASO in placing individuals in need of SUD treatment.

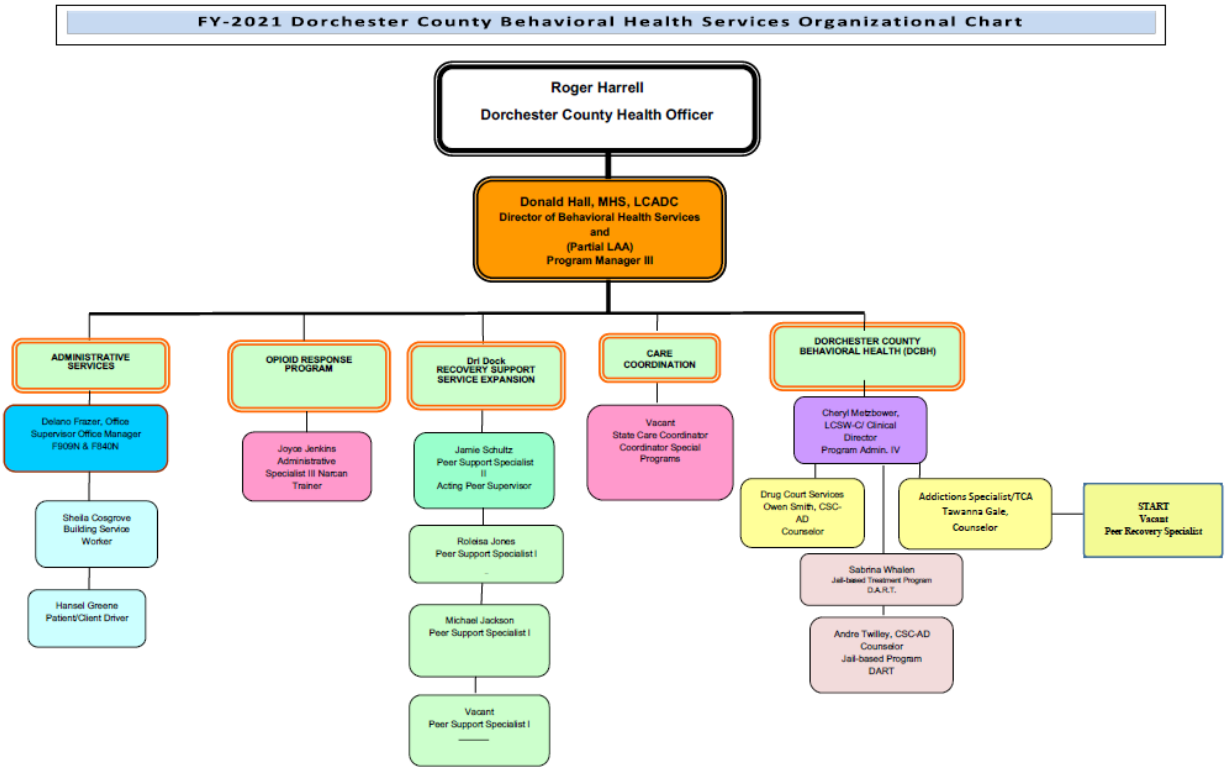
In January 2016, BHA issued an expanded definition of the role of the Local Addictions Authority (LAA) that delineated forty-four (44) functions, opposed to the five (5) originally issued. As the meetings with MSBH continued in FY2017, it was agreed upon that MSBH would share in limited LBHA integrated functioning with the Dorchester County Director of Behavioral Health Services to alleviate any question of impropriety or the appearance of a conflict of interest that may have existed. This was done in the interest of public health as Dorchester County Health Department continued to provide SUD treatment, now behavioral health treatment in the county. Dorchester County Health Department maintains its' position that the current provider structure, including the public system in the county is not sufficient to address the SUD/BH demands.

Figure 1, describes the organizational structure of the local behavioral health authority (MSBH & LAA), the relationships among the local behavioral health authorities, local government, local and state behavioral health advisory councils, Dorchester County Criminal Justice Network/Local Drug and Alcohol Abuse Councils (DCCJN/LDAAC), and provider agencies. Please note that the local mental health advisory councils are directly in collaboration with Mid-Shore Behavioral Health (MSBH). This design allows for bi-directional communication between local government, MSBH/LAA, local and state advisory councils, public and private providers, community representative and recovery representatives.

Figure 1. Organizational Structure of Local Behavioral Health Authority



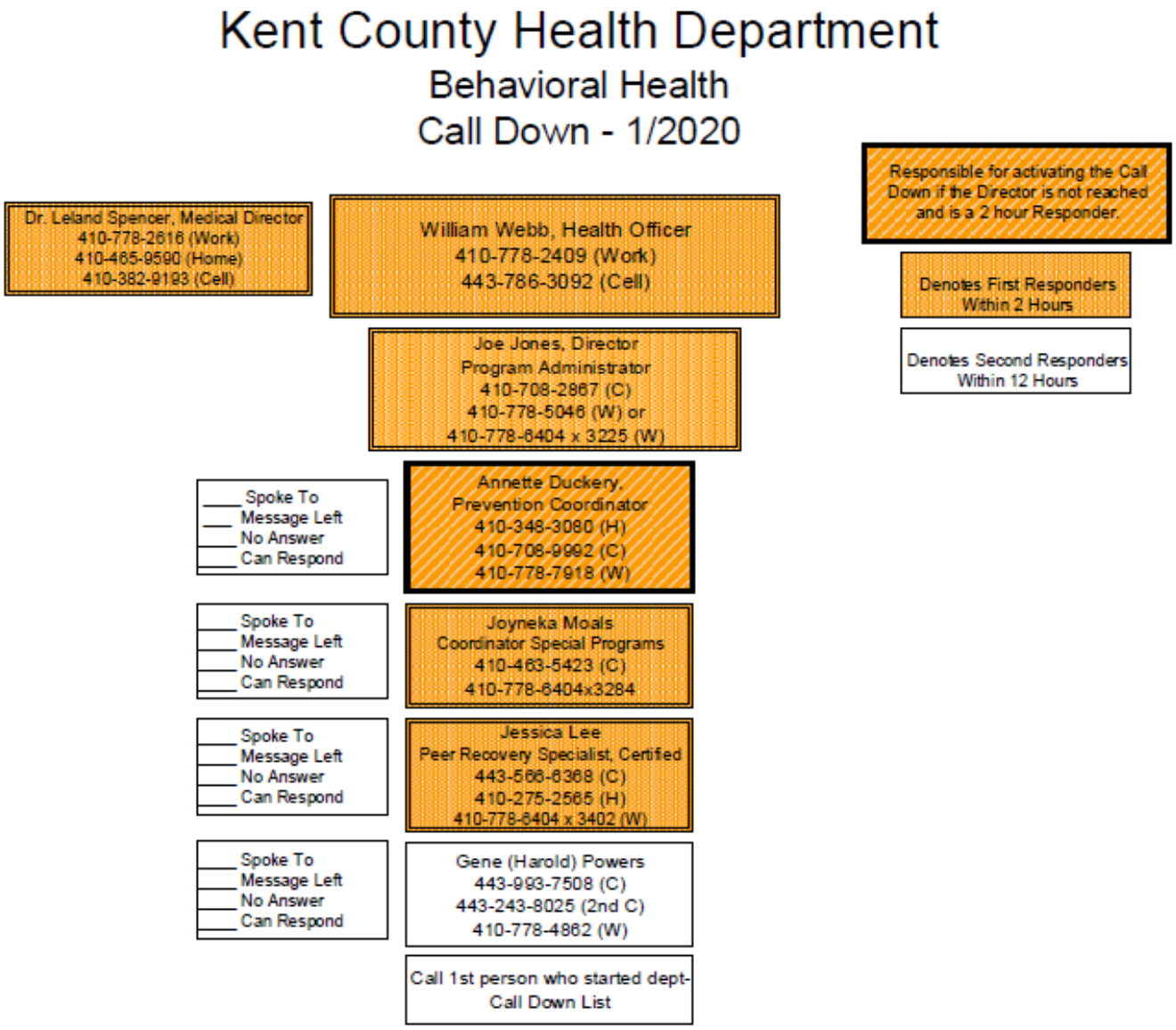
MSBH continues to work with the Dorchester County Behavioral Health Services to facilitate countywide provider meetings as a part of the LAA function partnership, collaboration and integration. The provider meetings address concerns about the SUD/BH service systems, access, capacity and quality of care in Dorchester County. There is at least one representative from MSBH serving on Dorchester County's DCCJN/LDAAC. There is cross-systems membership as several individuals serve on the LDAAC, RBHAC and the Local Management Board (LMB) providing enhanced cross-systems collaboration and integration. In additional, Dorchester County Criminal Justice Network/Local Drug and Alcohol Council (DCCJN/LDAAC) and the Opioid Operations Command Center (OOCC) share many of the same members offering increased inter-agency collaboration, planning and efficient use of resources.



Kent County Local Addictions Authority Organizational Structure:

The organizational structure of the Local Addictions Authority (LAA) for Kent County at present is a shared position. The Director of AF Whitsitt and the LAA are one of the same. There is a Memorandum of Understanding (MOU) with Caroline County LAA to mitigate conflicts of interest.

Identified as a conflict of interest is for Kent and Caroline County are: LAA exemption request for treatment payment from ASO, critical incident reports, audits of providers in LAA's jurisdiction and investigations of programs in the LAA's jurisdiction. The Kent LAA will appear to or handle exemptions for Caroline County and vise-a-versa.



The Kent County Local Drug and Alcohol Council (LDAAC) and Opioid Intervention Team (OIT) are one in the same with representation on council's team members. The OIT addresses the same issues and the same population regarding the opioid epidemic. As we have limited resources and time Local Advisory Councils members are also comprised of LDAAC and OIT members. This also gives us opportunity to inform of obstacles, new developments and progress at the LDAAC/OIT Council meetings.

Organizational Chart LDAAC-OIT-Local Advisory Councils

Local Drug and Alcohol Council	OIT	Local Advisory Councils
Health Officer & Chair of LDAAC Kent County Health Department	Health Officer & Chair of LDAAC Kent County Health Department	Opioid Overdose Fatality Review Council
Director of Whitsitt Ctr & Co Chair	Director of Whitsitt Ctr & Co Chair	PAST Program Advisory Council
Student Services KC Public Schools	Student Services KC Public Schools	OOCC Advisory Council
Behavioral Health Coordinator Mid Shore Behavioral Health	Behavioral Health Coordinator Mid Shore Behavioral Health	Providers Council Meeting
Clinical Director, Corsica River Mental Health Services	Clinical Director, Corsica River Mental Health Services	Kent County Preventions Council
Administration, University of Maryland Medical Center	Administration, University of Maryland Medical Center	LDAAC Steering Committee
Psychological Services at Eastern Shore Psychological Services - Kent County	Psychological Services at Eastern Shore Psychological Services - Kent County	
Coordinator of Kent County Public Schools	Coordinator of Kent County Public Schools	
Chief of EMS Kent County Emergency Services	Chief of EMS Kent County Emergency Services	
Recovery Program Specialists CMUS	Recovery Program Specialists CMUS	
Systems of Care Coordinator Kent County Local Management Board	Systems of Care Coordinator Kent County Local Management Board	
Director Kent County Local Management Board	Director Kent County Local Management Board	
ED Nurse Manager Shore Medical Center	ED Nurse Manager Shore Medical Center	
Psychological Services at Eastern Shore Psychological Services - Kent County	Psychological Services at Eastern Shore Psychological Services - Kent County	
District and Circuit Court Judge Kent County	District Court Judge Kent County	
Director of Social Services Kent County	Director of Social Services Kent County	
Kent County Commissioner	Kent County Commissioner	
Prevention Coordinator Kent County Behavioral Health	Prevention Coordinator Kent County Behavioral Health	
QA & Kent Heroin Coordinator at Kent County Narcotics Task Force	QA & Kent Heroin Coordinator at Kent County Narcotics Task Force	
Kent Co. Sheriffs Dept. Chestertown Police Dept. Rock Hall Police Dept.	Kent Co. Sheriffs Dept. Chestertown Police Dept. Rock Hall Police Dept.	
State's Attorney Kent Co.	State's Attorney Kent Co.	
Division of Community Supervision	Division of Community Supervision	
Superintendent of Kent Co. Schools	Superintendent of Kent Co. Schools	
Department of Juvenile Services	Department of Juvenile Services	
Warden of Kent Co. Detention Ctr.	Warden of Kent Co. Detention Ctr.	

MSBH Organizational Structure:

Mid Shore Behavioral Health, Inc. (MSBH) is a regional, non-profit Core Service Agency (CSA) serving the five counties of the mid-shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot). MSBH is the only remaining regional CSA in the state of Maryland. MSBH strives to enhance the regional behavioral health system of care through effective collaboration with consumers, natural supports, providers, community leaders, and stakeholders. It is our goal to develop a full array of accessible services and resources for consumers through partnership with our providers and community agencies. We offer guidance in understanding and navigating the behavioral health services and community resources available in our region.

*MSBH's **mission** is to continually improve the provision of behavioral health services for residents of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties through effective coordination of care in collaboration with consumers, their natural support systems, providers and the community at large.*

*The **vision** of MSBH is a rural behavioral healthcare delivery system that is clinically and culturally competent. This system will ensure access, have a community focus, be cost-effective, and be integrated to serve the community as a whole.*

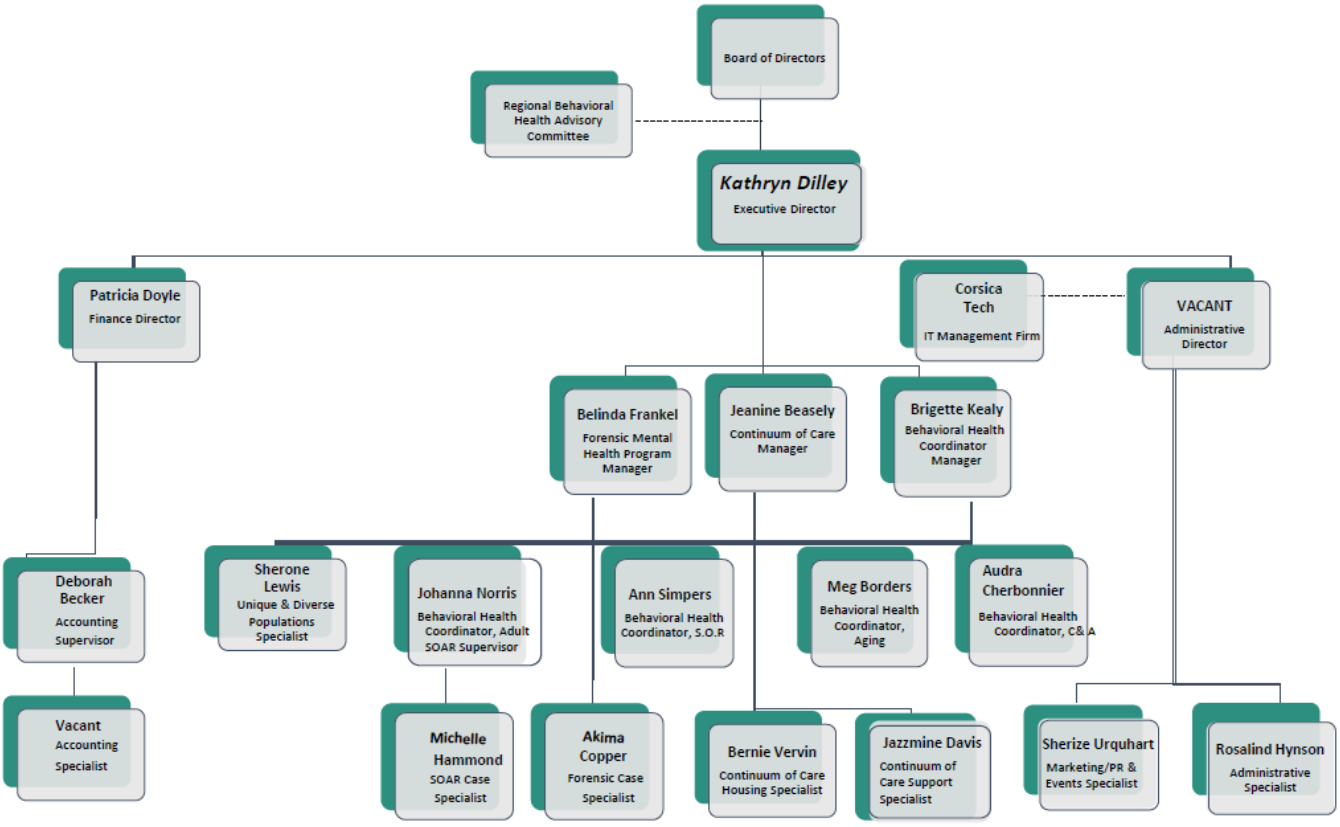
MSBH plans, develops, supports and manages a full range of prevention, intervention, treatment, and recovery support services that seek to meet the needs of individuals across the lifespan with mental health, substance-related, and co-occurring disorders. MSBH has primary responsibility for the mental health system of care and works closely with all five county health departments to support the development and management of the substance-related disorders system of care. MSBH strives to increase collaboration with our local health departments to focus on serving an integrated behavioral health system of care, its needs, gaps, and opportunities for enhancement through increased partnership. MSBH recognizes the importance of understanding the local systems of care and planning in the context of the broader statewide and national systems of care, as well as how the local Public Behavioral Health System (PBHS) is connected to, and reliant upon, cross-systems partnerships within the region.

MSBH, as an organization, is home to the Continuum of Care (CoC) for the mid-shore region, supporting consumers facing homelessness and needs for supportive housing. The CoC is unique in its regional model, being one of three CoCs in the state serving multiple counties. MSBH has a Forensic Mental Health Program that is a resource to consumers in the mid-shore region who are involved in the criminal justice system and are deemed in need of mental health evaluations and/or case management supports. MSBH is home to the Eastern Shore Pre-Admission Screening and Resident Review (PASRR)/Older Adult Specialist; this position is part of a cohort of six positions statewide identified to serve our aging population, treatment services, and community placements. This position serves eight of the nine Eastern Shore counties. MSBH has a SSI/SSDI Outreach, Access, and Recovery (SOAR) Specialist. The SOAR position serves our mid-shore region and has demonstrated an immediate impact in assisting individuals with behavioral health needs

who are at risk for homelessness, access SSI/SSDI benefits. MSBH added a State Opioid Response (S.O.R.) Behavioral Health Coordinator in April 2019 to oversee the implementation and management of the activities supported by the S.O.R. grant, Safe Stations, Crisis Beds, and Recovery Housing.

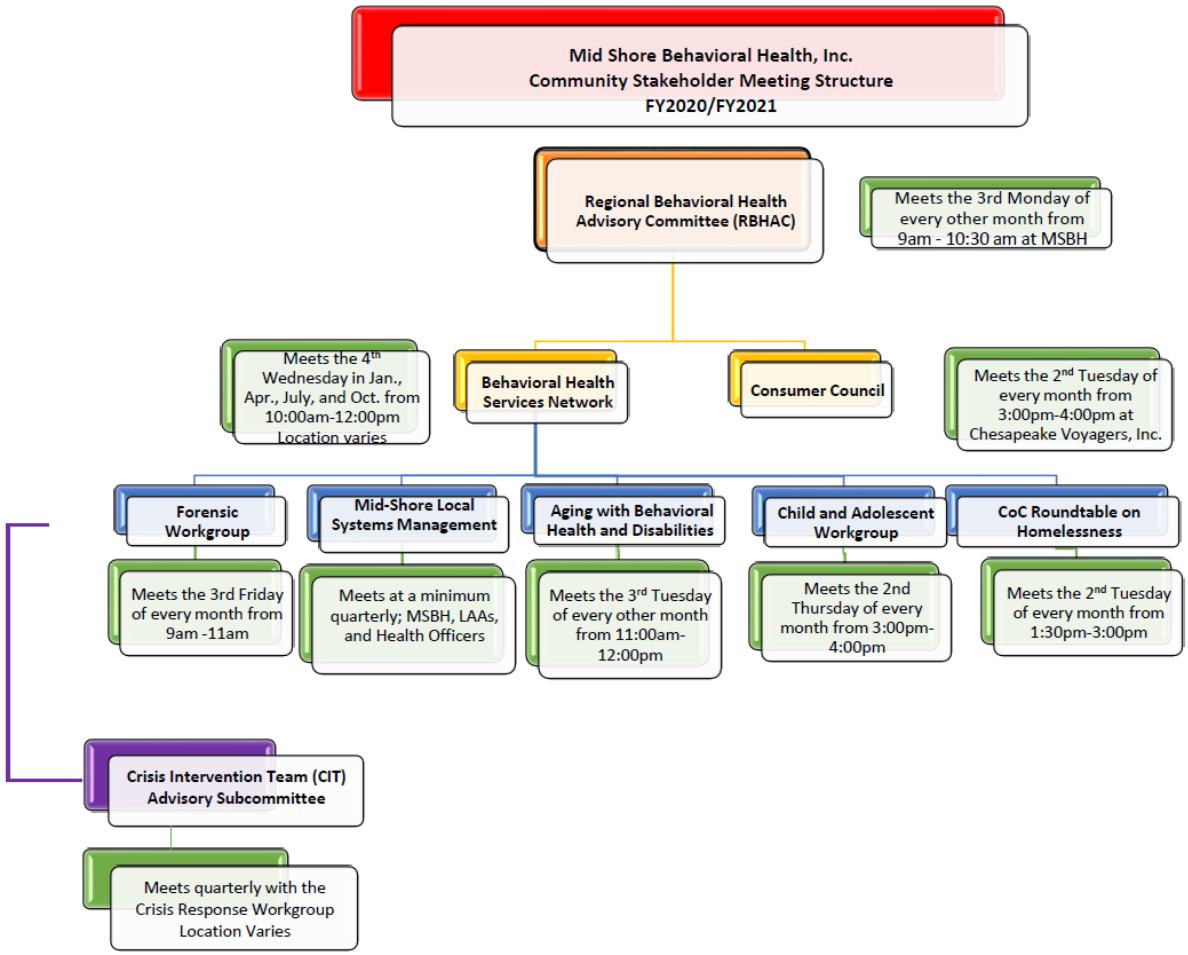
MID SHORE BEHAVIORAL HEALTH

Organizational Chart



It is important to note of the 18 positions on the organizational chart, several are funded in part by CSA Administrative support funding; one position is supported by BHA program funding; one position is supported by Federal Block Grant dollars; one position is supported by SAMHSA funding and three positions are supported by Housing and Urban Development (HUD)/Maryland Department of Housing and Community Development.

MSBH leads the Behavioral Health Services Network and Workgroup (BHSN) structure delineated in the chart below, with an expanded version in the Planning Section. Results Based Accountability or Operations Plans are offered for each workgroup as Appendices. Membership in these groups is open and anyone from our community is welcomed and encouraged to participate. MSBH prides itself on the oversight of the following groups and has noted that the availability of the following platforms for stakeholder engagement has supported our systems planning:



Queen Anne's County Local Addictions Authority Organizational Structure:

Queen Anne County's Department of Health serves as the Local Addiction Authority. Queen Anne's County is the hub of information for treatment services and support for all residents. Queen Anne's County supports walk-in clients, referrals, 8-505s, TCA, and are available to answer any question on recovery. Licensed Certified counselors and peers are available to speak with, receive a screening and assist with placement into an appropriate treatment provider. Referral for treatment is based on the client needs, level of care deemed appropriate, and client choice.

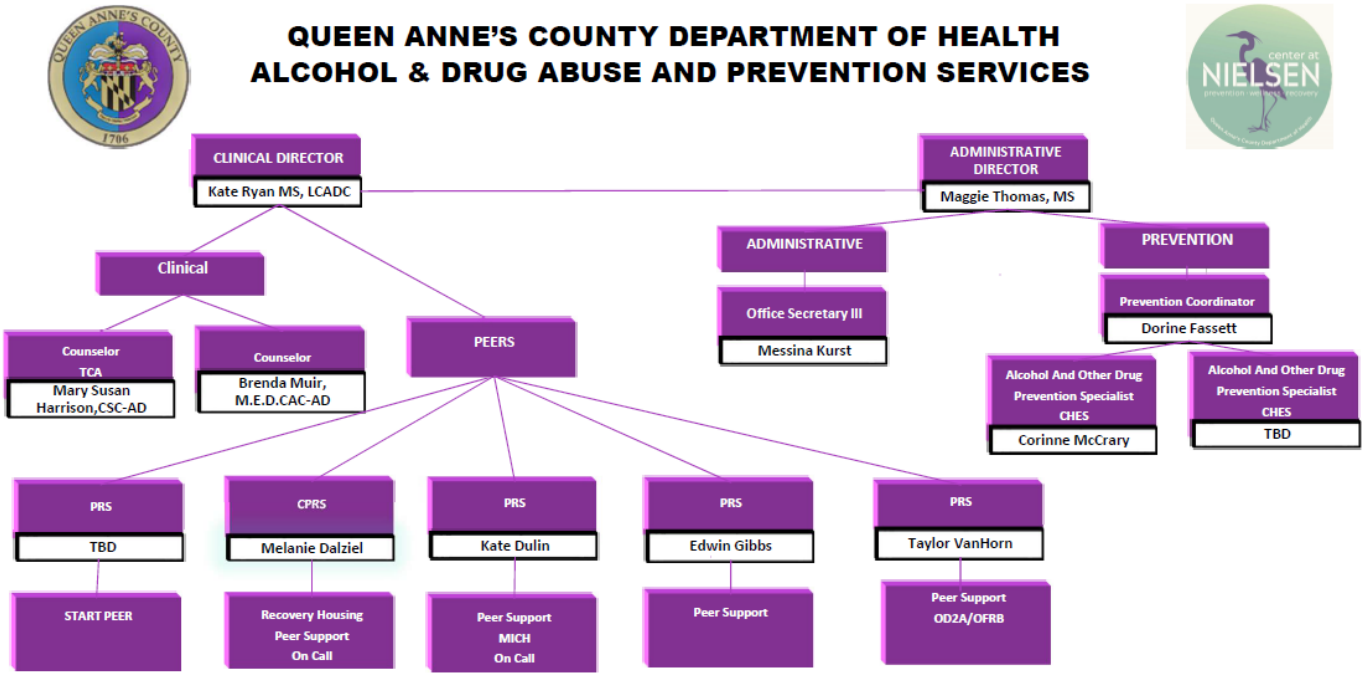
Detox, inpatient, intensive outpatient, long-term, outpatient, traditional 12 step, peer led 12 step, MAT, transportation, recovery housing and care coordination are all services available.

The peer specialist presence in Queen Anne's County has increased exponentially and has impacted the care and services residents receive positively. The peers are involved in all local leadership committees and councils, providing their lived experience to those who create funding streams and implement programs in the county. The focus of Queen Anne's county is to address the addiction epidemic as the public behavioral health crisis that it is. Substance Use Disorders and mental health issues all involve the dysfunction of the brain and how it operates, creating dis-ease in a person.

To address the person as a whole, Queen Anne's County has implemented innovative education and relapse prevention programs to our agency. Including peer-led recovery groups, anxiety and depression support group, a family support group, HIV group, offering space to Narcotics Anonymous. Peers take part in each of the support groups offered at the center.
Peers are the integral contact point of the overdose response plan, which is set into motion through Department of Emergency Services dispatch contacting the peer on call and informing them as to which local emergency room the survivor is being transported to. The peer arrives at the emergency room, meets with the survivor, and their family to discuss treatment options and offer support. In addition, the Queen Anne's County Sheriff's department also offers offenders being charged with any substance charges the opportunity to speak with a peer upon booking. This is a way to intervene prior to an overdose and support the person to make informed decisions. The MICH (Mobile Integrated Community Health) team also has a peer that responds with other medical professionals to address community health needs via calls made to 911, that would be better addressed through the offering of support and connecting to services in the community. This has dramatically reduced the use of 911 and preserved critical resources for true emergencies.

Most impactful has been the acupuncture pilot program which has been held only one evening at one of our partner providers. The data that has been collected has shown extremely promising relapse prevention, as well as increased treatment compliance.
Harm Reduction efforts have been implemented on a small basis, which consist of Naloxone training, in conjunction with CPR and Fentanyl test strips. We implemented the Naloxone training for the community, populations that are at risk, as well as agencies and companies in the area that are interested in learning how to save lives.

Community outreach through events has been a wonderful way to inform the public about what serves are offered at the center, since Queen Anne's County no longer provides direct treatment. Partner providers, their clients, medical offices, and information tables at local events are all ways that the peers are getting the word out. One of the biggest events that has taken place in the last few years is the Go Purple campaign. Queen Anne's County just finished its second successful



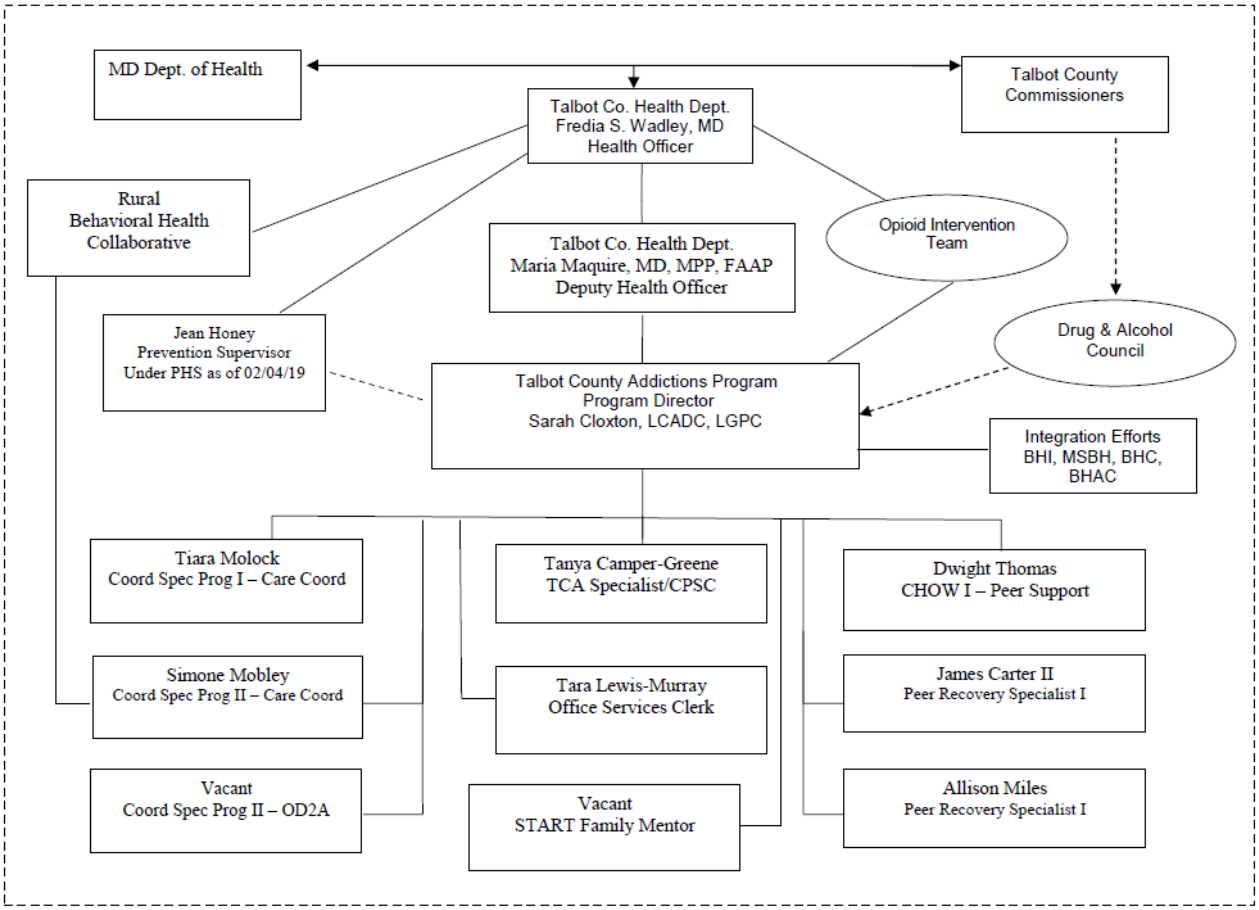
education and outreach campaign. This year, the events culminated with a Haunted Trap House, which received local, national, and international attention.
Through working closely with local providers and assessing gaps in services, Queen Anne's County is continually striving to ensure that all residents understand the services available and have easy access to them when they need them.

Talbot County Local Addictions Authority Organizational Structure:

The Talbot County Addictions Program (TCAP), as part of the Talbot County Health Department (TCHD), operates as the Local Addictions Authority (LAA) and is responsible for planning, managing, and monitoring publicly funded substance use disorder services for Talbot County. This entails oversight of non-governmental entities providing direct SRD treatment services in the jurisdiction to ensure adequate supply and quality of services, financial management, and review and investigation of providers. The LAA, in reference to SRD services in Talbot County, receives and participates in audit reviews, complaint investigations, and exception of need requests (uninsured exception).

The Local Addictions Authority is represented in a variety of meetings and functions to plan and assess for the jurisdiction's substance-related needs including the Local Care Team, Child Protection Team, Child Fatality Team, Local Drug and Alcohol Abuse Council, Behavioral Health Coalition of the Mid Shore, Addiction Consortium of the Eastern Shore, OMPP Coalition and Leadership Team, Opioid Task Force, ROSC Change Team, and organizes additional provider meetings as needed. TCAP collaborates with a variety of stakeholders for input and provisions

TALBOT COUNTY ALCOHOL & DRUG ABUSE SERVICES
ORGANIZATIONAL CHART FY2021
January 30, 2020



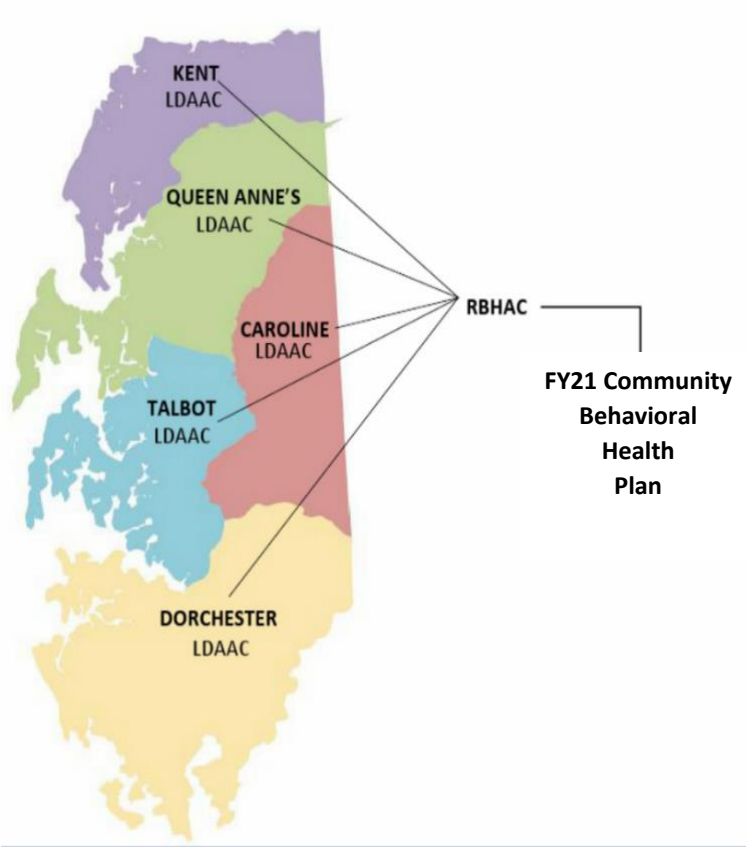
of recovery support services including DSS, Circuit Court and judiciary, public safety and corrections, community action agencies and coalitions, PBHS managers, recovery and wellness centers, care management programs, recovery residences, and 12-Step support. TCAP recognizes the importance of proceeding jointly in the provision and integration of services with stakeholders across the continuum of care and services.

Mid Shore Planning Collaborative Relationship with Local Advisory and Governing Bodies

By statute, each county council or board of commissioners serves as the Board of Health (BOH), with quarterly presentations from the county Health Officer. MSPC is asked occasionally to join the Health Officer in addressing the behavioral health needs of the county residents as part of the BOH report. MSBH presents at least annually to each county government's leadership, usually in May, which is Mental Health Awareness Month. Renewal of the Letter of Agreement has historically been approved at this meeting. MSPC, the Health Officers, and the LAA Directors involve county government elected officials in planning discussion or offer presentation at public meetings throughout the process.

By statute, MSBH Executive Director or a designee is an active member of each county Local Management Board (LMB). LMB participation often involves a significant leadership role, serving as an officer of the board or chair of a committee. The LMB for Caroline County is a non-profit entity, and Dorchester, Kent, Queen Anne's and Talbot Counties are part of county government. MSBH's Behavioral Health Coordinator for Child and Adolescent Services is an active participant, and often the leader of each county's Local Care Team.

MSPC has achieved the presence of and the facilitation of county-specific provider meetings in each of the mid-shore counties, Caroline, Dorchester, Kent, Queen Anne's, and Talbot. The provider meetings serve to involve the provider community in each county with addressing concerns about service systems, access, capacity, quality and development updates with system management transition.



The graphic to the left depicts the relationship between the county specific Local Drug and Alcohol Abuse Councils (LDAACs) and the Regional Behavioral Health Advisory Committee (RBHAC).

There is at least one representative from MSPC on each LDAAC, and members from each county LDAAC who have cross-systems membership on the RBHAC.

MSBH is responsible for the oversight and administrative function of the Regional Behavioral Health Advisory Committee (RBHAC). This committee is representative of an integrated advisory committee. RBHAC has membership from all five counties, with predominant membership from the consumer and natural support community. With systems integration planning.

MSPC leadership is supporting the discussion of the evolution of the RBHAC role and the LDAAC relationships with the consideration of a regional advisory committee development. MSPC members are serving on a state-wide subcommittee that is analyzing the Statute and legislative mandate language that applies to the local governing and advising bodies; LDAACS, RBHAC, the Behavioral Health Advisory Council, and Opioid Intervention Teams. It is the hope that by FY2022, that there will be language supporting integration and overlap of these advising groups that is respectful of jurisdictional interpretation with planning and sustainability of local guiding groups.

D. FY2019 HIGHLIGHTS AND ACHIEVEMENTS:

MSPC is proud to share highlights and achievements that were accomplished by the separate local authorities in FY2019. While we plan to move forward as a group, we acknowledge the unique greatness that we each possess as local authorities.

Year of Successful Transition – Caroline County Behavioral Health

Caroline County Behavioral Health (CCBH) experienced a great transition in FY19. A new Director and Clinical Supervisor were recruited to begin the restoration of staffing and programming. Providers had also left the agency including its psychiatrist. During the transition, new contracts were signed with University of Maryland School of Psychiatry to provide MAT telehealth oversight and for a private psychiatrist to provide 20 hours per week, of in-person services. The Prevention Coordinator left the position to provide SUD counseling and there was a lag in Prevention programming during this time; this position has now been filled. With increased expectations, qualified staff and supervision, the program was able to grow and set new goals including trauma-certification for all counselors and front-line staff in FY2020. With a Psychiatrist available, 20 hours per week and a growing need for school-based programming, Caroline County was able to expand School-based Mental Health with the addition of one full-time therapist in Denton Elementary and an enhanced to full-time therapist at Lockerman Middle School. CCBH continues to provide SUD assessment services in the middle and high schools, identifying high risk students, assessing and treating through the BEST (Building Esteem in Students Team) program.

In FY2019 planning began for co-locating the Mental Health and Substance Use Disorder services, in order to have true integration of behavioral health services; including regularly scheduled co-occurring clinical team meetings and to provide a 'one-stop shop' for our rural consumers who may have transportation challenges. Behavioral Health services are now housed in the Health Department, as of November of FY2020.

Through a HRSA grant and a partnership with the University of Maryland School of Psychiatry's research on the effectiveness of the mobile MAT treatment model in rural areas, Caroline County Behavioral Health started its Mobile Treatment Unit (MTU) to provide tele-MAT services in locations determined based on overdose data. This unit is staffed routinely with a Peer Support and a Nurse Coordinator, although counselors may hold private sessions with individuals and the health department may also enhance individuals' treatment experiences by providing individual and group counseling as part of MAT best practices. By making treatment services more accessible and convenient, the MTU served 56 clients in the first seven months of operation, surpassing the goal of 50 for the first year.

