WEEKLY NEWSLETTER

Your behavioral health resource for local trainings, events, program information, and more around the Shore!

Volume 4, Issue 8

States Gear Up To Help Medicaid Enrollees Beat Addictions

Pew's Stateline | By Christine Vestal

Under the Affordable Care Act, millions of low-income adults last year became eligible for Medicaid and subsidized health insurance for the first time. Now states face a huge challenge: how to deal with an onslaught of able-bodied, 18- to 64-year olds who haven't seen a doctor in years.

"It took a lot of time and effort to enroll everyone, particularly those who were new to the system," said Matt Salo, director of the National Association of Medicaid Directors. "The next big step, and the biggest unknown, is finding out exactly how this newly insured population will use the health care system."

Until now, the vast majority of Medicaid beneficiaries were pregnant women, young children, and disabled and elderly adults. Relatively few able-bodied adults without children qualified, so states did not set up their Medicaid programs to treat them.

The newly insured, most of them young adults, have different needs. Though not as sick as existing Medicaid beneficiaries, the newcomers are more likely to have undiagnosed and untreated chronic illnesses such as diabetes and heart disease than the general population.

The starkest difference between the new population and the old one, however, is that the new enrollees have much higher rates of drug and alcohol addiction and mental illness.

Of the estimated 18 million adults potentially eligible for Medicaid in all 50 states, at least 2.5 million have substance use disorders. Of the 19 million uninsured adults with slightly higher incomes who are eligible for subsidized exchange insurance, an estimated 2.8 million struggle with substance abuse, according to the most recent national survey by the U.S. Substance Abuse and Mental Health Services Administration.

In addition to increasing the number of people with health insurance, the ACA for the first time made coverage of addiction services and other behavioral health disorders mandatory for all insurers, including Medicaid. As a result, the number of Medicaid enrollees receiving addiction services is expected to skyrocket over the next two years.

Although Medicaid and other state and federal programs historically have provided care for people with serious mental illness, coverage of addiction treatments has been spotty. Optional under Medicaid until now, coverage in most states was limited, typically just for pregnant women and adolescents.

"It's the biggest change in a generation for addiction services," said Robert Morrison, executive director of the National Association of State Alcohol and Drug Abuse Directors. "Comprehensive addiction programs didn't exist in Medicaid until now."

THE PEW CHARITABLE TRUSTS

Continued on page 3

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Hey Youth!

We are here… We are listening… What do you need to be great?

Youth Engagement Specialists Paul Tue, Marty Bailey, and Rowan Powell want to connect with your youth! We are meeting in all counties on the Eastern Shore. If you and/or your staff would like an introduction to Youth M.O.V.E. Eastern Shore or if we have already presented to you and you would like a follow-up, please let us know. Our goal is to help all youth on the shore succeed and reach their full potential! Contact us today!

SAVE THE DATE!!!!!!

Generational Trauma: Changing the Cycle,
A Two Part Seminar

Part I: Defining Generational Trauma
Wednesday, March 18 1:00-4:15 PM
3 CEUs (pending)
Presented by Letha Moszer, LCSW, Salisbury University Department of Social Work, and
Audra Cherbonnier, Family Navigator, Maryland Coalition of Families

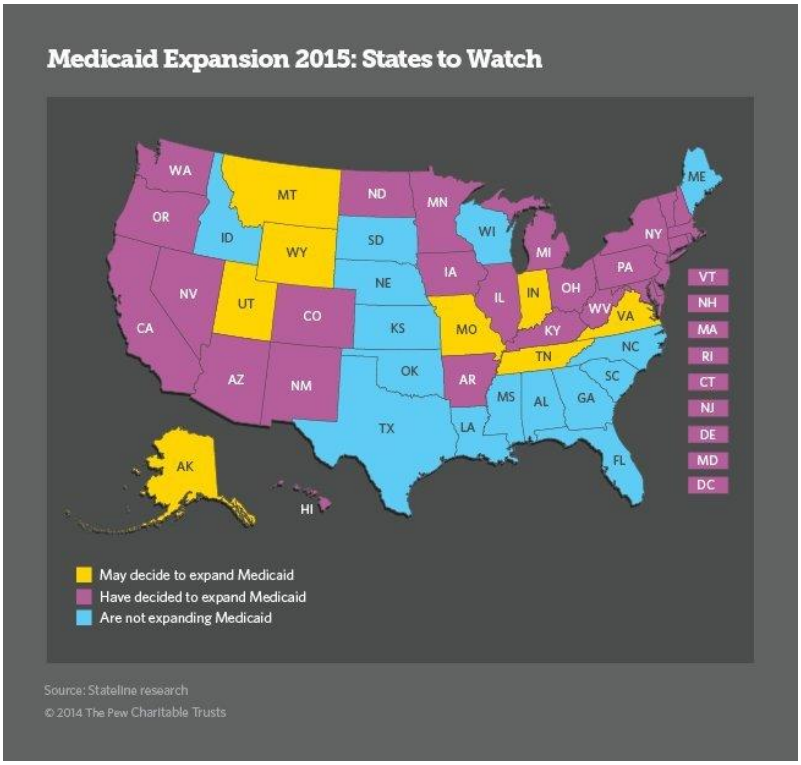
Part II: Managing Behaviors in the Home
(based on the lessons of Active Parenting)
Wednesday, April 8, 9:00 AM – 12:15 PM
3 CEUs (pending)
Presented by Sherri Allen, Family Support Partner, Maryland Coalition of Families
and Active Parenting Train the Trainer;
and Augustine Cook, Family Navigator, Maryland Coalition of Families

Sponsored by Rural CARES, a regional System of Care Community*

Watch for details of the training and registration information to follow. Registration is required but will be limited. **Preference will be given to those registering for both sessions!**

*Rural CARES is a regional System of Care Collaborative, part of The institute for Innovation and Implementation, University of Maryland School of Social Work. Rural CARES is funded under Federal Grant #SM059052, issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services. Opinions expressed in this and all publications are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Continued from Cover Story...



Big Demand, Short Supply

Behavioral health professionals typically earn far less than other health care providers, in part because few insurers have been willing to pay for their services. Many who enter the profession quickly abandon addiction treatment for more lucrative specialties. The result: a national shortage of addiction treatment providers.

Now, as billions of insurance dollars from Medicaid and all other insurers are becoming available, behavioral health experts say it will take time, training and new state licensing policies to expand the pool of providers to meet the new demand.

"Providers are now having to run to be ready to bill Medicaid and insurance companies, negotiate contracts with managed care companies and understand what this new market looks like," said Becky Vaughn, vice president for addictions at the National Council for Behavioral Health. "Medicaid directors are also hustling to catch up," she said.