Strengthening Collaboration – Dorchester County

In FY2019, the Dorchester County Behavioral Health Services (DCBH) continued to work diligently to strengthen collaborative relationships with community services and agencies. Dorchester County Behavioral Health Services, a public fee-for–service treatment program, utilizes a pharmacological approach in treating opioid addiction, providing Medication Assisted Treatment (MAT) through a contract with a physicians group. Dr. Eric F. Ciganek's Family Medicine practice manages the Buprenorphine/Suboxone/Vivitrol medication services at DCBH. DCBH successfully negotiated a contract, with a local psychiatrist, to become Medical Director and to provide mental health services for the forensically involved, co-occurring population, to begin in FY2020.

DCBH continued to provide Vivitrol treatment within the detention center, through a collaboration with the detention center medical staff and the Drug and Alcohol Recovery Treatment Program (DART), serving 126 offenders - 92 males and 34 females. Dorchester County was able to place two full-time counselors in the detention center, with plans to provide Intensive Outpatient Treatment Level 2.1 and Outpatient Level I Correctional in FY2021, supported by peer support and recovery services. DCBH also continued to implement Screening Brief Intervention and Referral to Treatment (SBIRT) in collaboration with DART, screening a total of 954 individuals. Through Dri-Dock Recovery and Wellness Center, Peer Recovery Specialists (PRS) conducted a peer-led Ex-Offenders Group, to help returning citizens reintegrate into the community; 92 returning citizens participated in FY2019.

DCBH continued its relationship with the Office of Problem-Solving Courts and served 35 Drug Court participants, six of which were Veterans. (Problem-Solving Court is also conducting a Veteran's Court in collaboration with the Veteran's Administration). DCBH provided SUD Level I Outpatient and Level 2.1 Intensive Outpatient Treatments, court consultations, toxicology screening and submits required reports to the Dorchester Problem Solving Court program.

Dri-Dock Recovery and Wellness Center, funded through the Recovery Initiative, had fourteen recovery-oriented activities in FY2019, which were attended by 451 individuals, including folks in recovery, their families and community members. Overdose Awareness Day and Memorial was attended by 34 individuals, in order to educate the community about Opioid Use Disorder and to remember those Dorchester County residents who died from an overdose in the past year. During all activities and events, recovery and treatment resource information was distributed to the attendees and direct peer support was available. During FY2019, 891 unique individuals were served at Dri-Dock Recovery and Wellness Center, with a total of 3,369 visits.

Through funding by the Opioid Operations Command Center, and in cooperation with Emergency Medical Services and University of Maryland Shore Medical Center – Dorchester (UMSMCD), On-Call Peer Recovery Support is offered to individuals that enter the emergency department after having

experienced an overdose. The PRS offers individual support, treatment options, Narcan and recovery resources, and will facilitate a referral to treatment if the individual is willing. Information is also provided to any family members or friends accompanying the individual. PRS responded to 22 suspected overdoses in 2019. In that period police responded to 26 suspected overdoses of which four were fatal. In FY2019 there were 46 suspected overdoses, of which six were fatal; peers responded to 40 incidents.

Numerous peer services are conducted at Dri-Dock, including a *Family Night* (meeting twice monthly for family members of individuals with SUD), *Coffee and Conversation* (for recovering individuals), and a Women's Support Group (for women with a SUD). Dri-Dock also regularly hosts Narcotics Anonymous (N.A.), Alcoholics Anonymous (A.A.), Emotions Anonymous, Spirituality and Recovery, Life Skills, and Yoga and Recovery meetings. PRS goes into communities identified as high-risk for drug activity seeking to interact with individuals to provide information on treatment options and recovery.

DCBH also partners with the Department of Human Services (DHS) to manage the Temporary Cash Assistance Assessor who is assigned to screen for SUD. During FY2019, of the 213 completed screens, 23 individuals were enrolled into SUD treatment.

Closing the Gaps – Kent County

The A.F. Whitsett Center (AFWC), located in Kent County, is an inpatient substance use residential treatment facility which is a resource not only to the mid-shore counties but throughout the state providing ASAM levels of care 3.7 W/M, 3.7 and 3.5, and care coordination. In FY2019, the AFWC began to provide medication assisted treatment (MAT) throughout a consumer's stay, in place of the detoxification-only model. This model required training staff on all secondary shifts, to screen and admit consumers into all levels of care and began to accept after-hours admissions. The AFWC now has an increased capacity to provide acute withdrawal management to 20 of the total inpatient capacity of 40. *Walk-in-Wednesday* began in April of 2019 and screened 81 individuals through the first three months; immediate admission could be facilitated if the ASAM level of care was met.

AFWC is one part of a robust system of outpatient and community efforts to address the 400% increase in overdoses (in Kent County) in FY2019. A cornerstone of this system is Recovery in Motion (RIM), a Peer Recovery Specialist (PRS) run, recovery program which provides connections to provider services, community resources, family support and care coordination. Total care coordination enrollments in FY2019 was 224 with 2662 peer to participant contacts and 70 referrals to treatment.

The Buprenorphine Initiative Grant allowed Kent County to purchase a Ford Transit vehicle for the provision of mobile treatment services. The 'No Harm in Helping' Program provides harm reduction education in the community and can administer monthly MAT injections to consumers

of the mid-shore and Cecil Counties. The ability to provide monthly injectable variations of MAT in the form of Vivitrol and Sublocade will bridge a significant gap in care of individuals in recovery whose need for daily medication has precluded their admissions to much recovery housing on The Shore.

Prevention has focused on both underage drinking and non-medical use of prescription drugs. Kent County Prevention has been able to implement the prior year's programs and add new programs by continuing to nurture past as well as forge new partnerships throughout the year. For underage drinking, the Kent County Public School system agreed to continue to partner to provide an evidenced based curriculum to all 9th grade students in health class. Kent County Prevention went into both the middle and high school on several occasions including red ribbon week, prom, back to school nights etc. to provide education and awareness activities and partnered to provide all-school assemblies for prevention education.

During prom season, Kent Count Prevention introduced a new program and media campaign for 11th and 12th grade families and students. The campaign was able to enlist new community partners which contributed to its success and great reviews. Students developed PSA's that aired on the radio as part of the larger media campaign. Working with a media consultant Kent County was given free radio spots, press releases and feature articles in the newspaper for Alcohol Awareness Month, prom season and throughout the year.

Prevention also worked with many different partners to implement programs for non-medical use of prescription drugs. There was a partnership with the high school to implement a new curriculum for prescription drug safety. Staff were able to partner with Law Enforcement for Take Back Day and the installation of three new drop boxes in the county. There has been a positive response from the officers, and they report the boxes are being utilized. Law enforcement has made these a sustainable resource for our community. Prevention was also able to procure 1,000 more Deterra bags free of charge to help with disposal efforts in addition to the initial 6000. There have been numerous Narcan trainings and Narcan dose kits given to the community at various events. Two peers have been trained to assist with the trainings and help get the powerful lifesaving tool utilized in the community. Prevention also partnered with the local Washington College for Overdose Awareness Day, Take Back Day and the Washington College Mental Health Fair to provide information and education to the students and Narcan training to the counseling and security staff.

Mid Shore Behavioral Health, Inc.

2019 State Opioid Response Grant

Mid Shore Behavioral Health, Inc. applied for, and was awarded the State Opioid Response (S.O.R.) grant in January 2019. The award was designed to expand opioid services on the Eastern Shore, with the focus on expanding crisis bed services, recovery housing, and initiating safe

stations. The purpose of a Safe Station is to have a place where anyone with a primary opioid misuse problem can walk in without an appointment, ask for help and begin the process to connect them to the treatment or resources they are ready to receive. In May 2019 the Eastern Shore Safe Station Coalition was initiated to support the launch of safe stations for the counties that chose to opt-in. Opening of Safe Stations were anticipated in Wicomico and Worcester Counties in August 2019.

The A.F. Whitsitt Center, located in Kent County, is an inpatient substance use residential treatment facility. Previously there was crisis bed availability through the Maryland Opioid Rapid Response Grant (MORR) for four beds. With the change this year from MORR to S.O.R. funding A.F. Whitsitt increased from four to an eight-bed capacity for crisis beds. Efforts continue towards expanding the capacity at the A.F. Whitsitt Center and advocating for sustainability for long-term facility management planning.

In Dorchester County a recovery house was established this year through S.O.R. Grant funding. Gratitude house is a 5-bed male house. The recovery house setting allows the consumer time to focus on their recovery while slowly integrating back into society. There are additional plans for Oxford House to open three Recovery Houses in Queen Anne's County in early 2020.

Across the Lifespan Conference

MSBH's 8th annual Across the Lifespan Conference was held on April 2, 2019. Each year, the conference has a topic of focus as it relates to consumers, "across the lifespan". This event focused on military veterans, exploring the topics of homelessness, suicide, PTSD and available community resources. The event is coordinated yearly in partnership with Dover Behavioral Health. 6 CEU's by Maryland Board of Social Work Examiners.

The conference speakers included: David Galloway of the Maryland Commitment to Veterans who has truly walked the walk and was therefore able to highlight the challenges the individual veteran may face and how he or she might be encouraged to accept support. The other speakers were Jessica Nesbitt of the Brain Injury Association of Maryland; John Clow of the VA Maryland Health Care System; Lore' Chambers, PhD from St. James A.M.E. Zion Church-Zion House and Brenda Jorden, Ph.D., LCSW-C from the School Social Work, Salisbury University. Each presenter shared relevant information for our military veterans, enlightening the conference participants of resources in our mid-shore region.

Children's Mental Health Matters Campaign

Mid Shore Behavioral Health's (MSBH) Child and Adolescent workgroup strives to raise awareness and to reduce stigma as a part of the Children's Mental Health Matters Campaign (CMHM). As part of the May 2019 campaign, MSBH in partnership with Talbot County Local Management Board showed two screenings of the documentary "Angst" which provides education and resources surrounding child and adolescent anxiety. The event took place on May

9th which also corresponded with the campaign's "Go Green" Day. MSBH purchased green shirts with the CMHM campaign logo for all staff to wear in support. After the film a panel of Behavioral Health experts were available to field questions and provide support. Over 100 people were in attendance. In addition, Megan Pinder, Child and Adolescent Behavioral Health Coordinator, was interviewed for the Star Democrat, a local newspaper on the Campaign and the initiatives out of the workgroup. The article also highlighted a local family's experience with accessing behavioral health services for their children.

CLAS Provider Survey

As part of the MSBH FY2019 Cultural and Linguistic Plan, local service providers were encouraged to participate in a survey about CLAS (Culturally and Linguistically Appropriate Services). The survey was created to assess cultural knowledge of the diverse population in the mid-shore region. The Provider Survey asked questions along the continuum of cultural and linguistic competency (CLC), to gauge if client cultural needs are considered a priority. Sixty individuals across the system of care (mental health, substance use, health department, social services) responded to the survey. The survey participants reported working in education, on local management boards, the health departments, Dept. Social Services, the Department of Corrections and homeless shelters. Majority (47%) of the responses reported having 0-20 employees in their agencies. Respondents reported that on average, they're serving 100+ clients; showing that many clients are being served with fewer employees as resources. Most of the agencies responded that they serve all the five mid-shore counties.

According to the survey, 14% of the agencies serve less than 50 non-English speaking clients, while 25% serve more than 50 and 22% are unsure. When asked if agencies utilize a client's natural supports (family, friends) for interpretation services, 31 of 54 responses were 'yes'! This is concerning as best practices are to use neutral, professionally trained interpreters for non-English speaking or clients who are deaf or hard of hearing. Inaccurate interpretations can have serious consequences in the healthcare system, which is based on client diagnosis. MSBH will continue to work with Providers in the community, to improve their CLC to best serve clients, improving health literacy and reducing disproportionalities in service.

Eastern Shore Behavioral Health Coalition

The Eastern Shore Behavioral Health Coalition has been in existence since 2015 and has demonstrated how a group of invested partners and collaborators, with a passion for consumers and the behavioral health community, can inspire change. Unlike our partners in advocacy with the Maryland Mental Health Association and Community Behavioral Health, the Eastern Shore Behavioral Health Coalition is a volunteer-based, unfunded group, who meet over the course of the year to prioritize issues impacting the Eastern Shore. The priority of this group is to address the needs impacting our rural landscape, that affects our consumer and provider community. The Coalition is led by MSBH and has representation from providers, Eastern Shore delegates, and community-based government organizations.

On January 2, 2019, the Eastern Shore Behavioral Health Coalition hosted its first session at the Winter Maryland Association of Counties (MaCO) Conference with the Eastern Shore Delegation. This session served as an update of the issues impacting the access to and delivery of behavioral health services on the Eastern Shore, as well as a work session to strategize the priority initiatives for the 2019 Legislative Session. Out of this session, the group identified the following priority areas for the 2019 session:

- Keep the Door Open 2019 Support
- Behavioral Health Workforce Crisis:
- Support resubmitting SB 211 – Medical Director via Telehealth/House Sponsorship.
- Support adding NP for Telehealth for ACT & MTT services – SB 704/HB 1652
- Psychiatrist Recruitment Issues: Use of SLRP (State Loan Repayment Program)/MLARP (Maryland Loan Assistance and Repayment Program for Physicians); Regulations, Restrictions: HPSA shortage info - geographic scores, MA designation scores, hourly requirements
- Continued Provider Credentialing Barriers
- Continued support of specific needs: SB 1101/HB 1310 –Prohibit limits on private insurance credentialing/paneling. Coalition to work on expanding sponsorship
- Child/Adolescent/TAY: Hospital and Acute/Residential Treatment Gaps/Level V Schooling
- Recovery Housing Regulations and Regional Impact

The Eastern Shore Behavioral Health Coalition was invited to review legislation with Senator Addie Eckardt during the 2019 session legislation related to the Medical Director regulations, as well as support for Psychiatric Nurse Practitioner leadership, and telehealth. The Eastern Shore Behavioral Health Coalition was invited for a special presentation to the Eastern Shore Delegation on March 1, 2019 for updates on legislation and continued engagement with the delegate group.

Forensic Mental Health Program – Consumer Focus

SpeT had been a participant in the Forensic Mental Health Program (FMHP) at MSBH. The case was reopened in January 2019, when a community agency called to report ongoing difficulties of client being stable in the community. Client was homeless and living at a shelter in the mid-shore, without money or food. Client had been living with a family member who was also the clients' Representative Payee. Problems resurfaced with their relationship, which led to the removal of the client from the home. Client was not taking medications nor engaged in therapy at the time of the forensic case manager's assessment. SpeT reported a diagnosis of Bipolar Disorder and ADHD, additional diagnoses of Schizophrenia, PTSD and an intellectual disability were documented in prior case notes.

The FMHP Case Manager focused on identifying priorities and linking SpeT with community resources and services. Because of client 'friends' at the shelter, taking advantage of client

financially, client was referred to Adult Protective Services as a vulnerable adult. Client was linked to Crossroads PRP and to Corsica River Behavioral Health for outpatient mental health services and medication management. Client transitioned from that shelter to another shelter and continued to attend Dri-Dock recovery and Crossroads PRP. Unfortunately, client was eventually asked to leave the shelter because of rule infractions. Fortunately, client was able to move in with a family friend who helps with budgeting and activities of daily living.

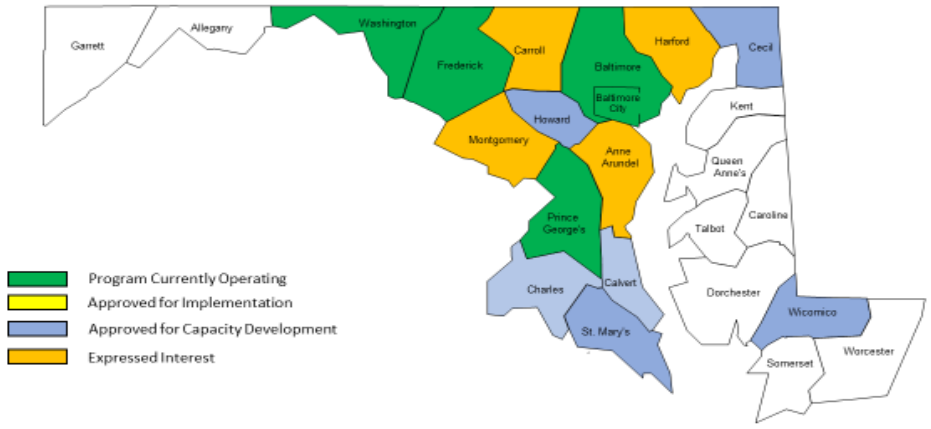
Throughout FY2019 the year, SpeT met with the FMH case worker 15 times and at least once a month. Client remains on probation and is compliant with mental health treatment recommendations and with the PRP services. The program continues to work to maintain client stability in the community.

Harm Reduction: Bridging to the Eastern Shore

In October 2018, MSBH was contacted by Kip Castner, Chief and Andrew Bell, SSP Coordinator with the HIV/STI Center for Integration and Capacity Infectious Disease Prevention and Health Services Bureau with the Maryland Department of Health to solicit interest in hosting a Harm Reduction Training on the Eastern Shore. MSBH was educated on the mission of the department, which is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations. MSBH embraced and welcomed the opportunity to partner with this group in hopes of infusing this mission into practice in our mid-shore and Eastern shore counties. At the time of the in-reach, to date, there had not been an entity or agency open to welcoming a training on Harm Reduction on Maryland's Eastern Shore.

Other counties in Maryland not only presented as open to trainings but were already demonstrating implementation of programming in their jurisdictions. (See map: January 2019)

Current Syringe Services Program Landscape



MSBH welcomed the opportunity to partner to bring the first Harm Reduction Training to the Eastern Shore on January 11, 2019. MSBH recognized and the value of engaging partners, providers, administrators, Health Officers, Law Enforcement, First Responders, and the peer support community to initiate a discussion on harm reduction, and plan for possible reachable first steps to implementation. The training was called "Public Health Approaches to the Opioid Crisis" and was attended by approximately 75 individuals. The training focused on educating the attendees on the impact that Adverse Childhood Experiences (ACES), social determinants of health, and stages of change have in addiction, and prevention and intervention planning. The training educated partners on the nine harm reduction strategies: Overdose Education and Naloxone Distribution, Syringe Services Programs, Law Enforcement Assisted Diversion, Harm Reduction Peer Work, Drug checking, such as via Fentanyl Test Strips, Drop-In Centers for People Who Use Drugs, Mobile/Field-delivered/Low Barrier Wound Care Services, Street-initiated/Targeted Case Management, and Health Hubs: mobile MAT/Low Barrier Buprenorphine/HCVtreatment.

The training included a special county-based break out interactive session in which each Eastern Shore county broke out in groups, discussed the impact of the opioid crisis by county, barriers to combatting the crisis, and identified possible first steps for implementing harm reduction strategies in the county. Each county presented on the "most achievable" harm reduction strategies and action steps for coordination and partnership. The training is one that MSBH hopes to replicate in the coming fiscal year and continue to strive to support implementation of harm reduction strategies in the mid-shore region.

Mid Shore Roundtable Homeless Solutions Program

At the end of FY18 the Mid Shore Roundtable on Homelessness (CoC) was informed by the Department of Housing and Community Development (DHCD) that the state would be merging homeless service program funding into one new program entitled, Homeless Solutions Program. The program would be administered locally by Continuums of Care and would go live in FY19. This was new funding for our CoC, as historically it was managed by local counties and local Departments of Social Services.

The Roundtable went to work planning a local application process to ensure current services would still be available throughout the region. Partners were brought to the table for planning and training purposes. The final award for the region was determined by DHCD, which awareded $854,368.00 to Mid Shore Behavioral Health Inc. for homeless services. MSBH was also awarded administrative funding through the grant, allowing for a new position to be created within the agency. The Continuum of Care Support Specialist was hired in October 2018 and was integral in the successful implementation of the program.

MSBH contracted with seven partner agencies to provide outreach, emergency shelter, rapid rehousing, and homeless prevention services to eligible persons throughout the mid-shore region. Partner agencies included His Hope Haven, Neighborhood Service Center, Queen Anne's County Department of Housing and Community Services, Haven Ministries, St. Martin's Ministries, Mid Shore Council on Family Violence, and Delmarva Community Services.

The Roundtable worked closely with partners to develop coordinated services throughout the region, a major goal of the program merger. The Roundtable Homeless Solutions Program/Coordinated Entry Subcommittee actively took over program planning, policy development and discussion, and case conferencing. Universal forms, incorporating program policies, were created by the Continuum of Care Support Specialist and were adopted by all partners. Program monitoring processes were also developed by the group.

Ultimately, the Homeless Solutions Program has strengthened the Mid Shore Roundtable Continuum of Care, allowing for more coordinated service delivery and local insight. The increased availability of rapid rehousing funding in the mid-shore region is critical in addressing homelessness. Partnerships have continued to strengthen throughout the region, allowing for people in need to connect with appropriate services more quickly. The Roundtable will actively evaluate the program, with continued insight from partners, allowing the progression toward the goal of eliminating homelessness in the mid-shore.

Mobile Crisis Team Expansion

MSBH was awarded Over the Allocation funding in FY19, which allowed the enhancement of the Eastern Shore Crisis Response services, that serve all eight counties on the Eastern Shore. The Eastern Shore Operation Center (ESOC) expanded its on-site phone counselor personnel to overnight and weekend hours 24/7, in February of 2019. The Mobile Crisis Teams (MCT) now has four overnight teams, which cover the entire Eastern Shore. The teams began expanding in February and currently the overnight teams are all fully staffed. MCT has included peers into their workforce, which has been a great addition.

Psychiatry Recruitment

To help address the chronic shortage of psychiatrists in the mid-shore region, which severely limits services to our consumer community, MSBH in partnership with the Eastern Shore School Mental Health Coalition and University of Maryland developed a recruitment and communications plan to elevate awareness of professional opportunities in our rural area. On April 3, 2019 the partners hosted a provider panel and introduction to the Eastern Shore for first year fellows with the University of Maryland School of Psychiatry, Child & Adolescent Psychiatry Program. The luncheon was held at the Aspen Wye Institute located in Queenstown, Maryland. Twenty-six people attended including six Outpatient Mental Health Clinics, Salisbury University, The Eastern Shore Area Health Education Center and eight Fellows. Following the presentation, there was a question and answer session with two local Child and Adolescent Psychiatrists, and

then a virtual tour of the region. After lunch, breakout sessions focused on tele health services, integrated health and the challenges of practicing in a rural region. The event received positive feedback and a commitment of 10 hours of Telepsychiatry services from one psychiatrist.

Roundtable Trainings

The Mid Shore Roundtable on Homelessness (CoC) has organized and hosted three significant training events throughout FY19. In December of 2018, the Roundtable organized a dual training on Maryland's Lead laws and regulations, as well as cultural competency. A representative from the Maryland Department of Environment presented on the various components of the State's lead laws. She also informed the group of their designated responsibilities regarding lead safety. The audience was also informed of their duties to inform the tenant of the rights. The Founder and Chief Executive Officer of the Chesapeake Multicultural Center located in Easton, Maryland spoke to Roundtable members about the importance of cultural competency in their field, rather than just mere cultural awareness. There were over 30 people in attendance.

In March of 2019, the Roundtable hosted a training session on Adverse Childhood Experiences (ACEs) and best practices for providing trauma-informed care. When serving those who have been impacted by homelessness, it is especially critical that providers are aware of the physical, emotional, and psychological effects that trauma may have on those individuals and families. The presenters for this training included a licensed clinical social worker from For All Seasons, Inc. and the Chief Executive Officer of the Chesapeake Multicultural Center. The presenters were both certified to give trauma-informed presentations and have attended various ACEs trainings and work sessions. There were over 60 people in attendance.

In June of 2019, the Roundtable organized an information session on substance use disorder to educate the homeless service providers in the mid-shore region on how to best serve those who are suffering from addiction. Each county's local addiction authority had a representative present, to inform the audience of the resources available in our region for those with substance use disorder. Following the presentations of available county resources, a Dorchester County EMT trained the entire audience in Narcan administration. He also walked the group step-by-step through the process of handling an overdose, as well as educated the group on Maryland's Good Samaritan Law. With use of rollover funding from FY2018, the Mid Shore CoC was able to purchase and provide each attendee with two doses of Narcan medication. Each homeless service provider was given multiple doses of Narcan, to store at their shelters in the event of an emergency. There were over 30 people in attendance.

SIM Conference with focus on the Child and Adolescent Population

MSBH sponsored the 5th Annual Sequential Sequence Mapping (SIM) Conference in November 2018. The annual conference, which looks at the intersection between the criminal justice system and behavioral health at various intercepts, along the criminal justice continuum, chose to focus on children and adolescents. The group consisted of the Department of Juvenile Service

staff, mental health and substance use providers, community mentors, school administrators, and family service workers. The participants discussed resources and gaps in our local system to help divert youth from further involvement in the criminal justice system. Representatives from the Governors' Office of Crime Control and Prevention discussed the 'Handle With Care' initiative, which has since begun in several mid-shore counties. Conferences attendees learned about new providers, organizations and legal processes that work to assist youth and their families. As is often the case during the conference, there was synergy among members and connections were made to enhance the services we have in our mid-shore region. The many gaps in services in our area, were also identified and discussed. The afternoon session was devoted to Mobile Treatment Services where a speaker from the University of Maryland discussed the history and implementation of this important program, and a local Mobile Treatment Team, and a Forensic Mobile Treatment Team from Baltimore presented on their programs.

Warm Hand-Off Initiative

The Warm Hand-Off Initiative stemmed from an agreement between MSBH and Choptank Community Health to understand what the integration of somatic and behavioral health might look like in our rural community where primary care and mental health providers may be separated by many miles. An initial Learning Session was held in March 2019, that focused on defining 'warm hand-off' for our region. The agreed definition that: "When a need is identified and triggers a transition of care, the members of the health care team enact an active referral process that is transparent and inclusive of the client, directly connecting them to the organization where they are being referred. Open communication and direct follow up post referral is essential to the process." The second Learning Session held in May 2019, focused on the development and distribution of a provider tool outlining the behavioral health resources in our community specific to the primary care providers specified requirements, and additional resources to assist primary care providers further their own integration process. At the conclusion of the final learning session, a Warm Hand-off Subgroup was established to continue the work, and to develop a Google Document allowing primary care and behavioral health providers to access and update an appointment waitlist on a weekly basis in an effort to speed referrals and smooth transitions.

Up and Running! - Queen Anne's County

Starting with a virtual blank slate in FY19 (with two part-time clinicians and one full time peer, no programming or wraparound services) the new LAA Director in Queen Anne's County embarked on a cram course, participating in all behavioral health meetings, coalitions and boards to assess community needs and gaps. The year has seen new funding to support integrated programming with qualified and committed staff.

A Naloxone training and a distribution program were initiated, first through partnership with Dorchester County and now fully supported by Queen Anne's County. CPR 'hands only' training

was provided at the same time as Naloxone training, with the knowledge that lives may be saved even if Naloxone is not enough. Fentanyl test strips are made available for those who may be interested, but only after the individual meets with a counselor. The individual interested in Fentanyl test strips receives a brief assessment of health, of social needs and of interest in referrals and community resources. The individual is then instructed on how to use the strips and may return for additional strips as needed.

Acupuncture was offered through one partner provider on one evening each week. This evidence-based therapeutic service has proved to be instrumental to not only the reduction of negative recovery symptoms, such as anxiety, depression, lethargy and poor appetite, it has also increased treatment compliance. Clients who opt for this service attend a group therapy session while the needles remain in place which enhances the therapeutic benefits of treatment. Providers in Queen Anne's have requested expansion of the service to include those who complete treatment successfully because 12 weeks of outpatient treatment may not be enough to secure a sustained recovery.

With the addition of a full-time clinician, three peer specialists, and one administrative assistant, the ability to perform outreach in the community has increased exponentially. The peers have taken part in recovery events all over the mid shore, partnered with faith-based communities and have met with recovery groups at all provider locations to ensure that as clients cycle through their programs, they are all aware of the services that Queen Anne's now offers.

One of the most successful programs to be implemented is the Overdose On-call Peer Program. The program was created with cooperation between the LAA, the Department of Emergency Services (DES), and the Sheriff's Department. Queen Anne's County's Peer Specialists each have a cell phone to receive all text alerts about calls that the DES responds to. The peers are then called via DES dispatch, if an overdose has occurred and informed of which emergency room the individual will be transported. Queen Anne's peers have been vetted as volunteers at three University of Maryland Shore Regional Hospitals (Easton, Chestertown and Queen Anne's) and report to the emergency room to meet with the survivor, and their families. The peers offer support, understanding and discuss services that are available in the community. If the call is from the Sheriff's Department, the peer will meet with the person who has been arrested for possession, or other substance-related charges and offer the same services. Our peer program has an almost 50% success rate for supporting the survivors, getting them into treatment within a few weeks.

One of the greatest impacts on a local jurisdiction's resources is the misuse of emergency services. Queen Anne's County's MICH (Mobile Integrated Community Health) team began five years ago to follow up with individuals who are frequent utilizers of emergency services to assess their need for social services or behavioral health interventions. With the addition of peer specialists to the team this year, a formal assessment of behavioral health needs may indicate a

need for substance use support. The peer will offer information and assistance in identifying and assisting these individuals toward their recovery goals. The MICH team is activated when a 911 call goes out and the responding team feels that the caller would benefit receiving additional services, which may include social services or a behavioral health referral. This year, peer specialists were added to this team. The peer reports with the rest of the MICH team for a formal assessment of needs. When it is determined that individuals may benefit from substance use support, the peer offers information and assistance to help them move toward their goals of recovery. If the client would benefit from mental health services, a referral to a partner provider is made so the client can be seen quickly. One recent success involved a client who was unable to leave home due to mental health and substances use issues but after engaging with the MICH team peer, the client not only started to venture out for clinic appointments but attends groups in the community and has widened their sphere of supports.

The increase in services in FY19 has seen an increase in recovery support groups, including family support groups, Narcotics Anonymous, a peer-led recovery group (for those who are not comfortable or successful in traditional 12 step groups), and an 'anxiety and depression' support group which is facilitated by Chesapeake Voyagers, Inc.

Deepening Partnerships - Talbot County

The Talbot County Addictions Program (TCAP) pursued a multi-pronged approach to develop and enhance needed services in the jurisdiction in FY2019. One of those approaches was TCAP's participation in the 'Stepping Stones to Progress' initiative spearheaded by Salisbury University to complete a prevention needs assessment for seven rural counties on the Eastern Shore which is an essential step to meaningfully target interventions. TCAP also met with research associates completing the Statewide Ethnographic Assessment of Drug Use and Services (SEADS) project. This project is a collaboration between researchers at the Johns Hopkins Bloomberg School of Public Health and the University of Maryland with support from the Maryland Department of Health (MDH) through CDC Public Health Crisis Response funds. As part of this project, the team conducted interviews with substance users, service providers, policy makers, and other stakeholders including health departments and individuals who engage with people who use drugs across the state. One of the many goals was to provide direction with respect to capacity building related to harm reduction, overdose prevention and other health concerns among people who use drugs.

TCAP applied for Substance Abuse Treatment Outcomes Partnership (STOP) funding which will enhance peer support while in a detention center and upon release. It will also provide coordination of treatment services as well as access to funding for local and distance recovery houses for Talbot residents. Talbot County also submitted proposals for State Opioid Response (S.O.R.) grant funding to expand recovery housing in the jurisdiction to include acceptance of individuals receiving all forms of medication-assisted treatment. The Talbot County Health

Department (TCHD) provided added support to local recovery houses including procurement of bed days, drug testing supplies, peer support, and care coordination for individuals staying at the residences. Over 3200 bed-days were funded in FY19, care coordination was provided to 129 individuals and over 4500 support service activities were provided, including outreach to overdose survivors through peer support specialists.

TCAP includes three Peer Support Specialists who are vetted with the local hospital to respond to Emergency and other hospital departments, to support individuals who are experiencing adverse effects of opioids and overdose. Since partnering with EMS and local law enforcement, TCAP peers have been able to reach most survivors who had received Narcan in the field. TCAP works with over 120 different agencies across the state; flyers with peer support information are maintained at over 60 locations; and rack cards have also been made available for providers, agencies, and events. TCAP staff attended and provided information at 35 events in the community during FY2019.

TCHD continues to leverage existing grants to provide the nasal form of Narcan in overdose response kits that are distributed following trainings. During FY2019, TCHD Prevention Program completed 35 trainings, trained and distributed Narcan kits to 414 people.

TCAP has an ongoing relationship with Chesapeake Voyagers, Inc., to provide resources, information, peer support, and trainings when possible. TCHD and Chesapeake Voyagers, Inc. sponsored an Intentional Peer Support (IPS) training in April 2019 that provided 30 CEUs toward peer support certification. TCAP procured an additional 11 trainings to build and support the peer support and behavioral health workforce during FY2019.

The Talbot Problem Solving Court maintained ongoing services for 18-23 participants. The grant request for FY20 was approved and fully funded with additional allocations for recovery housing, transportation, and Equine Assisted Therapy. Talbot CPSC will be the first in the state to utilize Equine Assisted Therapy with the grant beginning July 1, 2019. The Talbot County Teen Court program – a voluntary diversion program run by teens for teens - continues to work toward recruiting and utilizing youth volunteers. The recidivism rate for this program was a respectable 13% in FY19.

Life's Energy Wellness Center in Talbot County has broadened access to SRD and MH outpatient for children and adolescents, as well as enhancing tele-psychiatry services.

Talbot County has also experienced growth in medication-assisted treatment services including the provision of Vivitrol given to individuals before release from the local detention center.

E. PLANNING PROCESS

A "no wrong door" Experience

MSPC believes that a no wrong door experience for consumers of the PBHS is a necessity to the wellness of our region and this quality expectation drives the work of each local authority. Working to expand access to services is a responsibility that is a constant priority as systems managers of the PBHS, and a challenge in the rural mid-shore landscape. Navigating the PBHS can be cumbersome for consumers and their support networks and is particularly challenging when an individual is in crisis. A "no wrong door" system allows them to get information and services at the first point of contact. MSPC team members work continuously with regional providers to remain abreast of available services, reference and assist to mitigate waitlists, and provide up-to-date information to those individuals requiring assistance. MSPC works to foster partnerships with providers so that they are connected to one another and know where to refer consumers when they are unable to serve them. This practice of making sure a consumer is directly connected to the correct service from the first agency they are in contact with enhances the "no wrong door" experience. MSPC involves itself when there is an issue of capacity, access, loss or gain of a provider in the community, to ensure that is at the forefront of support of and involvement with our consumer populations' access to services.

MSPC recognizes that individuals may have a difficult time with system navigation and prides itself on working to provide several resources to reduce barriers to treatment while providing consumer support and guidance whenever it is requested. Across local authorities, MSPC members consult with each other when necessary for support for consumers in varying counties or based on presenting needs. MSPC also values the emerging and enhanced support that the peer support workforce as well as care coordinators have provided with supporting the management and organization of consumer needs, in addition to assisting with reducing stigma and openness to follow through with services. The peer support networks are an essential component to actualizing a "no wrong door" experience for many of our consumers. The peer network can also add to the success of sustaining and engagement in services with the additional support component of a peer.

Since the fall of 2018, behavioral health and primary care partners in the mid-shore, members of the MSPC, and MSBH have initiated a warm hand-off processes with our provider network. The genesis of the warm hand-off initiative ties directly to MSPC awareness that consumers in the region have not been managed or assisted with accessing services to properly address their behavioral health needs. The mindful practice of warm hand-off translates to providers being more accountable with assisting with linkage to integrated providers to serve their consumers. In January 2020, MSBH launched its "Warm Hand-Off" provider dashboard which is an interactive tool that behavioral health providers use to publish weekly updates to waitlists by insurance type, age group, and primary presenting need whether mental health or primary substance use treatment need. The hope of the implementation of this tool is for primary care providers and cross-systems groups to have access to a real time dashboard for ease with referral and access to services.

Each member of the MSPC team generates a reference and resource guide that is county specific. MSBH publishes an annual comprehensive Resource Guide that is used as a tool regionally across authorities and providers. Since FY2018, MSBH has represented integrated providers to include substance use disorder resources and recovery house resources. The guide is available both in hardcopy and electronically at the MSBH website (https://www.midshorebehavioralhealth.org/). A goal for FY2021 is to work to publish the Resource Guide on the MSBH website that is interactive with category filters, such as county and presenting need, to allow for community members to reference and refine their resource searches.

Local Authority Complaint Investigation and Contract Monitoring Processes

MSPC comprises six local behavioral health systems management authorities, each with their own unique approach to complaint investigations and contract monitoring. As a group, MSPC is working towards a goal of streamlining practices across counties and agencies to be complementary with both complaint investigations and contract monitoring processes. MSPC acknowledges that several providers in the mid-shore region are represented in more than one county, and the streamlining of the MSPC group processes will benefit what the provider experience is when a local authority is involved for contract or quality management activities.

In MSPC, three Local Addictions Authorities (LAA) are also providers in the mid-shore region and must observe remaining free of any conflict of interest activities as systems managers. Complaint investigations are considered an area where conflict of interest could present if an LAA was to investigate a complaint in their county. In order to mitigate any possible conflicts of interest, the LAAs have Memorandum of Understanding for cross-systems management for complaints, and some county specific needs.

FY2020: Conflict of Interest and Systems Management Integration by Agency

Agency/ County	Caroline LAA	Dorchester LAA	Kent LAA	Queen Anne's LAA	Talbot LAA	MSBH CSA
Conflict of Interest MOU/ Complaint Investigations	Kent LAA MOU	MSBH CSA MOU	Caroline MOU	Queen Anne's LAA	Talbot LAA	MSBH CSA & Dorchester LAA
Partial Systems Manager		MSBH CSA MOU				Dorchester LAA

MSBH has supported the region's five Local Addiction Authorities (LAA) since FY2015 in some variation of contracted LAA responsibilities, and fluctuation of counties supported over the course of our work towards local integration during the course of MSBH LAA support, complaint investigations have been a primary function of our role. Complaint investigation is a function that as a CSA, MSBH has supported since our inception in 1992, and we identify complaint investigations as an accomplishment of our quality management as an organization. Any time a

complaint is filed with MSBH, the complaint is investigated, and staff works to resolve the issue with the provider or complainant group to improve service provision.

Across the MSPC, complaint investigations are a quality initiative that each local authority continually works to improve with efficiency, process, compliance, with the common goal of resolution. A critical factor with complaint investigations is the origin of the complaint. MSPC manages complaints that are generated from consumers, constituents, providers, stakeholders, the Behavioral Health Administration (BHA), the Governor's Office, and the Administrative Service Organization (ASO). Each entity is expected to comply with timely investigations and reporting, as well as concluding the investigation. Depending on the critical nature or acuity of the complaint, MSPC may engage additional authorities such as the accrediting body, BHA, or the Maryland Department of Health's Office of Healthcare Quality (OHCQ), to be involved and/or assume the lead role on the complaint investigation.

MSPC participates on the ASO audits with all identified mid-shore providers, county-specific by LAA. Communication across loal authorities takes place to ensure that the LAA in the county and MSBH are represeted at an ASO audit if indicated by provider type. Audit participation allows opportunities to build relationships, re-enforce quality of care standards, and remain apprised of situations in the mid-shore community. When Program Improvement Plans (PIP) are issued, a reviews of the plan takes place, and the identified local authority schedules follow-up with the provider to determine whether corrective actions are in place and to report progress to ASO.
MSPC has prioritized our complaint investigation process as a quality improvement initiative with the goal of manualization of our procedures. This includes dissemination of information, documentation, responsiveness, management and follow-up, involvement of accrediting bodies and supportive regulatory entities, as well as groupthink with best practices for complaint resolution. Leadership of MSPC has served on the Accreditation Implementation Sub Committee with BHA since January 2017 to present (January 2020). MSBH serves as one of two local authority representatives on the subcommittee. The Accreditation Implementation Sub Committee's primary task is to assist with the development of the guidelines from BHA to local authorities regarding complaint and critical incident investigation and update the Critical Incident management and reporting process. MSBH has extended support to this group with the development of the document: *Local Behavioral Health Authorities, Core Service Agencies and Local Addiction Authorities Guidance for Patient/Family Member/Guardian Incidents, Complaints and Concerns Regarding Substance Use Disorder and Mental Health Services* as well as the revised *BHA Critical Incident Report form*.