For more than two decades, the U.S. Department of Health and Human Services has handed out grants to states to pay for addiction services. Walk-in clinics and residential facilities treated indigents and people in the criminal justice system, as well as uninsured people who paid out-of-pocket on a sliding income scale. Insurance was rarely billed. "Now, venture capitalists are starting to say there's money to be made," Vaughn said.

The first step for states is to create ACA compliant addiction benefit packages and fee structures to compensate the mostly small businesses that currently offer detox and rehabilitation services. Longer term, states are expected to loosen current behavioral health licensing requirements and offer professional and business training to promote an expansion of the workforce.

A Growing Population

So far, 8 million people have signed up for exchange insurance policies and 7.2 million have enrolled in Medicaid since last year, according to the most recent data from the U.S. Department of Health and Human Services. Because Medicaid enrollment is continuous, those numbers are expected to rise substantially this year and next.

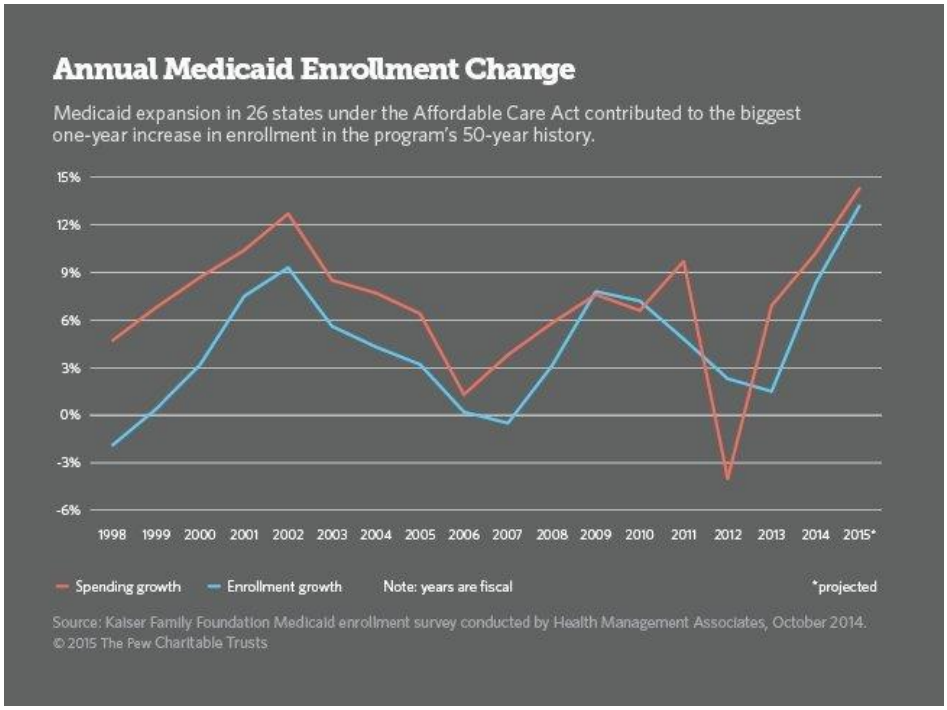
Under the ACA, states have the option of expanding Medicaid to adults with incomes up to 138 percent of the federal poverty level ($11,670 for an individual). The federal government will pay the entire bill for 2014 through 2016, and then it will pay a declining share over the following three years, and 90 percent thereafter. So far, only 27 states have taken up the option, but several GOP-led states are now considering it, potentially adding millions more adults to the Medicaid rolls this year.

Fourteen percent of the low-income adults who are newly eligible for Medicaid under the ACA have drug and alcohol addictions, compared to 10 percent in the general population. Because the new Medicaid population is dominated by young, single men—a group at much higher risk for drug and alcohol abuse—Medicaid enrollees needing treatment could more than double, from 1.5 million prior to the 2014 Medicaid expansion to about 4 million in the next five years.

Without treatment, their overall health care costs will be considerably higher. Compared to people without addictions, alcohol and drug abusers have poorer overall health. Their families often have poorer health as well.

Because of this, most Medicaid agencies want to find and treat newly eligible adults with substance use disorders as quickly as possible. The hope is that they will turn their lives around and move up the income scale and out of Medicaid altogether, said Salo of the Medicaid directors association. Medicaid officials also want to make sure people with addictions see a primary care doctor before their physical health worsens.

It's not clear what portion of the adults who signed up for expanded Medicaid coverage last year have addiction disorders. In general, people with serious addiction disorders are not the first to sign up and maintain insurance coverage. Even less clear is when and whether they will seek help.



Low Treatment Rate

In 2012, about 22 million Americans were classified with a substance use disorder. Of those, 2.8 million had problems with both alcohol and drugs, 4.5 million had problems with drugs but not alcohol, and 14.9 million had problems with alcohol only. Only 2.5 million received help, according to the most recent National Survey on Drug Use and Health.

People with drug and alcohol problems are prone to deny that their substance use is a problem, and most tend to neglect their health even when they have insurance. The majority do not seek addiction treatment until they end up in crisis. When they or their families decide treatment is needed, it is often difficult to find a facility nearby that can take them.

"Up until now we have only had penetration rates of about 10 to 15 percent of the people who need services," Vaughn said. "No other chronic disease would have that kind of low (treatment) rate."

In the coming months, states and the federal government will begin releasing data, based on actual Medicaid claims, showing how many newly eligible Medicaid enrollees are using their new health cards, and for what. So far, there is only anecdotal evidence and limited state data.

In California, for example, 10,568 newly enrolled beneficiaries had signed up for addiction services by May, an increase of more than 30 percent under the state Medicaid program. The number of adults in Washington state's Medicaid treatment facilities doubled in the first six months of the year. Vermont Medicaid officials also said they saw a substantial increase in the number of Medicaid enrollees seeking treatment.

Colorado's director of health policy and planning, Susan Birch, said Medicaid officials there feared the worst but were "delighted" to find the 290,000 newly enrolled adults were healthier than expected. "We budgeted as if they would be in more of a dire, acute stage," she said. "People aren't coming in as sick as we thought and they're not staying as long in our (Medicaid) system," Birch said.

Part of the reason some Medicaid agencies are initially seeing milder cases of addiction is that many of the heaviest and most prolonged drug and alcohol users in Colorado and elsewhere have already ended up in jails, prisons and emergency rooms, or entered the state health care system as indigents.

In addition, many states have covered a limited number of addicted adults under special state-funded programs aimed at helping their poorest residents with severe mental illness and addictions. As a result, the number of new Medicaid enrollees with severe addiction cases, those that already have caused serious health problems, could be relatively low.

But states are no longer willing to wait for people to walk into a local clinic and ask for help. Instead, many state Medicaid agencies are working with primary care physicians and hospitals to reach people with addictions before their physical and mental health crumbles and their work and family relationships fall apart.

"We're talking about those that are pre-catastrophic cases," Birch said. "We hope we can keep people from getting worse before they get into the organ transplant and suicide realm," she said. Colorado has launched a statewide collaboration program between primary care doctors and behavioral health specialists to ensure that happens.

A Huge Payoff

Much of the current emphasis on addiction services stems from medical research showing that individuals with untreated drug and alcohol disorders are among the heaviest users of the health care system, contributing to a substantial share of rising Medicaid, Medicare and private health care spending. Mounting evidence also shows physical health care costs decline dramatically when people with substance addictions get treatment. The longer they maintain sobriety, the lower their medical bills are.

"All of a sudden there's a great deal of interest in people who are 'high utilizers' of emergency rooms and who don't have any connection to health care," said Art Schut, CEO of Arapahoe House, Colorado's largest provider of drug and alcohol addiction services. "Many of the people we used to deal with didn't have a primary care physician, and we couldn't get them one," he said.

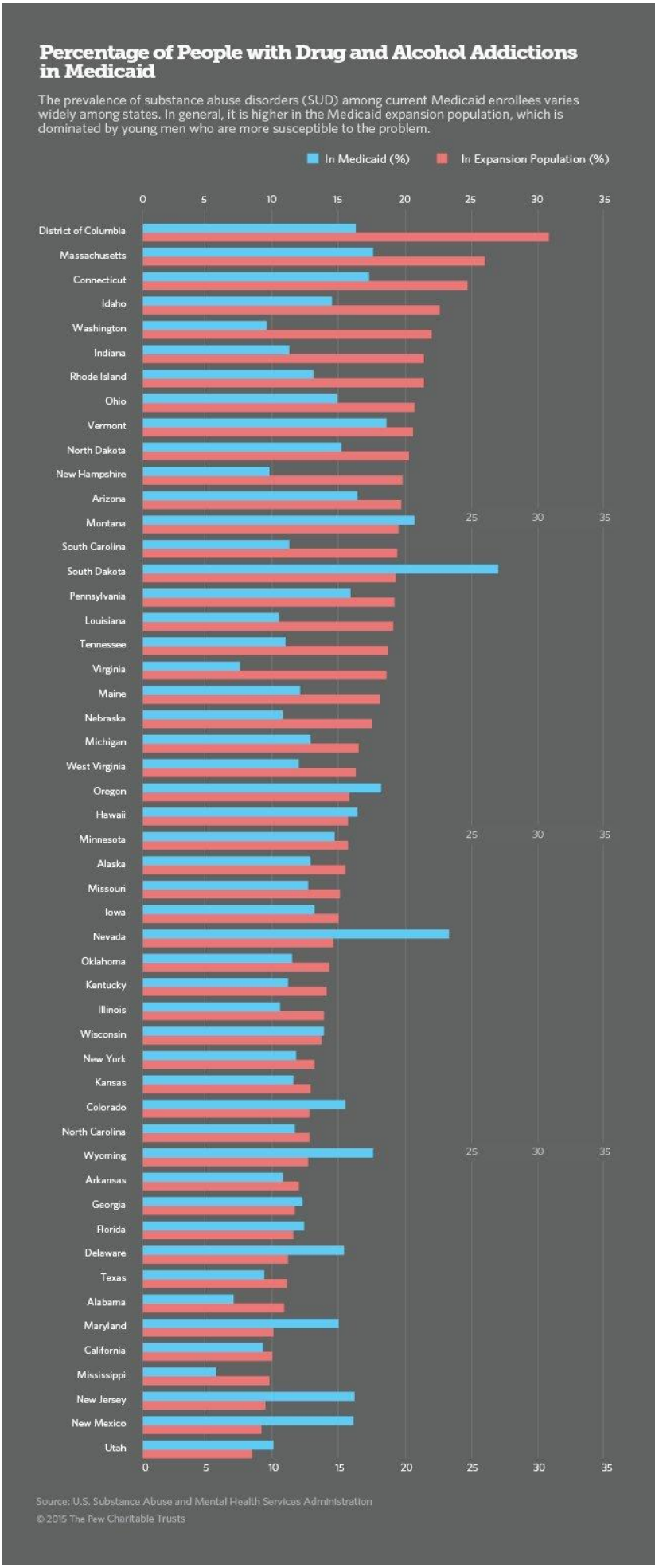
A major goal for nearly all states is to find ways to better integrate physical and behavioral health, including addiction treatments. Now that addiction treatment is an integral part of Medicaid's overall health plan, Schutt says he expects health outcomes to improve and costs to go down.

"We're at the point where we're actually treating substance use illness the way we treat other illnesses. There's a realization in the commercial and public marketplace that health outcomes are important and that SUD (substance use disorder) treatment contributes significantly to overall health. It's transformational for health care, not just substance use," he said.

In Washington state, for example, the health agency invested in a drug and alcohol treatment program in 2005 and found that for every dollar spent, the state saved $2 in medical and nursing facility costs in the first four years.

"It's hard for Medicaid directors watching mounting claims for addiction medications and treatments to take into account the expenses they're not seeing," said Morrison, director of the state alcohol and drug abuse group. But he said nearly every state agency is on board with the concept that addiction treatments, including medications, do result in substantial overall health care savings.

Colorado's Schut says most providers already are trying to integrate physical and behavioral health, but until Medicaid agencies develop better financing options, their efforts will be hard to maintain. "The ACA opportunities are a dream come true," he said, "but we're not quite there yet."



Source: http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/1/13/states-gear-up-to-help-medicaid-enrollees-beat-addictions

MARCH 12TH, MARCH 26TH, APRIL 9TH, APRIL 23RD FROM 4 TO 5 PM

Youth Motivating Others through Voices of Experience. Youth M.O.V.E is a **YOUTH** led organization that has chapters all throughout the USA. The organization is dedicated to improving the services and systems that support positive growth and development of youths. By uniting the voices of youths across the nation, who have various systems experience including mental health, juvenile justice, education, and child welfare. If you feel that Youth M.O.V.E is something that you can benefit from, or you are ready to share your voice then contact your Youth Engagement Specialist, Rowan Powell.

Youth M.O.V.E of the Eastern Shore has expanded to the Lower Shore!