MSBH has supported solicitation of feedback from the Maryland Association of Behavioral Health Authorities (MABHA) group and has presented with BHA to the MABHA the draft Complaint and Critical Incident processes for engaged feedback. MSBH has collaborated with LAA partners with the implementation of the guidelines. MSPC has advocated along with the MABHA group, for the implementation of the revised complaint and critical incident reporting processes and forms at the State level. Currently, MSPC is utilizing Draft form of the aforementioned documents and guidelines.

MSPC has worked to enhance collaboration on with our contract management and monitoring responsibilities. MSBH has supported all LAA partners with the transition to a Condition of Award system for sub grantee monitoring and in the summer of 2019, MSBH shared all contract monitoring tools with each LAA partner. MSPC is working to streamline processes for efficiency and consistency in contract management. This approach, which encompasses all aspects of contract monitoring, allows for our sub vendors to have a consistent experience across multiple contracts regardless of local entity.

MSPC has embraced a graduated monitoring schedule that includes pre-contracting conferences, standing quarterly and annual reports, review of monthly invoices and deliverables, complaint investigations as needed, and an annual site visit. If a program improvement plan is implemented, MSPC will monitor accordingly to ensure implementation of the plan. New and exiting providers receive more oversight and support during transitions and when implemting new awards.

MSBH requires sub-vendors to attend a quarterly Behavioral Health Services Network (BHSN) meeting as part of their contract. The meeting is an opportunity to network and provide updates regarding exisiting and new programs and discuss gaps or needs in the PBHS. Providers are encouraged to present intiatives that they are offering or are aware of to inform others. Additionally, subvendors are required to participate in regularly scheduled BHSN workgroups meetings that address forensic, homeless, aging, and child and adolescent populations.
An initiative for FY2021 is to formalize cross-local authority agency workplans with contract monitoring, reporting, and BHA required monitoring as an exercise to enhance cross-authority processes orientation and streamlining and to assist with mitigating duplication of administrative functions.

Planning Processes: Assessing the System of Services: Gaps and Unmet Needs

MSPC monitors challenges and changes at the regional, state and national levels and works to address issues while anticipating how change may impact the system of care in the mid-shore region. Evaluation of needs occurs through several mechanisms including facilitation of the MSBH Behavioral Health Services Network workgroups (BHSN), county-based provider meetings, engagement with community members and stakeholders, and utilization of data. MSPC collaborates with peers in systems management roles as well to support the analysis of community needs. Integral partners in the mid-shore are the Local Management Boards, Opioid Intervention Teams, Local Drug and Alcohol Abuse Council(s), Regional Behavioral Health Advisory Committee, and our regional hospital provider, University of Maryland's Shore Regional Health System.

Through collaboration with partners and community members, MSPC is supported with assessing our unmet needs and gaps in services in the region. In addition to relationships in the region, data is a key element of confirmation of the needs in the region and trends with utilization and primary needs. Data comes from several origins, CRISP, OD statistics and overdose mapping, OIT,

Opioid Task Force, SEADS study, ASO utilization, and provider/contract specific reporting. MSPC utilizes data that highlights that as a region, we are primarily in need of workforce to support our services gaps. In December of 2019, the Eastern Shore Behavioral Health Coalition supported an analysis of the Health Professional Shortage Area (HPSA) zones defined by the Health Resource and Services Administration, and the mid-shore and Eastern Shore are all indicated as disparity zones for primary care, and three of the five mid-shore counties are mental health disparity zones. This information is being used to highlight the needs of the region and support advocacy with workforce initiatives through legislation and grant initiatives.

MSPC team members represent the Mid-Shore Counties Local Systems Management Integration Workgroup. This group represents leadership from each local authority, the five mid-shore counties Health Officers, and agency team members. MSPC has utilized this group to address regional service needs as well as work to plan for integration of local authorities and system oversight. MSBH believes that being proactive in creating a regional a comprehensive Local Systems Management Integration Plan will benefit the communities we serve in improving health disparities and inequities and prioritize the no wrong door experience. This planning process will ensure that all individuals seeking support, their family and natural supports, will have access to an integrated system of care, and the system will be evaluated to support integrated behavioral health needs.

MSPC references the Crisis Services Strategic Plan from FY2018 as a guiding document to continually improve the crisis response system in the mid-shore. The Crisis Services Strategic Plan was completed by all mid-shore local authority partners and is representative of a vision for enhanced crisis response services for the region. Participants informed MSBH of community needs, taking into consideration their unique region and community needs. This plan included adding crisis beds to the region, assessing the possibility of a crisis walk-in center, and moving to a 24/7 mobile crisis response structure. MSPC has worked to respond to enhancing our region's access to the services deemed necessary in our region, and with additional funds from BHA, the State Opioid Response Grant, and Opioid Operational Command Center funding, has been able to expand all services. The mid-shore region has expanded crisis beds, implemented a 24/7 mobile crisis team response, and has brought Safe Stations to the Eastern Shore Region.
MSPC references the work of the Mid-Shore Rural Health Collaborative as a guiding group that is working in with the mid-shore counties to address healthcare access and challenges to delivery of care in the region. MSPC is represented on the Rural Health Care Collaborative by way of the five mid-shore county Health Officers. Identified priorities include addressing access to clinical services, transportation disparities, addressing social determinants of health, and enhancing coordination of services across providers and social services.

MSPC is working to address increasing access to behavioral health services and recovery support systems wherever possible, and to work to build an integrated, robust continuum of services. MSPC supports seeking out expanded resources and funding opportunities to support the mid-shore region. MSPC intends to expand the resources that are being identified for the region as

we complete a more comprehensive reginal needs assessment with the intention of utilizing this data to secure additional funding and support for service expansion in the region.

Stakeholder Engagement in Community Planning

Deliberate involvement of community stakeholders is an ongoing priority for the MSPC members. In the mid-shore region, each county has established meetings and workgroups that engage stakeholders and yield community involvement with planning. In the mid-shore region, each county has a Local Drug and Alcohol Abuse Council (LDAAC) and has representation on the Regional Behavioral Health Advisory Council (RBHAC). In FY2020, each county achieved the establishment of county specific provider meetings that engage providers across the integrated continuum. These provider meetings meet quarterly and compliment the mid-shore region's BHSN quarterly engagement with providers; each committee requires participation and representation from the consumer and community.

MSPC members engage on several state-wide and local engagement groups. Memberships include representation on Maryland's Behavioral Health Advisory Council, Local Systems Management Integration Advisory Committee, mid-shore counties Local Management Boards, Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) Advisory Council, Maryland's Forensic Services Advisory Council, Opioid Misuse Prevention Program Executive Leadership group, the Eastern Shore Behavioral Health Coalition, and Maryland's Behavioral Health Coalition. An initiative that is being led by the MSPC is the development of the Enrichment of Access to Behavioral Health in the mid-shore initiative. This is an initiative in partnership with UMSRH and the behavioral health, primary care, and key-stakeholders in the mid-shore, that will convene in March 2020 to address service gaps and community planning for integrated health care in the region.

MSPC participates on several BHA level committees and work groups. MSPC team members are represented at the following work groups at BHA: Older Adult/PASRR Work Group, Adult Services Meeting, RRP Process Work group, Child and Adolescent Work Group, and Crisis Intervention Team Advisory Committee. MSPC prioritizes opportunities to be engaged in process related subcommittee opportunities in collaboration with BHA. MSPC leadership are represented at the Maryland Association of Behavioral Health Authorities (MABHA) group, and the regional Addictions Consortium of the Eastern Shore (ACES) group.

MSBH supports several population specific workgroups that meet over the course of the fiscal year. The workgroups are a key element of the work of MSBH to interact with local providers and consumers. MSBH manages the following workgroups that meet at least six (6) times annually: Forensic Workgroup, Crisis Intervention Team (CIT) Advisory Subcommittee (meeting quarterly with the Forensic Workgroup), Child and Adolescent, Mid-Shore Local Systems Management Integration Workgroup, Aging with Behavioral Health and Disabilities, Continuum of Care Roundtable on Homelessness, and Consumer Council. A new coalition that developed in FY2020 is the Eastern Shore Safe Station Coalition. This group represents all partners on the Eastern Shore that are launching and managing Safe Stations in the region.

The Forensic Workgroup focuses on groups of stakeholders, including: recovery programs and persons in recovery (peers); legal representatives such as public defenders, probation officers, judges, police officers and first responders; behavioral health providers and programs; and housing programs, shelters, and people impacted by homelessness. The workgroup invites community partners to guide future workgroups by suggesting topics that are relevant to our community. The FMHP, hosted it's sixth Annual Sequential Intercept Model (SIM) meeting on January 28, 2020. The theme of SIM meeting this year was Human Trafficking; an educational and interactive meeting to address the SIM and the overlay of how human trafficking can be combatted with this model.

MSBH is the lead agency for our five-county Continuum of Care, The Roundtable on Homelessness. The group brings together local homeless service providers in the region while overseeing funding from the Department of Housing and Urban Development and the Maryland State Department of Housing and Community Development for homeless programs. All mid-shore local homeless service provider partners including emergency shelters, transitional housing, homeless prevention, rapid rehousing and permanent supported housing programs participate in the group. Coordination of services is a main goal for the group to ensure those who are faced with homelessness are served quickly and by the most appropriate service. The group strives to have peer involvement and it is a HUD requirement that a formerly homeless person sits on the executive committee of the group. The Roundtable has met this requirement for the past five years.

MSPC strives to be inclusive of diverse and unique populations such as deaf and hard of hearing, visually impaired, LGBTQ, Veterans, and diverse groups with stakeholder engagement. MSPC has prioritized working on racial equity and social justice as priority population group for stakeholder engagement and representation on leadership and governing bodies. MSPC will be focusing on addressing health disparities of minority populations and the impact these groups have, and their unique culture differences. MSBH surveyed our provider network in the Spring of 2019 to work to address need and culturally sensitive messaging and reach to all groups in the mid-shore community.

MSPC has identified that there are groups serving the mid-shore that may benefit from enhanced partnership and group representation. MSPC is hopeful that in FY2021, the following groups are supported and facilitated by MSPC; Recovery Housing and Treatment Workgroup for the mis-shore, Peer Support Workgroup, and a Social Justice and Racial Equality for the mid-shore are implemented.

Local and State Behavioral Health Advisory Councils

MSPC prides itself on the prioritization of inclusion of our local and state advisory counterparts as a part of our planning process. Throughout the course of the year, MSPC facilitates, as well as participates in various local and state workgroups and advisory committees. As described in the Organizational Structure section of the plan, MSPC includes stakeholders in the planning and evaluation program/jurisdictional services. Input from consumers, natural supports, the provider

community, legislative representatives, and local stakeholders is obtained throughout the year and contributes to the Annual Community Behavioral Health Plan.

MSPC is representative of six local advisory councils. In the mid-shore, each county in pursuant with the Annotated Maryland Code Health General 8-1001- Local Drug and Alcohol Abuse Council (LDAAC), which are represented in each of the five mid-shore counties, and the Maryland Code Health General 10-308, Mental Health Advisory Committee represented by one Regional Behavioral Advisory Committee (RBHAC). RBHAC serves to represent our mid-shore counties to advise and assist in the planning and evaluation of the publicly funded mental health and substance related disorder services. The LDAACS serve to represent the substance use advisory and criminal justice advising for each county. Most LDAAC members are also representative of local Opioid Intervention Teams (OIT) pursuant with Inter-Agency Heroin and Opioid Coordinating Council 01.01.2015.13. These advisory entities review and evaluation of behavioral health needs of the local public health system, including quality of services, gaps in the system, and interagency coordination. Each advisory group is included in the integrated Community Behavioral Health Plan endorsement processes for the MSPC FY2021 Annual Plan.

The LDAAC groups and the RBHAC are integral to the development of the Community Behavioral Health Plan, as it these governing bodies contribute reports and strategic plan by county, in addition to endorsement documentation of the plan. Over the course of the fiscal year, each advisory group will receive updates in the implementation of the Goals, Objectives, and Strategies for the plan

In FY19, leadership from MSBH was invited to join the State of Maryland Behavioral Health Advisory Council. Through the participation on the state-level advisory council, MSBH leadership joined the new subcommittee, Recovery Services and Supports Committee. MSBH leadership engaged the Council in the Summer of 2019 with consideration for an evaluation of Annotated Code of Maryland, Health General 7.5 - 305, and federal Public Law (PL) 102-321, to be included the analysis of Local Advisory Council Statutes. Particular attention for the matrix review of statute language to ensure the representation of local authority integration and the relationship with advisory councils across leadership groups. In the Spring of 2020, a workgroup is planning to convene that will have representation from MSPC, BHA, MABHA, Maryland Delegates, OOCC leadership, and MDH, to initiate the analysis of the statute language and how governing language can support integration and leadership across partners in the State of Maryland.

MSPC is an active participant on the state level Behavioral Health Coalition as well as the Chair of the Eastern Shore Behavioral Health Coalition. MSPC remains abreast of the legislative impact on the delivery and access to the public behavioral health systems, as well as supporting the education of our regional legislative body by way of our activities supported by our local coalition to present and engage with our legislative representatives at our annual legislative presentation at the Winter Maryland Association of Counties Conference and presentation during session to the Eastern Shore Delegation. Priority areas for 2020 include the Keep the Door Open Act, provider credentialing and workforce, expansion of Psychiatric Nurse Practitioner scope, and tele health allowances for rural communities.

MSPC has engaged with the Lt. Governor's Commission on Mental and Behavioral Health. Several MSPC members were represented at the mid-shore presentation from the Commission on December 18, 2019. In addition, MSPC has been following the Behavioral Health System of Care Workgroup at the state-level to remain abreast of the developments with analyzing the delivery and management of the PBHS.

Emergency Preparedness

Caroline County Local Addiction Authority:
Caroline County Behavioral Health will utilize our Emergency Preparedness Plan for our local Jurisdiction. Caroline County will coordinate with other nearby jurisdictions when an emergency arises to fill any gap services necessary. The need for substance-related disorders has exploded with the opioid epidemic. The mid-shore regional Public Behavioral Health System needs to look at ways to improve access to both mental health and substance-related disorders treatment across the spectrum. The integrated Eastern Shore Crisis Response System is growing exponentially, particularly with the continuous training of CIT officers. Both the helpline call center and the mobile crisis teams urgently need increased capacity to meet needs currently. During a disaster, these services would need to expand quickly and efficiently.
In Caroline County, where the health department is the largest single provider of behavioral health services, there has been limited provider expansion. A list of key staff contacts to be reached in case of emergency is included in the document. Caroline County implements a call-down tree within the Health Department for emergencies. Caroline County Behavioral Health also supports the Emergency Preparedness plan for the mid-shore and will work collaboratively with MSBH.

Dorchester County Local Addictions Authority:
DCBHS is a division of the Dorchester County Health Department and is therefore subject to comply with the Dorchester County Continuity of Operations Plan (COOP) for the local health department. The mid-shore region is also included in the Mid Shore Behavioral Health Emergency Operations Plan. DCBHS is committed to compliance with either plan if there is a disaster or traumatic event that would require activation of one or both plans. If both plans are in effect DCBHS will follow the Dorchester County COOP, unless directed otherwise by the local Health Officer. Both the Continuity of Operations Plan and the MSBH Emergency Operations Plan can be referenced in the Appendices. DCBHS will assist MSBH in every way necessary to ensure private providers in Dorchester County comply with requirements and actions related to the County's All Hazards Plan.

Kent County Local Addictions Authority:
Kent County is fortunate to have a robust Director of Emergency Preparedness. Kent County has drills and have been able to respond to the natural disasters in our community, hurricane Isabel

September 6, 2003, other weather-related problems involving loss of electricity due to storms and being ready for epidemic point of dispensing and evacuation preparedness. Kent County PRS were also ready to aid consumers who were enrolled in a local possible closure of a MAT program under DEA investigation in our jurisdiction.

KCBHC will utilize the Emergency Preparedness Plan for the jurisdiction. Kent County will coordinate with other nearby jurisdictions when an emergency arises to fill any gap services that are deemed necessary. The need for substance-related disorders has exploded with the opioid epidemic. The mid-shore regional Public Behavioral Health System needs to improve access to both mental health and substance-related disorders treatment across the spectrum. The integrated Eastern Shore Crisis Response System is growing exponentially, particularly with the continuous training of CIT officers. Both the helpline call center and the mobile crisis teams urgently need increased capacity to meet current needs. During a disaster, these services would be expected to respond to quickly and efficiently in the face of overwhelming spike of need.

As part of the "Agreement to Cooperate" each provider in Kent County must submit a continuity of operations plan with Behavioral Health Administration. If there were to be a disruption in services due to natural, environmental, lack of resources or other disruptions of services each program should have a contingency plan. As the LAA for Kent County each provider in the jurisdiction includes as part of their application packet, a contingency plan for the program should they be met with factors which mandate the programs closure on that site the provider has 30 days prior to closure must notify the LAA of the program closure and contingency of operations plan (COOP). The AFWC has an evacuation agreement with the Kent County Community Center at Worton, which allows for the provision of consumers and staff to have temporary shelter. The contingency plan is for us to be able to discharge consumers ready for discharge and to refer our other consumers to appropriate levels of car.

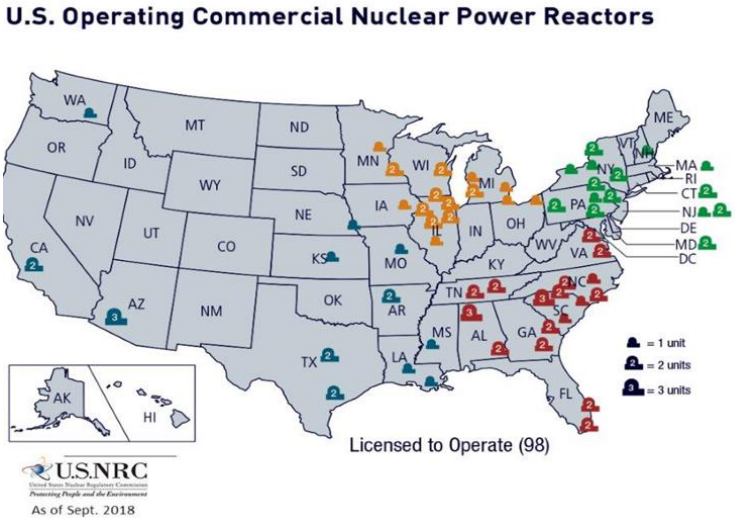
Kent County has enhanced the all Hazards Plan to include the nuclear threat from North Korea and now with the possibility of leaving the nuclear arms deal for short range nuclear missiles agreement with Russia. In 2020, there has also been a heightened risk of terrorism domestic and abroad due to the bombing and termination of Iran's General Qassem Soleimani on January 4, 2020. There have also been bombing of United States occupied bases in Iraq and heightened domestic and International terrorist threats. We also, now have the threat of the coronavirus that has spread to the United States from China just this month, January 2020.

If there were to be a nuclear missile air burst the nuclear fallout area is a one-thousand-mile radius, excluding wind drift factors. If there were to be a nuclear missile land strike the nuclear fallout area is a one-hundred-mile radius, excluding wind drift factors. Either of these disasters would include our jurisdiction should an attack on our Nation's Capital ever become a reality. The All Hazards Plan can be viewed in appendix E.

Outpatient services needs to improve for MH and SUD. Kent County would expect more trauma cases to present after a disaster. A list of key staff contacts to be reached in case of emergency is included in appendix G of this document. KCBHC also supports the Emergency Preparedness plan for the mid-shore and will work collaboratively with MSBH.

It should be noted that we are near the 50-mile Ingestion Exposure Pathway Zone of some power plants. Portions of Kent County lie just beyond the ingestion exposure pathway zones of three nuclear power plants located beyond the boundaries of the County, yet Kent is within the toxic-release area zone.

Maryland and parts of Kent are included within the 100-mile plume area of some of the nearby nuclear power plants: Calvert Co. Cliffs Nuclear Plant, Peach Bottom Nuclear Plant, Salem Nuclear Plant and Hope Creek Nuclear Power Plant. In today's environment, there is also a real threat of the terrorist use of biological agents in addition to the "usual" disasters of weather, transportation incidents, radiological, and hazardous materials.



Kent would like to include a regional approach of educating our population regarding: reducing stigma related to: mental health, substance use disorder and suicide, benefits of increasing harm reduction measures including the benefits of syringe programs, wound care, safe use, Good Samaritan Law, Narcan and drug disposal and safe storage.

Mid Shore Behavioral Health:

MSBH is guided in its emergency preparedness philosophy and procedures by a series of documents, created by MSBH staff and incorporating current research into organizational disaster readiness. These documents are updated annually to reflect, for example, changes in our organizational chart, internal procedures, or recommendations of emergency planners in our jurisdiction. The aforementioned documents are included in the Appendices of this plan. They

are: MSBH Emergency Contact Plan, MSBH Emergency Operations Plan, and MSBH Disaster Preparedness Internal Evacuation Procedures.

MSBH is responsible for supporting each of the mid-shore counties with emergency response and maintains an MOU with each county outlining responsibilities in the event of an emergency. MSBH has designated team members for each of the mid-shore county. These individuals attend scheduled emergency preparedness meetings in their respective county assignment and are indicated as the point of contact in the Emergency Call-Tree document and in MSBH Emergency Preparedness documentations and packets.

Responsibilities during an emergency are related to, but not limited to the following:

- Ensure communication and response arrangements with the Eastern Shore Crisis Response system; Eastern Shore Operations Call Center, Mobile Crisis Teams, contact with Crisis Intervention Team response personnel.
- MSBH will be available for support to provider community with support with triage of individuals in need of mental health services and access to treatment.
- Communicate with Residential Rehabilitation Programs for confirmation of needs and emergency response.
- Provide counties with primary and alternate point of contact for mental health services, as well as a 24 hours/day, 7 days/week contact during emergencies.
- Assist with the assessment of mental health needs of staff, victims, and volunteers during and following a disaster.
- Assist Mental Health Team and Emergency Response personnel with the coordination and provision of mental health service support in clinics, and other designated areas such as triaging, debriefing, and the counseling of people, staff, and volunteers who are exhibiting signs and symptoms of stress and/or anxiety, or any other maladaptive symptoms, as a result of a naturally occurring or terrorist initiated disaster.
- Direct mental health staff to report to specific locations, as determined in coordination with County Emergency Response Staff.
- Plan and assist in the coordination of follow-up services to ensure long-term recovery, such as additional community interventions, individual or family counseling, or community education.

In addition to MSBH responsibilities in an emergency, MSBH has incorporated requesting that all the sub vendor groups provide a copy of their agency COOP/Emergency Response Plan at the time of FY2020 contract site visits. This requirement was an addition to the FY2020 MSBH Contracting requirements.

Queen Anne’s County Local Addictions Authority:

Queen Anne's County's Emergency Preparedness Plan consists of the coordinated response of the department of emergency services and department of health personnel through the Queen Anne's County Department of Emergency Services, QAC Health Officer, county officials, the public

information officer, and close collaboration with other local and state agencies. The Emergency Plan is included in the Appendix section.

Talbot County Local Addictions Authority:
Talbot County Health Department Emergency Management Plan is included in the Appendix section of the Plan. The Plan addresses the coordination of emergency services and mobilizing emergency personnel under the Talbot County Department of Emergency Services, the TCHD Health Officer, County Officials, local Public Information Officer, and in collaboration with other State agencies and responders. During FY2018-2019, TCAP participated in Continuity of Operations planning (COOP) which will be made available during FY2020.

F. SERVICE DELIVERY AND RECOVERY SUPPORTS

1. Treatment Services

a. Behavioral Health treatment in recovery support services across the lifespan

Mid Shore Planning Committee (MSPC) provides support for and participation in behavioral health initiatives related to prevention, treatment and recovery across the lifespan. MSPC remains apprised of available services via annual updates of MSBH resource guide, which includes mental health and substance use disorder treatment options. Area providers also inform MSPC of individual programmatic changes and updated resources. MSPC continually looks for gaps in services and works with community partners to develop and sustain adequate service accessibility.

In order to address the gaps in behavioral health services in our rural mid-shore region, MSPC starts with the view of the community we have captured through a trauma-informed lens. Poverty, poor quality housing (or none at all), food insecurity, racism, and geographic isolation, are some of the social determinants that impact both the region and the health of its inhabitants. These stressors disproportionally affect those individuals and their families who may be isolated by behavioral health diagnoses.

Our region's continuum of care spirals out from the individual and as each unit of care is identified (children, mothers, grandparents, schools, church, community organizations), provides wrap-around services that contract or expand as needs emerge and recovery progresses. Through provider-focused and community-wide training, supported by the MSPC, our initiatives to restore and improve behavioral health interventions are reducing silos and building new partnerships in integrated care.

SRD Services

Individuals at risk for relapse due to an unstable recovery/living environment

MSPC recognizes that many individuals with SRD in the mid-shore region are at risk of relapse due to unstable housing. Unstable housing is prevalent among injection drug users (IJU). At the A. F. Whitsitt Center (AFWC), SRD Treatment Center in the mid-shore, finds that those with unstable housing affects between eighteen and twenty-five percent of AFWC population. There is a high rate of mental health disorders and SRD/co-occurring disorders of those with unstable living arrangements or homelessness. Recovery residences (RR) can provide the stability and support for the co-occurring population without housing. With semi-structed recovery environments many behavioral health consumers are able to gain periods of recovery which allow for stabilization and self-improvement in many life areas. During the transition from inpatient treatment to community housing, the care coordinators and peer recovery specialist (PRS) assist in the stabilization process. They can assist with securing housing funding for up to sixty-days, transportation and linkage to needed services and treatment. Kent County has introduced the No Harm in Helping (No HiH) mobile MAT unit which provides monthly injections for RR consumers in the mid-shore and Cecil County area. This provides an option for RR owners

to accept MAT referrals without the daily oversight and management obstacles that comes with daily MAT prescriptions. The one-time monthly injectable Vivitrol or Sublocade also eliminates the possibility of medication diversion, irregular patterns of administration, eases the consumers difficulties regarding refills and allows the RR house managers uncomplicated MAT process in the RR.

Opioid-related dx engaged with MAT

There are limited options available on the mid-shore for those consumers with an opioid-related disorder seeking treatment. MAT along with counseling is considered the best-practice treatment of choice for these individuals. This type of treatment is being offered in the Caroline County outpatient clinic setting and on the Mobile Treatment Unit (Eastern Shore Mobile in Caroline County). Mobile Treatment for these consumers brings MAT to their own community and addresses the transportation issue as well. MAT treatment may be provided in the form of a tele relationship with distant contracted providers as is the case on the Mobile Treatment Unit as well as our other treatment locations on the mid-shore, due to the lack of providers in the area. This enables more MAT treatment options for our consumers with an opioid diagnosis and additional treatment slots available for more consumers to be able to seek treatment.

Individuals Identified as IV drug users

Dorchester County continues to be a part of the mid-shore effort to address opioid misuse prevention. Prevention Services continue to serve as the lead representative for Dorchester County, participating on the Mid-Shore OMPP Leadership Team and the OMPP Coalition. Prevention Services is responsible for the continuous effort in collecting data, implementing the strategic plan, guiding the coalition, and working with the evaluation team to evaluate the program and its data. Through this process, decisions are made as to what types of educational materials are needed in the county and the region.

The development of information to disseminate is collected from many sources such as the Substance Abuse and Mental Health Services Administration (SAMSHA), the State Behavioral Health Administration, Maryland Poison Center, local law enforcement data, MSBH data, Beacon (Value Option's OMS), information and questions posed at local public forums, and other state and national substance use data reports from universities.

When high risk and high cost patients are identified either by clinical staff, Peer Recovery Specialist Certified or referring agencies, they are assessed to determine level of care and support needs. Individuals appropriate for level III residential treatment programs are routinely referred to Care Coordination and to Dri-Dock Recovery and Wellness Center for peer support as well. Coordination of care for high risk and high cost patients, specifically patients identified as IV drug users are managed through a referral process to the local health department, in Dorchester County to Dorchester County Behavioral Health or one of the local private providers. Once a comprehensive assessment has been completed, the individual is placed in the appropriate level of care based on the most current edition of the American Society of Addition Medicine Patient Placement Criteria. All treatment is provider by utilizing best practice approaches including Motivational Interviewing, Cognitive Behavioral Therapy, and Trauma Informed Therapy. A

pharmacological approach in treating opioid addiction, Medication Assisted Treatment (MAT) is utilized when clinically appropriate; medications including Buprenorphine/Suboxone/Vivitrol are prescribed by an addictions physician when needed. When appropriate individuals are referred to Level III.7 treatment.

The mid-shore counties utilize the A.F. Whitsitt Center for crisis beds specifically for individuals experiencing opiate withdrawal. In Dorchester County, high risk and high cost patients are case managed by clinical staff with special attention from the clinical supervisor, a LCSW-C, during any waiting period prior to admission to residential treatment. The Care Coordinator works with the individual to help ascertain resources to address primary needs prior to admission to residential treatment and upon discharge. Contacts are made with MSBH when appropriate for assistance with difficult cases.

Transitioning from incarceration to the community

Regionally MSPC offers services through the detentions centers to assist with transitions into the community such as the Maryland Community Criminal Justice Treatment program (MCCJTP) and transitional housing. Specifically, Dorchester County Behavioral Health Services, operates an accredited SRD program, Drug and Alcohol Recovery Treatment Program (D.A.R.T.), in the Dorchester County Detention Center. The program utilizes an evidence-based best practice curriculum, "A New Direction" which has proven to be effective with the incarcerated population. The Screening, Brief Intervention and Referral to Treatment (SBIRT) to has been instituted at the time individuals are first entering the detention center to identify those that might need SRD services. If an individual has a positive urine screen, they may be referred to the D.A.R.T. Program for treatment. The treatment methods utilized are Motivational Interviewing, Trauma Informed and Cognitive Behavioral Therapies. A pharmacological approach in treating opioid addiction is also used. Prior to release, individuals have an opportunity to start Vivitrol. They will also be referred for outpatient treatment and are provided with a contact person, appointment time and date and be connected with a Peer Recovery Specialist to help with the transition. If the individual chooses not to go to treatment, they will be connected with a Peer Recovery Specialist to provide recovery support resources to include housing information, employment help, and assistance with vital documents. In the near future, Medication Assisted Treatment (MAT) will be offered when medically appropriate; the medications that will be offered to manage opioid use disorders are Buprenorphine, Suboxone, and Vivitrol. All individuals released from the Detention Center are given Narcan upon release.

Individuals who are HIV positive

The Health Departments assist individuals who are HIV positive. Individuals can receive case management services, referral to the local FQHC, as well as eligibility for Care Coordination and Peer Support services through their local jurisdiction. The Care Coordinator acts as the primary interface between ambulatory providers, programs, community partners and their patients. Care Coordinators are responsible for conducting ongoing face-to-face or telephone meetings with the patient bi-monthly or as needed to allow for coordination and support to access,

participate, continue in and avoid duplication of services, and to update the patient's plan utilizing positive goals and objectives. At times, Peer Recovery Support Specialists may work closely with these individuals to assist in accessing treatment and support services within the community. The Health Departments will continue to review the need for harm reduction strategies, information, training, and utilization in the jurisdiction to reduce the incidence and prevalence of communicable diseases through injection drug use.

Co-occurring Disorders

Queen Anne's County works with local providers for substance use and mental health disorders closely to ensure that all needs are met. Queen Anne's County itself provides wrap around services to those providers, such as MAT (Vivitrol and Buprenorphine), Fentanyl Test Strips, Naloxone, family support groups, Narcotics Anonymous, a peer-led recovery group, as well as hosts an anxiety and depression support group. Within the Center at Nielsen (located at the QADOH) a wellness center exists where peers can meet with their recoverees, assist in employment searching, participate in a life skills class, meditation group, art therapy group, access to the public behavioral health system, learn about the multiple treatment options available, as well as arrange for transportation to appointments. Queen Anne's is finishing a second-year pilot program which offers acupuncture, from a partner provider which continues to be successful. It has been such an integral addition to the outpatient group, the clinicians and participants are eager to see it continue and grow.

Pregnant women and women with children

There is limited housing for pregnant women after the third trimester in the mid-shore. Most of the programs who will accept pregnant women and women with children are on the Western Shore. The AFWC averages 3-6 pregnant women of women with children in need of services per month. This is an identified gap service for the mid- shore area.

Mental Health Services

Individuals with serious and persistent mental illness and co-existing conditions

Individuals with serious and persistent mental illness and co-existing conditions can attend the Psychiatric Rehabilitation Program (PRP) through mid-shore community providers, in addition to the Residential Rehabilitation Program; both programs build on recovery and independence. Other community providers, such as Shore Regional Health in Cambridge, offer intensive outpatient treatment for persistent mental illness. The mid-shore also has an inpatient facility in Cambridge for serious mental illness that requires acute stabilization.

In addition, Mobile Treatment programs are able to meet individuals in the community. Eastern Shore Crisis Response is a 24/7 call center that manages behavioral health crisis and has the ability to dispatch Mobile Crisis to respond to individuals 24 hours per day.

Peer Support is also available to support individuals on their path to recovery. Chesapeake Voyagers has locations in all 5 counties and offers supportive groups and guidance from peers on living with a behavioral health diagnosis.

Court and criminal justice involvement

The Forensic Mental Health Program (FMHP) works directly with defendants who have behavioral health needs and criminal justice involvement. FMHP provides mental health assessments and recommendations as well as case management services to clients in the community. Staff collaborate with other agencies including RRPs, outpatient behavioral health programs and housing programs. The FMHP program receives referrals from the courts, public defenders, families, detention centers, state hospitals, Dept of Corrections, behavioral health providers, and probation agents. FMHP works closely with Problem-Solving Courts in Talbot and Caroline Counties ensuring mental health treatment needs are met. The FMHP also hosts a monthly workgroup on a variety of topics that impact the forensic community. This workgroup is attended by a broad spectrum of professionals serving clients who are forensically involved. FMHP also hosts an annual workshop that focuses on behavioral health resources and needs for individuals along the criminal justice continuum.

Traumatic brain injury (TBI)

Traumatic brain injury (TBI) is a serious public health problem in the United States. Maryland's Behavioral Health Administration (BHA) within the Maryland Department of Health (MDH) has been identified as Maryland's lead agency for Traumatic Brain Injury (TBI). In 2014, there were approximately 2.87 million TBI-related emergency department visits, hospitalizations, and deaths in the US, including over 837,000 of these health events among children. TBI's occur in people across the lifespan from children to the elderly. There are a few local behavioral health providers that provide treatment for those diagnosed with a TBI in the eastern shore region and a brain injury support group through Shore Regional Medical Center. For more severe TBI cases would be referred to BHA as the lead agency for TBI's.

Homelessness

MSBH serves as the lead agency for the Mid Shore Roundtable on Homelessness, the five county Continuum of Care, and coordinates homeless services for the region. Through this group we work to connect people experiencing homelessness with needed services emphasizing housing first.

Co-occurring Disorder

Mental health problems and substance use disorders sometimes occur together. Mental health problems can sometimes lead to alcohol or drug use, as some people with a mental health problem may misuse these substances as a form of self-medication. More than one in four adults living with serious mental health problems also has a substance use problem. Someone with a mental health problem and substance use disorder must treat both issues. Treatment for both mental health problems and substance use disorders may include rehabilitation, medications, support groups, and talk therapy. There are services on the Eastern Shore that provide the

necessary services to treat this co-occurring disorder. However, there is a shortage of clinicians that are willing to treat both simultaneously due to its complexity and their lack of knowledge/education in this area.

Victims of Trauma

MSBH has continually acknowledged the delicate needs of victims of trauma and educating Providers and the community about trauma-informed services. MSBH hosted and supported three screenings of the ACE's documentary: Resilience screening in Caroline and Talbot Counties. These screenings were offered to the community at large, with time for discussion to answer questions and address concerns.

MSBH also acknowledges the effects of generational trauma in diverse populations (ex. Indigenous People and African Americans) and the need for specific training. It is also noted that many mid-shore Providers have specialized training to address complex and various other types of trauma in client treatment and the community at large.

Deaf and hard of hearing

MSBH continues to monitor the Deaf and Hard of Hearing contract through Arundel Lodge Inc. (ALI) and other private providers who serve the deaf population. The Behavioral Health Coordinator (BHC) for the Deaf and Hard of Hearing contract noticed that ALI was not using the full amount of their FY19 contract. Working with the Finance Department, the BHC was able to amend the contract, therefore providing funds for more individuals to be served.

The staff at MSBH received training from a Licensed Interpreter, about deaf culture and best practices for communicating with deaf individuals. Staff will continue to advocate for services that are culturally sensitive for the deaf community.

Individuals transitioning from RRP to supportive housing

Individuals transitioning from a more intensive level residential rehabilitation program (RRP)-services to Supportive Housing in the mid-shore region receive support during their transition by the residential rehabilitation program during their treatment and in some cases post discharge. The mid-shore continues to struggle with affordable housing which makes options for transitioning individuals limited. Main Street Housing continues to be a support for this population. They work with the residential rehabilitation program to establish a less structured step-down residence that supports an individual as they adjust to living independently. If Main Street Housing is not an option, an individual is often placed on the list for income based housing and additional supports such as Targeted Case Management are offered.

Individuals transitioning from RRP to independent living

Individuals transitioning from RRP to independent living are often successful when supportive services such as Targeted Case Management, outpatient behavioral health treatment, Supported Employment and/or day programming such as Psychiatric Rehabilitation Program are in place prior to the transition out of the residential program. Often, goals are established between the

provider and the individual detailing what services are needed. The residential programs work collaboratively with community providers to establish a stable transition.

Forensically involved individuals who are ready to discharge from State Hospital

The Forensic Mental Health Program is available to work with defendants leaving the state hospital who will be living in the community and may need additional case management support. The State hospital and/ or the court can complete a short referral form to the FMHP program for case management services. The case manager will be in contact with the client to ensure they are connected to resources. If the court requests, the forensic program can monitor attendance in treatment and inform probation agents and/or the Judge of progress or setbacks.

TAY transitioning from treatment centers

Although MSBH does not provide direct services to Transition Aged Youth (TAY), they oversee supported employment, RRP and the Healthy Transitions programs which are all programs that TAY coming out of residential treatment centers would be referred into.

b. Development and implementation of integrative behavioral health treatment services and recovery supports.

Best Practices for evidence-based treatment for best outcomes

MSBH continues to facilitate county-specific provider meetings that include partnerships with LAAs, private and public providers, recovery houses, forensic professionals and peer support agencies (Chesapeake Voyagers, Inc. and Dri-Dock Recovery and Wellness Center). Facilitation of a monthly integration workgroup which comprises MSBH staff, the five LAAs and corresponding health officers (when available) will meet to advance systemic integration efforts. MSBH is also involved in awareness campaigns with somatic care providers furthering the implementation of Screening Brief Intervention and Referral to Treatment (SBIRT) and Behavioral Health Integration in Pediatric and Primary Care (BHIPP). Additionally, MSBH partnered with Choptank Community Health, A Federally Qualified Health Center to support best practices in “warm hand-off” to promote integrated treatment. Choptank Community Health is adding behavioral health services to its existing programming, a resource the mid-shore region desperately needs.

MSBH focuses on ongoing integration efforts with facilitation of BHSN workgroups, as well as attendance at existing workgroups in the community, including Healthy Tilghman in Talbot County, The Safety Net (previously Partnership for Suicide Prevention, now combined with the Anti-Bullying Committee) in Queen Anne’s County, and LDAAC participation in each of the five mid-shore counties. MSBH collaborates with local Departments of Social Services on high needs utilizers through regular participation at Multi-Disciplinary Meetings. In addition, the Forensic Mental Health Program and SOAR program work directly with clients to access benefits through DSS to assist clients in successful integration back into the community.

c. *Behavioral health service needs/challenges/gaps*

The mid-shore region's behavioral health service needs are unique to the rural Eastern Shore. Workforce continues to be the primary need on the mid-shore. There is a lack of prescribers, health outreach workers, peers and clinicians. There is also a need for more culturally and linguistically competent professionals.

Limited workforce, in turn, increases the demand for mobile crisis interventions. These interventions have increased exponentially due to lengthy waitlists to access care. MSBH has worked to move mobile crisis services to a 24 hour a day model. Currently individuals may participate in an initial urgent care assessment but wait one month or more to access a psychiatrist and/or prescriber. Behavioral health professional licensure boards present barriers to obtaining timely application approvals, compounding problems for providers already having heavy caseloads.

MSBH facilitates an Outpatient Mental Health Clinic (OMHC) Directors meeting quarterly to address common trends, themes, and service delivery needs in our region. To address shortages in the child and adolescent professional workforce, OMHC directors often market open positions to graduating college students. To promote recruitment, this group brought psychiatric fellows in their last year of fellowship to the Eastern Shore in the spring of 2019. Another way to address these workforce barriers is through collaboration, often sharing prescribers, psychiatrists and clinicians to best meet client needs.

Transportation also remains a significant barrier to accessing treatment. Limited public transportation does exist, but transit rides can take an entire day both in town centers and rural areas, given that the mid-shore spans more than 2,200 square miles. Some providers offer limited transportation for clients, as do wellness and recovery centers in both Dorchester and Talbot Counties. Queen Anne's County also offers limited transportation from its health department. MSBH continues to collaborate with providers to secure grant funding for vehicles and drivers, however, those requests have been unsuccessful. In some counties, Medical Assistance (MA) transportation will not retrieve children from school and will only transport one guardian per child. MSBH continues to participate in regional groups tasked with addressing transportation issues. There are voluntary ride-sharing nonprofits, however, these are not available for individuals with behavioral health diagnoses. Peer-to-peer transport continues to be discussed but lack of funds to reimburse for mileage, gas, and repairs prohibit such an endeavor.

As with transportation, housing can be problematic due to cost, location, safety and availability. Quality, affordable housing is limited in the few town centers where most services are located. There is also a need for more recovery housing in the mid-shore region, particularly for individuals receiving medication assisted treatment. Those who secure recovery housing will pay $150 to $200 weekly for a shared room.

MSBH continues to inform our partner network on the community bond grant program through Maryland Department of Health's Office of Capital Planning, Budgeting and Engineering Services.

When the application is released, it is disseminated to local providers through various means. These grants have been used by many of our partners in the past.

MSBH works closely within the regional Behavioral Health Coalition to educate state and regional legislators and raise awareness about gaps, barriers, and other system needs.

d. Program or system management processes.

i. *Coordinating the care of high risk and high cost individuals*

MSPC collaborates with community providers in identifying and coordinating treatment options for high risk/high cost individuals. To assist with the behavioral health needs of high risk/high cost youth and families, MSBH regularly participates in all five county Local Care Team (LCT) meetings. MSBH attends meetings through the Department of Social Services in all five counties, University of Maryland Shore Regional Health, local health departments, and community providers that address the needs of high risk/high cost adults.

MSPC coordinate care for high risk/high cost individuals with a primary substance use diagnosis. Provider meetings are held in every county in the mid-shore. These meetings routinely include discussion about care coordination opportunities for individuals meeting criteria for Level 3.7 treatment. County provider meetings also highlight waitlists and unique programmatic interventions and barriers. Area crisis teams support individuals who are waiting for an available treatment bed. MSBH successfully secured funding from the State Opioid Response (SOR) grant for eight 3.7 crisis beds specifically for individuals experiencing opiate withdrawal. Priority is given to mid-shore residents although, if beds are available, individuals from the Eastern and Western shores may be placed. The S.O.R funding also allowed MSBH to support the implementation of two Safe Stations on the Eastern Shore. The Safe Stations provide 24/7 access to treatment for consumers with substance use disorder (SRD), specifically opioid misuse disorder. MSBH also created the Eastern Shore Safe Station Coalition. This coalition coordinates services for SRD consumers across the Eastern Shore.

SSI/SSDI Outreach, Access, and Recovery (SOAR) is another program implemented within MSBH to assist with providing services to the high risk/high cost population. The MSBH SOAR Case Specialist assists individuals with the Social Security benefits application process and makes referrals to needed community services.

MSBH identified a need for services focusing on high risk/high cost older adults. MSBH has a PASRR Specialist on staff to assist aging individuals with behavioral health diagnoses and/or forensic histories who are caught in the revolving door of long-term care and inpatient psychiatric hospitals. Partly due to judicial directives to maintain available slots for the evaluation and stabilization of incarcerated individuals with behavioral health needs, there is an expectation that these older adults be discharged from state psychiatric hospitals to alternative settings in the community.

Complex consumers, those who have somatic, behavioral health, and/or require physical assistance with daily living activities, are not appropriate for residential rehabilitation facilities. Assisted living facilities are prohibitively expensive without the Community Options Waiver which, because of long waiting lists, can only be accessed after a nursing home stay. Nursing homes are not prepared due to lack of staff, lack of staff training, and minimal behavioral health provider support to care for these individuals. Because of the chronicity of serious mental illness and the likelihood of exacerbations with transitions to such an unfamiliar and unsupported environment, those individuals who are accepted often need stabilization in an acute psychiatric unit. Despite the possibility of fines, a nursing home may not agree to have the individual return. These individuals are characterized as 'stuck' patients.

The PASRR Specialist at MSBH, through informal relationships with the Eastern Shore Psychiatric Center, the local psychiatric inpatient unit, Adult Evaluation and Review teams, and interested nursing home administrators, has worked to characterize the issues that surround unsuccessful transitions. Assisting all parties to identify the information essential to person-centered and facility-centered planning and providing on-going support as requested during the transition phase, has resulted in some success in reducing the traumatic cycle of acute psychiatric admissions.

ii. ASAM Patient Placement Criteria and documentation of medical necessity to reduce authorization denials and over-utilization of high cost services.

MSBH facilitates trainings for community providers to be American Society of Addiction Medicine certified, while partnering with Maryland Department of Health (MDH) to stay abreast of changing criteria and training needs. MSBH conducts an annual survey every spring to determine community and provider training needs within the region and then works to identify, facilitate, and support trainings. ASAM criteria and application for placement identification have been a priority with the transition to fee-for-service. MSBH continues to support our providers with interpretation of the fee reimbursement structure.

Training needs will continue to be determined during meetings with providers and through the monitoring function for grant-funded services and those entering inpatient/residential levels of care with public funding. MSPC will review and discuss the needs for biopsychosocial assessment, utilization of guidelines for placement, continued stay, and transfer/discharge, understanding of dimensions of change, intensity of services, identifying priorities in service planning, and how patients are participating in their own care. MSPC will also promote and/or procure ASAM trainings through entities with permission agreements that support the development of the knowledge and skills required to implement the ASAM Criteria and provide updates and information for providers to proactively address the changes. MSPC will promote the use of ASO audit materials that appropriately address the clinical use of ASAM and medical necessity criteria as well as documenting in the client assessment, treatment plan, progress/contact notes, and

electronic infrastructure to reduce authorization denials, retractions, and over-utilization of high cost services.

iii. Needs and gaps in housing

Housing continues to be a major issue in the mid-shore region with affordability and quality being at the forefront. As a region, we work closely with the state Department of Housing and Community Development and the federal Department of Housing and Urban Development to bring funding to the region for housing solutions mostly in the form of housing subsidy programs. While these programs are integral pieces of the system, they do not create new housing. We have seen an increase in the amount of available recovery housing in the region but there is still a need for more.

MSBH continues to inform our partner network on the community bond grant program through Maryland Department of Health's Office of Capital Planning, Budgeting and Engineering Services. When the application is released, it is disseminated to local providers through various means. MSBH staff have attended community bond grant workshops sessions to help provide assistance and information on the benefits of the program to our partners. These grants have been used by many of our partners in the past.

e. *Office-based Buprenorphine therapy within your jurisdiction.*

The expansion of buprenorphine treatment and Medication Assisted Treatment (MAT) is a priority in the mid-shore region. Buprenorphine is available in Caroline County by way of Telehealth prescribing. There are also Buprenorphine providers in Queen Anne's and Dorchester counties. MSBH continues working with LAAs, LDAACs and provider meetings to identify gaps in this service. A mobile Buprenorphine unit is slated to serve individuals in Caroline County. The mobile unit will be operated out of a recreational vehicle (RV) that will meet consumers where they are in the community to provide MAT.

Dorchester County Behavioral Health Services and MSBH continue to collaborate to provide Buprenorphine training (Wavier 2000) for primary care providers in the mid-shore area. This project teams public and private providers with primary care providers to deliver SRD/BH treatment for those individuals needing SRD management medications. This is a unique opportunity to partner somatic care with behavioral health care further addressing the 'no wrong door concept." To date there have been nineteen providers trained in November of 2019, thirteen (13) physicians and six (6) nurse practitioners. This was done in partnership with Dorchester County Behavioral Health Services, MSBH, Talbot County Health Department, and University of Maryland Shore Medical Center, Talbot County.

Currently there are two methadone providers in the mid-shore region; however, there are multiple providers who prescribe Vivitrol and Suboxone. Withdrawal management includes

residential crisis beds at A.F. Whitsitt and step-down programs from in-patient, long-term treatment facilities for those interested in reducing or eliminating the use of MAT substances. Additionally, detention centers in the mid-shore region offer in-house MAT, as well as provision of MAT for individuals upon release.

f) Efforts to address co-occurring disorders and Dual Diagnosis Capability Training

Current efforts to address co-occurring disorders include utilizing screening tools, comprehensive assessments, and integrated treatment planning. Local inpatient and outpatient treatment facilities have recognized the importance of addressing both substance abuse and mental health simultaneously in order to have better outcomes. Integrated treatment involves coordinating substance-abuse and mental health interventions, rather than treating each disorder separately without consideration for the other.

Local providers/programs treating co-occurring disorders include a psychoeducation component as part of the consumers treatment. Psychoeducation increases awareness of the symptoms of the disorder(s) and the relationship between mental disorders and substance abuse. Relapse-prevention education can also help consumers become aware of cues that make them more likely to abuse substances and help them develop alternative responses.
Integrated treatment often involves forms of behavioral treatment, such as cognitive behavioral therapy or dialectical behavioral therapy. The goal of therapy is to help improve coping skills and improve maladaptive behaviors. This is sometimes used in combination with medication. Comprehensive treatment includes collaboration between clinicians, physicians/psychiatrists/nurse practitioners, and other community services that offer support with issues related to housing, health, work, and other life skills.

Clinicians entering the field of behavioral health have little to no education from graduate level course work on dual diagnosis or integrative treatment of care as part of their required curriculum. Unless a graduate student chooses an elective related to dual diagnosis treatment or had an internship with on the job training, they will leave graduate school without the basic knowledge and/or training to manage consumers with a dual diagnosis. Other training that is received in the behavioral health field related to co-occurring disorders has been done through continuing education credits (CEU's) mostly on the Western Shore of Maryland but sometimes can be found on the Eastern Shore. The trainings held on the Western Shore can be a challenge for clinicians both due to the cost and distance to travel, and the cost of the training itself. These barriers can leave clinicians unprepared to treat and properly diagnose a consumer with a co-occurring disorder.

g) *Crisis response services and diversion activities.*

MSBH and Cecil County CSA currently contract with Affiliated Santé Group (ASG) for Eastern Shore Crisis Response Services (ESCRS). ESCRS comprises the Eastern Shore Operations Center

(ESOC), a 24/7 hotline, four Mobile Crisis Teams, and Crisis Intervention Team (CIT) coordination and training for Law Enforcement. ASG phone counselors hold bachelor's and master's level degrees in human services and are supervised by licensed mental health professionals. ESCRS programs are co-occurring capable and working toward enhanced. All staff are trained in conducting Crisis Risk and ASAM assessments. ESCRS are CARF accredited.

ESOC's 24/7 crisis, resource and Urgent Care Clinic hotline serves all nine counties of Maryland's Eastern Shore. ESOC, starting in January of 2019, now has in-house phone counselors from midnight to 8 a.m. Previously, the phones were transferred to Baltimore County ASG call center after midnight. Phone counselors assess for safety, ascertain the crisis, provide support, complete a comprehensive clinical evaluation, and triage the referral options. Interventions included information and referrals; crisis plans; mental health, non-mental health, and substance use referrals; critical incident stress management; and calling 911.

ESOC serves as the single point of entry for scheduling all urgent care appointments, specifically from the six hospitals/emergency centers and three behavioral health units. ESOC conducts follow-up calls to consumers until such time as the consumer is stabilized, the consumer's safety and well-being is ensured, and the consumer no longer presents as requiring ESOC services. The aforementioned efforts assist in diverting the consumer from emergency department and in-patient treatment.

Starting in January 2019, ESCRS began implementing the overnight, midnight to 8 a.m. Mobile Crisis Teams. ESOC now dispatches Mobile Crisis Teams 24/7 when appropriate to residents in Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, and Wicomico Counties. Worcester County has a previously existing team dispatched through 911 consist of a Mobile Crisis Specialist and an on-call supervisor who will partner with a police officer. ESCRS now has two Peer Specialists, in addition to Mobile Crisis Specialists, to supplement the overnight team. Mobile Crisis Teams (MCT) are physically located in Wicomico, Dorchester, Queen Anne's and Cecil counties. The three overnight teams are in Wicomico, Dorchester and Cecil and they are fully staffed 24/7.

One of the main objectives of ESCRS is to divert consumers from unnecessary emergency department visits and reducing the response from law enforcement/EMS responders. ESCRS tries to effectively support individuals experiencing a behavioral health emergency in the least-restrictive environment. Along with the support provided from the phone counselors and the Mobile Crisis Teams, ESCRS links consumers to community behavioral health services to meet the emergent and general behavioral health needs of the consumer. The goal is to divert consumers from hospital and jail admissions.

In an effort to address crisis events related to law enforcement presence in homes, MSPC supports the Handle with Care model. The model is set up to make school staff aware when law enforcement has been in a child's home (as a result of a potentially traumatic event) so that the school may have alternative interventions available to promote positive coping and refer to

additional resources when necessary. Dorchester County, Caroline County and Queen Anne's County are all in various stages of implementing the program.

h) Services provided to individuals with pathological gambling addiction and their families.

In April 2018, the Maryland Coalition of Families (MCF), in partnership with the University Of Maryland Center Of Excellence on Problem Gambling, hired a Program Coordinator for Problem Gambling. This program offers support to families that have members with gambling addiction. MCF uses a regional approach, with the five mid-shore counties being included in their "Eastern" region, along with Somerset, Worcester and Wicomico counties. Referrals are made through the 800-GAMBLER hotline, by warm line transfer. Due to the lack of providers with this expertise in the Eastern region, the Program Coordinator has reached out to behavioral health providers and local businesses to offer MCF as a resource. Unfortunately, there has not been much interest in services, as gambling is socially accepted. Currently, there is limited data to illustrate the breadth of the problem in the Eastern region as well as throughout the state of Maryland. However, Maryland Center for Excellence on Problem Gambling through the University of Maryland School of Medicine is collecting data focused on Maryland residence. In addition, the ASO fee-for-service reimbursement structure that began on January 1, 2018, should provide additional data.

The MCF Program Coordinator for Problem Gambling throughout 2019 has presented information to the community, partnering with outpatient behavioral health clinics, and promoting an online support group or regional Gam-Anon group. MSBH supported this program by inviting the Program Coordinator to present at Behavioral Health Services Network quarterly meetings and monthly workgroups.

i) Tobacco cessation services and activities

Tobacco cessation services are primarily provided by the Local Health Departments Prevention Programs throughout the mid-shore region. The mid-shore counties provide smoking cessation products, referrals for screening and counseling. Like most counties in Maryland, the mid-shore county schools have seen a recent spike in the use of electronic smoking devices among middle, and especially high school students. As illustrated in the 2000-2016 Monitoring Changing Tobacco Use Behaviors report, 2016 data from the YRBS/YTBS show that 15.8% of high school students currently use ESDs, slightly higher than the state average of 13.3%.

In Caroline County a prevention specialist is located within the behavioral health program and works in conjunction with the health department's prevention team to do tobacco cessation/prevention education and outreach, especially to school-aged adolescents, and other populations for wellness promotion in the community.
Queen Anne's County tobacco cessation is managed through the Prevention grant which is allocated through MDH. Queen Anne's county offers smoking cessation products, referrals for screening and counseling

The Kent County Health Department has local priorities of collaborating with schools and school systems to reduce tobacco use by raising awareness, strengthening policies and training and educating staff, parents, and other Supporters. They also partner with schools and school systems to implement science-based prevention programs to educate students on the dangers of electronic cigarettes and vaping. If needed, they will connect students with available cessation services.

As Kent's priorities have shifted away from adult cessation to youth prevention, the cost-effective Quitline 1-800-QUIT-NOW is promoted as an accessible and convenient alternative to in-person cessation groups through the health department. Kent continues to offer individual counseling to adults seeking service on an as-requested basis. Clients are offered counseling, a starter pack of NRT as supplies last, and referral to the Quitline.

Kent County has been successful in helping organizations adopt smoke -free policies. There is opportunity to re-educate community leaders about the importance of smoke-free outdoor areas, especially in light of the ESDs normalization.

j) Peer Recovery Specialists (PRS) and/or Certified Peer Recovery Specialists (CPRS) in the provision of services

MSPC utilizes Peer Support Specialists throughout its programming to offer recovery support and resources to the clients of the agency. The local LAAs use peers in a combination of services such as assigning peers to Mobile Treatment Units, START Program located in Dept. of Social Services, provide follow up to the jurisdictions individuals post-overdose, see referred clients of the outpatient SRD and Mental Health clinics for identified needs, and the County detention center re-entry programs. All counties have a presence or are in the process of obtaining clearance to be able to access hospital ED's to meet real-time with those individuals who have overdosed. When a survivor of an overdose from any substance is transported to one of the three local Shore Regional Hospitals, peers report to the emergency department to meet with the survivor and their family to offer services, treatment and support.

Peer Support Specialists also provide public awareness, outreach, and education often collaborating with Prevention Specialist at many events in the community and they actively attend the LDAAC meetings and other community-focused SRD committees.

Queen Anne's County is the only jurisdiction in Maryland to support those who overdose on substances and take them to the emergency room, either on their own volition, or through an emergency petition, via the QA Sheriff's department. In the two plus years that this has been in effect, only two survivors have chosen the emergency petition route. The rationale behind this is the medications that the survivors are ingesting are commonly used in surgical procedures, where once these are administered, the client is not allowed to make their own decisions. Once under the influence of strong opiate, especially Fentanyl, the client is not in a state where they are able to make clear and sound decisions for their best interests. The goal is to transport the

survivor to a medical facility where they are evaluated beyond the obvious effects of an overdose and treat them medically if needed. The peers are able to alleviate the pressure on the nursing/medical staff at the emergency departments, be the liaison with local law enforcement, as well as ensuring that the survivor has contact information to someone who will be able to transport them to a safe environment.

The Queen Anne's Mobile Integrated Community Health (MICH) team peer is notified when a survivor is transported to the emergency room at Anne Arundel emergency department. Peers also offer 24/7 to the QA Sheriff's department for anyone arrested for possession or substance related charges. Peers are sent to offer support and discuss treatment options.

At the wellness and recovery centers across the mid-shore, Peers welcome walk-ins and discuss what recovery could look like to them, taking into consideration their needs, their lifestyle and childcare. Counselors are available to meet with the clients to enroll them officially in programs that require ASAM and diagnostic criteria, then the peers take over the case management.

2. Outreach and Public Awareness

a) Public awareness education and information. Engage culturally and linguistically diverse individuals.

Prevention staff from health department

Regionally the Prevention Staff within the Health Department typically will work with the Behavioral Health Prevention Coordinator at community events that would benefit from having a focus on SRD/MH. This complementary approach allows the health departments and the behavioral health programs to reach a larger number of people from the community. Literature is obtained and disseminated in English and Spanish for the large Hispanic population as well as a Spanish interpreter is available at some events. In addition, the health department's insurance office (MCHIP, MA, etc.) is often available to provide outreach to the community at many of the events which assists those who are interested in signing up for insurance.

Translation/Interpreters, information in other languages

MSPC attempts to have translation services in Spanish provided by an interpreter specifically hired to translate during intakes, individual sessions and groups in the health dept. and at off-site locations when needed. For other languages, the agency staff is available to utilize the language line when necessary or the voice interpreting devices located at the agency. In some situations, an Interpreter is also available to attend events in the community where there is likely to be Hispanic attendance. Handouts, education materials, forms, and other materials are printed in English and Spanish.

Peers for outreach, Recovery events, Narcan training (along with the kit)

MSPC's Peer Recovery Specialists attend outreach events throughout the mid-shore to introduce agency's services as well as provide education about SRD and Mental Health, recovery and awareness. They have been instrumental in promoting Purple events, as well as various activities

within the schools, American Legion, Wellness Days, IWIK, education on the Mobile Treatment Unit MAT treatment available, recovery resources available in the community, and outreach to the faith-based organizations. Peers and Prevention Specialists are able to provide Narcan education to the community and provide each person with a Narcan kit to keep. These Narcan kits are also distributed to law enforcement, the local library, town council members, and anyone who desires to receive one, along with training.

b) Collaborative efforts with providers to support evidence-based practices for individuals with mental illness and SRD.

Choptank Community

Choptank Community Health. Inc., a Federally Qualified Health Center (FQHC) provider in Caroline, Dorchester and Talbot counties in the mid-shore region, has decided to pursue a full integration of healthcare services by becoming a provider of mental health services in addition to primary care, dental care, and pediatric services that are currently being offered at their agency locations. Choptank Community Health has offered school-based services in Caroline and Talbot counties, and has offered access to behavioral health at most of their locations that has historically been an on-site/co-location with mid-shore behavioral health providers. After the conclusion of a twelve-month organizational assessment and consultation, Choptank Community Health has decided to embark on becoming a direct provider of behavioral health services. The addition of the behavioral health component will be an asset by way of expanding the provider capacity in the mid-shore and will support the integrated model of healthcare delivery by offering these services on-site and will assist with combatting stigma by including behavioral health as a treatment provided and screened for regardless of presenting needs. Choptank Community Health is hoped to support the workforce needs with allowances for support with recruitment and residency initiatives that may be more appealing for psychiatry recruitment and loan forgiveness.

Caroline Health Department moved into one location

Caroline County combined their Behavioral Health program into one location at the Caroline County Health Department this past year. It is the first step toward integrating the SRD and Mental Health programs as one. In the new location, the staff can now more easily refer clients to the other discipline when needed and hold co-occurring clinical team meetings and problem-solving discussions. Policies and procedures are becoming more integrated as well as staff meetings and clinical team meetings will begin to move in that direction now that all are in one location and working closer together. Staff training and professional development will support the idea of integration, with one of our goals to have all counselors and therapists become trauma-certified. All staff, from the front office staff to the Director, attended a workshop on becoming trauma informed last year. This will be the beginning of the forward movement toward full integration in the near future.

Provider meetings and workgroups include MH and SRD Providers

In serving the BH Providers, it is often efficient to meet with them in a group setting, to discuss common concerns and goals for consumer treatment in the community. MSBH facilitates a Provider meeting in each of the five mid-shore counties. The providers decide the frequency and agenda items, based on their level of need. Standing agenda items often include discussion about the Administrative Service Organization (ASO), new treatment modes, Providers who have recently come into or recently left the county, and treatment service expansion. It is the intention of the MSPC to expand the Provider meetings where needed and to customize the meetings to meet the needs of each county and the region.

BHSN – MH and SRD related topics

MSBH hosts a quarterly Behavioral Health Services Network meeting, which comprises provider and consumer representation. Staff takes into consideration challenges and changes at the regional, state and national levels and works to address behavioral health issues while anticipating how change may impact the system of care. During 2019 BHSN quarterly meetings, MSBH welcomed presenters from various agencies, throughout the mid-shore region, to share the services that they provide to in the community. The following presentations were presented during the 2019 meetings:

- Crossroads Community – Healthy Transitions
- State Opioid Response
- CLAS, Cultural &Linguistic Competency
- MD Commitment to Veterans
- Mid Shore Roundtable Point in Time results
- LGBT-On Our Own
- Presentation from DDA and DORS
- Warm Hand-Off Initiative
- START (Sobriety Treatment & Recovery Teams)
- Arundel Lodge-Deaf and Hard of hearing services

Safe Stations

With State Opioid Response Grant Funding there has been the implementation of two Safe Station on the lower shore. This was a collaborative effort with the Wicomico and Worcester County Health Departments. The implementation of the Safe Stations was designed to be a Peer Run Model to enhance the “buy-in” from consumers with Opiate Use Disorders. There has been support from local and state level programs including the OOCC (Opioid Operation Command Center) and the, the GOCCP (Governor’s Office of Crime Control and Prevention), A. F. Whitsitt, Sun Behavioral Health, Hudson Health, local law enforcement, Fire and Rescue Squads, and Recovery Housing.

LDAAC

Health General 8-1001- Local Drug and Alcohol Abuse Council, requires that each county in Maryland have a Local Drug and Alcohol Council (LDAAC). Each of the county LDAAC’s is served by the local addiction authorities (LAA). The purpose of the LDAAC is to present information

about issues of substance use and to problem solve how to address those issues within the county. MSBH supports each of the mid-shore region LDAAC's, serving in various capacities in each county. For example, in Caroline County, MSBH has an administrative role with the LDAAC; scheduling the meetings, creating the agenda and facilitating guest speaker presentations. Although separate in function, the LDAAC's members come support county "Go Purple" efforts during the month of September. The activities for Recovery Month, are coordinated through each county LDAAC, beginning August 31st.

START

All five of the mid-shore counties have initiated the implementation of the Sobriety Treatment and Recovery Teams (START) model and its strategies. This model is administered by the Local Social Services Departments in collaboration with the Local Health Departments. START Family Mentors (individuals in long-term recovery) will be employed by the local HDs and co-located in the LDSS office where they will share cases with LDSS caseworkers. The model is a child welfare led intervention for families with children 0-5 years old who have been affected by child maltreatment and parental substance use disorders. All five counties are in different stages of implementation.

Trauma Informed Care Trainings

MSPC recognizes the importance of increasing training opportunities and curricula for recovery support services, integration and evidence-based models for SUD and co-occurring disorders including trauma informed care. Training and information is important in identifying social determinants to health, reducing stigma, enhancing knowledge and capability for identifying and treating SUD and co-occurring disorders, especially for the behavioral health workforce and behavioral health services delivered in various settings to help reduce gaps in the service delivery system. The goal is to achieve wrap around services complementary to current treatment and recovery support services and new initiatives for a complete, holistic client-centered approach involving the community and professionals that includes important principles of trauma informed care. Trauma informed trainings provide useful tools to support individuals with behavioral health challenges and co-occurring disorders including trauma and brain injury. There is also a one-day introductory training available for Peer Recovery Specialists that provides a foundation of trauma informed care knowledge and skills needed to work with recovering individuals who are currently experiencing trauma or in the past. This training assists Peer Recovery Specialists with defining social, environmental, physical, emotional, and other factors that influence trauma, identifying the impact of trauma related to stress reactions and responses, defining Adverse Childhood Experiences (ACEs) and explore the results of the ACE test, identifying vicarious and secondary trauma, and addressing recovery principles and how to build a framework for continued support. Because of this training, Peer Recovery Specialists will have the capability to use trauma informed care principles to support their work with individuals. The overall framework of this training will help to strengthen the breadth of knowledge and skills supporting recovery for those individuals in need.

MSPC plans to promote, sponsor and secure trainings approved by the Maryland Addictions and Behavioral-Health Professionals Certification Board (MABPCB) including Continuing Education Units (CEUs) in the domains for peer credentialing as well as approved sponsors for Social Workers, Psychologists, Professional Counselors and Therapists, and Alcohol and Drug Counselors to provide continuing education units.

Caroline County has implemented staff training and professional development to support the idea of integration, with one of their goals to have all counselors and therapists trauma certified. All staff, from the front office staff to the Director, attended a workshop on becoming trauma informed last year. This will be the beginning of the forward movement toward full integration in the near future.

c) MH and SRD prevention promotion and awareness activities in FY 2019.

Everything Purple

Caroline County participated in the showing of the Jim Wahlberg movie "If I Knew" which was shown to the community at the high schools. In addition, Caroline County Behavioral Health provided outreach and support to the high school students and families during these activities which had a large showing of support from the community. Many agencies were also present offering services and support in bringing awareness to the opioid epidemic. In addition. The local Sheriff's department had drug take back activities. In addition, Narcan education and distribution, mental health awareness, and prevention discussions/education and resource handouts were provided by our Prevention Specialist to the community including a special focus on our high school student's population. Drug Free Caroline supported the Summerfest events in Caroline County, hosting a table with purple light bulbs, T-shirts and substance use information. A Peer

and an advocate orchestrated the “Fed Up! Rally” at a local church in Denton, with music, community agency vendors and everything for a family friendly event.

The Go Purple campaign began in Talbot County and has spread to not only all five of the mid-shore counties, but to counties all over the state. It is an education/awareness/stigma reduction campaign in each county focusing on opiates. Each county’s leadership gathers to plan events and outreach, typically involving Naloxone training, CPR training, and identifying recovery resources in the community. The campaign seeks to start conversations within families and neighbors to share information and provide support. Chris Herren was the headliner this year, a former professional basketball player, who succumbed to addiction, lost almost everything, but recovered. He now tours the country, meeting with the youth to teach through his own story what addiction looks like on ‘Day 1’ but also that they are not alone.

Each year, Go Purple campaigns in the five mid shore counties continue to grow in size and scope and regional participation.

The Dorchester Goes Purple: Awareness Starts At Home Campaign kicked off with a free outdoor concert on the Choptank River, with music and local BBQ, and ended with a parade of boats glittering with purple lights gliding along a parade route lined with homes and boats illuminated in purple. Dorchester hung banners with awareness messages throughout the county and posted these awareness messages each week on Facebook. When residents spotted the banner in the community that matched the ones posted on Facebook, they could post a comment identifying the location under the message. All participants were then entered in a drawing. This was a very successful way to increase community involvement. Many new businesses and organizations “went purple” and their pictures were shared on social media. Presentations were made to all the town councils in the county.

Queen Anne’s County has completed its second year of this successful campaign. In addition to various outreach efforts at local events, the Go Purple project culminated with the ‘Haunted Trap House’. This multi-night event took over one year to plan and implement and included participation from all county agencies, public, private and faith-based groups, as well as private citizens. The premise of this very successful event was based on a 30-year old version of Queen Anne’s County’s ‘Haunted Crack House.’ The title and story were updated to address the current crisis in addiction and was presented on three evenings. The presentation began outside with a party of teenagers when one experiences an overdose. Real police and EMTs drive up and provide support and arrest the suspects (actors). The scenes then moved inside, first with a court scene. The two actors that were ‘arrested’ were being sentenced on drug charges. (Queen Anne’s County State’s Attorney, bailiff, and the court clerk played themselves in the scene.) The second scene took place in the ‘jail’ where two real inmates who were close to release and had been chosen by the detention center and project directors, spoke to the public. They related how they ended up in detention and what plans they had in place to remain in recovery when they were released. (The warden of the detention center brought the inmates himself and assured their

safety and comfort.) Subsequent scenes addressed family trauma, substance use, stigma, treatment, and recovery. Citizens who were in recovery shared their personal stories with the public. As each group entered the room, a pocket guide of regional resources was handed to each participant, avoiding the need to self-identify. The final scene was the girlfriend and her younger sister – the older sister leaves the room and the younger sibling finds a substance and inhales it and overdoses. Although the scene was first written depicting a fatal overdose, those in the recovery community as well as the target population of youth/teenagers felt that the message should be one of hope, so the last scene remained open to interpretation. Following a debriefing when the group could ask questions, they were moved to a resource room where CPR and Narcan training were offered, data was collected through a questionnaire, and regional community services and providers were available to provide information on accessing services.

This event received local, national and international accolades, with media coverage in coverage The Washington Post, the Daily UK, Daily Telegraph in the Netherlands, ABC, Yahoo, Philadelphia Inquirer, and High Times, Maryland Public Television. The Chief Medical Officer for the White House Office of National Drug Control Policy attended and lauded it as an excellent example of prevention and education efforts which should be replicated across the country.

Kent County's 6th annual "Backyard Bash" attracted over 200 attendees at the A.F. Whitsitt Center. This family friendly promotion of recovery fellowship and sober socialization provides many opportunities for the community to get help and information for themselves or someone they know in recovery. This event provides harm-reduction information, wound care, information about the Good Samaritan Law, safe disposal of medications, Narcan trainings, safe use information in partnership with local mental health and substance use resources. Most importantly the Backyard Bash provides networking and support for every phase and person involved in the recovery process.

Tony Hoffman spoke at Kent County High School (500 students and 75 adults) and Chestertown Middle School (300 students and 50 adults) and all students received 'Kent Goes Purple tee shirts. Mr. Hoffman also spoke to 50 community members during a luncheon at Washington College. The Kent Goes Purple 5K Color Run and Kent Goes Purple at Worton Park were attended by well over 200 folks at each event. Parents and community members had the opportunity to explore the Hope Trailer, a mock bedroom set up like a teenager's bedroom that exhibits potential hiding places for illicit drugs, and to explore issues surrounding the opioid crisis and the youth population. In total, over 1280 residents participated in networking opportunities information about harm reduction and anti-stigma and other trainings. The Kent County commissioners, law enforcement, emergency services, peer recovery specialists, speakers in recovery, faith-based organizations, treatment professionals and members from other community services attended and fully supported these events.

Talbot-Fed Up Rally served as the Going Purple Kick-off event. Christ Church in Easton, MD hosted a recovery service which was followed by a provider and community vendor fair with live music,

food, family friendly events, and presentations from individuals in recovery. Talbot Goes Purple hosted the debut of documentary: The American Opioid Crisis: Talbot Goes Purple. The event was well attended by community members, and was followed by a memorial walk and the lighting of the courthouse and downtown Easton.

Community Events

Ham and Narcan

The Peer Recovery Specialist in Kent County held and attended many community events to promote overdose awareness and the resources available to assist in preventing overdoses. A breakfast was held on Saturday "Ham and Narcan" which resulted in 38 Narcan trainings and information distributed regarding harm reduction, wound care, Good Samaritan Law, safe disposal drug drop-off boxes locations.

Data Waiver 2000

MSBH, DCBH, Talbot County HD, University of MD Shore Regional (UMSRH) and Maryland Addiction Consultation Service (MACS) partnered together to host a MAT Data Waiver 2000 training. There were sixteen participants who attended the training. This training was a half and half training, meaning half of the training is done in the classroom and the other half is completed online. This has been an ongoing initiative to enlist primary care physicians to prescribe Buprenorphine.

Harm Reduction

MSPC has been working to bring Harm Reduction initiatives to the community. Most of the Local Addictions Authorities in the mid-shore have enhanced their distribution of Narcan, training of community members and stakeholders, in addition to welcoming new initiatives such as Fentanyl testing strips and mobile treatment units for the screening and prescribing of MAT to the region. The mid-shore region has been recognized for the Mobile Treatment Unit in Caroline County, that is working to expand their reach in the county for mobile MAT screening and treatment and is a partner for some new grant activities targeting at risk farming and agricultural workers. In Kent County, the implementation of the "No Harm In Helping" mobile unit is a new initiative to provide outreach, screening and prescribing, administration of MAT, as well as mobile Narcan training and Fentanyl distribution. Education of the mid-shore stakeholders remains a priority for the MSPC group. The buy-in of community partners and providers to move towards a system that embraces a harm-reduction philosophy, and desires to enhance harm-reduction, and implement the harm-reduction priorities is a challenge in the mid-shore. Partners are often more conservative with services and initiatives, so education remains at the forefront of the work. In March of 2020, MSBH will be hosting an all-day Harm Reduction training presented by Maryland's Harm Reduction Training Institute. The hope of this training is to educate partners and identify new harm-reduction priorities that can be introduced and advanced existing initiatives in the mid-shore.

Across the Lifespan

MSBH's 8th annual Across the Lifespan Conference took place on April 2, 2019. Each year, the conference has a topic of focus, as it relates to individuals "across the lifespan". This year the population focus was military veterans, focusing on homelessness, suicide and PTSD. Resources were available for veterans in the community. The event is always coordinated in partnership with Dover Behavioral Health. Conference speakers included: David Galloway of the Maryland Commitment to Veterans who is a veteran peer and shares the challenges that individual veteran may face; Jessica Nesbitt of the Brain Injury Association of Maryland; John Clow of the VA Maryland Health Care System; Lore' Chambers, PhD from St. James A.M.E. Zion Church-Zion House and Brenda Jorden, Ph.D, LCSW-C from the School Social Work, Salisbury University. Each presenter shared relevant information for our military veterans enlightening conference participants of resources in our mid-shore region.

Resilience Screening

MSBH partnered with several local community agencies and providers to present a "Night of Hope," where a film titled "Resilience" by James Redford was provided to community members and providers. In April, the film was shown in two sessions: an afternoon session for clinicians and other human services professionals, and an evening session for all interested community members. It was made free to the public in efforts to spread awareness and education on adverse childhood experiences (ACEs) and the effect it has on individuals and children. MSBH was also able to sponsor and host a second screening of the film in May for community members, and it was attended by many school officials. In addition to education and awareness, the goal of the "Resilience" screenings was to help in the elimination of stigma surrounding mental health and further emphasis the need for early intervention and prevention.

Children's MH-Angst

Throughout the month of May, MSPC participates in various events throughout the community to bring awareness to children's mental health. The purpose of the Children's Mental Health Matters Campaign is to help defeat the stigma associated with children's mental health and substance use, and to connect families to resources throughout the state that can assist families in receiving services. On Children's Mental Health Matters day, MSBH sponsored a screening of the Angst movie to raise awareness around anxiety with an emphasis on youth and their families. It was held at the Avalon Theater in Talbot County where there was an afternoon showing and an evening showing. Licensed clinicians were made available throughout the viewing by local providers to ensure supports and services were readily accessible to the audience.

Faith based initiatives

MSBH participated in various Purple Events during the month of Recovery, September. MSBH SOAR Case Specialist Michelle Hammond was invited to talk about mental health in the faith based community. This discussion was held on a local broadcast, MCTV, *Rabbi's Roundtable*. The discussion was featured to bring awareness to mental health and substance abuse and how Mid Shore Behavioral Health can be a resource for the faith-based community. This segment was available to the public. Additionally, the case specialist received a second invitation to participate

in Talbot Goes Purple Faith Based Night. MSBH team members collaborated with 18 community churches in Talbot County during this night. Behavioral Health resources were distributed, and pamphlets were shared to post on church bulletins.

Drug Free Caroline promoted Purple Sunday by mailing letters to churches in Caroline County and distributing purple bags with information about substance use and recovery. Many of the pastors/ministers were receptive of sharing a message of hope and acknowledging members of the congregation who are in recovery.

Multicultural Festival

MSBH participates in the annual Multicultural Festival, a celebration of the diversity within our community, including the multiple generations of ethnic groups within our region. Many vendors were present, MSBH represented the Behavioral Health resources for the mid-shore region.

3. Sub Grantee Monitoring

MSBH Sub Grantee Monitoring Processes

MSBH operates from a streamlined internal process for efficiency and consistency in contract management. This approach, allows for our sub vendors to have a consistent experience across multiple contracts regardless of the behavioral health coordinator responsible for the monitoring. Most Conditions of Award (COA) for MSBH are encompassing of all five mid-shore counties, some COAs covering all nine counties of the Eastern Shore. MSBH behavioral health coordinators are assigned a county to serve as a point of contact and support for resources, guidance, and mediation if needed.

Graduated monitoring schedules are established to include pre-contracting conferences, standing quarterly and annual reports, review of monthly invoices and deliverables, complaint investigations as needed, and an annual site visit. If a program improvement plan is implemented, MSBH will monitor accordingly to ensure implementation of the plan. New and exiting providers receive more oversight and support during transition.

The contracting schedule begins with the annual Pre-Contracting meeting in early May. MSBH invites all sub-vendors for a discussion of discuss changes and expectations for the upcoming fiscal year. Once all contracts are ratified, MSBH Behavioral Health Coordinators and Finance Department monitor contracts through regular submissions from the sub-vendors. This enables MSBH staff to have better oversight of the contracts as they move through the fiscal year, allowing for the better usage of BHA dollars.

MSBH values the importance of a meaningful site visit. On-site and desk-top audits are completed with vendors throughout the year. MSBH uses templates for site visit monitoring reporting in contract management to provide consistency to the process. Site visits are scheduled with providers on a mutually agreed upon date and time. Once scheduled, MSBH

sends a site visit confirmation that includes requests for file access, documentation, and other pertinent information. An agenda for the visit is also included. During the visit, monitors are looking at internal controls, contract deliverables, scopes of work, provider policies, and the conditions of award as outlined by BHA. Site visit reports are forwarded to the sub-vendor within thirty days of the visit. MSBH staff works closely with the sub-vendor to correct any findings.