If you want to be a part of this amazing organization then email or call Rowan Powell:
410 924 4898
rpowell@msmhs.org

MCDONALDS
5616 Market Street
Snow Hill, MD 21863
Phone: 410-632-5460

MARCH 4TH, MARCH 18TH, APRIL 1ST, APRIL 15TH, APRIL 29TH 4 TO 5 PM

Youth Motivating Others through Voices of Experience. Youth M.O.V.E is a **YOUTH** led organization that has chapters all throughout the USA. The organization is dedicated to improving the services and systems that support positive growth and development of youths. By uniting the voices of youths across the nation, who have various systems experience including mental health, juvenile justice, education, and child welfare. If you feel that Youth M.O.V.E is something that you can benefit from, or you are ready to share your voice, then contact your Youth Engagement Specialist, Rowan Powell.

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410 924 4898
rpowell@msmhs.org

Wicomico Family Partnership
408 Coles Circle
Suite G
Salisbury, MD 21804

YOUTH M.O.V.E LGBTQ

There is a new Youth M.O.V.E group now on the Lower Shore.

This Youth M.O.V.E. group focuses on Lesbian Gay Bisexual Transgender Queer youth, and issues facing this population of youth. Youth M.O.V.E. is a youth led national organization focusing on youth speaking up and advocating for themselves and other youth. Any youth between the ages 14 to 17 interested in joining should fill out this form and send it in or contact Rowan Powell. The next meetings are March 3rd, March 17th, March 31st, April 14th, and April 28th at Wicomico Family Partnership, 408 Coles Circle Suite G, Salisbury, MD 21804. The meeting will run from 4 to 5 PM.

Name: _____

Date of Birth: _____

Address: _____

Email: _____

Phone: _____

Youth M.O.V.E Eastern Shore has started a LGBTQ Group for Wicomico, Worcester, and Somerset Counties.

If you are interested in joining, or simply have some questions, email or call Rowan Powell.

Email:
rpowell@msmhs.org

Phone:
410-924-4898

FAX- 410 770-4809

28578 Mary's Ct,
Easton, MD 21601

YOUTH M.O.V.E LGBTQ

There is a new Youth M.O.V.E group on the Mid Shore.

This Youth M.O.V.E. group will focus on Lesbian Gay Bisexual Transgender Queer youth, and issues facing this population of youth. Youth M.O.V.E. is a youth led national organization focusing on youth speaking up and advocating for themselves and other youth. Any youth between the ages 14 to 25 interested in joining should fill out this form and send it in or contact Rowan Powell. The next meetings are March 13th, March 27th, April 10th, and April 24th at Rise Up, 618 Dover Rd, Easton MD, 21601. The meeting will run from 5 to 6 PM.

Name: _____

Date of Birth: _____

Address: _____

Email: _____

Phone: _____

Youth M.O.V.E Eastern Shore has started a LGBTQ Group for the Mid Shore.

If you are interested in joining, or simply have some questions, email or call Rowan Powell.

Email:
rpowell@msmhs.org

Phone:
410-829-7646

FAX- 410 770-4809

28578 Mary's Ct,
Easton, MD 21601

PRESS RELEASE

Contact: Sharon Huseman
410-819-8067
shuseman@talbotpartnership.org

FOR IMMEDIATE RELEASE (EASTON- February 12, 2015)

Marijuana and Mental Illness

Marijuana is the most commonly used illegal drug in America: approximately one in 10 adult Americans report having used marijuana in the past year. In recent years, laws addressing the use and possession of marijuana have been changing, and many states—including Colorado, California, Massachusetts and now Maryland—have passed regulations either legalizing marijuana for medical purposes or decriminalizing the non-medical use of marijuana. While different groups of professionals have had varied responses to the implications of this new legislation, mental health professionals have been largely united in expressing their concerns of the negative impact marijuana has for people with mental illness. **Furthermore, the scientific data is clear that regular marijuana abuse is linked with increased risk of legal troubles and jail time, difficulties at school and at work, as well as abuse of alcohol and other drugs.**

What Happens When A Person Uses Marijuana?

Marijuana causes a person to feel "high," which can involve peaceful feelings such as being happy, silly, hungry or tired. **People with mental illness are more likely to also experience negative emotions such as depressed mood, anxiety—including physical symptoms of shortness of breath and heart palpitations—or even paranoia.** These reactions are most likely related to marijuana's interactions with certain chemicals in the brain, including the neurotransmitter dopamine.

Many people incorrectly believe that marijuana isn't addictive. While many people who use marijuana do not become addicted to this drug, **recent scientific research has shown that a significant percentage of individuals who use marijuana will become physically dependent on the drug.** This means that stopping their marijuana abuse will cause these people to experience a withdrawal syndrome. While not a medical emergency—compared with withdrawal from other substances such as alcohol—**it can cause symptoms of fatigue, low energy and worsening depression or anxiety.**

What Is The Relationship Between Marijuana And Mental Illness?

The overwhelming consensus from mental health professionals is that marijuana is not helpful—**and potentially dangerous—for people with mental illness. Using marijuana can directly worsen symptoms of anxiety, depression or schizophrenia through its actions on the brain.** People who smoke marijuana are also less likely to actively participate in their treatment—missing more appointments and having more difficulty with medication-adherence—than people who abstain from using this drug.

The relationship between marijuana and psychotic illness, specifically schizophrenia, has been studied for many years and is receiving increasing publicity in the mainstream media. **Certainly not all people who smoke marijuana will develop schizophrenia, but people who are at risk of developing this illness—including individuals with close family relatives that have severe mental illness—will be more likely to experience psychosis if they are using marijuana.** In this population of individuals, people who regularly smoke marijuana are diagnosed with schizophrenia at a younger age, hospitalized more frequently for their illness and are less likely to experience complete recovery even with high quality treatment. This is particularly concerning, as approximately one-third of people in America with schizophrenia regularly abuse marijuana.

What Treatments Are Available For People With Marijuana Abuse And Dependency?