MSBH requires sub-vendors to attend a quarterly Behavioral Health Services Network (BHSN) meeting as part of their contract. The meeting is an opportunity to network and provide updates regarding exisiting and new programs and discuss gaps or needs in the PBHS. Providers are encouraged to present intiatives that they are offering or are aware of to inform others. Additionally, subvendors are required to participate in regularly scheduled BHSN workgroups meetings that address forensic, homeless, aging, and child and adolescent populations.

MSBH is responsible for the monitoring of Residential Rehab Programs (RRPs), Group Homes for Adults with mental health needs, and Residential Crisis services. The Residential Rehabilitation Program currently has 18 small group homes with a total of 88 beds across the mid-shore region. The site requirements are monitored annually using the Residential Rehabilitation Program Housing Inspection Form. This objective is to provide a safe, comfortable, healthy and recovery-oriented environment to RRP residents. The COMAR regulations 10.63.04.07 are used as guidelines for inspection purposes. Upon completion of inspection the provider is issued a Certificate of Approval for each year of compliance with the regulations depicted in COMAR 10.63.04.07. The Residential Specialist is required to attend BHA's Annual Mandatory Fire and Environmental Safety Training for Residential Specialists. The Residential Specialist also supports the monitoring of the Residential Crisis beds for mental health needs located at the A.F. Whitsitt Center to ensure compliance with licensure and accreditation.

Local Addictions Authorities Sub Grantee Monitoring Process:

Contracting volume varies by Local Addictions Authority (LAA) in the mid-shore region. Sub-grantee monitoring standards are outlines as follows:

The LAA contracts and develops scopes of work with sub grantee with language that is respective of the Conditions of Award (COAs) offered by BHA. COAs and compliance with the scope of work are reviewed at the time of the site visit with the sub-grantee. The Behavioral Health Administration Grant Monitoring tool is used along with the Behavioral Health Administration Provider Record Review Form. Any areas of non-compliance are followed by a corrective action plan and quarterly site visits are put in place to monitor progress.

Graduated monitoring Processes:

Step I: First year of public funding, program receives quarterly monitoring.

Step II: Monitor twice in a fiscal year if no corrective action plan required for one full year and no change in clinical supervisor within the past year.

Step III: Monitor one time during the fiscal year if no corrective action plan was required for two consecutive fiscal years.

Providers are encouraged to refer to the Provider Manual, substance use data dictionary, resources offered by the ASO for data entry and to maintain reporting requirements as needed. Providers receive alerts regularly from the ASO and are encouraged to contact the ASO directly for specific questions. Providers can consult with the Local Addiction Authority to put forward discussion and feedback to BHA and ASO for response. Provider Council meetings offered by the ASO are supportive platforms for process, claims, and oversight updates. Data entry and reporting requirements are also routinely discussed at quarterly provider meetings.

MSPC Sub Grantee and the ASO

MSPC participates with ASO on all audits identified for mid-shore providers. While MSPC may not contract directly with all providers, audit participation allows opportunities to build relationships, re-enforce quality of care standards, and remain apprised of situations in the mid-shore community. When Program Improvement Plans (PIP) are issued, MSPC reviews the plan and schedules follow-up with the provider to determine whether corrective actions are in place and to report progress to the ASO.

MSPC is responsible for the local management of the Agreement to Cooperate process. "Before applying for licensure under Subtitle 10.63 - *Community-Based Behavioral Health Programs and Services*, behavioral health programs in Maryland must enter into an Agreement to Cooperate with the CSA, LAA, or LBHA in each of the relevant counties or Baltimore City in which the program operates. Agreements are required when submitting an initial application, renewal application, or when a change to a program's license is requested (e.g., change in service array or locations). Please note that separate agreements are not required per site, unless there is a change to the program's existing license, such as adding a new location".

MSPC confirms the compliance with proper accreditation, licensure application, and at the time of a new site designation, MSPC will support a site-visit in support of BHA/OHCQ to endorse the site location before completing the Agreement to Cooperate. MSPC mutually supports the cross-county provider networks and if needed, will consult with partners across local authority location prior to signing off on the Agreement to Cooperate.

Once the Agreement to Cooperate is established, MSPC requires correspondence and cooperation with the provider and if needed, supports members of MSPC with the following responsibilities: complaint investigations, provision of service endorsement or limitations, and correspondence with termination of agreements and planning for consumers impacted with the closure of a program.

H. REPORT AND ANALYSIS OF UTILIZATION DATA

Introduction

Mid Shore Planning Collaborative (MSPC) recognizes that measurement-based care in behavioral health, both mental health (MH) and substance related disorders (SRD), is paramount in developing and maintaining an effective system of care in the mid-shore region. The goal of the data analysis is to assist in evaluating current service structures, identification of need for expanded services, and address gaps in the system of care.

The data analysis section is organized as follows:

- Introduction
- Important Information about the Data being reviewed
- Mid-shore Demographics: Population, Poverty Levels, Medical Assistance Data
- Target Areas – data analysis, summary, and recommendations, related FY21 Goals and Objectives
  - Children and Adolescent Population
  - Adult Population
  - Special Populations and Other specific areas for review
    - Across the life span
    - Targeted Case Management
    - Veterans
    - Primary Substance at Admission
    - Opioid Related Overdose Deaths
- Complete mid-shore, five county, combined data tables
  Note – Individual county and agency data tables are located in Appendices

Analysis Format:

1. Target area for analysis.
2. Data analysis narrative along with supporting graphs and charts.
3. Analysis Summary -- identifying critical factors and possible explanations.
4. Recommendations and MSPC strategies to address the data outcomes.

Important notes about the Data and Tables being analyzed:

The following analysis utilizes the data from Maryland's Public Behavioral Health Systems (PBHS) made available to MSBH and mid-shore county LAA's by Beacon Health Options Maryland, the Administrative Service Organization (ASO) and the Behavioral Health Administration (BHA). The data tables presented and analyzed are templates prescribed by BHA. Three years of data was provided for analysis, FY17 through FY19 and reflects only those services utilized through the Medicaid system and for uninsured consumers. Data provided is across a number of service offerings in our mid-shore region along with statewide utilization data.

- Data references for the following regions:
  - Mid-shore – refers to the data for five counties – Caroline, Dorchester, Kent, Queen Anne's, and Talbot
  - Statewide – refers to data for the State of Maryland. It also includes expenditures for Maryland residents that were treated in other states where Maryland Medicaid pays for the out of state services.
- The data marked 'Mental Health' or 'MH' pertains to data provided to MSBH. The data marked 'Substance Related Disorder' or 'SRD' relates to data provided to mid-shore county LAA's.
- The analysis is a review of the five mid-shore county combined data unless specifically noted to be an analysis of a specific county's data.
- Mid-shore county LAA substance related disorder (SRD) data was compiled into one set of data tables for analysis of the region as a whole.
- Consumer counts may be duplicated across coverage and service types; however, the consumer count totals represent unduplicated counts.
- Fiscal year 2019 includes claims filed through September 30, 2019, for the SRD Data Offered, August 30, 2019 for the mid-shore counties combined MH Data; ASO data was incomplete as claims may be submitted up to twelve months from date of service.
- If the number of persons served is less than 10, the data is suppressed (table cell will be shaded/blacked out) to protect personally identifiable information (PHI).
- Complete PBHS data tables for mid-shore region, combined five county SRD data, can be found at the end of this section. Complete mental health and substance related disorder data tables for mid-shore counties aggregate, and each of the five mid-shore counties distinct county data, can be found in Appendices section.

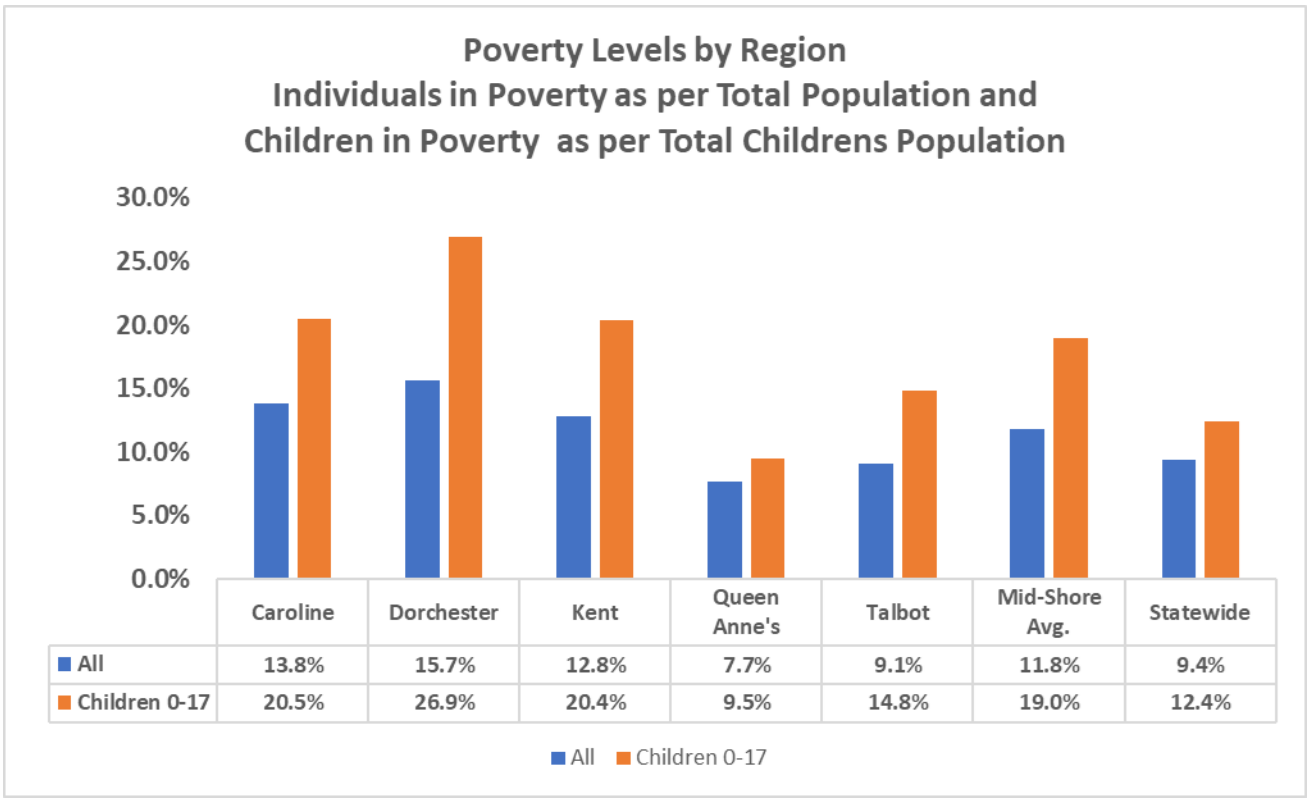
Mid-shore Demographics – 'Rural Nature of the mid-shore Region'

Maryland's mid-shore region is comprised of five counties: Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. Mid-shore has a population of 171,904 and covers 2,710 square miles. Mid-shore region is primarily rural and has health care delivery system challenges driven by economic challenges, significantly higher poverty among children as compared to Maryland statewide averages, transportation barriers, inadequate healthcare staffing, and shortage of needed service offerings.

The following charts (Chart 1A through 1F) are reflective of the challenges that the mid-shore region is confronted with in providing for the behavioral health services to meet the needs of the community.

Charts 1A and 1B – In comparison with statewide data, the mid-shore poverty rates for adult and children are among the highest in the State of Maryland.

CHART 1A



	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid-Shore Avg.	Statewide
All	13.8%	15.7%	12.8%	7.7%	9.1%	11.8%	9.4%
Children 0-17	20.5%	26.9%	20.4%	9.5%	14.8%	19.0%	12.4%

BHA provided statistics from the U.S. Department of Agriculture and Economic Research Service 2017 data – percent of total population in poverty.

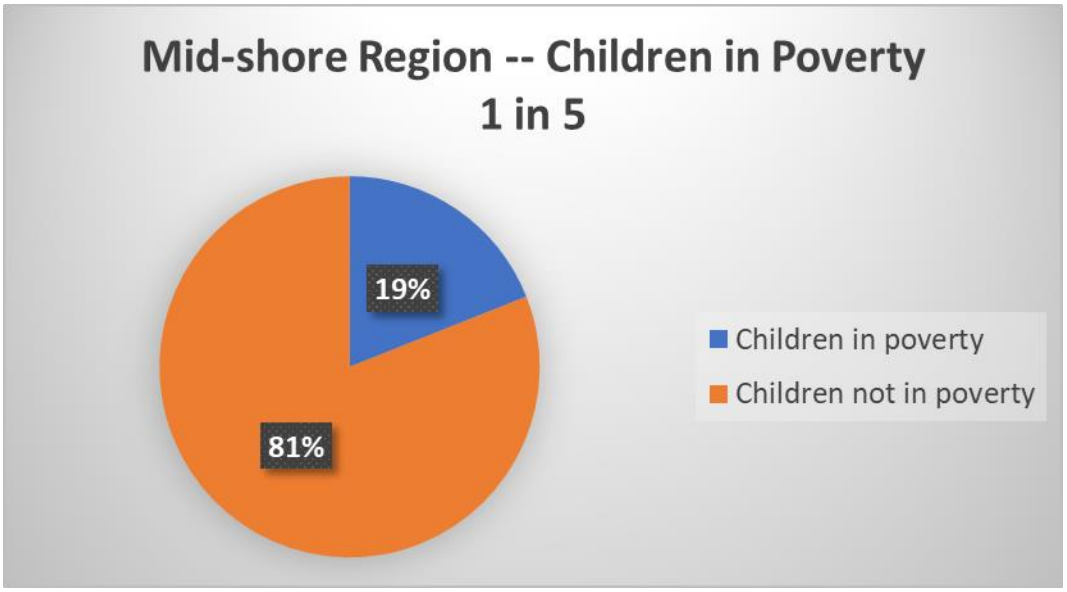


CHART 1B

Population Information from Maryland Vital Statistics, estimated July1, 2018.

Chart 1C and 1D -- A large portion of the mid-shore population is eligible for medical assistance (MA) as compared to statewide eligibility – mid-shore 27% as compared to statewide 23%. This data is in accord with the higher poverty levels for the mid-shore region as compared with the state. Further, of the total mid-shore population, 1 in 20 are receiving mental health services whereas statewide 1 in 28 are receiving services. In relation to substance related disorder services, in the mid-shore region 1 in 37 are receiving services whereas statewide it is 1 in 55. Regarding eligibility and MH/SRD penetration, mid-shore has a higher penetration rate as compared to statewide in both MH and SRD.

CHART 1C – The Number of MH/SRD Served in Reference to the Region's Total Population

County	Population*	Population -- Medical Assistance Eligibility** FY19	Population provided MH Medical Assistance FY19		Population provided SRD Medical Assistance FY19	
Caroline	33,304	12,054	1,842	1 in 18	1,011	1 in 33
Dorchester	31,998	12,936	2,541	1 in 13	1,401	1 in 23
Kent	19,383	5,003	953	1 in 20	625	1 in 31
Queen Anne's	50,251	8,428	1,426	1 in 35	852	1 in 59
Talbot	36,968	8,589	1,583	1 in 23	768	1 in 48
Mid-shore	**171,904**	**47,010**	**8,345**	**1 in 20**	**4,657**	**1 in 37**
State	**6,042,718**	**1,405,552**	**215,660**	**1 in 28**	**109,717**	**1 in 55**

**Population statistics – Maryland vital statistics, estimate July 2018*

*** Average MA Eligible supplied by UMEC Hilltop Institute*

Medical Assistance Eligibility and Penetration as a Percent of the Eligible Population

Region	% of Total Population MA Eligible	MH Penetration as a % of MA Eligible Population	SRD Penetration as a % of MA Eligible Population
Caroline	**36.2%**	**15.3%**	**8.4%**
Dorchester	**40.4%**	**19.6%**	**10.8%**
Kent	**25.8%**	**19.0%**	**12.5%**
Queen Anne's	**16.8%**	**16.9%**	**10.1%**
Talbot	**23.2%**	**18.4%**	**8.9%**
Mid-shore	**27.3%**	**17.8%**	**9.9%**
State	**23.3%**	**15.3%**	**7.8%**

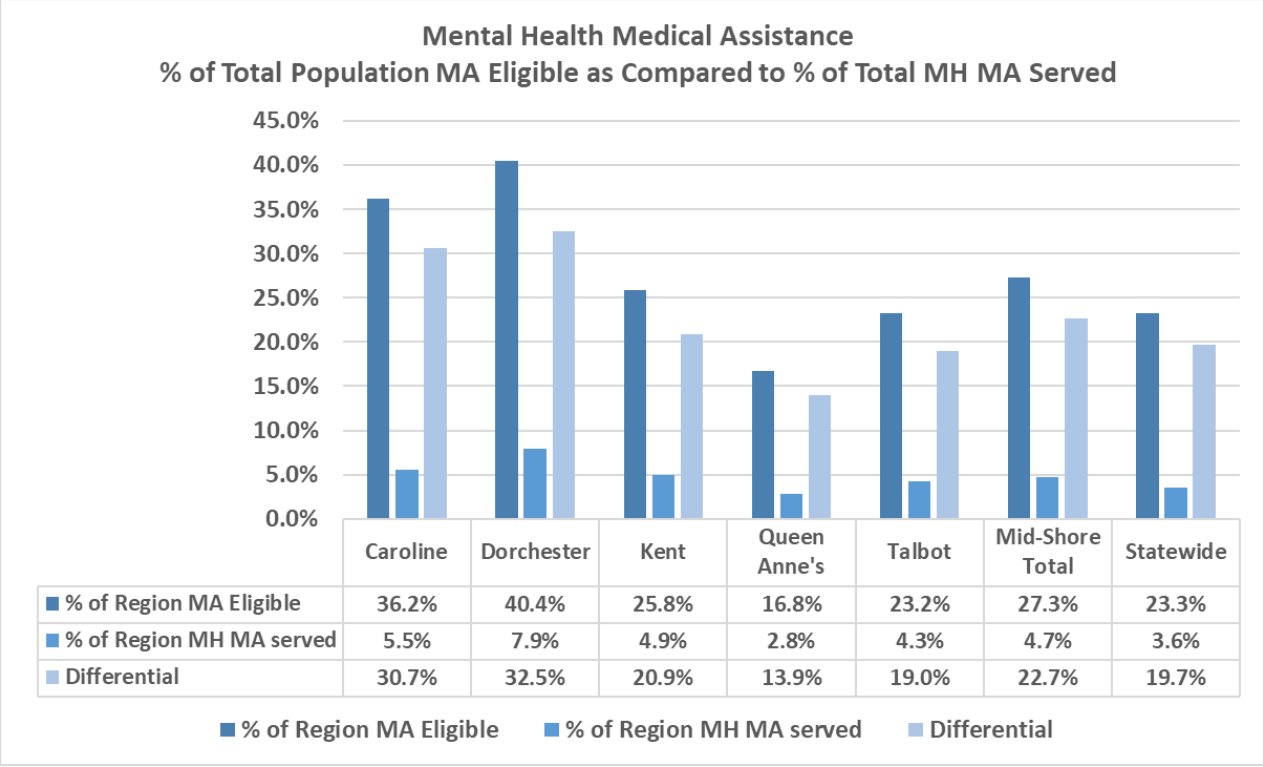
BHA provided statistics from Maryland Vital Statistics, estimated populations July 1, 2018. Average MA Eligible supplied by UMBC Hilltop Institute. See 'Accessing the Public Behavioral Health System' table.

CHART 1E and CHART 1F—As previously pointed out, there is a larger MA eligible population in the mid-shore region as compared to statewide. The following charts review the eligible information to help assess the potential extent of individuals in the mid-shore region that are not receiving needed services.

The mid-shore compares favorably with the state regarding the percent of eligible receiving services. However, given the larger eligible population in the mid-shore region there may be a substantial number of individuals still in need of service. If we assume the statewide data is a base from which to assess 'standard' region needs, then we need to review both the MA served data and the 'differential' data (difference between MA eligible population and the percent of the population served).

For example, in Chart 1E Mental Health, the differential for Dorchester county is 32.5% whereas the state differential is 19.7%. When we review this differential information, the substantially higher percent eligible (Dorchester eligible is almost twice the statewide average) and factor in the high poverty levels and rural barriers to treatment, the mid-shore may have a very large population in need of services.

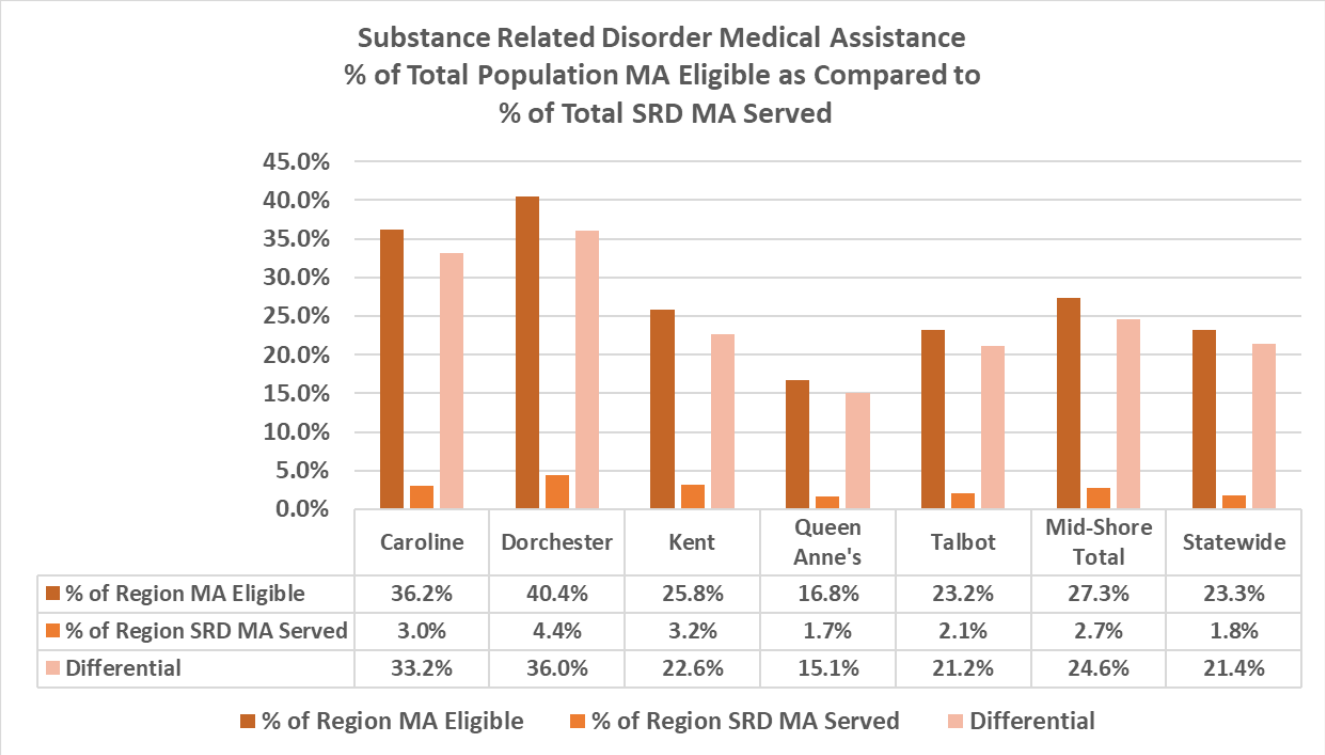
CHART 1E – Mental Health



	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid-Shore Total	Statewide
% of Region MA Eligible	36.2%	40.4%	25.8%	16.8%	23.2%	27.3%	23.3%
% of Region MH MA served	5.5%	7.9%	4.9%	2.8%	4.3%	4.7%	3.6%
Differential	30.7%	32.5%	20.9%	13.9%	19.0%	22.7%	19.7%

Data is from the combined mid-shore region MH table "Accessing the Public Behavioral health System". Additionally, the % of region MH MA served was computed from the data in this table.

CHART 1F - SRD



	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid-Shore Total	Statewide
% of Region MA Eligible	36.2%	40.4%	25.8%	16.8%	23.2%	27.3%	23.3%
% of Region SRD MA Served	3.0%	4.4%	3.2%	1.7%	2.1%	2.7%	1.8%
Differential	33.2%	36.0%	22.6%	15.1%	21.2%	24.6%	21.4%

The statistics were developed from the BHA provided table 'Average Medical Assistance Eligibility, PBHS MA Participation and PBHS MA Penetration Rates' for FY 19.

The mid-shore region supports a large population being served. Further, based on estimates and challenges of the region to seeking treatment, mid-shore has a large population in need of both mental health and substance related disorder services.

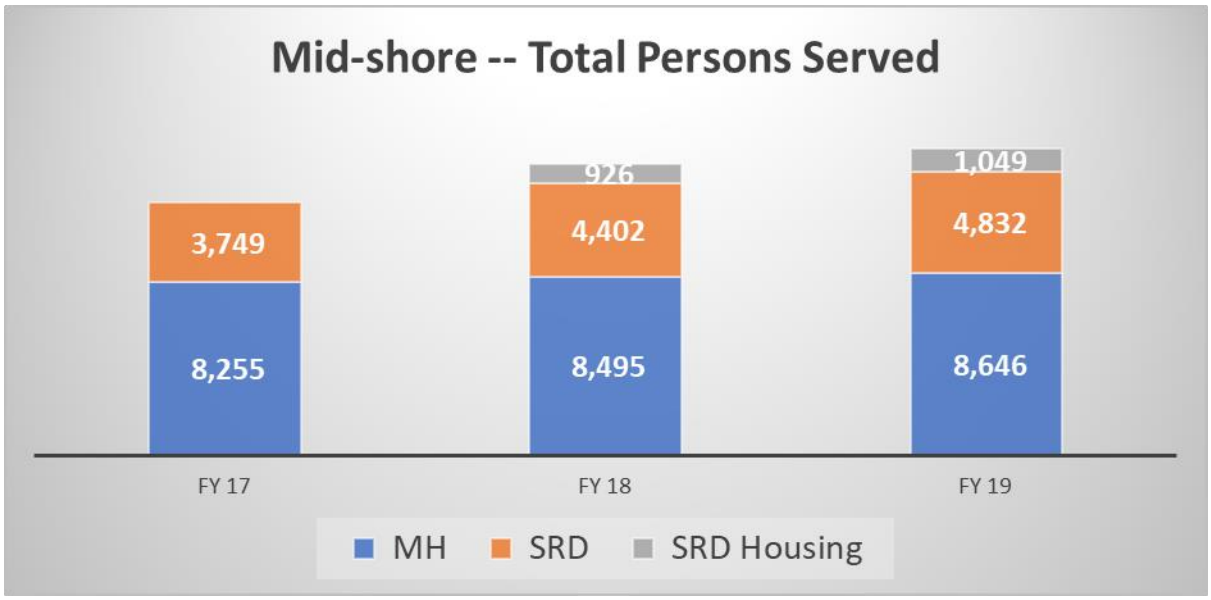
Challenges to receiving treatment:

- Lack of a transportation systems along with longer distances to travel to receive care.
- High unskilled labor population where workers must choose between attendance at work or seeking needed healthcare treatment.
- Lack of needed providers and services
- Economic barriers limiting gainful employment, or sufficient wages to meet the needs.

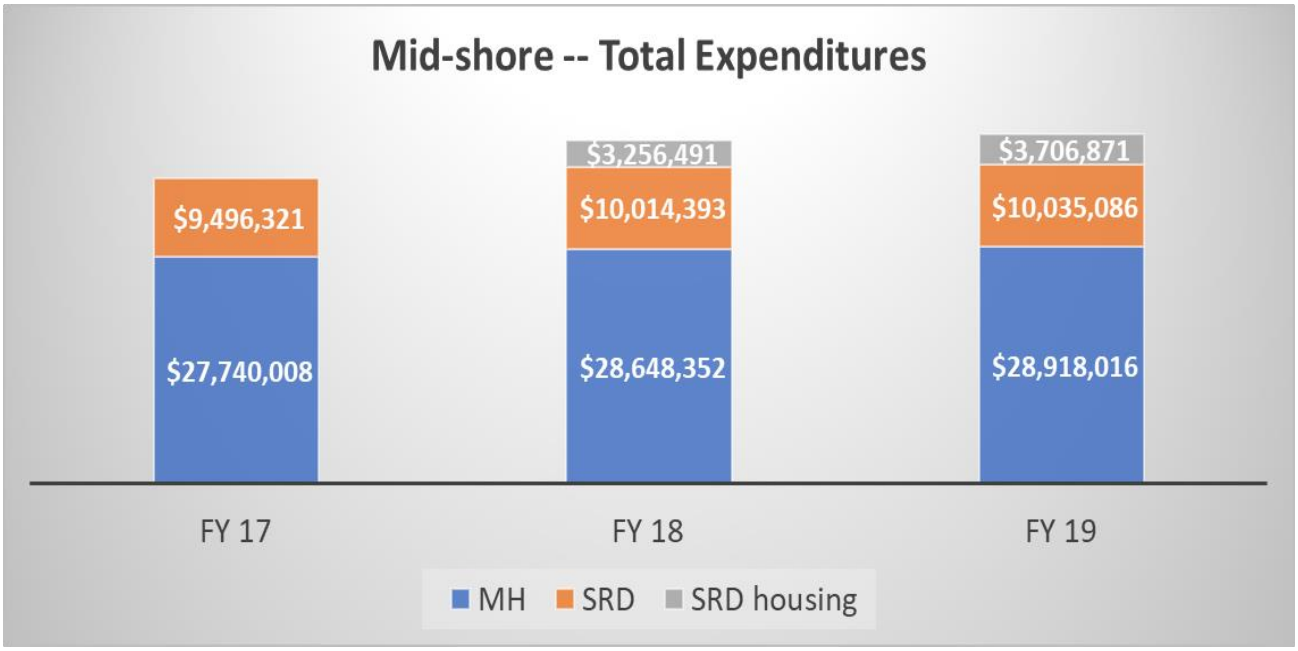
Overview of mid-shore Region for Three Year Period

The data analysis that follows reviews both mental health and substance related disorders. It reflects the combined data for MSBH, and the combined five mid-shore county LAA's. The state and regional health authorities recognize that our region requires a collaborative integrative approach to best provide for the challenges of our region.

Mid-shore area data totals show an overall increase in persons served in both the MH and SRD populations. Concurrently the expenditures per population are also increasing. Important note -- starting with FY18, SUD housing, previously grant funded, became fee for service. The material increases in persons served and in expenditures for FY18 and FY19 primarily relates to the new fee for service expenditures for residential housing. The data represented by this change is reflected in the following bar charts.



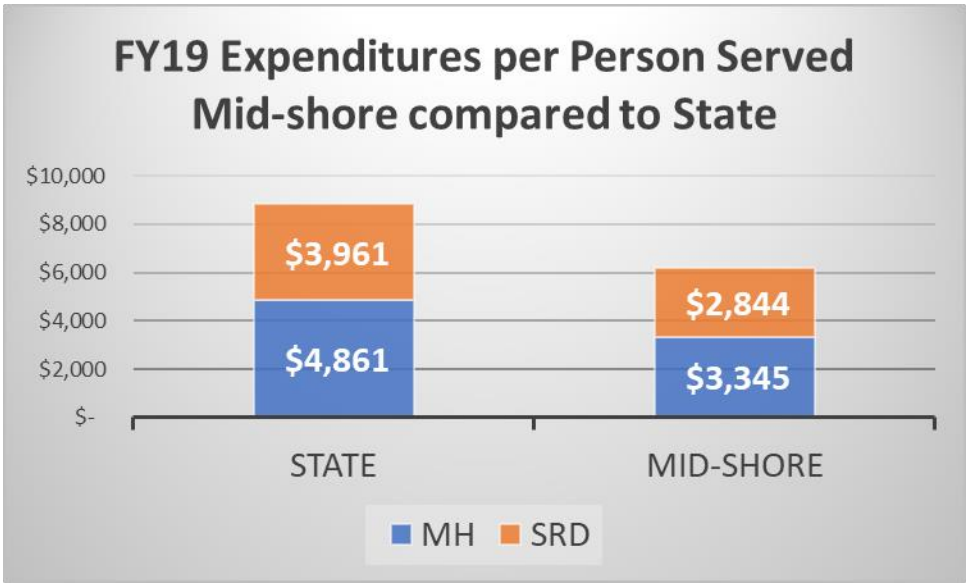
**MH and SRD Tables 1a. Three Year Comparisons by Age*



**MH and SRD Tables 1b. Three Year Comparisons by Service Type*

Expenditures per Person Served

The mid-shore region continues to be materially below the average for state 'expenditures per person served' in both MH and SRD services. As reviewed in the introduction, the rural nature of our region impacts both services available and ability of individuals to obtain needed services.

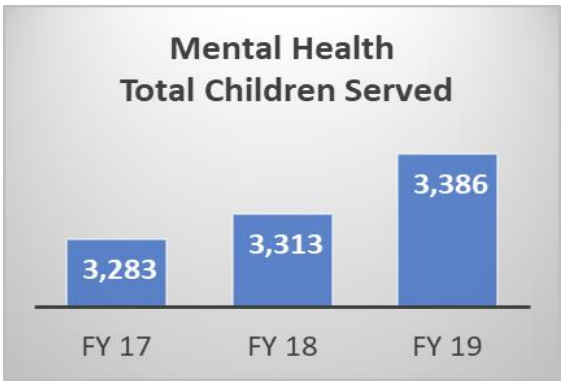


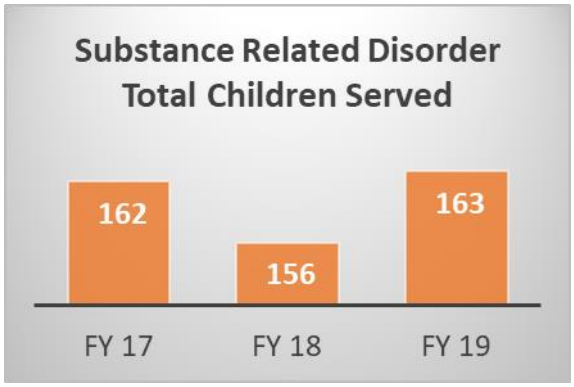
**MH and SRD Tables 3b. FY19 Comparisons: Cost per Person Served*

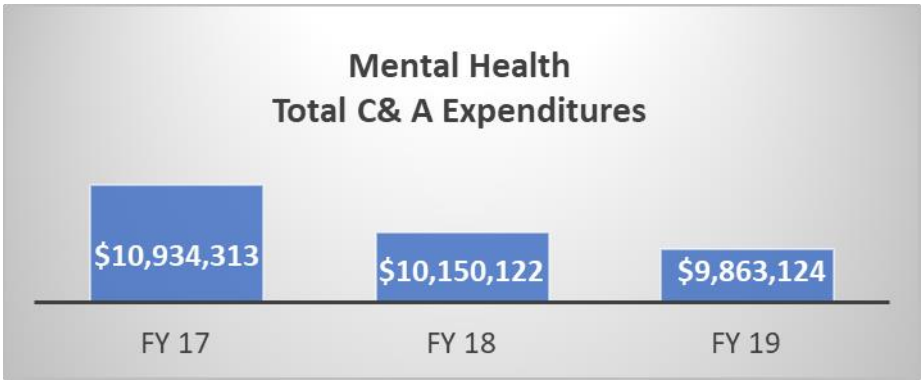
Children or C&A population: Early Child (0-5), Child (6-12), and Adolescent (13-17)

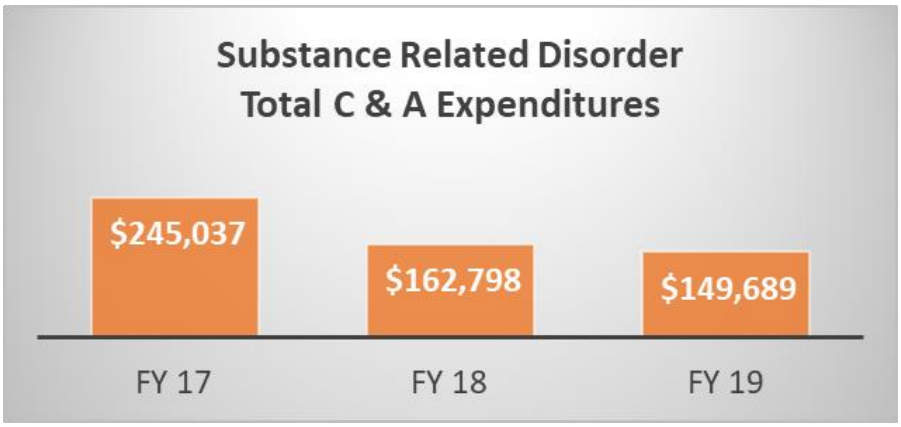
In review of the children served and related expenditure data for the period from FY17 to FY19 -- The MH data shows an increase annually in children served, however, it is showing reduced expenditures each year. The SRD number of children served annually has remained relatively constant for the three-year period however the corresponding expenditures have decreased each year.

Following charts are from MH and SRD Table 2a. Child/Adolescent 0-17

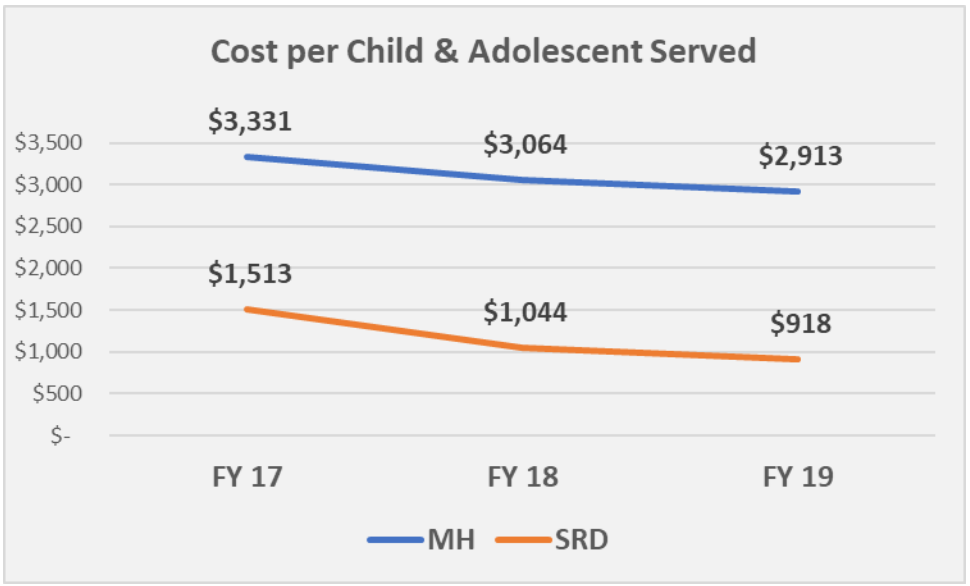






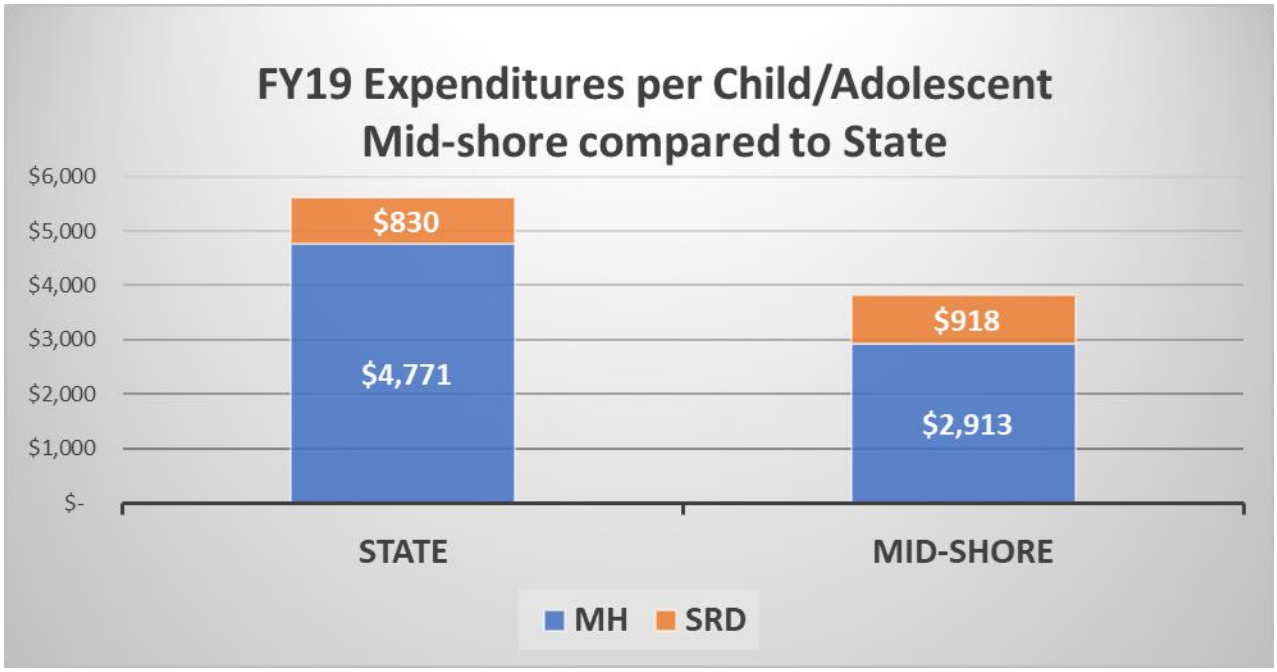


There is a downward trend in expenditures per child/adolescent (C/A) population for MH and SRD – from FY17 to FY19 the MH data shows $418 reduction per C/A and SRD shows a reduction of $595 per C/A.



**MH and SRD cost per C&A derived from Tables 2a. Child/Adolescent*

The reduced expenditures for SRD places the expenditures per C/A at $918. This is in line with the state expenditures per C/A – the state shows $830 per C/A (*computed from SRD Table 3a*.). However, for mental health there is a significant disparity between state and mid-shore expenditures per C/A served. The state provides $1,858 more per C/A served than is provided to a mid-shore C/A.



**MH and SRD State and Mid-Shore data compiled from Table 3a.*

Children's Mental Health Services

For MH services we have a minor increase in children served while concurrently a reduction in expenditures. There is a significant positive change shown in the targeted case management services, with both an increase in children served (67%) and a corresponding increase in expenditures (137%) for these children. *This is specifically reviewed in the 'special population' section of this data analysis section.* The remaining MH service changes are minimal or reflect a reduction in expenditures relative to the number of children served.

Mental Health -- Table 2a. Child / Adolescent - 0 - 17 EXCERPT

	Persons Served						Expenditures				
	FY 2017	FY 2018	% Chang	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
Case Management	78	88	12.8%	147	67.0%		$276,422	$197,947	-28.4%	$469,398	137.1%
Inpatient	137	95	-30.7%	97	2.1%		$1,793,658	$1,554,201	-13.4%	$1,151,192	-25.9%
Outpatient	3,255	3,298	1.3%	3,361	1.9%		$5,316,485	$5,488,180	3.2%	$5,651,772	3.0%
Partial Hospitalization	33	7	-78.8%	13	85.7%		$126,580	$11,795	-90.7%	$24,799	110.3%
Psychiatric Rehabilitation	428	415	-3.0%	449	8.2%		$1,363,776	$1,468,504	7.7%	$1,564,872	6.6%
Residential Treatment	31	18	-41.9%	11	-38.9%		$1,757,029	$1,168,687	-33.5%	$739,071	-36.8%
**TOTAL	3,283	3,313	0.9%	3,386	2.2%		$10,633,950	$9,889,314	-7.0%	$9,601,104	-2.9%

Children's Substance Related Disorder Services

For SRD services provided to C&A, the data chart below shows clearly the lack of services or no service offerings at all to this population. If there are minimal or no service offering there are children not getting the needed services. This will lead to problems in adulthood with a greater potential of the problem requiring a more complicated treatment for the adult.

Substance Related Disorder -- Table 2a. Child / Adolescent - 0 - 17 EXCERPT											
	Persons Served					Expenditures					
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
SUD Inpatient	1	0	-100.00%	0	#DIV/0!	$3,538	$0	-100.00%	$0	N/A
SUD Outpatient	117	103	-11.97%	101	-1.94%	$68,687	$46,945	-31.65%	$53,238	13.41%
SUD Partial Hospitalization	7	1	-85.71%	0	-100.00%	$20,094	$67	-99.67%	$0	-100.00%
SUD Residential ICFA	8	8	0.00%	0	-100.00%	$45,712	$42,346	-7.36%	$0	-100.00%
SUD Intensive Outpatient	10	4	-60.00%	4	0.00%	$32,291	$11,636	-63.97%	$12,475	7.21%
**TOTAL	162	156	-3.70%	163	4.49%	$9,251,289	$13,108,084	41.69%	$13,592,274	3.69%

Critical factors, possible explanations, and identified system of care needs:

The critical factors driving the results reflected in the child and adolescent data is the chronic need for services, providers and facilities in the area of inpatient, outpatient and residential treatment services to adequately and appropriately care for the mid-shore region children. The data is also reflective of the need for adequate professional staffing, especially psychiatrists.

Specifically, the mid-shore region has experienced the loss of two outpatient child and adolescent psychiatrists in FY18, and there have been no new providers replacing these services. In addition, there is no option for inpatient or residential treatment services across the entire Eastern Shore. Children needing inpatient, partial hospitalization or residential treatment services must travel to Delaware or the Western Shore of Maryland.

Adolescents with a substance related disorder are at risk for higher tobacco use, poorer school attendance, and increase in arrests. As of 2019, there are no inpatient adolescent substance use treatment facilities across the state of Maryland. This leaves a large gap in services for adolescents with a primary substance use disorder diagnosis.

Summary and Recommendations

Through data analysis, it is apparent that the entire state of Maryland and the Eastern Shore region, is in need of more child and adolescent services, specifically psychiatrists and inpatient and/or residential programs. More than 40% of Maryland children have been exposed to at least one adverse childhood experience (John Hopkins Bloomberg School of Public Health, Child and Adolescent Health Measurement Initiative) (ACES), and suicide rates among young people are on the rise. Without adequate services to meet the behavioral health needs of these children and young people, our region will continue to suffer with ever increasing health disparities.

It is very difficult to recruit and retain child and adolescent specific psychiatrist to the Eastern Shore. MSBH has partnered with the Behavioral Health Administration and University of Maryland to secure time in June 2020 with first-year psychiatry residents to market the Eastern Shore as an option to fulfill their residency requirement and the critical need for this specialty area. It is our hope that by introducing these new providers to the career opportunities and the beauty and uniqueness of the Eastern Shore early in their decision making on where they want to develop their practice, they will choose to create a home here and work in a long-term capacity. As a result of these efforts in 2019, one psychiatry resident committed to and began providing tele-mental health on the mid-shore. Additionally, to assist in addressing the psychiatrist shortage, MSBH continues to support the expansion of tele-health providers. This would greatly assist with this shortage and would be expected to have a very positive impact in our rural region.

MSPC continues to advocate with legislators to keep the child and adolescent population and the need for increased behavioral health treatment options a priority. It is a goal of MSBH to keep legislators informed of the lack of services and the need to support any legislation that may aid in expansion of these services. MSBH leads the Behavioral Health Coalition of the mid-shore and meets regularly with legislators to educate them on the ever-changing behavioral health services arena.

" Our youth with mental health and substance use disorders cannot succeed academically unless we are addressing their behavioral health needs". *Keep the Door Open MD, the Behavioral Health Coalition from Mental Health Association of Maryland.*

MSPC is aware that Peninsula Regional Medical Center, located in Salisbury, Maryland, has submitted a Certificate of Need (CON) and received approval for 15 child and adolescent inpatient behavioral health beds. Even though there is no anticipated opening date for these beds, this is a promising development that will help to address a need and would help to serve Eastern Shore youth and families reducing some burden in terms of transportation and parental participation in treatment. However, the need for substance related treatment programs for adolescents continues to require attention and funding, as this remains a gap in our system of care.

Child and Adolescent Recommendations, Goals and Objectives:

Partnering with behavioral health providers, identifying and addressing the needs of children and adolescents, such as a lack of child and adolescent providers, lack of community-based and inpatient services, and need for additional early intervention and prevention programs, along with supports for the families and caregivers of these children and adolescents. Mid-shore Behavioral Health hosts a Child & Adolescent workgroup in order to identify gaps in services and provide resources to our communities and providers, as well as developing result-based accountability goals.

MSPC general operations support each of our five county community efforts to meet the needs of our child and adolescent population. MSBH also employs staff with expertise specific to the child and adolescent population.

MSPC has built upon FY2021 goals 1, 2, and 3 to target some of the specifically identified child and adolescent issues in our communities:

- **MSPC Goal 1: Enhance the health and wellness of our mid-shore community.**
  In an effort to address the lack of providers and services available to the child and adolescent population on the mid-shore, MSPC will promote awareness of child and adolescent behavioral health issues and needs by participating in community and partner meetings, developing resources and seeking additional funding opportunities for our 5-county region. MSBH will continue to host the Child and Adolescent workgroup in an effort to identify gaps in services as well as share and develop new and existing resources.

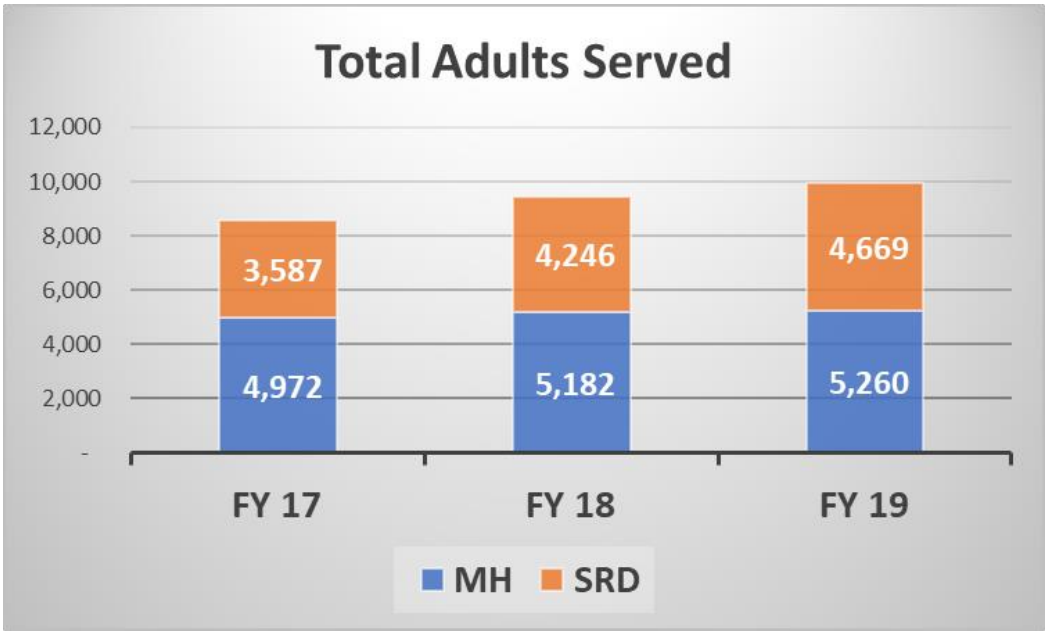
- **MSPC Goal 2: Strategically address the impact of social determinants across the lifespan.**
  In order to address social determinants, MSPC will work alongside community stakeholders to promote, support and/or provide community education on the effects of adverse childhood experiences (ACES). MSPC will also strategically work to advance our relationships with public and private schools in order to promote behavioral health in school-based wellness centers.

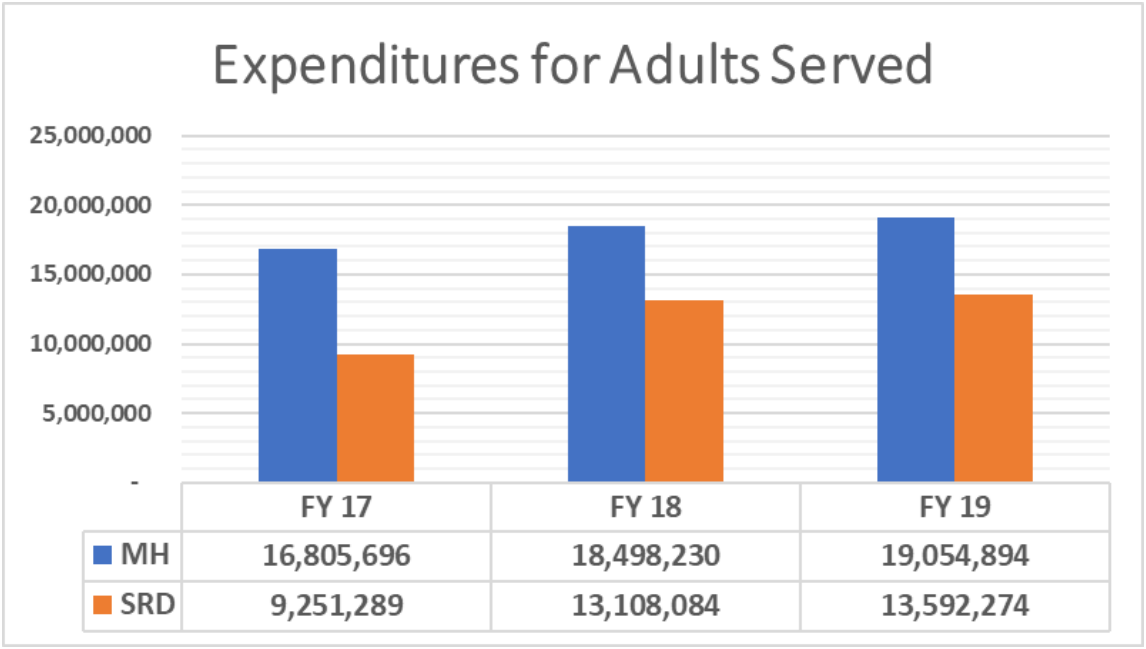
- **MSPC Goal 3: Build and support a regional behavioral health system of care.**
  This MSBH goal initiates collaborative work on problems that are escalated due to the rural area of our region. MSPC will enhance the knowledge of behavioral health needs and resources collaborating with community partners to increase trainings, support groups, and awareness initiatives through the lifespan, including maternal behavioral health, children and adolescents. MSBH will provide oversight of child and adolescent funded services through participation in statewide, regional and local partner meetings in an effort to create a regional behavioral system of care. MSPC will build partnerships within schools to increase awareness of the impact of the use and misuse of substances.

Adult Population: Transitional (18-21), Adult (22 -64), and Elderly (65 and over)

There has been growth in the number of individuals served for both mental health and substance related disorders along with an increase in expenditures.

Following charts are from MH and SRD Table 2b. Adults – Ages 18 and Over





	FY 17	FY 18	FY 19
MH	16,805,696	18,498,230	19,054,894
SRD	9,251,289	13,108,084	13,592,274

Adult Mental Health Services

Mental Health Table 2b. Adults - Ages 18 and Over EXCERPT											
	Persons Served						Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
Crisis	18	23	27.8%	32	39.1%		$45,625	$80,054	75.5%	$148,028	84.9%
Inpatient	353	398	12.7%	323	-18.8%		$3,494,697	$4,228,370	21.0%	$3,797,143	-10.2%
Mobile Treatment	107	112	4.7%	165	47.3%		$675,459	$785,353	16.3%	$1,013,084	29.0%
Outpatient	4,604	4,794	4.1%	4,842	1.0%		$5,721,452	$6,115,749	6.9%	$6,675,529	9.2%
Partial Hospitalization	10	11	10.0%	5	-54.5%		$52,746	$39,106	-25.9%	$13,865	-64.5%
Psychiatric Rehabilitation	580	628	8.3%	727	15.8%		$5,831,251	$6,321,578	8.4%	$6,521,642	3.2%
**TOTAL	4,972	5,182	4.2%	5,260	1.5%		$16,805,696	$18,498,230	10.1%	$19,054,894	3.0%

Crisis, mobile treatment, outpatient, and psychiatric rehabilitation services show annual increases in persons served and expenditures. Of note:

- Outpatient persons served increase in FY19 by 48 persons served however the expenditures increased by $559,780. This represents a material increase in cost per person served for this service. FY18 -- $1,276 per person and in FY 19 -- $1,379 per person.
- Psychiatric Rehabilitation there is a decrease in cost per person served. FY18 -- $10,066 per person and in FY19 -- $8,971 per person, a reduction of $1,095 per person.
- Inpatient and partial hospitalization declined in number served and expenditures.

Adult Substance Related Disorder Services

Regarding SRD data, in July 2017 residential treatment services entered into the fee- for- service structure. This transition to the ASO accounts for a substantial portion of the increase in SRD in FY18 and FY19, both in persons served and expenditures. This data is reflected below -- SRD table 2b. data excerpt.

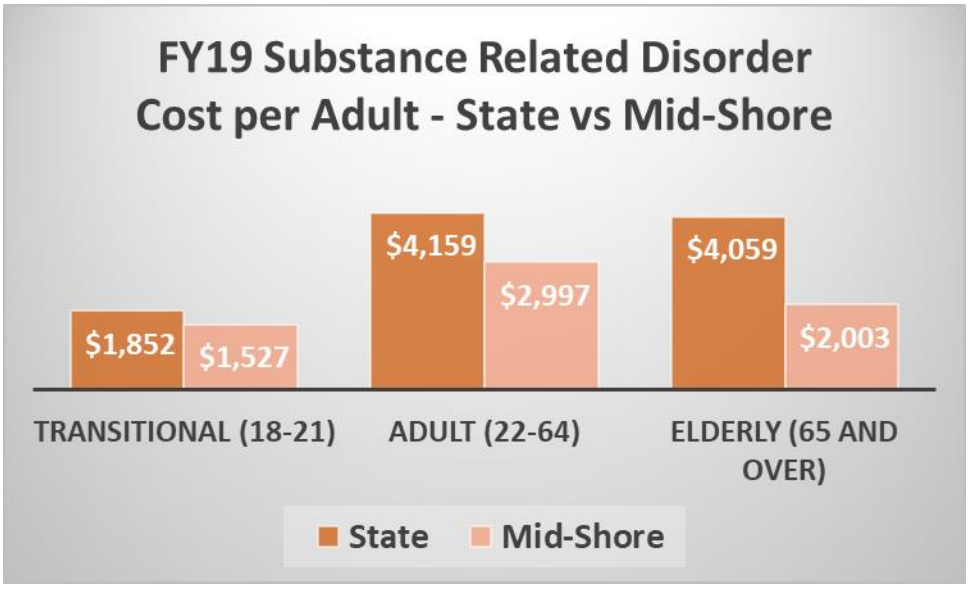
Substance Related Disorder Table 2b. Adults - Ages 18 and Over EXCERPT											
	Persons Served						Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
SUD Inpatient	72	62	-13.89%	57	-8.06%		$176,959	$269,731	52.43%	$196,795	-27.04%
SUD Outpatient	2,347	2,721	15.94%	3,097	13.82%		$1,919,688	$2,745,889	43.04%	$3,182,134	15.89%
SUD Partial Hospitalization	248	165	-33.47%	116	-29.70%		$641,391	$441,681	-31.14%	$384,445	-12.96%
SUD Labs	2,875	3,165	10.09%	3,503	10.68%		$2,852,380	$2,843,855	-0.30%	$3,016,280	6.06%
SUD Intensive Outpatient	355	441	24.23%	411	-6.80%		$1,136,618	$1,481,416	30.34%	$1,274,172	-13.99%
SUD Court Ordered Placement -	0	25	#DIV/0!	40	60.00%		$0	$383,932	#DIV/0!	$525,771	36.94%
SUD Women with Children/Pregr	0	6	#DIV/0!	8	33.33%		$0	$133,619	#DIV/0!	$112,131	-16.08%
SUD Residential All Levels	0	448	#DIV/0!	503	12.28%		$0	$2,348,567	#DIV/0!	$2,514,639	7.07%
SUD Residential Room/Board	0	447	#DIV/0!	498	11.41%		$0	$390,373	#DIV/0!	$445,381	14.09%
**TOTAL	3,587	4,246	18.37%	4,669	9.96%		$9,251,289	$13,108,084	41.69%	$13,592,274	3.69%

SUD inpatient, partial hospitalization, intensive outpatient declined between FY18 and FY19 in number served and expenditures. Outpatient services show annual increases in served and expenditures.

Comparisons of state and mid-shore expenditures per adult served

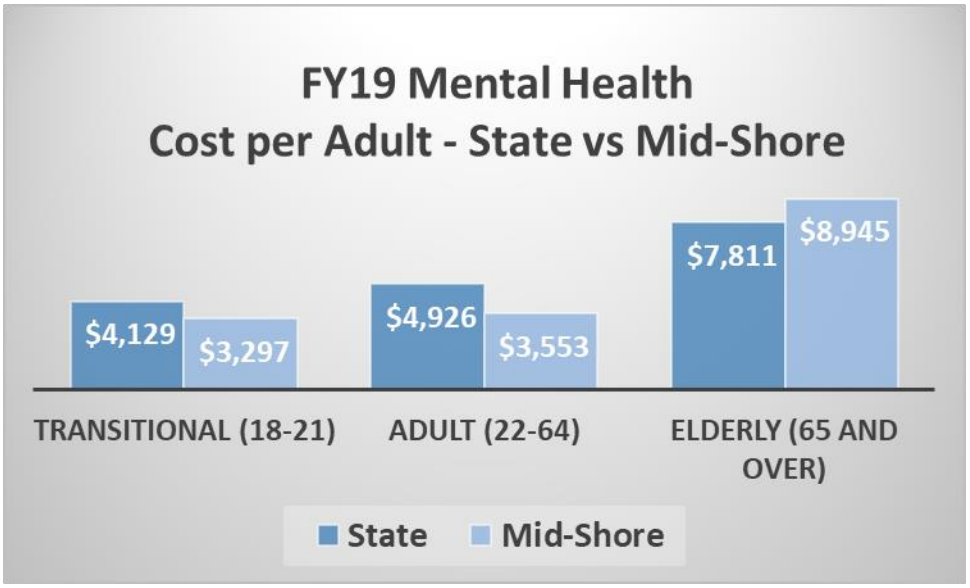
Mid-shore area expenditures for adults have overall been increasing, however, compared to statewide average expenditure per person served, the mid-shore area is significantly below statewide expenditures for transitional (18-21) and adult (22-64) populations. The expenditures for the mid-shore elderly (65 and over) population is significantly above statewide average.

Following charts are from MH and SRD data Tables 3b. Please note, the 65 and over population is provided care by Medicare and the individuals represented in this data pool are the few who can also access Medicaid (poverty or other conditions enable Medicaid additional coverage).



There are various possible reasons for this disparity between state and mid-shore cost per adult in all age groups and for both MH and SRD, with the exception for the MH 'over 65' age group:

- Shortage of providers and service offerings
- Individuals unable to avail themselves of the services that are available
- Lack of public and private transportation
- Ability to take off work and meet financial needs of the family



- Childcare enabling the parent to seek treatment

Conversely, the 'cost per adult' numbers may also be reflecting greater efficient use of existing resources. Communities may be providing necessary support to families and individuals in need, reducing the need for specific services.

Critical factors, possible explanations, and identified system of care needs:
Similar to the child and adolescent population, there continues to be a provider shortage in behavioral health services for adults. There are long waitlists, provider capacity barriers, and limited resources for those entering the community after inpatient treatment, incarceration or those waiting to be treated in an outpatient setting. Tele-health is a growing resource to the region but remains underutilized. Community providers are beginning to understand the importance of interagency collaboration and the benefits of the warm hand-off model of care.

According to this data analysis, persons served via inpatient treatment, outpatient treatment and psychiatric rehabilitation have increased in the mid-shore region. Increasingly individuals are being identified as co-occurring and referred to services by either our community providers or crisis services. Mobile Treatment (MTT) has served the region well, and the data supports the utilization of this service by our mid-shore consumers. The onboarding of a second MTT provider into the jurisdiction in FY20 has proven to be a valuable resource. Psychiatric rehabilitation services are also being utilized to build on life skills and provide structure during the day, all of these services are interrelated. A possible continued correlation between the increase in persons served during FY17-FY19 is the paralleled increase of opiate use and the state of emergency for opioid use in Maryland. Additionally, the resulting treatment resources that developed out of an increase in grant funding to manage the state of emergency allowed for greater access to treatment resources, for example recovery housing and care coordination.

According to this data analysis, aging adults (elderly age 65 and over) in our region have a higher expenditure rate when compared statewide. A possible explanation for this disparity is the population is served by both Medicare and Medicaid and are usually complex and costly. This, in combination with our rural region, and resulting barriers to receiving services may affect preventative care, consequently impacting health later in life as well as impacting expenditures for the healthcare of the aging population.

Recommendations and MSPC goals and objectives:
Partnering with behavioral health providers, identifying needs of the aging population and addressing those needs, such as a lack of transportation, affordable housing, and social isolation are key to decreasing the effects of health-related disorders in this population. Mid Shore Behavioral Health hosts an Aging with Behavioral Health and Disabilities workgroup to bring community providers together to work on the identified gaps in services to the aging population, as well as develop result-based accountability goals. The Pre-Admission Screening and Resident Review program (PASRR) position was

birthed out of this workgroup and its advocacy concerning the growing elderly population and the lack of services to meet the needs of the aging mid-shore community members.

MSPC supports each of our five county community efforts to meet the needs of our adult population. MSBH has individuals on staff with expertise specific to transitional age group (18 – 21), Adult (22-64), and Elderly (65 and over).

MSPC has built upon goals 1, 3 and 5 to target some of the specifically identified adult needs in our region:

MSPC Goal 1: Enhance the health and wellness of our mid-shore community.
MSPC has identified priority groups to expand reach for defeating stigma and engaging the community in leadership and outreach activities. MSPC will be focusing on the diversifying efforts to reach across cultures in the mid-shore region and engage stakeholders from the faith-based and underserved populations. MSPC will strategically work with established workgroups, Eastern Shore Behavioral Health Coalition, and community leaders to educate and outreach with constituents.
MSPC Goal 3: Build and support a regional behavioral health system of care.
This MSPC goal initiates strategies to address issues impacting service delivery that are prevalent in a rural area. MSBH will work collaboratively with agencies to improve access to behavioral health services and expand services in the region. Priority new initiatives include the expansion of telehealth services in the region, working to expand the reach of the mobile treatment units, peer outreach, as well as the expansion of our crisis response system and crisis access to treatment. MSPC is working with its community partners to enhance prevention, screening, intervention, treatment, and recovery supports**.**
MSPC Goal 5: Collaborate to expand and sustain a dynamic rural workforce.
As part of this goal MSPC is advocating through the Behavioral Health Coalition with legislatures for awareness and policy change that will support expansion of provider types and mode of treatment delivery to balance the behavioral health workforce crisis in our rural region. Incentives such as student loan forgiveness, Health Professional Disparity Area (HPSA Scores) assessment, outreach and recruitment initiatives are being explored to attract providers into the area. Additionally, telehealth is being recognized and utilized by providers to meet the need of a lack of prescribers and behavioral health providers in our region.

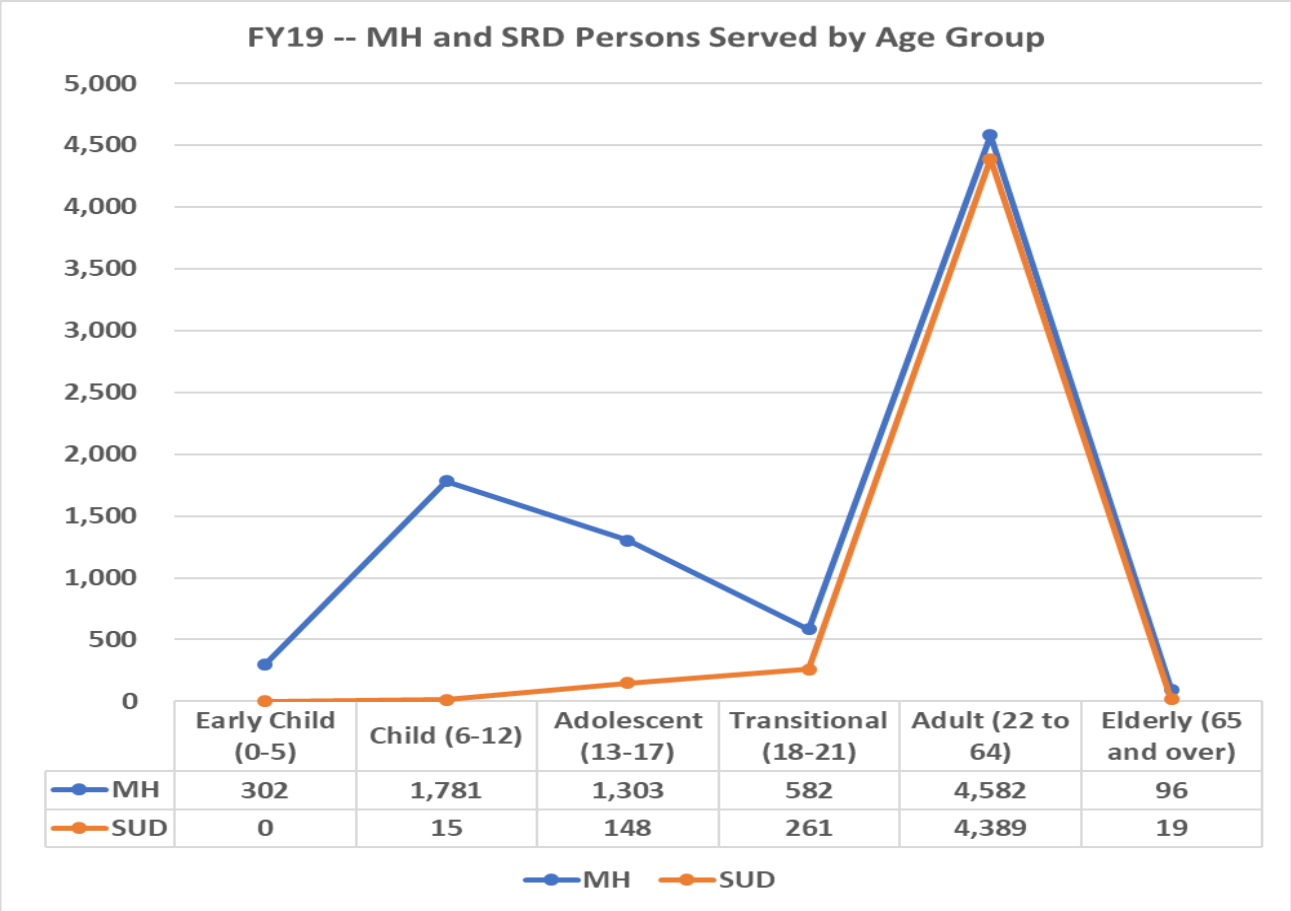
Special Populations and Other Specific Areas for Review

Across the life span – Number of individuals served in each age group for both MH and SRD

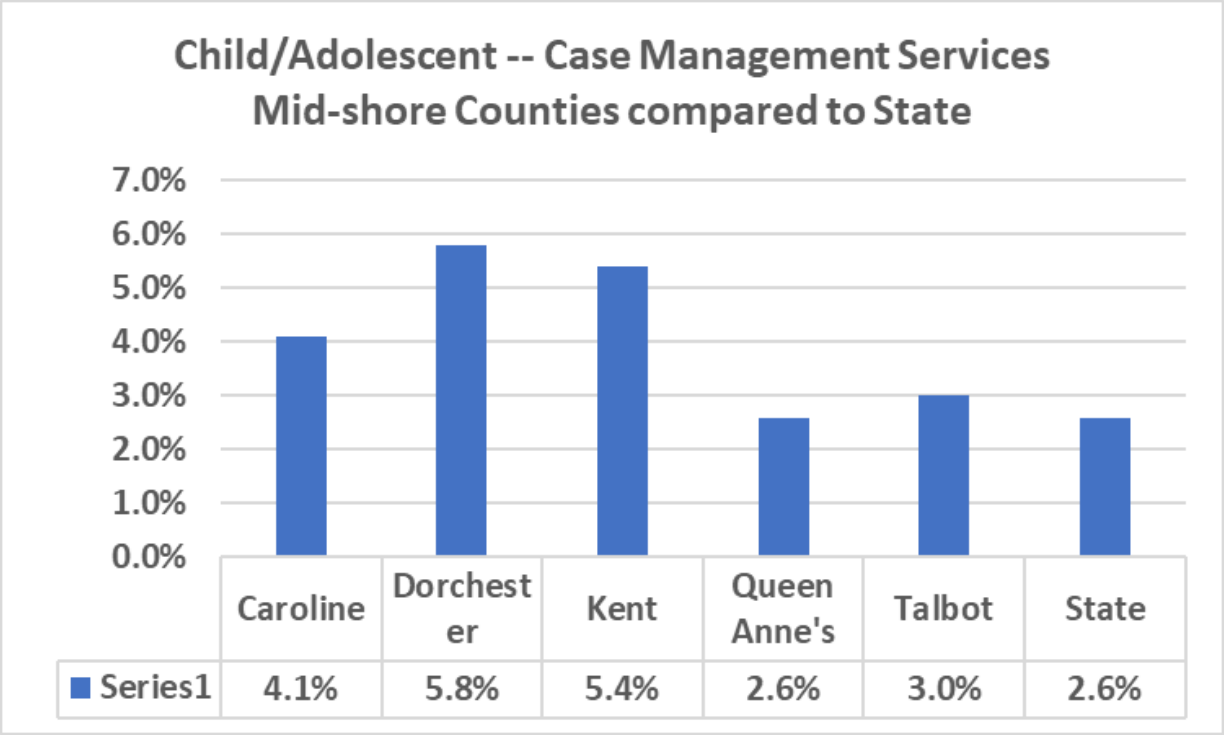
This chart shows a comparison of mental health utilizers to substance related disorder utilizers by age group. Of interest is to see the differentials within each age group. For C&A we see the initial high use of mental health services and then the use of these services declines substantially into the transitional age period while concurrently the SRD services utilized start to increase into the transitional age period. The adult populations approximate equal use of both MH and SRD services. *Data -- Table 1a MH and SUD.*

MSPC acknowledges that during the adolescent developmental period it is crucial to utilize partnerships within schools to provide behavioral support, prevention and early intervention programs. During the early adult/transitional age developmental period, having resources and programs to offer individuals who have emerging substance related issues is an area that lacks resources in the mid-shore. MSBH is a part of two transition age youth programs that offer person-centered competitive employment, housing, supported education services and psychiatric rehabilitation programming for those individuals meeting the TAY criteria.

Targeted Mental Health Case Management Capacity Analysis



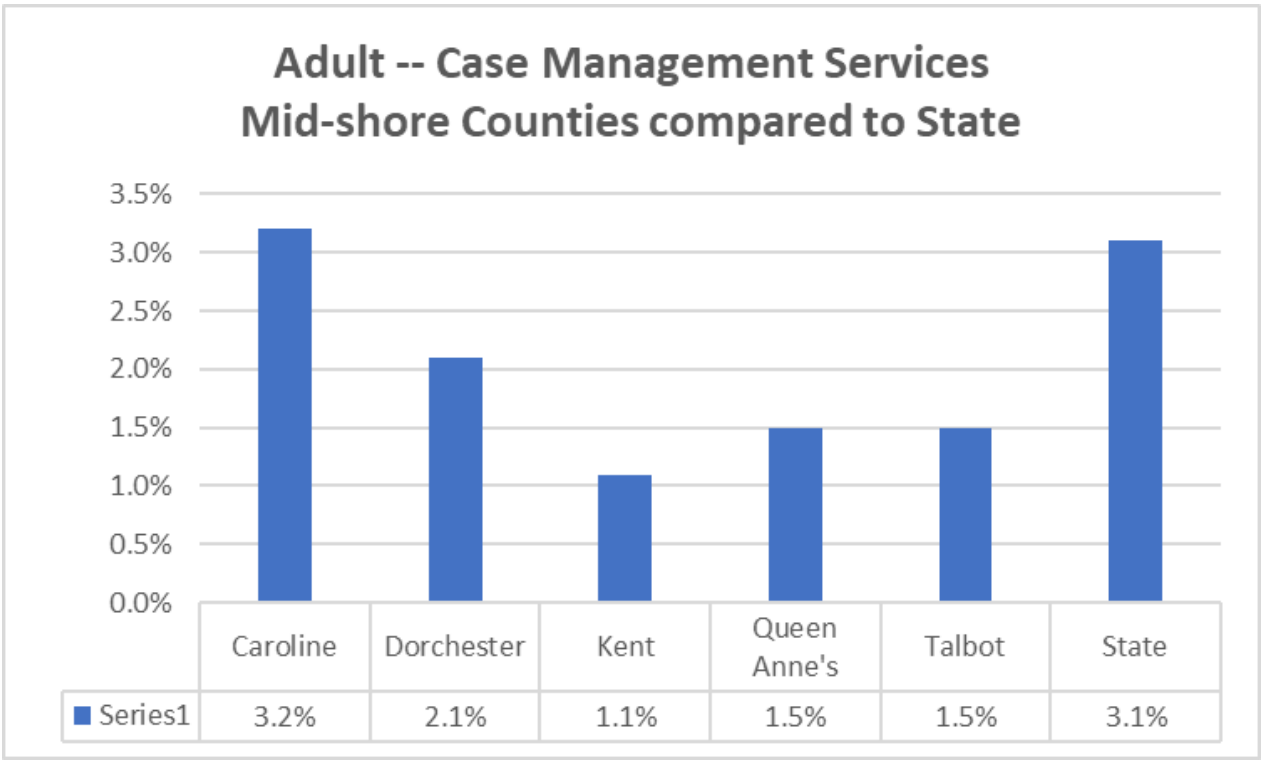
	Early Child (0-5)	Child (6-12)	Adolescent (13-17)	Transitional (18-21)	Adult (22 to 64)	Elderly (65 and over)
MH	302	1,781	1,303	582	4,582	96
SUD	0	15	148	261	4,389	19



Data – Table 2ci

The mid-shore region compares favorably statewide in providing Targeted Case Management (TCM) Services. The areas in the mid-shore that have the greatest need for services, Caroline, Dorcheste3r and Kent are high utilizers of TCM services due to the shortage of providers and community-based services.

The Child and Adolescent TCM program on the mid-shore is managed by WrapAround MD. They have provided TCM in the mid-shore for the past 2 years. The number of children and youth being served has continued to climb since the change of providers in October 2017. In FY2019 the number of individuals served increased 67% and expenditures increased 137%. Wraparound MD works well to engage families of children and adolescents in TCM and to keep them engaged. The growth in referrals also warranted the addition of care coordinators (average of 9), two supervisors and an intake coordinator. WrapAround MD has a positive presence on the mid-shore and works together with agency partners to provide services and supports needed to youth. WrapAround MD continues to recruit additional staff in order to meet the referral needs and address staff turnover. Increased expenditures may be partially as a result of staff turnover/retention and staff recruitment. The mid-shore expenditures continue to be below statewide average per person spent. Targeted Case Management services on the mid-shore continue providing community-based services in order to support children and adolescents with behavioral health needs in their homes and communities. The current contract with WrapAround MD runs through September 30, 2022. As the timeframe for contract renewal draws near, a request for proposals will be posted.



Data – Table 2cii

The mid-shore region lacks the TCM providers needed to service the adult population in the mid-shore region. The mid-shore region only has three TCM providers whereas the child and adolescent population has eleven (11).