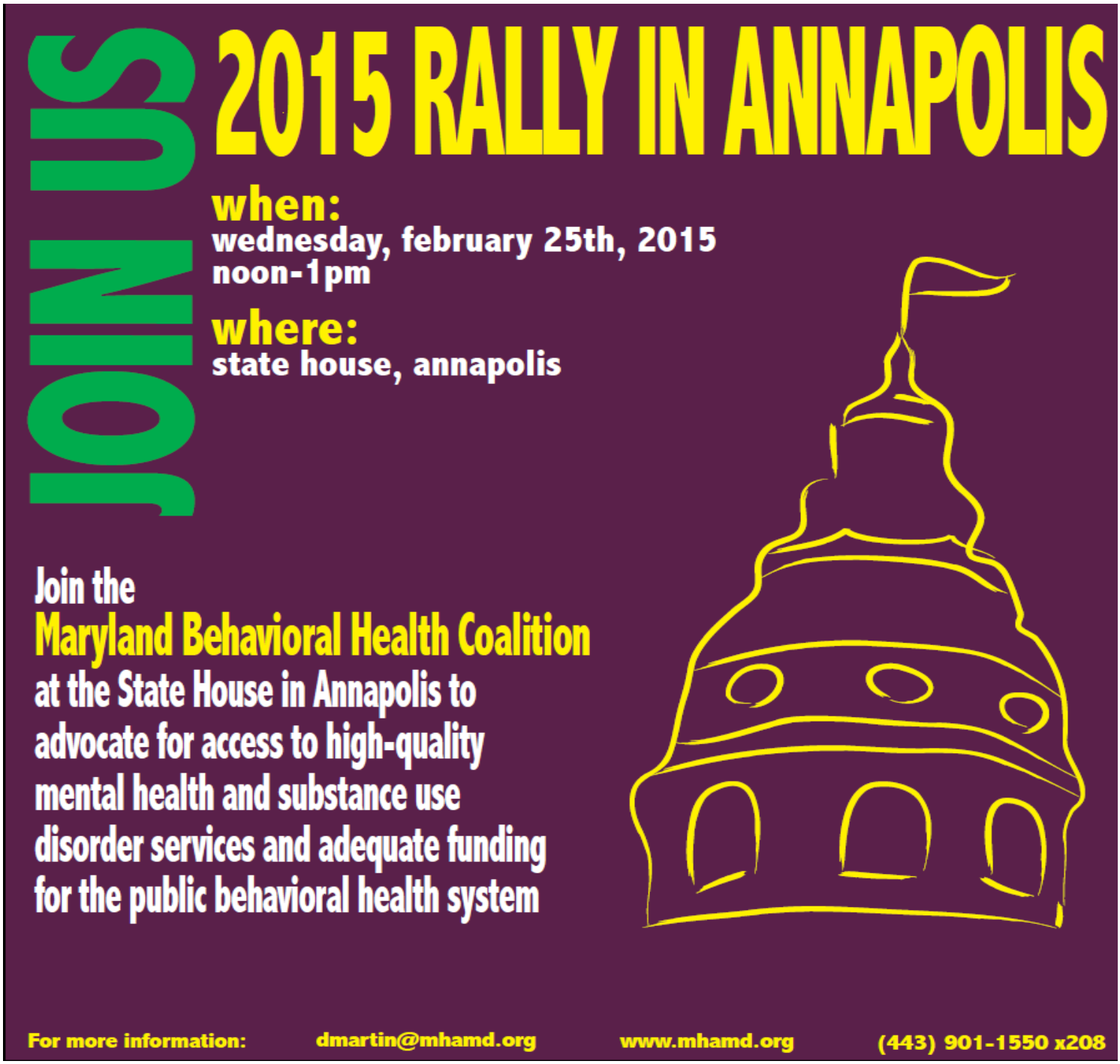
Multiple scientific studies have shown that treatment of mental illness is more effective in people who are not actively abusing marijuana. This is not to say that people with mental illness cannot be treated while they are still using marijuana; however, treatment of mental illness is generally more effective once individuals are sober and more able to be actively participating in their treatment.

There is no medication that can cure marijuana abuse. A number of different medications have been studied, but the details of this are largely beyond the scope of this review and have not yielded consistent results. Some people find therapy to be a helpful part of maintaining their sobriety. This can include self-help groups such as Marijuana Anonymous, Alcoholics Anonymous, Narcotics Anonymous or Smart Recovery. Individual therapy can also be useful, and some people will find that cognitive behavioral therapy (CBT) is an important part of their treatment plan. Another form of therapy called "motivational interviewing"—an interactive, patient-centered model of treatment focused on finding inspiration for behavioral change—has been found to be effective in helping people to stop using marijuana. These and other tools can be useful, as a significant majority of people will relapse at some point in their lives, even if they are eventually able to achieve long-lasting sobriety.

Family, friends and others can be most helpful in providing empathic and non-judgmental support of their loved ones. With this support and effective psychiatric treatment, many people with marijuana abuse and mental illness will be able to actively participate in their recovery journey.

Reviewed by Ken Duckworth, M.D., and Jacob L. Freedman, M.D., March 2013

For further information about how to prevent substance abuse contact **Talbot Partnership Caring for our Community at 410-819-8067** or visit www.talbotpartnership.org.



"Working together to prevent substance abuse."

FOR IMMEDIATE RELEASE:

Contact: Charlene Jones
Dorchester County Health Dept.
Direct Line: 410-901-8162
charlene.jones@maryland.gov

PDFD promotes assets for raising successful youth

Asset #38 Self Esteem

48% of the youth surveyed have this asset in their lives.

Not everyone has high self-esteem. Although it may come naturally for some, others have to be encouraged. Children learn to believe in themselves based on what they hear and how they are treated by adults. Adult's actions also teach children how to treat others. Children that know they are loved, cared for and valued grow to love, care for and value others. They are also successful in school and other activities. Children who feel good about themselves have positive relationships and are less likely to fall prey to negative peer pressure. For the month of February, Partnership for a Drug Free Dorchester (PDFD) is promoting Self Esteem, Asset 38 of Search Institute's 40 Developmental Assets. PDFD offers the following tips to promote self-esteem to build strong, capable and interesting youth:

At Home

- Compliment your child and other children.
- Let children hear you say positive things about them to someone else.
- Acknowledge the small things, i.e. completing chores, helping without being asked, or simply for say something nice.

At School

- Teach young people about affirmations.
- Send parents positive communications about student behavior and/or accomplishments.
- Talk privately to students about your concerns.

In the Community

- Acknowledge youth when you know they have done something well or with good intentions.
- Ask youth their opinions about community concerns.
- Personally ask them to participate in your activities.

In the Congregation

- Acknowledge student milestones.
- Take care to see that all youth are engaged in programs.
- Call youth that you have not seen in a while.

Now log onto PDFD's Facebook page at www.facebook.com/drugfreedorchester and share how you are being an asset builder for Planning and Decision Making. There are probably lots of activities you do that are worth sharing and may inspire others. For more information, view Search Institute's website: www.search-institute.org/assets or contact Charlene Jones, PDFD Coordinator, at 410-901-8162. *Note: This is part of a series of articles provided by Partnership for a Drug Free Dorchester (PDFD) to promote the 40 Developmental Assets, the most widely used approach to positive youth development. PDFD is a community coalition established to prevent alcohol, tobacco, and other drug abuse in Dorchester County.*

New Employment Opportunities!