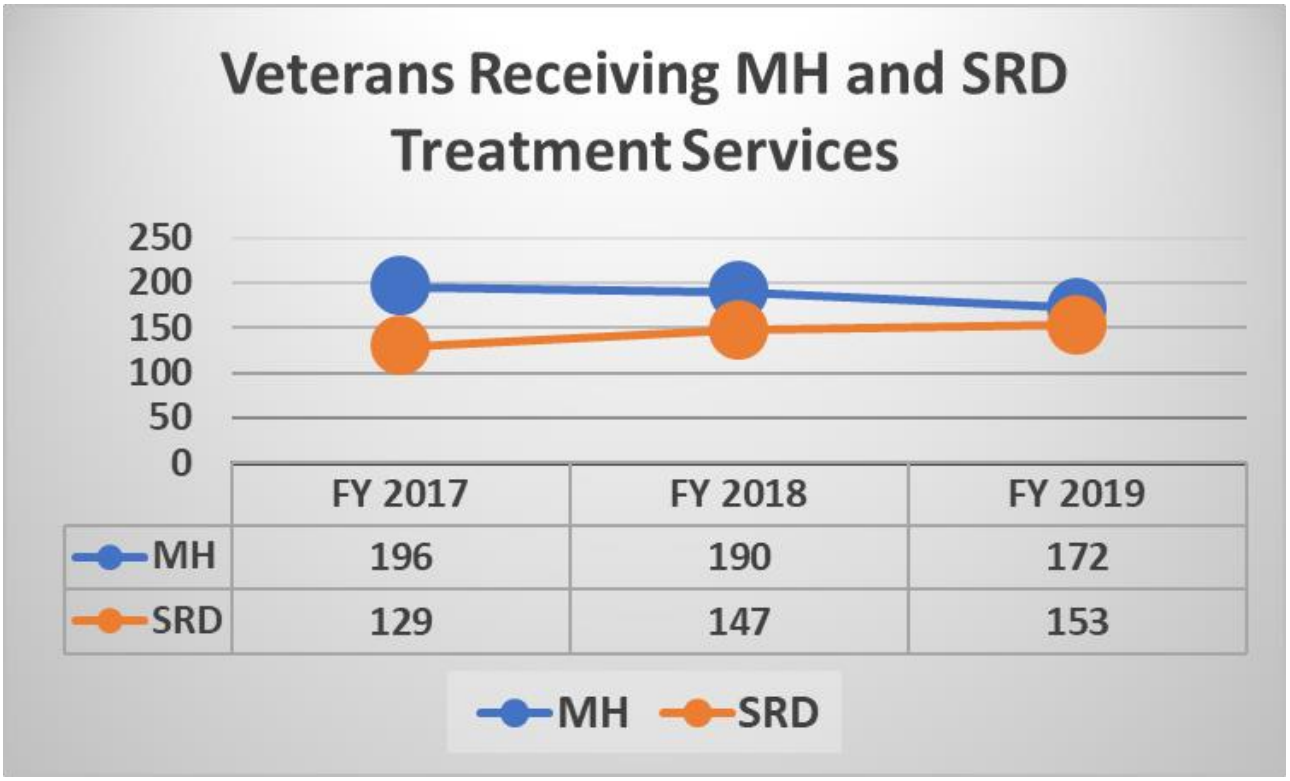
The Adult TCM program on the mid-shore is managed by Corsica River Mental Health Services (CRMHS). They have been the certified TCM provider for over 5 years (previously housed under CCI but by the same team). In FY2019 the number of individuals served decreased 23% and expenditures decreased 8%. The program is managed by a TCM supervisor who carries a caseload and two other TCMs. The cost per individual served continues to be below the statewide average. They generally carry a caseload over by around 22 clients. Carrying a higher case load is difficult due the size of our region and travel time between clients. The regional program tries to address this issue by assigning case managers to specific regional areas of the mid-shore. The highest population of need for the program tends to be in Caroline and Dorchester County. The TCM provider has been open to employing more TCMs but the number of referrals does not support program expansion at this time. During fiscal year 2019 there was no waitlist and the referrals were difficult to contact or refused services. In addition, the overall number of referrals decreased. This may account for the reduction in numbers served for fiscal year 2019. Also, it is noteworthy that some people who would be eligible for TCM services in the mid-shore region are accessing services through PRP programs. The TCM program is a valuable resource for the mid-shore region as it helps to stabilize individuals who are discharging back to the community from more intensive environments such as inpatient stays. This service provides linkages to resources and

monitors achievement of goals for members of the mid-shore community enabling them to become independent individuals.

MSBH in FY19 released an RFP for provider selection compliance. In FY 20 the new cycle of the contract went into effect. This occurs every 5 years according to contract guidelines. TCM remains a fee for service contract.

Veteran population – Treatment services

Data tables and charts in this section are derived from -- BHA provided tables 'Number of Veterans Receiving MH and SRD Services and Related Expenditures in FY 2017 – FY2019'



Veterans on the Mid Shore Receiving SRD Services

Veterans Receiving Substance Related Disorder Services			
COUNTY	**FY 2017**	**FY 2018**	**FY 2019**
Caroline	28	35	28
Dorchester	41	44	59
Kent	16	18	18
Queen Anne's	21	24	23
Talbot	23	26	25
Midshore Total	**129**	**147**	**153**

The mid-shore Counties of Caroline, Dorchester, Kent, Queen Anne's and Talbot each have United States Veterans accessing Substance Use Disorder Treatment Services within their jurisdictions. Kent County had the fewest number of Vets receiving services during the three years indicated (FY2017-FY2019/ total number 52), while Dorchester County had the highest number of Veterans who received SUD services over the same 3-year period, 144. Caroline County served 147, Queen Anne's County, 68, and Talbot County, 74, respectively, during the same 3-year time period. SUD Treatment Providers within the Mid-shore region of the Eastern Shore have extended their treatment services to include outreach to Veterans. Formal arrangements for SUD Treatment Providers to be credentialled with the Veteran's Administration as treatment providers are underway. The advent of Veteran's Courts, as in the case of The District Court for Dorchester County Regional Veterans Treatment Court (VTC), currently presided over by Judge Melvin Jews, have come into being to assist Vets in accessing SUD and Mental Health treatment which began in 2018. Entities like these seek to divert eligible defendants who have served in the military with an honorable and/or other than honorable discharge with a substance use disorder and/or mental illness from the traditional criminal justice system to a specialized treatment court. Veteran's Justice Outreach Coordinator's (VJO's) on the Eastern Shore have recognized the need for local community based behavioral health treatment providers to be able to provide treatment for the Veteran. VJO's on the shore are actively working for local providers to receive reimbursement for services rendered to Vets.

Veterans Receiving Substance Related Disorder Services			
COUNTY	**FY 2017**	**FY 2018**	**FY 2019**
Caroline	$66,223	$96,370	$149,626
Dorchester	$159,215	$231,229	$309,481
Kent	$89,469	$75,047	$46,385
Queen Anne's	$64,063	$113,466	$59,601
Talbot	$85,417	$111,618	$88,517
Midshore Total	**$464,387**	**$627,730**	**$653,610**
Statewide Total	**$14,827,008**	**$19,467,870**	**$22,504,809**

Statewide total expenditures for Substance Use Disorder Treatment for Veteran's as a whole are growing, as are expenditures for Veterans in Caroline, Dorchester, and Talbot Counties. Both Queen Anne's and Kent Counties have seen a decrease in expenditures, although the population is relatively consistent. Kent County's expenditures have decreased $43,084.00 between FY2017 and FY2019, while Queen Anne's expenditures declined by $4,462.00. Some former service men and women with SUD or Mental Health needs continue to be served within the Veteran's Administration's Health Care System, often times having to drive to Baltimore or Perry Point Maryland in order to access specialized services. Statewide, as the number of Veteran's receiving SUD Treatment services continues to rise, expenditures have also steadily risen from $14, 827,008 in FY2017, to $19,467,870 in FY2018, and finally $22,504,809 in FY2019, an increase of over seven and a half million dollars over three years.

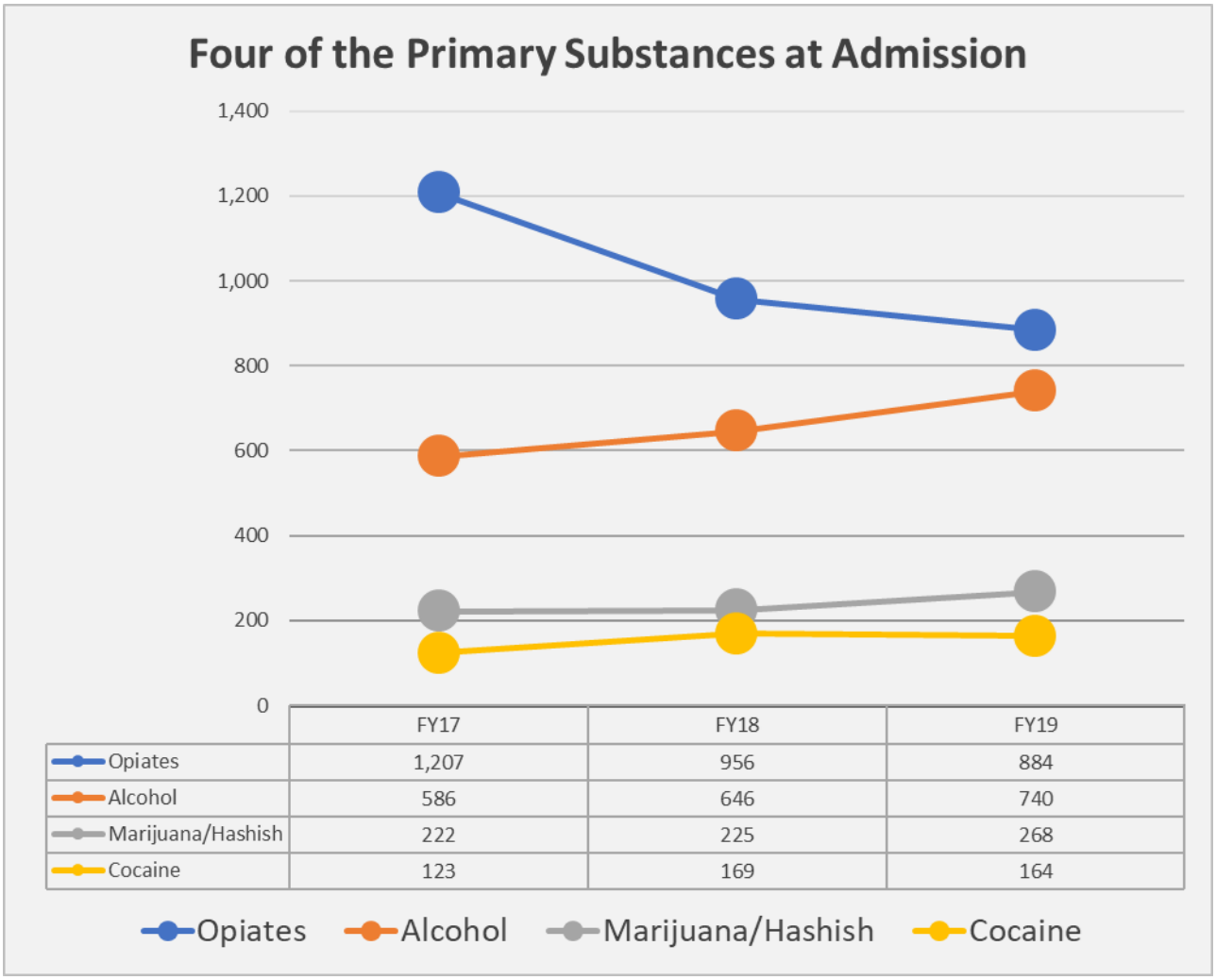
Veterans on the Mid-shore Receiving MH Services

Veterans Receiving Mental Health Services			
	FY 2017	**FY 2018**	**FY 2019**
Caroline	57	50	40
Dorchester	52	58	55
Kent	17	17	17
Queen Anne's	34	32	29
Talbot	36	33	31
Mid-shore Total	196	190	172

The number of mid-shore veterans accessing mental health services through the public behavioral health system continues to decrease yearly as do the numbers across the state of Maryland. One factor that may affect the above numbers is the aging veteran population, which are now able to be served under Medicare, rather than Medicaid.

The mid-shore has been challenged with the loss or restructuring of mental health providers in the region during this time, as well. Caroline County was significantly impacted during this time period with the loss of service providers at Caroline County Behavioral Health. During FY19, this has begun to stabilize, and the rebuilding process has begun. Access to other programs may prevent usage of the public behavioral health system. Veterans Treatment Court is being utilized to assist in accessing mental health and substance use treatment for veterans. Also, the Mid-shore region has a strong veterans service supports system that quickly connects veterans to services needed.

Primary Substance at Admission

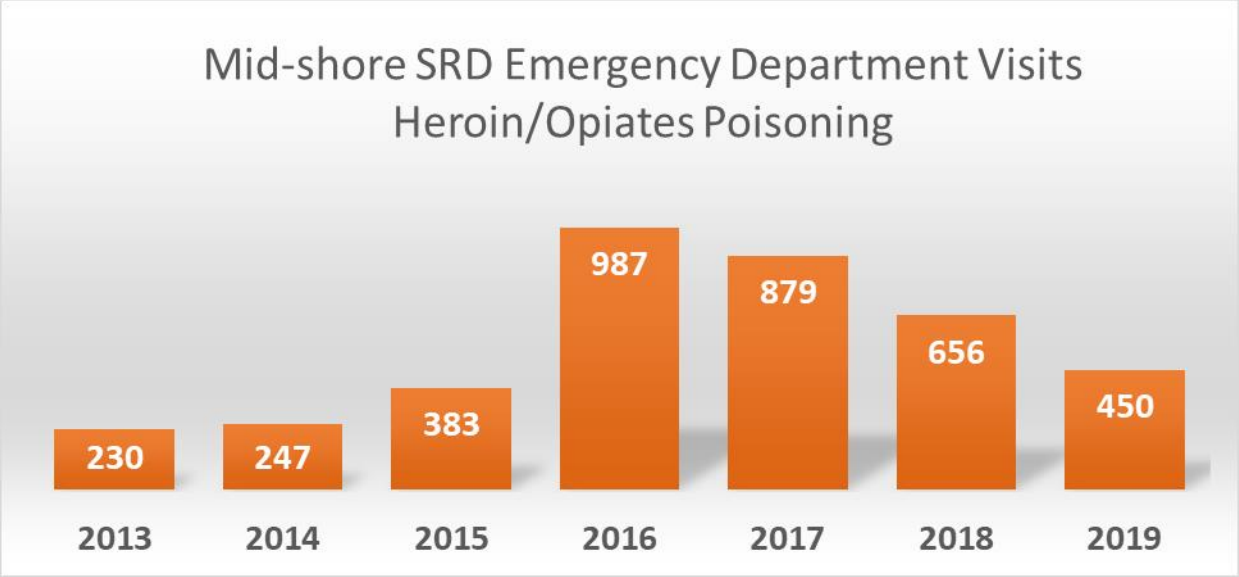


	FY17	FY18	FY19
Opiates	1,207	956	884
Alcohol	586	646	740
Marijuana/Hashish	222	225	268
Cocaine	123	169	164

In FY19 the region has seen a decrease in Opiate use as we continue to focus on prevention, harm reduction initiatives and expanding access to treatment and recovery housing. Unfortunately, alcohol use continues to increase in our region. Historically alcohol use has been a concern in our rural counties and with an increase in socially acceptable forms of use such as, microbreweries and wineries, the use of alcohol has increasingly become a part of our region's "social scene". This chart shows that prevention and treatment of Opiates has positively changed the direction of the numbers using, it may be beneficial to apply this same attention to alcohol use for our region, as a way to change the upward trajectory of individuals in need of treatment. MSPC is working collaboratively on Initiatives to address alcohol abuse in the mid-shore in FY2021.

Opioid Data

Mid-shore emergency room visits for heroin and opiate poisoning



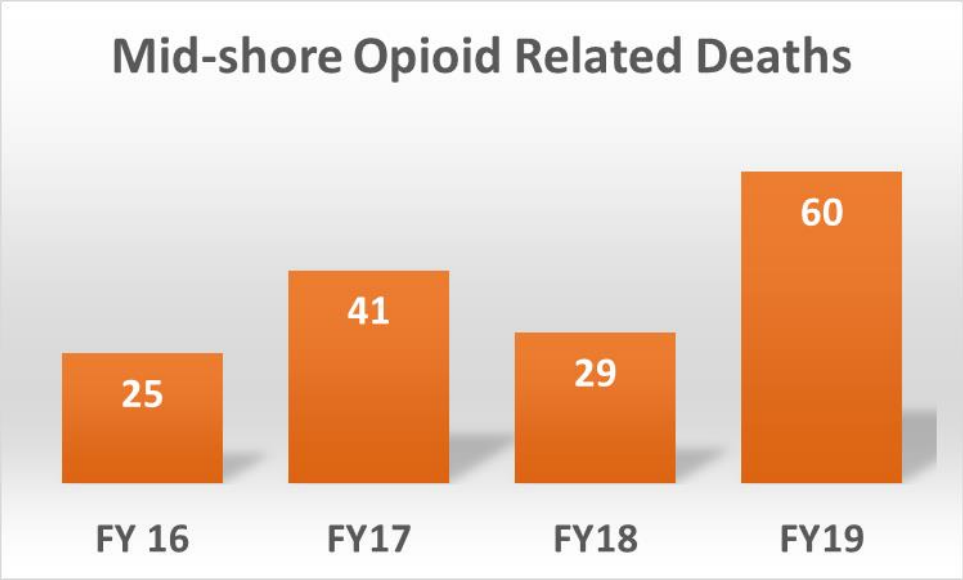
**Data from University of Maryland Shore Regional Health*

Opioid Related Overdose Deaths

The following three charts/table are derived from BHA SRD table 'Number of Opioid Related Overdose Deaths by County'

Region	CY 2017	CY 2018	CY 2019	% Change CY17-18	% Change CY18-19
Statewide Total	2,009	2,143	1,539	6.7%	-28.2%
Mid-shore	41	29	60	-29.3%	106.9%

Opioid Related Overdose Fatalities in the Mid-Shore Region



In 2019, statewide data shows there were 1,539 overdose deaths involving opioids in Maryland, a 28.2% reduction from the prior year.

Number of Opioid Related Overdose Deaths by County		
COUNTY	**% Change CY17-18**	**% Change CY18-19**
Caroline	20.0%	88.0%
Dorchester	-25.0%	66.7%
Kent	-50.0%	400.0%
Queen Anne's	175.0%	-27.3%
Talbot	42.9%	-10.0%

In FY 2017, there were 41 opioid related overdose fatalities in the mid-shore Region. By FY2018, overdose fatalities in the region dropped to 29, then climbed again to 60 in FY2019. Both Dorchester and Kent Counties experienced 25% and 50% decreases respectively in opioid overdose fatalities between FY2017-2018. Caroline, Dorchester and Kent Counties each experienced a substantial increase in opioid related overdose deaths between FY2018-2019.

Illicit fentanyl is thought to be a factor in the increase of overdose fatalities. Heroin is standardly laced with the inexpensive but deadly drug. Some individuals have switched to heroin as it has become difficult and more expensive to obtain prescription opioids.

Since the advent of Governor Larry Hogan's 2017 Heroin and Opioid Prevention, Treatment and Enforcement Initiative, entities and services have been established and function within the mid-shore Region to address and ameliorate the negative effects of the current opioid crisis. The statewide Opioid

Operational Command Center has created Opioid Intervention Teams, multi-disciplinary teams which meet regularly in each county to address that jurisdiction's needs. Opioid Overdose Prevention Plans, originally established in 2013, have been modified to address the current issues and needs of the community. Overdose Response Programs are available in each jurisdiction. Naloxone education is provided, and the life-saving medication is distributed. Certified Peer Recovery Specialists are available to provide outreach to overdose survivors and their families. The Good Samaritan Law provides statewide protection from arrest and prosecution for individuals experiencing or assisting in an emergency overdose situation. The Prescription Drug Monitoring Program aims to reduce prescription drug misuse and diversion statewide as well. Overdose Fatality Review Teams within the Mid-shore counties conduct confidential case reviews of overdose deaths with the goal of preventing future deaths. Recovery and Wellness Centers are available to those seeking a recovery-oriented environment and paraprofessional services.

Local Law Enforcement agencies and local Emergency Management Systems (EMS) personnel in Maryland jurisdictions respond to opioid overdoses, both nonfatal overdoses and those which result in fatalities, throughout the region.

The mid-shore Region has services in place to address the current opioid crisis. Local providers offer a variety of services which are located within the five-county rural region. Due to the high volume of referrals, waiting lists are present in some rural jurisdictions. Waiting lists serve as impediments to accessing services in a timely manner. Local agencies provide SUD Treatment and services which include Level 1(Traditional Outpatient), Level 2 (Intensive Outpatient), Medication Assisted Treatment (MAT) in conjunction with outpatient SUD treatment, Methadone Maintenance, Partial Hospitalization Programs, Twelve Step Fellowships, and Faith Based initiatives.

Although there continues to be a shortage of MAT prescribers on the Eastern Shore, Mid Shore Behavioral Health Services Inc, Dorchester County Behavioral Health, Talbot County Health Department and Shore Regional Health hosted a MAT Waiver Training for Buprenorphine Medication-Assisted Treatment for physicians on November 6, 2019 in Easton. This event was well attended and provided an opportunity to obtain increased prescribers on the Eastern Shore for individuals seeking MAT. Potential prescribers had an opportunity to network and collaborate with local SUD Treatment Providers with the goal of forming treatment partnerships within the local community. Transportation continues to be a substantial barrier to individuals receiving SUD services, especially in rural settings. Some agencies, including Dorchester County Behavioral Health, provide transportation for clients from the high poverty, rural county to attend their SUD Treatment Program.

Data Tables

The following data tables are provided in this section -- Mid-shore region combined county data tables for both mental health and substance related disorders. Individual county data tables for both mental health and substance related disorders are provided in the Appendixes.

The following is a reference to the guiding priorities and goals that MSPC referenced in the development of our FY2021 Community Behavioral Health Plan Goals and Objective. The development of the MSBH FY2021 Goals was a process that involved the leadership and team members from each mid-shore local authority and was endorsed by the Health Officers for each of the mid-shore counties. FY2021 Goals are driven from experiences with our provider community, consumers, and stakeholders. Local Systems Management Integration planning and the assessment of our mid-shore region of care are key elements of the planning.

Behavioral Health Administration Systems Management Integration Domains:

1. Leadership and Governance *(vision, community engagement, management, policy advocacy, innovation).*
2. Budgeting and Operations *(financing and billing, technology infrastructure, resource and expense sharing).*
3. Planning and Data-driven Decision Making *(data analysis, community needs assessment, network adequacy, program outcomes).*
4. Quality *(provider training, client experience, complaints, performance improvement, licensing and credentialing).*
5. Public Outreach, Individual and Family Education *(messaging, communication, feedback).*
6. Stakeholder Collaboration *(with providers of BH, somatic care, community services, and other partners).*
7. Workforce *(recruitment, training and development, retention).*

The Substance Use and Mental Health Services Administration (SAMHSA) Priorities & Goals – Strategic Plan FY2019 - FY2023:

Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services

Goal: Reduce opioid misuse, use disorder, overdose, and related health consequences, through the implementation of high quality, evidence-based prevention, treatment, and recovery support services.

Priority 2: Addressing Serious Mental Illness and Serious Emotional Disturbances

Goal: Reduce the impact of serious mental illness (SMI) and serious emotional disturbance (SED) and improve treatment and recovery support services through implementation of the comprehensive set of recommendations put forward by the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).

Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use

Goal: Reduce the use of tobacco (encompassing the full range of tobacco products and reduce the misuse of alcohol, the use of illicit drugs, and the misuse of over-the-counter and prescription medications and their effects on the health and well-being of Americans.

Priority 4: Improving Data Collection, Analysis, Dissemination, and Program and Policy Evaluation

Goal: Expand and improve the data collection, analysis, evaluation, and dissemination of information related to mental and substance use disorders and receipt of services for these

conditions to inform policy and programmatic efforts, to assess the effectiveness and quality of services, and to determine the impacts of policies, programs, and practices.

Priority 5: Strengthening Health Practitioner Training and Education

Goal: Improve the supply of trained and culturally competent professionals and paraprofessionals to address the nation's mental and substance use disorder healthcare needs across the lifespan.

Mid-Shore Rural Health Collaborative (RHC)

Senate Bill 1056, effective July 1, 2018, established the Rural Health Collaborative Pilot for Maryland's Mid-Shore Region (Caroline County, Dorchester County, Kent County, Queen Anne's County, and Talbot County). The purpose of the RHC is to develop and direct the establishment of a Rural Health Complex (or multiple Complexes) to better coordinate and integrate delivery of clinical services and social services. On or before December 1, 2020, the RHC is to determine "standards and criteria that a community must meet to establish a Rural Health Complex."

Priority Concepts for Rural Health Model:

• Establish community hubs (one point of entry for individuals) for coordination of clinical and social services to improve outcomes (decrease cost, prevent complications, and reduce hospital admissions)

• Establish partnerships with EMS to help residents find appropriate clinical and social services for high users of 911 for non-emergencies

• Coordinate clinical services and/with social services for patients being discharged from an inpatient setting

• Coordinate all clinical and social services at the medical home – includes behavioral health and dental health

• Establish fixed bus routes to health and social services hubs (e.g., County Ride)

• Work with third-party payers (e.g., Aetna) to provide and/or subsidize transportation

GOALS, OBJECTIVES, & STRATEGIES FY2021

Goal 1: Enhance the health and wellness of our mid-shore community.

Objective 1: In partnership with consumers, their natural support systems and the community at large, promote awareness and understanding of behavioral health.

Strategy 1A. MSPC will support an integrated media presence and increase public knowledge throughout the mid-shore.
Performance Measure: Media presence will include a regional resource guide, user-friendly websites, intentional social media, printed collateral, and a weekly e-newsletter. Track social media posts, likes, retweets, and shares.
Performance Target: 600 Resource Guide distribution; Minimum of 40 weekly e-newsletters distribution; 1000 social media interactions annually.

Strategy 1B. MSPC will increase public knowledge of behavioral health through community events.
Performance Measure: MSPC will participate in and track community events to inform the public on behavioral health resources, information and systems processes.
Performance Target: Host, sponsor, and/or volunteer a minimum of 30 information tables annually and conduct 40 presentations annually.

Strategy 1C. MSPC will engage the regional business and faith-based community in the promotion of awareness of whole health and wellness.
Performance Measure: Intentional marketing and outreach to provide information on behavioral health topics and resources to regional businesses and faith-based community.
Performance Target: Contact and present information to 40 businesses and/or faith-based organizations within the region.

Strategy 1D. MSPC will foster consumer advocacy within the public behavioral health system in the mid-shore region.
Performance Measure: Contribute to regional activities for peer recovery supports and family mentor support through the local Wellness and Recovery Center and Family Advocacy Organizations.
Performance Target: Support and/or promote a minimum of one event from each county's peer recovery program, monthly.

Strategy 1E. MSPC will promote and support Mental Health First Aid (MHFA) trainings.

Performance Measure: Seek out opportunities to bring MHFA Training to the region. Support any other agencies that offer MHFA Training and help identify organizations in need of MHFA Training.
Performance Target: Support at least 10 MHFA trainings in the mid-shore region.

Objective 2: Collaborate with key stakeholders to expand knowledge of behavioral health among professionals and the community, promoting integrated care and working towards health literacy.

Strategy 2A. MSPC will increase public awareness of behavioral health priorities and trends by way of data sharing.
Performance Measure: MSPC will promote public behavioral health awareness and improved communication through the sharing of relevant data and trends. Maintain and expand electronic distribution list to serve as an avenue for distribution of data.
Performance Target: At a minimum, extend annual PBHS data out to the distribution contacts and partner agencies, and present trends to community stakeholders and advisory councils. Increase attendance by 10% in FY2021.

Strategy 2B. MSBH will continue to manage the Behavioral Health Services Network (BHSN) and its representation of an integrated system of care.
Performance Measure: The Behavioral Health Services Network (BHSN) is a group that meets quarterly to discuss trends, changes, and issues concerning behavioral health on the Eastern Shore. The network is the avenue through which MSBH regularly meets with consumers, peers, family members, providers and community leadership to share information, concerns and ideas about what is happening on a federal, state and local level related to behavioral health. The provider council model is expanded to include representation from all interested community stakeholders. The BHSN strives to be representative of integrated priorities and provider types.
Performance Target: Host quarterly BHSN meetings with rotating priorities, and rotating county meeting locations. Allow for attendee feedback, and guidance with BHSN meeting presentations and needed areas for education and training.

Strategy 2C. Representatives from MSPC will present at and/or support conference activities. and conference sponsorships, in an effort to support, promote and spread the most relevant behavioral health information.
Performance Measure: MSPC conference presentations at the following annual conferences: Sequential Intercept Model Annual Meeting, Across the Life Span Annual Conference, and any other conference presentation opportunities as identified.
Performance Target: One presentation at each of the conferences listed above and those identified during FY2021.

Strategy 2D. Host an annual Caliber Awards to celebrate excellence in the mid-shore region's behavioral health community.
Performance Measure: Host annual awards ceremony with the community stakeholders in attendance; present awards for achieving excellence in the public behavioral health system in the areas of creative cost-effective programs, empowerment of consumers, and interagency/community collaboration. Create award or certificate categories to recognize positive behavioral health practices throughout the region and across the system of care continuum.
Performance Target: Host one award ceremony with a minimum attendance of 75 community members with a minimum of ten community awards presented.

Objective 3: Identify and address the culture and stigma associated with behavioral health in the mid-shore.

Strategy 3A. MSPC will support provider and community education in an effort to defeat behavioral health stigma.
Performance Measure: Host, sponsor, and/or volunteer at public events to promote behavioral health, wellness, and awareness.
Performance Target: MSPC will participate, organize, or sponsor a minimum of six public events in FY2021.

Strategy 3B. Conduct a survey on the MSPC websites to gain baseline data for areas most needed to address stigma reduction.
Performance Measure: MSPC will distribute the survey on websites, at community events.
Performance Target: Collect a minimum of 300 surveys from consumers in the region.

Strategy 3C. In order to incorporate anti stigma messaging, MSPC will promote and participate in mid-shore substance use awareness initiatives with a concentration on the "Going Purple" campaign.
Performance Measure: Engage and market regional community events. Participate on county-level planning committees for community events, school-based initiatives, and provider targeted activities.
Performance Target: Representation on all five mid-shore planning committees and participate in each county's "Going Purple" campaign.

Strategy 3D. MSPC will continue to promote suicide prevention and awareness.
Performance Measure: Collaborate with local stake holders to address and implement suicide prevention across the life span by way of educational materials, assessing availability and access to services and promotion of American Foundation for Suicide Prevention best practices.
Performance Target: At least one member of the MSPC will join the planning committee for the American Foundation for Suicide Prevention Out of the Darkness walk in the mid-shore region.

Highlight suicide prevention articles and information at least 15 times in the weekly newsletter in FY2021.

Objective 4: Actively involve members of the mid-shore community in behavioral health systems management.

Strategy 4A. MSPC will promote, garner membership in and support growth with peer organizations.
Performance Measure: Contribute resource expertise and systems involvement with peer organizations.
Performance Target: Support local peer involvement through two regional community events during FY2021.

Strategy 4B. Collaborate with faith-based institutions to develop and implement community recovery support programs/services for SRD using Peer Recovery Specialists.
Performance Measure: Increase knowledge and community support for the SUD community in all five counties.
Performance Target: Develop and implement three faith-based community recovery support program services for SRD in the mid-shore region.

Strategy 4C. MSBH participation in national, state and local conferences in an effort to support, promote and spread the most relevant behavioral health information.
Performance Measure: Attendance at BHA sponsored conferences, the annual On Our Own of MD conference, the Crisis Intervention Team (CIT) International Conference, and Tuerk Conference on Mental Health and Addictions Treatment.
Performance Target: 100% attendance at conferences listed above. Disseminate at least one relevant piece of information from each of the conferences list above to our behavioral health provider network.

Strategy 4D. MSBH will lead the Eastern Shore Behavioral Health Coalition.
Performance Measure: Participate in local and state-level Behavioral Health Coalitions to aid with providing accurate and impactful data and facts for decision making and advocacy.
Performance Target: Host a minimum of four meetings of the Eastern Shore Behavioral Health Coalition. Plan and facilitate annual Eastern Shore Delegation Legislative forum to prepare for legislative priorities in FY2021. Monitor legislative changes and developments to be reviewed at Behavioral Health Coalition meetings and identify priority areas as a group.

Strategy 4E. MSPC will diversify advising and governing bodies by involving consumers, youth, family members, and advocacy organizations' participation.

Performance Measure: MSPC will involve representation from consumers and family members on the Board of Directors, LDAACs, RBHAC, and Consumer Council. Encourage consumer, youth, family, and advocacy organization representation on the MSBH BHSN and workgroups.
Performance Target: Monitor membership of all formalized groups to include representation from the aforementioned target members. Extend administrative support to the mid-shore Consumer Council and ensure that the Council meets at least six times annually.

Strategy 4F. Identify behavioral health needs and community resources for individuals aging within the mid-shore region through the Aging with Behavioral Health and Disabilities Workgroup.
Performance Measure: Host bimonthly meetings; create and/or update annual goals; collaborate with BHA to promote, advocacy by offering education to service providers, health care workers, older adults, caregivers and the public. Attend local Commission on Aging meetings and MAP interagency meetings in an effort to share resources and promote integrated systems of care for the aging population. Identify and seek additional resources through grant funding opportunities.
Performance Target: Host a minimum of six meetings in FY2021 and share goals in FY2021.

Strategy 4G. MSBH will address behavioral health needs, trends, and gaps in services through the BHSN Child and Adolescent Workgroup.
Performance Measure: Collaborate with state and local stakeholders to promote existing resources and encourage resource development specific to child and adolescent population. Offer education to service providers, community partners, and the public, informing them of the behavioral health needs of the child and adolescent population. Identify and seek additional resources through grant funding opportunities.
Performance Target: Host a minimum six meetings in FY2021 and share goals in FY2021.

Strategy 4H. MSBH will continue to identify behavioral health needs for individuals who are involved with the criminal justice system through the BHSN Forensic Workgroup.
Performance Measure: Invite community stakeholders to participate in the workgroup and give input on topics that affect the forensic population. Continue to strengthen partnerships with community agencies in supporting the forensic population.
Performance Target: Confirm that three of the five counties are present at each monthly workgroup session and share in FY2021.

Strategy 4I. MSPC will support the formation of a Mid Shore Recovery House Workgroup.
Performance Measure: Collaborate with local recovery house owners to establish workgroup parameters.
Performance Target: Host a minimum of three meetings to establish need and membership list.

Strategy 4J. MSPC will support the formation of a Mid Shore Peer Recovery Workgroup.

Performance Measure: Collaborate with mid-shore organizations that provide peer support for behavioral health services.
Performance Target: Host a minimum of two meetings to establish partnerships, purpose, mission of the workgroup.

Strategy 4K. MSBH will continue to coordinate updates to the Sequential Intercept Model (SIM) for the mid-shore region through the BHSN Forensic Workgroup.
Performance Measure: MSBH prioritizes keeping the relevancy of the SIM to reflect the evolving forensic system of the region. By way of the SIM Annual Meeting, identify priority areas for the FY2021 Forensic Mental Health Program (FMHP).
Performance Target: Organize and facilitate the annual SIM meeting annually.

Strategy 4L. Support county-based provider meetings with a concentration on integrated system supports and developments.
Performance Measure: MSPC will organize and facilitate county-based provider meetings. County-based provider meetings allow for concentrated county specific developments and needs to be addressed with our behavioral health provider community.
Performance Target: Meeting frequency will vary depending on the county represented.

Strategy 4M. MSBH will participate and provide behavioral health leadership support to mid-shore Local Care Teams (LCT).
Performance Measure: Ensure compliance with Maryland statute and directives from the Governor's Office for Children regarding Local Care Teams (LCT). Participate in each county LCT as scheduled. Promote awareness and access for families to LCT; provide technical assistance with accessing appropriate level of care; educate LCT members on statewide resources and behavioral health systems changes.
Performance Target: Attendance and input at each mid-shore LCT meeting.

Strategy 4N. MSBH will participate and provide behavioral health leadership support to mid-shore Local Management Boards (LMB).
Performance Measure: Support LMB activities of development and maintenance of services and systems for children, adolescents and families.
Performance Target: Attendance and input at each mid-shore LMB meeting.

Goal 2: Strategically address the impact of social determinants across the lifespan.

Objective 1: Recognize the role of systemic social injustice and racial inequity and how it inhibits wellness in the mid-shore community.

Strategy 1A. Improve access to and community awareness of, culturally sensitive behavioral health services for populations with unique needs, including but not limited to: deaf and hard of hearing, traumatic brain injury (TBI), older adults, veterans, LGBT+ and developmental disabilities.
Performance Measure: Develop a Cultural and Linguistic Competency (CLC) workgroup to identify service needs for the underserved populations. Recruit workgroup members and develop the purpose, mission, and vision for the workgroup.
Performance Target: Host quarterly CLC workgroup meetings beginning January 2021.

Strategy 1B. Increase awareness of behavioral health providers to address health disparities.
Performance Measure: Create a section in the e-newsletter titled "Best Practices," which will educate providers on ways to better support consumers.
Performance Target: The newsletter will include 12 "Best Practices" sections in FY2021.

Strategy 1C. Address trauma-related needs for the Latino Population.
Performance Measure: MSBH will continue to contract annually for the provision of coordinated therapeutic counseling with the bi-lingual advocate to the Latino/Hispanic population identified as victims of domestic or sexual violence as well as those identified as experiencing trauma.
Performance Target: Review contract and communicate with provider agency throughout FY2021 about the need for increased services for this population.

Strategy 1D. MSPC will promote the advancement of providers in the mid-shore behavioral healthcare system, to be linguistically competent in having interpretation and translation services for non-English speaking or Limited English Proficient (LEP) individuals who are served in their respective communities.
Performance Measure: Encourage providers to use the Language link for individuals who present as having limited English proficiency. Recommend that agencies hire staff whose primary language is other than English.
Performance Target: Providers who identified as lacking in this area will have plans in place to access language line and will have increased usage of the service.

Strategy 1E. Improve cultural and linguistic competency of MSPC staff, on the continuum to cultural humility and promote awareness to other community agencies of the need for culturally competent services throughout the region.
Performance Measure: Provide training that aims to improve cultural awareness to MSPC staff, board and committees.
Performance Target: Facilitate and/or host at least one cultural humility training in FY2021.

Strategy 1F. Queen Anne's County will implement new peer-led groups that will be tailored to address the unique needs of diverse populations.
Performance Measure: Increase support groups for populations who experience social injustice; the group will promote whole health.
Performance Target: Form two support groups for unique populations (ex. LGBT+, MAT recovery, faith-based, and women) in FY2021.

Objective 2: Address the issue of homelessness in the mid-shore.

Strategy 2A. Serve as the lead agency for the Mid Shore Roundtable on Homelessness, the five county Continuum of Care (CoC).
Performance Measure: Facilitate monthly meetings of the Roundtable on Homelessness. Facilitate annual application to HUD for the CoC grants. Provide support and technical assistance to CoC partners in the provision of services for those who are homeless. Complete the annual homeless assessment report, annual housing inventory for homeless services report, and CoC annual performance measures.
Performance Target: Facilitate 12 monthly Roundtable meetings and successfully submit all HUD required applications and reports.

Strategy 2B. Serve as the lead agency for the Mid Shore Roundtable on Homelessness Continuum of Care Homeless Management Information Systems (HMIS).
Performance Measure: Maintenance, training and support of our bi-regional HUD required HMIS system which supports local homeless service providers data needs.
Performance Target: Systems support to 100% of mid-shore HMIS users.

Strategy 2C. Conduct the Mid Shore on Homelessness annual Point in Time Homeless Count during the last week of January.
Performance Measure: Facilitate a comprehensive annual count during the last week of January, partnering with emergency shelters, transitional housing programs and homeless service providers to get as accurate a count as possible of those who are homeless in the mid-shore region.
Performance Target: Plan and execute the Point in Time Count on the Last Wednesday of January 2021 and provide results to the community.

Strategy 2D. Implement the Homeless Solutions Program (HSP) in the region through the Mid Shore Roundtable on Homelessness.
Performance Measure: The Homeless Solutions program provides funding for emergency shelter, homeless prevention, rapid rehousing, outreach services and Homeless Management Information Systems (HMIS) support activities to our local homeless service provider partners.
Performance Target: All eligible program services will be available in all five counties and administered in a consistent coordinated manner 100% of the grant period.

Strategy 2E. Operate Continuum of Care (CoC) Housing Programs for those who are literally homeless and disabled in the mid-shore region.
Performance Measure: Coordinate the implementation of CoC Housing program in the mid-shore region through grants from HUD and BHA. Complete and submit the annual application for continued funding of the local units.
Performance Target: Maintain a minimum of 53 units of housing in the mid-shore region.

Strategy 2F. Work with community providers to link persons who are homeless or at risk of becoming homeless to case management services through the Project for Assistance in Transitioning from Homelessness (PATH).
Performance Measure: Contract annually for the provision of PATH outreach and case management services to cover the five-county region. Connect homeless service providers to the PATH program to help them assist connecting people to behavioral health services.
Performance Target: The PATH program will serve a minimum of 75 people in the region annually.

Strategy 2G. Promote affordable community housing for behavioral health consumers through the Main Street Housing Program.
Performance Measure: Contract annually for the provision of one FTE Project Coordinator to manage and coordinate housing development projects in the mid-shore region.
Performance Target: Maintain an 85% occupancy rate of the 47 available mid-shore units.

Strategy 2H. Implement the Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) program in the mid-shore region.
Performance Measure: Employ 1 FTE SOAR Case Specialist. Facilitate regional SOAR workgroup and regional SOAR trainings. Recruit and provide assistance to SOAR case managers.
Performance Target: The SOAR Specialist will submit a minimum of 20 disability claims using the SOAR Process and provide one regional training.

Objective 3: Address the needs of individuals who are impacted by the criminal justice system.

Strategy 3A. Continue to monitor the Maryland Community Criminal Justice Treatment Program (MCCJTP) which includes mental health screening and mental health management in the local detention centers.
Performance Measure: Contract annually for the provision of MCCJTP services in all mid-shore detention centers; Analyze the effectiveness and efficiency of the program through contract data deliverables. Attend quarterly MCCJTP meeting at BHA.
Performance Target: FY2021 data deliverables for the MCCJTP contract will show 100% compliance with contract deliverables

Strategy 3B. Partner with agencies who serve the forensic population, through the FMHP, to evaluate and make recommendations for those individuals and connect them with behavioral health resources.
Performance Measure: Accept referrals, provide evaluations and clinical reports with recommendations such as appropriate placement, treatment interventions, and clinical factors for consideration.
Performance Target: Manage referrals and complete a minimum of 100 of the evaluations requested annually.

Strategy 3C. Provide Forensic Mental Health Case Management in the mid-shore region, which will include linking clients to resources, managing communication between programs and the courts, and advocating for treatment diversions from incarceration.
Performance Measure: Provide general and intensive case management to identified clients. Case management activities are geared towards prevention of recidivism, stabilization in the community, and greater self-sufficiency.
Performance Target: Provide intensive case management to a minimum of 10 forensic clients annually and provide general case management to a minimum of 40 forensic clients annually.

Strategy 3D. Participate in providing mental health assessments and recommendations to the local Problem Solving Courts on all incoming participants.
Performance Measure: Provide mental health assessments, perspectives, and recommendations for individuals considered for Problem Solving Court and participate in Problem Solving Court team meetings.
Performance Target: Meet with all referrals to the Problem Solving Court programs and provide written recommendations concerning mental health needs. Attend all of Problem Solving Court team meetings and provide data on participant mental health participation that is obtained from their mental health provider.

Objective 4: Work collaboratively with the mid-shore community to promote a Trauma-Informed system of care.

Strategy 4A. Promote Trauma Informed Care integration throughout the local Public Behavioral Health System.
Performance Measure: Identify and promote certifications and training opportunities to our network. Track number of and attendance at trainings.
Performance Target: Facilitate and/or host at least one Trauma Informed Care training in FY2021.

Strategy 4B. Continue to monitor the Trauma Addictions Mental Health and Recovery (TAMAR) program in mid-shore detention centers.
Performance Measure: Provide TAMAR services in the Caroline and Dorchester County detention centers and explore options on expanding the program to the entire region.
Performance Target: TAMAR will serve a minimum of 80 individuals during FY2021.

Strategy 4C. Provide education to community partners regarding Adverse Childhood Experiences (ACEs) and their impact on development.
Performance Measure: Work with community stakeholders to promote, support and/or provide training on ACEs.

Performance Target: Promote, support and/or provide at least three trainings on ACEs in the mid-shore region during FY2021.

Objective 5: Continue to work collaboratively with local partners to improve the provision of transportation resources.

Strategy 5A. Involvement in local efforts to reduce transportation barriers to accessing behavioral health services.
Performance Measure: Advocate for the transportation needs of the behavioral health community. Support the development and implementation of programs that address transportation needs. Explore grant opportunities to expand transportation services. Participation on the Regional Transportation Planning Council (RTPC).
Performance Target: Attend 4 Regional Transportation Planning Councils during FY2021; Support 100% of new transportation programs and peer transportation programs.

Strategy 5B. MSBH will monitor and manage Consumer Support Funds that can be used for transportation needs associated with a consumer's behavioral health treatment goals.
Performance Measure: Utilization of Consumer Support in compliance with the Conditions of Award and MSBH internal protocols to provide transportation services for consumers in the public behavioral health system.
Performance Target: Process and approve 90 consumer support requests annually.

Objective 6: Partner in the development of opportunities to support gainful employment of community members in the mid-shore.

Strategy 6A. Work to increase consumer employment through linkages to the Division of Rehabilitation Services (DORS) and the Department of Labor, Licensing and Regulation (DLLR).
Performance Measure: Educate the provider network on employment service available through DORS and DLLR and develop partnerships to these agencies to connect consumers.
Performance Target: Provide a minimum of one training to the provider network from both DORS and DLLR at the Quarterly BHSN meeting.

Strategy 6B. Promote BHA's supported employment program to increase awareness for consumers, transitional-age youth, and families.
Performance Measure: In collaboration with supported employment provider, promote the role the program plays in facilitating consumer recovery and economic self-sufficiency.
Performance Target: Increase the amount of supported employment requests by 20% during FY2021.

Objective 7: Enhance our relationship with private and public-school systems.

Strategy 7A. Collaborate with the local Public Education Systems' School-Based Behavioral Health Services or School-Based Wellness Centers to promote behavioral health integration.
Performance Measure: Promote strong somatic and behavioral health integrated services within each local county school system; participate in the Eastern Shore School-Based Mental Health Coalition; Participate on the Advisory Boards of School-Based Wellness Centers as invited.
Performance Target: Attend quarterly school-based behavioral health committee meetings in FY2021.

Goal 3: Build and support a regional behavioral health system of care.

Objective 1: Promote a "No wrong door" culture across multiple community access points.

Strategy 1A. MSPC will support new strategies for the utilization of the Behavioral Health Integration Program in Primary Care (B-HIPP) project.
Performance Measure: Collaborate with local health systems and Federally Qualified Health Centers to identify and implement telehealth evidence-based behavioral health screening, referral and management.
Performance Target: Participate in the B-HIPP telehealth advisory committee and support the promotion of this initiative in the mid-shore, specifically Dorchester County.

Strategy 1B. MSPC will strengthen the collaboration of providers to effectively evaluate, triage, and offer community support and treatment to consumers. The continuum of opioid related treatment options is enhanced through the State Opioid Response (SOR) grant.
Performance Measure: Support and promote the opioid specific crisis beds developed with the SOR grant funding. Monitor program compliance and quality service delivery.
Performance Target: Provide SOR bed crisis services to up to 225 adults per fiscal year.

Strategy 1C. MPSC will support existing and expand recovery housing in the mid-shore region.
Performance Measure: Provide referrals to existing recovery housing and assist with Administrative Service Organization (ASO) transition. Inclusion of recovery house staff in the mid-shore recovery house workgroup.
Performance Target: Provide bi-annual updates to behavioral health community via BHSN on provider statuses.

Strategy 1D. MSPC will support and promote Safe Stations.
Performance Measure: Partner with community stakeholders to promote existing Safe Station locations. Support opportunities for the development of new Safe Station locations in other mid-shore counties.

Performance Target: Through collaboration between stakeholders and community members, and presentations given at the Eastern Shore Safe Station Coalition, support and promote a minimum of two safe station community events.

Strategy 1E. MSPC will promote tobacco cessation to the behavioral health community.
Performance Measures: Promote efforts to behavioral health treatment providers to support smoking cessation services in their programs. Track and disseminate regional tobacco related data.
Performance Target: Distribute tobacco cessation literature at a minimum of 5 community events.

Strategy 1F. MSPC will work with primary care physicians and behavioral health providers to strengthen the "Warm Hand-off" process.
Performance Measure: MSPC will educate and encourage providers to use the provider waitlist dashboard and distribute the developed "Warm Hand-off" Tool Kit. The dashboard will be uploaded and available to view on the MSBH website.
Performance Target: Minimum of 10 providers on the mid-shore will participate in the waitlist dashboard. MSPC will develop a marketing initiative to promote the dashboard with the primary care provider network in the mid-shore.

Strategy 1G. Host a Data Waiver 2000 training for private physicians to prescribe Buprenorphine.
Performance Measure: Sponsor at least one Data Waiver 2000 training.
Performance Target: Six physicians receive Data Waiver 2000 training and will initiate prescribing in the mid-shore within the next two years.

Strategy 1H. Expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) practices to somatic care providers.
Performance Measure: Promote somatic care provider awareness of SUD screening tools in support of integrated healthcare delivery. Educate and encourage the utilization of SBIRT through the warm hand-off and other initiatives.
Performance Target: Six new somatic care providers will utilize SBIRT within the next two years.

Strategy 1I. Dorchester County and MSBH will facilitate MOUs between private physicians and private and public behavioral health providers to collaborate in the provision of medication-assisted treatment (MAT).
Performance Measure: Build relationships between physicians providing MAT and SRD treatment providers over the next two years.
Performance Target: Six MOUs between private physicians and behavioral health providers will be established.

Objective 2: MSPC will promote and monitor the development, access and sustainability for the provision of services for the following target populations:

Maternal Health, Post-Partum, Newborn, Early Childhood

Strategy 2A. MSPC will enhance knowledge of maternal behavioral health treatment and resources.
Performance Measure: Collaborate with local health systems and Salisbury University to increase availability of trainings, support groups, and awareness initiatives. Support development and implementation of best practice screening and referral processes.
Performance Target: Attend a minimum of one presentation/training at Salisbury University. Invite subject matter experts to present at one Behavioral Health Services Network meeting.

Strategy 2B. MSBH will support and monitor the provision of integrated behavioral health services for children, adolescents, and transitional-aged youth.
Performance Measure: Provide oversight of revised 1915i implementation, Targeted Case Management (TCM) plus, Care Coordination Organization, Residential Treatment Services, Respite, and Crisis Services. Explore opportunities to create Child and Adolescent Crisis Bed services in the region. Participate in Child and Adolescent MABHA Subcommittee.
Performance Target: MSBH will attend the Maryland Association of Behavioral Health Authorities (MABHA) Child and Adolescent Coordinators group and Care Coordination Organization provider meetings. Complete annual audit of care coordination organization. Promote 1915i providers and services at mid-shore county LCT meetings.

Strategy 2C. MSBH will maintain partnership with the Department of Social Services and promote Mobile Crisis and Stabilization Services (MCSS) to prevent placement changes for children enrolled in MCSS program.
Performance Measure: Maintain the contract for the provision of MCSS regionally. Meet with DSS representatives and the vendor to review the provision of services; attend Family Involvement Meetings (FIMs) as needed for individual youth and families.
Performance Target: Minimum of four program meetings annually with DSS representatives and the contract vendor. Respond to MHSS RFP if indicated.

Strategy 2D. MSPC will support the expansion of the Sobriety Treatment and Recovery Team (START) Program in the mid-shore region.
Performance Measure: START family mentors will be hired, trained, and implementing initiative. Work with mid-shore provider community for program implementation to support START model fidelity. Collaborate with the University of Maryland Technical Assistance to address implementation and overcome barriers to program success.
Performance Target: Over the next two years, all mid-shore counties will be implementing the START program.

Strategy 2E. MSPC will conduct outreach in the school systems and health department wellness fairs that will target school-aged students on the negative impacts of initial use and/or misuse of substances.
Performance Measure: Collaborate with mid-shore county educational leadership to garner support for outreach and education initiatives.
Performance Target: Implement an awareness initiative in two of the five mid-shore counties in FY2021.

Transitional-aged Youth (TAY)
Strategy 2F. MSBH will contract and support the Healthy Transitions grant.
Performance Measure: Support contract vendor in implementing program model. Support provider compliance with unduplicated TAY participants by marketing the availability of this service to generate referrals. MSBH will work in collaboration with BHA and local provider to address program needs and meeting the conditions of award.
Performance Target: In FY2021, MSBH will monitor grant activities to include condition of award compliance, data reporting, and program quality.

Strategy 2G. MSBH will develop, enhance and promote behavioral health support services for TAY.
Performance Measure: Provide oversight of existing TAY services through regular meetings with contracted provider and annual audit. Advocate for expansion of TAY services and promote TAY services throughout mid-shore region.
Performance Target: Monitor program for compliance related to conditions of award. Track attendance at TAY meetings and program developments.

Adult Population
Strategy 2H. MSPC, in collaboration with the Eastern Shore Behavioral Health Coalition will organize a subcommittee of regional, county and local stakeholders to address increased capacity and sustainability of the A.F. Whitsitt Center.
Performance Measure: Cultivating interested Eastern Shore stakeholders in the development of the subcommittee. Work in partnership with leadership from the Kent County Health Department in analyzing facility infrastructure and capacity building opportunities.
Performance Target: Subcommittee will meet quarterly to support the development of the A.F. Whitsitt Center sustainability plan.

Strategy 2I. MSBH will address complex consumer needs through treatment team collaboration.
Performance Measure: Track weekly programs team meeting minutes including individuals identified as high service utilizers to effectively reduce costs and improve treatment. Support the facilitation of treatment team meetings for individuals identified as high service utilizers by local

partners, BHA or the ASO. Inclusion of Eastern Shore Hospital Center social work and psychiatry staff during programs team meeting to support community transition planning for individuals preparing for discharge.
Performance Target: During FY2021 MSBH team will meet weekly to track high service utilizers and monitor their needs and report outcomes. Track number of supported individuals leaving state hospital.

Strategy 2J. MSBH will ensure the provision of crisis intervention services in the region.
Performance Measure: Contract annually for the provision of Urgent Care Clinics, Eastern Shore Operations Center, Maryland Crisis Hotline (MCH) and Mobile Crisis Teams. Monitor utilization of adult services through contract data deliverables. Advocate to increase capacity of the regional crisis response system. Inclusion of mid-shore systems managers to address quality service delivery.
Performance Target: Through FY2021 MSBH will monitor contracts quarterly, identifying growth of services, utilize data to define systems gaps, and an annual review of services to ensure appropriate funding allocation.

Strategy 2K. MSBH will provide consumer support for mid-shore residents transitioning out of psychiatric state hospital level of care.
Performance Measure: Track placement in Residential Rehabilitation Programs (RRP). Partner with hospital Social Work Department(s) to support local resource availability and assist with community integration of high needs individuals.
Performance Target: By implementing statewide initiatives in our region, we will work to reduce wait time on RRP waitlist for state hospital referrals to no more than one month.

Strategy 2L. MSBH will facilitate the Residential Services Committee quarterly meetings to promote efficient and effective utilization of housing resources in the mid-shore region, specifically Residential Rehabilitation Program (RRP) services.
Performance Measure: MSBH will assist providers of RRP programming to support appropriate utilization of housing resources and increase program compliance.
Performance Target: Track sign-in sheets and minutes for each quarterly meeting. Monitor programs to encourage program compliance.

Strategy 2M. Caroline County will work collaboratively with the Caroline County Detention Center and University of Maryland in the planning and development of their MAT program by participating on the committee, attending scheduled meetings, and providing staffing and other programming support as necessary.

Performance Measure: Support the implementation of the MAT program in the detention center by way of attending meetings and providing staff support with an SRD Counselor and Peer Recovery Specialist.
Performance Target: In FY2021, the SRD Counselor will assess three inmates scheduled for re-entry in need of outpatient SRD treatment, within the first three months of the program start-up. The Peer will meet with 10 inmates scheduled for re-entry, within three months of the program start-up.

Strategy 2N. MSPC will coordinate a Peer Response Overdose (PRO) workgroup with the goal of developing a streamlined response across the mid-shore.
Performance Measure: Engagement of LAA leadership in the mid-shore, emergency managers, peers and UMSRH leadership to meet and develop a mid-shore peer overdose response protocol.
Performance Target: In FY2021, develop and strive to implement the protocol.

Strategy 2O. Caroline County will establish a protocol for Peer Response after an overdose.
Performance Measure: Development of peer overdose response protocol, in conjunction with EMS and the local hospitals.
Performance Target: In FY2021, implement protocol and support real-time linkages to treatment and provide face-to-face outreach to the 39% that refuse transport.

Strategy 2P. MSBH, Caroline County Health Department, and other partners will implement the Farming Stress Management Project.
Performance Measure: Collaboration with key stakeholders, county leadership, and farming community to increase outreach, awareness, and education in the community.
Performance Target: Successful implementation of Farming Stress Project by March 2021. Participate in one outreach education event per month to disseminate educational materials to the community.

Strategy 2Q. Caroline County Mobile Treatment Unit (MTU) will continue to support the expansion of treatment services in the county.
Performance Measure: Expand locations identified within the jurisdiction to meet additional consumer needs. Add an individual clinical counseling component to the services offered on the unit for consumers.
Performance Target: One additional location will be identified in FY2021 and that location will see a minimum of five clients per week in the first three months on the MTU by the counselor.

Aging Population

Strategy 2R. MSBH will continue to track institutionalized adults with behavioral health needs and support facility administration in the use of the Pre-admission Screening and Residential Review (PASRR) process, provision of care for their residents and training for staff.

Performance Measure: Behavioral Health Coordinator for Aging Adults/Eastern PASRR Specialist will determine through Long Term Support Services database, the long-term care facility of residence of individuals who have screened positive through a Level II PASRR and report to Administrative Service Organization (ASO). Support BHA's development of a protocol for follow up of these individuals to confirm provision of appropriate services. Through collaboration with LTC Ombudsmen, AERS, MCT's, and related stakeholders begin to identify facilities that admit individuals with behavioral health needs to identify training opportunities.
Performance Target: Track the number of individuals visiting to regional long-term care facilities, the number of trainings provided, number of consultations requested by facility staff as indicators of developing partnerships and report quarterly to BHA.

Strategy 2S. MSBH will support Preadmission Screening and Residential Review (PASRR) process reform through collaborative efforts with BHA's Office of Older Adults.
Performance Measure: Full participation in bimonthly calls and quarterly reporting to BHA's Office of Older Adults.
Performance Target: Identify at least one aspect of PASRR in the rural Eastern Region that should focus advocacy for reform.

Strategy 2T. MSBH will assist with placement of individuals with behavioral health needs who may remain in a restrictive level of care and present as candidates to transition to a lower level of care.
Performance Measure: Collaborate as requested with discharge planners of the Eastern Shore Hospital Center and community hospital behavioral health unit discharge planners to characterize the individual's behavioral health needs, identify possible area nursing home providers and assist with development of a care plan with built-in transition supports. Begin to identify characteristics of successful transfers.
Performance Target: Track number of requests for assistance, number of successful transfers and receiving facilities, and report to BHA quarterly.

Strategy 2U. MSBH will identify and characterize gaps in services for community-dwelling older adults with chronic and/or emergent behavioral health needs.
Performance Measure: Collaborate with the region's Areas on Aging, Adult Protective Services, Adult Evaluation and Review Services, local CSA's, crisis teams, caregivers and consumers, to identify and support efforts to maintain these at-risk individuals safely in the community and identify service gaps.
Performance Target: Track emergent issues, consultations, referrals and then report to BHA quarterly.

Goal 4: Implement an integrated systems management structure.

Objective 1: Mid-shore counties local behavioral health systems managers, will continue to work collaboratively toward regional system integration.

Strategy 1A. Mid-Shore Counties Local Systems Integration Workgroup will develop a regional behavioral health systems integration plan.
Performance Measure: The Mid-Shore Counties Local Systems Integration Workgroup, which includes the mid-shore Local Addictions Authorities (LAA), their leadership and invested stakeholders, will meet in support of expanding our provider community, promote access to services, and collaborate on local systems development. Workgroup priorities will concentrate on systems integration on a local and state level, and change management. The workgroup will assist with the continued growth of the goal of regional planning and needs assessment, in addition to strengthening the local authority role and presence in our community. The workgroup will review, plan, and disseminate information regarding national, state, regional, and local initiatives. The workgroup will develop a regional integration plan for a regional Local Behavioral Health Authority.
Performance Target: MSPC will organize and facilitate Local System Integration Workgroup meetings. MSPC will develop a formalized timeline for mid-shore counties LBHA development. MSPC will delineate essential elements necessary for regional integration and present these to BHA, MDH, and local governing bodies. In FY2021, the workgroup will develop a formal integration plan outlining a three-five-year implementation.

Strategy 1B. MSPC will prepare for an integrated behavioral health regional needs assessment.
Performance Measure: Collaborate with systems management partners to strategize and plan for a regional behavioral health needs assessment. Research best practices for an integrated needs assessment that would support a rural model of systems management and behavioral health services delivery. Work to garner community and stakeholder involvement in the needs assessment. Review and analyze all available mid-shore needs assessments and strategic plans to establish priorities and develop goals, objectives, and strategies to address disparities in the PBHS.
Performance Target: Plan for implementation of a regional needs assessment to be initiated by the conclusion of FY2021.

Objective 2: MSPC will work with system partners to develop an integrated leadership and governance model in the mid-shore.

Strategy 2A. Maintain a Regional Behavioral Health Advisory Committee (RBHAC) and engage the committee in strategic planning to formalize an integrated structure.

Performance Measure: MSPC will engage committee by way of providing pertinent information regarding local systems management, state and local integration initiatives, and soliciting committee feedback and guidance.
Performance Target: RBHAC meetings will include agenda items that focus on systems integration, with the goal of one formal revision to the committee's bylaws by the end of FY2021.

Strategy 2B. MSPC will serve and lead the mid-shore region's Local Drug and Alcohol Abuse Councils, Substance Use Committees, and related community initiatives.
Performance Measure: MSPC will be represented on each mid-shore Local Drug and Alcohol Abuse Councils (LDAAC), Opioid Misuse Prevention Program (OMPP), mid-shore counties Opioid Intervention Teams (OIT) and Regional Opioid Task Force with Shore Regional Hospital. MSBH will maintain responsibility of administrative and leadership duties for Drug Free Caroline (the Caroline County LDAAC).
Performance Target: MSPC will be represented at 100% of the LDAAC meetings in each mid-shore county over the course of FY2021. MSBH will be responsible for the 11 Drug Free Caroline meetings in terms of organization, planning, and leadership. MSPC will contribute to the state-level advisory councils planning committee for integration planning.

Strategy 2C. MSPC will participate/facilitate Maryland's Local Advisory Council Subcommittee on the assessment of the local advisory councils.
Performance Measure: MSPC will support the coordination of state-wide stakeholders to collaborate to address the legislative, Statute, and local governing expectations of local advisory council responsibilities. Stakeholders will be represented from local authorities, BHA, Maryland's General Assembly, OOCC leadership, Behavioral Health Advisory Council, and MDH.
Performance Target: To assess and develop guiding principles in preparation for recommendation for integrated advisory council language in calendar year 2021 legislative session related to integration of local advisory committees and councils.

Strategy 2D. MSBH will maintain an integrated Board of Directors.
Performance Measure: MSBH Board members will include leadership from all counties representing integrated services, law enforcement, healthcare, local hospital, fiscal, school based, quality, legal, peer leadership and providers represented.
Performance Target: 100% compliance with our board composition as defined in the MSBH Bylaws.

Objective 3: MSPC will assess, develop and plan for an integrated budget and operational structure.

Strategy 3A. Develop foundation model of integrated funding in support of systems management integration planning.

Performance Measure: MSPC will evaluate the current funding pattern and structure of each local authority, to assess preparedness for an integrated model. MSBH will identify priority funding that requires additional support from our state leaders to guide an integrated funding model development. MSPC will work collaboratively with our local systems management leaders to render support and data to support the fiscal plan to endorse local integration.
Performance Target: MSPC will work over the course of FY2021 to inform regional leadership of budgetary responsibilities currently managed in a non-integrate structure. MSPC will evaluate procurement procedures in preparation for blended funding. MSPC will evaluate capacity to integrate funding. MSPC will work with system management partners to draft a budget management model that will support enhanced fiscal management of integrated funding streams.

Strategy 3B. MSPC will implement a Regional Behavioral Health Annual Plan.
Performance Measure: MSPC will collaborate across agencies to implement the integrated systems annual plan. MSPC will inform local stakeholder groups to include mid-shore LDAACs, RBHAC, and Consumer Council to foster representation of all stakeholders of the plan implementation process.
Performance Target: For FY2021 Behavioral Health Annual Plan, collaborate with MSPC partners to monitor annual plan strategy implementation, and track progress. Promote accountability to stakeholder and governing groups with plan implementation progress reporting.

Objective 4: MSPC will practice coordinated quality management of our regional behavioral health system.

Strategy 4A. MSPC will plan for the integration of program planning, contract management, and reporting.
Performance Measure: MSPC will work to manualize current practices for contract management and reporting to support agency structure and preparation for an integrated model of systems management. MSPC will evaluate current contract oversight procedures and determine what agency needs would be a priority for expanded systems management and contract management.
Performance Target: MSPC will solicit the support and technical assistance of our local and state leadership with the development of a formalized procedure for the operational oversight of integrated funds, programming, and contracts. MSPC will engage leadership to partner in planning for an integrated contracted management process and reporting requirements.

Strategy 4B. MSPC will manage and utilize behavioral health data which is representative of the mid-shore region.
Performance Measure: Monitor and evaluate the performance of local PBHS through data available from the administrative service organization (ASO), OMS, State Health Improvement

Process (SHIP), and other sources. Utilize data-driven decision making to improve quality, efficiency, and outcomes of behavioral health services within the PBHS.
Performance Target: In FY2021, develop and gain support for a mechanism of sharing integrated data for the mid-shore region with local system management partners to support enhanced planning. Promote the use of technology to improve information sharing, data collection, evaluation and performance, and systems planning.

Strategy 4C. MSPC compliance and coordination with the ASO in quality oversight and regulation.
Performance Measure: MSPC will work in collaboration with the ASO to provide regional oversight of the quality and performance of the behavioral health provider community. MSPC will participate in site visits conducted by the Office of Health Care Quality (OHCQ), BHA Office of Compliance, Administrative Service Organization, and Consumer Quality Team (CQT). Monitor program improvement plans (PIPs) and provider compliance with audit outcomes. Support the provider with advocating for timely reporting of performance, clarification of regulatory changes, and education of any changes to ASO structure that would impact service delivery.
Performance Target: MSPC will participate in all ASO and quality assurance departments to monitor and support quality behavioral health services in the mid-shore region. MSPC will comply with reporting and monitoring practices. MSPC will track site visit reports, participation in external site visits, and submissions of PIPs.

Strategy 4D. MSPC will work to formalize contract monitoring practices to support an integrated model of quality oversight.
Performance Measure: MSPC will work to streamline and support the expansion of contract management as we work towards an integrated model of systems management. MSPC will create a contract management manual following the annual timeline of practices that include pre-contracting, revision of scopes of services, provider/sub vendor education and collaboration, quarterly reporting locally and state level, data collection and analysis, site visits, and reporting.
Performance Target: By the conclusion of FY2021, MSBH will have a manualized contract management procedure that will support the current oversight and projected expansion of integrated systems oversight of our sub vendors and community providers.

Strategy 4E. MSPC will support quality assurance practices with accreditation, licensure, and compliance expectations on a state and local level, and will support integrated systems collaboration.
Performance Measure: MSPC will monitor quality practices with our behavioral health provider groups; observe and adhere to the expectations of accreditation maintenance; comply with licensure expectations and regulation; communicate expectations from the state and accrediting bodies. MSPC will partner with BHA to support compliance with quality regulations and Agreement to Cooperate expectations.

Performance Target: MSPC will support mid-shore behavioral health providers with quality practices, correspondence with state and accrediting bodies, assistance and assurance of compliance with accrediting bodies, and collaborate with LAA partners with any provider that is co-occurring capable and providing services.

Strategy 4F. MSPC will manage complaints and critical incident reporting in support of an integrated model.
Performance Measure: MSPC will continue to engage in the development and leadership of crafting the best practice model for complaint and critical incident reporting on a state level, and support training, education and implementation of these practices on a local integrated systems level. MSPC will encourage consumers, family members, support entities, and vested community members to report issues or concerns about a provider to support quality services and practice. MSPC will support investigations and follow up to provider types that are co-occurring in nature.
Performance Target: MSPC will investigate all the complaints and critical incidents logged in the mid-shore region despite provider type and location to support an integrated model of response. MSPC will respond within the timeline expectations of the complaint and manage a log and history of reports and outcomes. MSPC will solicit the support of BHA, regulatory agencies, and accreditation bodies as needed for support with investigation outcome management.

Strategy 4G. MSPC will develop an integrated Mid-Shore Counties Behavioral Health Emergency Response Plan that comprises a regional approach.
Performance Measure: Update all local authority Disaster Preparedness plans annually. Promote increased numbers of regional behavioral health professionals registered in the Maryland Responds medical and public health volunteer corps. Support the maintenance of a regional Critical Incident Stress Management team. Attend region-specific emergency preparedness meetings in all mid-shore counties. Monitor behavioral health provider and acute care emergency preparedness plans.
Performance Target: MSPC will develop a regional behavioral health emergency plan representative of cross-county and regional infrastructure response. Require that all sub vendors provide copies of their Emergency Preparedness documents/policies as a part of contracting for FY2021. MSPC will collaborate with all mid-shore Emergency Operations Mangers to validate the behavioral health response plan needs in each county. MSPC will strive to provider Emergency Preparedness training to provider network in FY2021 to present the Behavioral Health Emergency Response Plan.

Goal 5: Collaborate to expand and sustain a dynamic rural workforce.

Objective 1: Identify and implement strategies to address the inadequate workforce in our rural region.

Strategy 1A. MSPC will support workforce expansion in our rural region.

Performance Measure: Continue and build new partnerships to engage residents to explore behavioral health career opportunities. Work with local higher education institutions to engage students in internship opportunities throughout the region.
Performance Target: Promote at least three career expansion opportunities and identify five local providers to participate in internship opportunities.

Strategy 1B. MSPC will work closely with our legislative partners to promote initiatives that support Behavioral Health workforce expansion.
Performance Measure: Promote federal, state, and local opportunities for higher education loan repayment and other incentives to work in mid-shore region. Participate in the regional Behavioral Health Coalition's legislative efforts with regards to professional licensure and paneling.
Performance Target: Participate in legislative events that highlight the workforce expansion.

Strategy 1C. In partnership with the Eastern Shore Behavioral Health Coalition, MSPC will continue to advocate for a streamlined credentialing process for licensed clinicians.
Performance Measure: Partner with local outpatient mental health clinics to identify specific challenges that providers face with professional credentialing. Support legislation that addresses barriers to credentialing.
Performance Target: Host a minimum of one meeting with local providers and legislators to discuss barriers to credentialing and cultivate potential solutions.

Strategy 1D. Support and promote Tele psychiatry/Video Conferencing Infrastructure on the mid-shore.
Performance Measure: Promote the continued expansion of the current tele health infrastructure in the mid-shore region, with a focused emphasis on meeting the needs of underserved populations.
Performance Target: Monitor and refine a tool to tele psychiatry/video conferencing services provided in the mid-shore region. Increase services to underserved populations.

Strategy 1E. Promote the utilization of peer support and the hiring of consumers who have obtained the Peer Recovery Specialist certification as positions become available.
Performance Measure: Partner with local providers to create new positions for peer recovery specialists. Educate providers on the benefits of employing peers.
Performance Target: Work to develop five new peer support positions in the region.

Strategy 1F. Partner with the University of Maryland School of Psychiatry for Fellow recruitment.
Performance Measure: Partner with the University of Maryland School of Psychiatry to recruit and retain Psychiatry Fellows to expand provision of services on the Eastern Shore.
Performance Target: Host an annual Fellowship luncheon on the Eastern Shore to market the region as a desirable opportunity for physicians completing fellowship.

Objective 2: Enhance and sustain our current community workforce.

Strategy 2A. Contract with local provider to offer Crisis Intervention Team (CIT) training and certification opportunities to the mid-shore region.
Performance Measure: Support the collaboration and partnership between law enforcement, emergency first responders, correctional facilities, Mobile Crisis Teams, local Emergency Departments, and acute inpatient psychiatric units to effectively respond to behavioral health crisis in the community. Through these partnerships, offer behavioral health and other community supports to enhance diversion wherever possible. Advocate for the availability of supports and resources that address the behavioral health needs of law enforcement and emergency first responders. Participation in quarterly Crisis Advisory Subcommittee and Maryland Mental Health and Criminal Justice Partnership Crisis Intervention Teams Subcommittee.
Performance Target: The provider will host a minimum of four CIT trainings in FY2021. Increase stakeholder engagement by three new partner contacts that could support additional training and collaboration on a state-level.

Strategy 2B. Support the current behavioral health workforce through continuing education and relevant training opportunities.
Performance Measure: Serve as an approved sponsor of the Maryland Board of Social Work Examiners for continuing education credits for licensed social workers. Pursue and provide training opportunities to address workforce training needs.
Performance Target: Provide a minimum of 25 CEUs and 3 sponsored community training opportunities to the mid-shore workforce during FY2021.

Strategy 2C. Sponsor one American Society of Addiction Medicine (ASAM) and DSM-5 training on the mid-shore for clinical staff.
Performance Measure: 20 clinicians receive ASAM and DSM-5 training from the Mid Shore providers.
Performance Target: Host one training on ASAM and DSM-5 to providers in the mid-shore region in FY2021.

Strategy 2D. Sponsor required Peer Recovery Support Specialist training on the Mid Shore for recovering individuals seeking to become Certified Peer Support Specialists.
Performance Measure: 20 individuals receiving Peer Recovery Support Specialist training from the Mid Shore.
Performance Target: Provide two required trainings for Peer Recovery Support certification.

Strategy 2E. In collaboration with the Upper Shore Workforce Investment Board, provide job training for individuals in recovery.
Performance Measure: Increase Peer Recovery Support Specialist employment in the Mid Shore.
Performance Target: 10 mid-shore residents in recovery will receive employment training and will be connected employment opportunities.

COVER PAGE

Names of Organizations, Addresses, E-mail and Telephone # of Lead Designee:

Caroline County Behavioral Health
403 South 7th Street, Denton, MD 21629
Terri Ross LCSW-C, terri.ross@maryland.gov 410-479-8169

Dorchester County Behavioral Health
524 Race Street, Cambridge, MD 21613
Donald Hall MHS LCADC, donald.hall@maryland.gov 410-228-7714

Queen Anne County Health Department
205 N. Liberty Street, Centerville, MD 21617
Maggie Thomas MS, Maggie.thomas@maryland.gov 410-758-1306

Mid Shore Behavioral Health Inc.
28578 Mary's Court, Suite 1, Easton, MD 21601
Katie Dilley LCSW-C, kdilley@midshorebehavioralhealth.org 410-770-4801

Kent County Behavioral Health
300 Scheeler Road, Chestertown, MD 21620
Joe Jones MHS LCADC, joe.jones@maryland.gov 410-778-5046

Talbot County Health Department
100 South Hanson Street, Easton, MD 21601
Sarah H. Cloxton LCADC, sarah.cloxton@maryland.gov 410-819-5696

**Also known as Mid Shore Planning Collaborative (MSPC).

(a) **Address:** see above

(b) **Region (MDH/BHA designated region):** Caroline, Dorchester, Queen Anne, Kent and Talbot counties

(c) **Name of contact person (Agency/Organization Lead or Designee):** see above

(d) **Brief overview of services provided by agency/organization (***no more than 95 words***):**
We provide local authority systems management for the mid-shore region.

(e) **Agency/organization mission statement:**
As a group of individual agencies at this time, we are working on local systems management integration and development of our group mission statement.

(f) **Agency/organization vision statement:**
As a group of individual agencies at this time, we are working on local systems management integration and development of our vision statement.

PART 1: CLAS SELF-ASSESSMENT:

See FY2021 Community Behavioral Health Plan Appendices.

PART 2: OVERARCHING GOALS AND SELECTED STANDARDS FOR PRIORITY FOCUS

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES
Standard 15-We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
Strategies to build competency*:* Establish a diverse, regional CLC Workgroup to meet regularly and host a CLC Conference. Share FY21 CLC Strategic Plan in the weekly MSBH e-newsletter, on all entity websites, in email to agency stakeholders and providers, and by way of published materials in the clinics. Share the National CLAS Standards with team members, stakeholder, and community meetings.
Performance Measures*:* Ongoing *CLC Leadership group* meetings, quarterly-sign in sheets, agenda items, meeting "exit surveys", tracking through website engagement.
Intended impact: To educate and to raise awareness among community stakeholders and service providers. To improve services-increasing Cultural and Linguistic Competency, provided to consumers throughout the region. Encourage participation of consumers in the CLC Workgroup.
GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS BEHAVIORAL HEALTH SERVICES
Standard 6-We inform all individuals of the availability of verbal, signing and written professional language assistance services in their preferred language or form of communication.
Strategies to build competency*:* Signage/posters at each facility, that reference availability of language assistance for clients and community. Review language assistance policy and resources with all staff at each agency (LAA/CSA). Review use of the Language Link and other Translation/Interpreting services. Be intentional in acknowledging the efforts and improvements providers, throughout the year.
Performance Measures: Gather public school and health department data of (race, gender, ethnicity, rural) demographics of mid-shore region. Conduct pre/post survey of each entity (LAA/CSA), using social media and CLC Workgroup meetings. Include CLC in contract monitoring cite visits; include CLC language in Scope of Work for FY21 contracts.
Intended impact*:* To reduce stigma of accessing mental health and substance use treatment in underserved populations. Increase access of CLC services to behavioral health consumers and for the

community at large. To prevent communication barriers to individuals accessing services, who have limited English proficiency.

GOAL 3: CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES

Standard 12-We conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of the community we serve.

Strategies to build competency*:* Identify community health assets, initiate FY21 outreach to assets, and inform assets of the CLC Strategic Plan. Facilitate quarterly CLC Workgroup meetings to plan the community assessment (for FY22), using the Blueprint Worksheets.
(Negotiate data sharing agreements, identify disparities and disproportionalities from the data.)

Performance Measures*:* Referencing A Blueprint for Using Data to Reduce Disparities/Disproportionalities in Human Services and Behavioral Health Care (Dr. Karen Francis et al). Capture ongoing progress in workgroup agendas, meeting minutes, develop a timeline to sponsor the FY22 CLC Regional Conference, create a platform of assessment distribution (email, newsletter, website). Use data analysis from FY21 CBH Plan to determine if CLC Workgroup progress is met.

Intended impact: Strengthened partnerships via the CLC Workgroup, engagement of workgroup members from various cultures. Increase awareness of the disproportionalities in underserved populations of the mid-shore. Data provision to the community.

GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS IN MARYLAND'S PUBLIC BEHAVIORAL HEALTH SYSTEM

Standard 13-We partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Strategies to build competency*:*
Meetings with partners outside of the behavioral health field. Observance of monthly awareness themes (ex. Recovery/Purple, Domestic Violence, Minority Health Awareness, Hispanic Heritage). Attend and contribute to FY21 Strategies, the BHA CLC Committee meetings and trainings, disperse information to CLC Workgroup. Connect with local school systems and community colleges (diversity committees). Incorporate the Warm Hand-off initiative, Mid-Shore Roundtable on Homelessness, and expand LAA partnerships.

Performance Measures*:* Share Workgroup progress with the BHA CLC Committee, for feedback. Review the event attendance and community involved. The MSPC will survey the targeted population for acceptance and promotion of awareness event.

***Intended impact**:* Stakeholders who are not Behavioral Health Providers but serve the community, are knowledgeable of CLC appropriate services (via survey) and seek to implement CLAS Standards in their respective agencies.

GOAL 5: ADVOCATE FOR AND INSTITUTE ONGOING WORKFORCE DEVELOPMENT PROGRAMS IN CULTURAL AND LINGUISTIC COMPETENCE REFLECTIVE OF MARYLAND'S DIVERSE POPULATION
Standard 3-We recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the community we serve.
***Strategies to build competency**:* Review agency/governing body polices with regard to diversity and inclusion (through a cultural lens). Mandatory CLC trainings for all Board of Directors, agency committees, and staff throughout the year. Share CLAS Standards and FY21 CLC Strategic Plan with governing body, HR or hiring department staff and as part of new hire process.
***Performance Measures**:* Update policies to reflect a more culturally sensitive lens. Survey MSPC entity staff diversity, track attendance of CLC trainings. Review plans of MSPC partners to actively recruit, hire and retain individuals of diverse cultures.
***Intended impact**:* The community will see that MSPC partners are intentional in seeking to have an understanding and to demonstrate the value of employing diverse cultures.