CBH: Executive Director

Reports to: Board of Directors
Schedule: Full time
Classification: Exempt

Apply Now

JOB SUMMARY:
The Community Behavioral Health Association (CBH) is the professional association for Maryland's network of 50 community-based behavioral health service programs serving 160,000 people with behavioral health needs. CBH is seeking a dynamic **Executive Director** to be responsible for all aspects of its mission and operations. The Executive Director will ensure that CBH serves its member agencies through advocacy and public policy negotiation, training and technical assistance in clinical and management aspects of community behavioral health service delivery; strategic positioning including partnerships and other operational arrangements that help member agencies grow and thrive; and information dissemination on policy and programmatic issues of relevance to the field. The Executive Director is also responsible for the subsidiary, Community Behavioral Health Education Fund (CBHEF). Successful candidates for this position should possess a graduate degree in public administration, minimum of ten years (10) experience in a leadership position and knowledge of community-based behavioral health services, public policy, reimbursement and management.

Shore Behavioral Health: Therapist and CNAs

Shore Behavioral Health is Hiring! We are looking for Part Time and Relief CNA's with Behavioral Health and Addictions experience. We are also looking for a Full-time Therapist to work together with our treatment team providing a structured group and activity schedule as well as treatment planning for inpatient individuals with acute Behavioral Health and Addictions issues. Apply online through the Shore Health Systems' website: http://umshoreregional.org/careers. If you have any questions about the positions, please contact Jaclyn Weston at 410-822-1000 ext. 8454

SAMHSA: CSAT Director

Are you interested in being a strategic leader to improve public health in substance abuse treatment? SAMHSA is looking for candidates to fill the position of Director of the SAMHSA Center for Substance Abuse Treatment (CSAT).

CSAT provides national leadership to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT's focus is to improve access, reduce barriers, and promote high-quality, effective treatment and recovery services for people with these problems, substance use issues, or addiction, as well as for their families and communities.

The CSAT Director provides leadership in planning, implementing, and evaluating the Center's goals. He or she is the focal point for SAMHSA's efforts to improve and expand treatment for substance use disorders; plans, directs, and provides overall administration for the programs of CSAT; coordinates Center consumer education functions and develops effective strategies and materials; and monitors the conduct of equal employment opportunity activities of CSAT.

Interested candidates should apply to the announcement through www.usajobs.gov.

Closing Date: March 2, 2015

Learn More About the Position and Apply

DRI-DOCK 

COMMUNITY HEALTH OUTREACH WORKER I

FULL-TIME CONTRACTUAL

Recruitment #15-000205-0004

DATE OPENED	2/5/2015 11:45:00 AM
FILING DEADLINE	2/19/2015 11:59:00 PM
SALARY	$11.53/hour
EMPLOYMENT TYPE	Full-Time
HR ANALYST	Carolyn Chase
WORK LOCATION	Dorchester

GRADE
06

LOCATION OF POSITION
Department of Health and Mental Hygiene
Dorchester County Health Department
206 Sunburst Highway
Cambridge, MD 21613

MAIN PURPOSE OF JOB
The Contractual Community Health Outreach Worker I which is the Peer Recovery Support Specialist is the entry level of work providing health and disease prevention information to medically underserved populations in the community and assisting them in adopting healthy behaviors. The main purpose of the Peer Recovery Support Specialist is to provide a linkage to resources and services to assist DriDock participants and Care Coordination/DSAP clients. The incumbent will utilize their lived experience, share their personal story/experience, strength, and hope to assist those still struggling and/or returning with addiction and/or mental health issues. The employee will also provide continued and/or expanded support for those in all phases of recovery. This position provides client transportation to/from treatment, appointments, etc.

MINIMUM QUALIFICATIONS
Education: Graduation from an accredited high school or possession of a high school equivalency certificate.
Experience: None.
NOTE: 1. Experience providing assistance to individuals in a health care or social services setting may be substituted for the required education on a year-for-year basis.
2. Candidates may substitute U.S. Armed Forces military service experience as a non-commissioned officer in Health Services classifications or Health Services and specialty codes in the health related field of work on a year-for-year basis for the required experience.

LICENSES, REGISTRATIONS AND CERTIFICATIONS
Employees in this classification may be assigned duties which require the operation of a motor vehicle. Employees assigned such duties will be required to possess a motor vehicle operator's license valid in the State of Maryland.

SELECTION PROCESS
Applicants who meet the minimum qualifications will be evaluated. The evaluation may be a rating of your application based on your education, training and experience as they relate to the requirements of the position. Therefore, it is essential that you provide complete and accurate information on your application. Please report all related education, experience, dates and hours of work. For education obtained outside the U.S., a copy of the equivalent American education as determined by a foreign credential evaluation service must accompany the application. All information concerning your qualifications must be submitted by the closing date. We will not consider information submitted after this date. For Recorded Job Information Call: 410-767-6018.

BENEFITS
CONTRACTUAL EMPLOYEE HEALTH BENEFITS

FURTHER INSTRUCTIONS
Online application process is **STRONGLY** preferred. If online process is not available, please send your paper application to: DHMH, Recruitment and Selection Division, 201 W. Preston St., Room 114-B, Baltimore, MD 21201. The paper application must be received by 5 pm, close of business, on the closing date for the recruitment, no postmarks will be accepted.
Incorrect application forms will not be accepted.

If you need to submit additional information, the preferred method is to upload. If unable to upload, please fax requested information only to 410-333-5689.

Appropriate accommodations for individuals with disabilities are available upon request by calling: (410) 767-1251 or MD TTY Relay Service 1-800-735-2258.

We thank our Veterans for their service to our country, and encourage them to apply. As an equal opportunity employer Maryland is committed to recruiting, retaining and promoting employees who are reflective of the State's diversity.

THE COPPER RIDGE INSTITUTE
AFFILIATED WITH THE
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

Upcoming Educational Offerings

All programs marked with an asterisk are **free to attend in-person. For more information about our live webinars, please click here.*

*Hip Fractures, Delirium, and Dementia
March 4, 2015 - 11am-12pm - Eldersburg, MD
Ann Gruber-Baldini, PhD, University of Maryland
Attend in-person or online.
More information

*Legal Issues and Dementia: Capacity, Decision Making, and Guardianship
April 1, 2015 - 11am-12pm - Eldersburg, MD
Mary E. O'Byrne, Esq, Frank, Frank, & Scherr, LLC
Attend in-person or online.
More information

*Alzheimer's Disease Research Update
May 6, 2015 - 11am-12pm - Eldersburg, MD
Ann Morrison, PhD, RN
Attend in-person or online.
More information

Brain Disorders, Yoga, and Mindfulness: Maximizing Quality of Life through Non-medical Approaches
May 15-16, 2015 - 9am-4pm - Eldersburg, MD
Nicole Absar, MD, RYT, and Michelle Flemming, RYT
More information

Check out this video featuring Marge Mulcare and Kim Burton discussing *Suicide Prevention for Older Adults*, presented by QACTV!

MAKING STRIDES TOGETHER

NAMIWalks Maryland

Honorary Co-Chairs Senator Ben Cardin and Mrs. Myrna Edelman Cardin

WHY WE WALK...

- To have fun!
- To support our communities
- To raise awareness about mental illness
- To show recovery IS possible
- To change perceptions & to STOMP STIGMA!
- To raise vital funds for our FREE public programs
- To ensure that hope and help are available

To register, visit
www.namiwalks.org/maryland
To learn more or to volunteer,
Contact NAMI Maryland at:
events@namimd.org or
410-884-8691

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of American affected by mental illness.

NAMI Maryland
National Alliance on Mental Illness

10630 Little Patuxent Pkwy, Suite 475
Columbia, MD 21044
877.878.2371
www.namimd.org

Upcoming NAMI Programs for Veterans, Service Members and their Loved Ones!

NAMI Homefront is a 6-session adaptation of the NAMI Family-to-Family Program created specifically for the families of Service Members and Veterans dealing with mental illness.

NAMI Homefront focuses on the unique needs of military and veteran communities, such as post-deployment and post-discharge transitions. The course is designed to help family members understand and support their loved one while maintaining their own well-being.

Register for Our Spring NAMI Homefront Courses:

NAMI Montgomery County

1.) **Dates:** 6 consecutive Mondays starting March 2nd
Time: 6:30 PM - 9:00 PM
Location: Mental Health Association of Montgomery County, 1000 Twinbrook Parkway, Rockville, MD 20851
Registration is required! To register: Click here or call 301-949-5852

NAMI Prince George's County

2.) **Dates:** 6 consecutive Tuesdays starting March 31st
Time: 6:00 PM - 8:30 PM
Location: 1101 Memorial Chapel (Conference Room)
University of Maryland, College Park, MD 20740
Registration is required. To register: Call (301) 429-0970 or email NAMI Prince George's County.

Let us know if you know of any organizations who would be willing to spread the word/post flyers about our upcoming NAMI Homefront Courses!

NAMI Peer-to-Peer

FREE Course on Living Well with Mental Illness

Veterans and Service Members Welcome!

NAMI Peer-to-Peer is a free, 10-session course for adults living with mental illness. NAMI Peer-to-Peer provides an educational setting focused on recovery that offers respect, understanding, encouragement and hope.

The NAMI Peer-to-Peer education program is:

- Free and confidential
- Held once a week for two hours
- Great resource for information on mental health and recovery
- Taught by trained Peer Mentors living in recovery themselves
- This teaching team includes a civilian and a veteran

Classes start:
Date: Tuesday, February 24th 2015
Location: Edgewood Senior Center, Edgewood, MD
Time: 1:00 PM - 3:00 PM
To register call: 410-884-8691 or email us!

NAMI Maryland
10630 Little Patuxent Parkway
Columbia, Maryland 21044
410-884-8691

SAMHSA-HRSA
Center for Integrated Health Solutions
Making Integrated Care Work
eSolutions is a monthly newsletter that brings you practical solutions and resources on primary and behavioral healthcare integration from across the United States.
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
SAMHSA

e-Solutions January 2015

Oral Care is Rooted in Whole Health

Based on an interview with Jen Koberstein, Vice President of Program Services, ***Dental Lifeline Network***

Oral health is essential to whole health. Good oral health improves a person's ability to speak, smile, smell, taste, and show feelings and emotions.[1]

Dental health contributes to general health and wellness, self-esteem and quality of life. When left untreated, dental infections and can cause numerous physical health problems, including pain, complications of other chronic conditions, loss of teeth, nutritional problems, and even death.

It is important for integrated primary and behavioral health care providers to pay attention to the relationship between dental health and whole health. Individuals with diabetes or those taking certain medications for mental illnesses are at increased risk for oral health problems and dental infections, and those infections can compromise the management of co-morbid health conditions. Oral health problems can prevent individuals from being able to undergo necessary medical care, including surgeries and chemotherapy.

Including dental services in integrated health care is about more than improving health and preventing disease. It is about supporting people to not feel isolated, to have confidence, to smile again. Getting dental care can be life-changing. When a community mental health center in Colorado began a mobile dental care program, on the first day, each person came out of their appointment with tears of joy, having received comprehensive oral health care for the first time in their life.

In one **study**, 61 percent of people with severe mental illness reported fair to poor dental health, and more than a third had oral health problems that made it difficult for them to eat. Another study found people with severe mental illness are 3.4 times more likely to lose all their teeth than the general population.

Access and Cost

According to the **National Association of Dental Plans**, more than 120 million Americans do not have dental coverage, and those without coverage are 67% more likely to have heart disease and 29% more likely to have diabetes than people with dental coverage.

Preventable oral health conditions are far too often addressed in emergency departments with pain medications and antibiotics. As with all forms of health care, barriers to care can include access and cost, yet oral health also can be excluded or overlooked in whole health discussions.

How can integrated primary and behavioral health providers address oral care?

Integrated care providers do not need to have an in-house dentist to address oral health. Primary care and behavioral health providers can take steps that stress the importance of dental care to overall health and self-esteem, and play a part in the prevention and intervention of dental infections for those you serve.

Providers can begin by simply asking basic questions about oral care habits, such as the last time they visited a dentist or if they experience any tooth pain or bleeding gums. Beginning the conversation opens up the discussion for how oral care fits into health and quality of life.

It is also important for pharmacists and providers to be aware of the effect medications can have on oral health. Many antipsychotic medications can cause dry mouth or decrease resistance to infection, which can exacerbate decay and increase risk of systemic complications. People who are immunosuppressed, have had chemotherapy or have had recent surgery can be at higher risk for dental infection.

It is important for integrated care providers to be mindful of those who have had a traumatic experience and as a result may be uncomfortable seeking dental care. Integrated care providers can ask questions about past experiences to gauge the appropriate supports and comfort level of each individual in getting dental services. A **brochure** from the Western Massachusetts Training Consortium, a SAMHSA PBHCI grantee, outlines provider considerations for trauma survivors in dental settings.

Integrated care providers should know where to refer people for care. Many states have low-cost dental clinics and many federally-qualified **health centers** (FQHCs) provide dental services to individuals without dental coverage. **Donated Dental Services** (DDS), a program of Dental Lifeline Network, was born out of the need for comprehensive dental care for those who otherwise would have no access. Through a nationwide volunteer network, the program provides free comprehensive dental care to the elderly, to people who are medically compromised and to people living with disabilities. Social workers act as care coordinators for the program, certifying qualification for the program, assessing individuals' needs, and connecting people to appropriate services. Providers can look up contacts in their state and refer individuals for care.

Building a relationship with dental care providers also opens the opportunity for bidirectional referrals. Oral health specialists can conduct informal behavioral health screening if they notice signs of trauma, self-injury, or substance use (e.g., meth mouth, smell of alcohol on breath) during dental exams.

It is also important to know what coverage might exist in each state. In states where there is a Medicaid Dental Benefit for adults, be sure to let enrollees know how they can access dental care.

For more on what providers can do to address oral health, check out this month's quick tips.

1 https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health

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Grantee Spotlight: Bringing Oral Health to Integrated Care

Leslie DeHart, Director of Administrative Services, Central Oklahoma Community Mental Health Center

When submitting their application for SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) grant program, the **Central Oklahoma Community Mental Health Center** knew it would be important to include dental care. Many of the people they saw were in their twenties and couldn't afford procedures that might save a tooth; instead they were left with only one option: tooth extraction.

For those in recovery from behavioral health conditions, poor oral care can hamper confidence. As outlined in a recent **article**, the benefits of a healthy smile (and the implications and misperceptions of an unhealthy one) extend well beyond health – affecting self-esteem, employment, and personal relationships. Staff at the center noted that conversations about finding employment would bring up concerns of confidence in going to job interviews – not necessarily from concerns about prior experience, but specifically concerns about the first impression.

Initially, the center struggled to find a local partner to offer dental services, and in their research for other local resources, came across the Oklahoma Dental Foundation (ODF) – a charitable dentistry focused on access and affordability. ODF established the first mobile dental care program in Oklahoma, and although the population they typically served – children and women returning from incarceration–didn't match the center's target population, they agreed to work with the center.

Through ODF's MobileSmiles program, dentists and dental hygienists volunteer their time for basic services at the center. Twice a month, the mobile unit would visit the center and individuals could line up or make appointments to get basic services, including cleanings. Center staff would coordinate consent forms, schedule payments, and take care of paperwork to make it easy for individuals to use the program. The center would pay $600 per day for the van to visit. Word of mouth about the service led to requests from other individuals in the community not enrolled in the center's care calling up to ask about taking advantage of this program.

Realizing that many clients need more than just basic care, the center partnered with Neighborhood Services, a low cost dental clinic in Oklahoma City, and the University of Oklahoma School Of Dentistry to provide a tiered system of care. Dentists and hygienists from Neighborhood Services would arrive onsite and convert an entire exam room into a setting where they could offer a more extensive suite of services, such as root canals and dentures. Surgeries and other complex procedures would be coordinated with the School of Dentistry. Coordination allowed all care providers to share records, follow up, and provide necessary aftercare. The center would pay for care, but found the program was successful when clients contributed what they could – even if it was $10.

Today, the center has yet another way to bring dental care to those they serve – through partnering with their local community health center with a complete dental clinic. Their close partnership enables them to coordinate all care – primary medical, behavioral and dental –through a shared central electronic health record.

Center staff finds it essential to include oral care in every assessment and knows that without creative community partnerships, they wouldn't have been able to address oral health. The people they serve have noted their appreciation as well – and the goodwill from word of mouth across the community has brought new people and partnerships to the center.

How does your organization address oral care through community partnerships? Share your strategies, email ***integration@thenationalcouncil.org****.*

Quick Tips: 5 Ways to Incorporate Oral Care in Integrated Settings

Dental health is a critical component of whole health. Here are some ways you can address oral care in your integrated care environment.

- Ask basic oral care questions during appointments to engage individuals and encourage preventive care. Questions can include if they experience any dental pain, if they have bleeding gums, or when they last visited a dentist.
- Provide educational materials on the importance of regular oral care in your center's common areas and exam rooms. The **National Institute of Dental and Craniofacial Research** and the Health Resources and Sercives Administration's **Maternal and Child Oral Health Resource Center** have brochures and fact sheets on a number of oral health topics.
- Know about your community's **free and no cost clinics** iso that you can make referrals, as appropriate, and visit **Donated Dental Services** to find programs in your state.
- Consider the various ways you can bring dental care to your organization such as setting up a mobile van, inviting dental professionals to your center on a regular basis, partnering with local community health centers that offer dental services, or connecting with local dental providers as part of your coordinated care efforts. Check out these resources to get this process started:
  - HRSA's **Integration of Oral Health and Primary Care Practice** report
  - **User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies**
  - **Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers**
  - Know your state insurance coverage laws, including whether Medicaid offers any dental benefits.

Visit our **Oral Care webpage** for more resources.

Featured Resource

Advancing Behavioral Health Integration within NCQA Recognized Patient-Centered Medical Homes reviews the National Committee for Quality Assurance's (NCQA) patient-centered medical home (PCMH) standards and how they relate to the integration of behavioral health into primary care. HRSA-supported safety-net providers that have integrated behavioral health services can use this resource as a guide when preparing to apply to be recognized as a PCMH with NCQA.

Hot Topics

The National Health Services Corps (NHSC) is accepting applications through March 30 for their **Loan Repayment Program**. Primary care medical, dental and behavioral health clinicians can get up to $50,000 to repay their health profession student loans in exchange for a two year commitment to work at an approved NHSC site in a high-need, underserved area. Want to learn more about the NHSC? Check out our guide to **Understanding the National Health Service Corps.**

SAMHSA's new mobile app, **Suicide Safe**, can help primary care and behavioral health providers integrate suicide prevention strategies into their practice and reduce suicide risk among their patients. **Sign up** to be notified when it is released.

SAMHSA's **Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorders: A Brief Guide** offers guidance on the use of medication assisted treatment (MAT) with extended-release injectable naltrexone for the treatment of opioid use disorder. It covers patient assessment, initiating MAT, monitoring progress, adjusting treatment, and deciding when to end treatment.

The CDC Division of Community Health developed a new online training, Community Approaches to Advance Health Equity, to help practitioners learn how to incorporate health equity principles into all aspects of their work. Participants will be encouraged to consider proven policy, systems, and environmental improvement strategies that address health disparities in chronic diseases. The course is available through **CDC Train**.

Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States, from the Center for Health Care Strategies and the Centers for Medicare & Medicaid Services, identifies important considerations for states in developing opioid dependence-focused health homes, including opioid treatment program requirements, collaboration across multiple state agencies, supporting providers in transforming into health homes, and encouraging information sharing.

Webinars

Coming soon from CIHS: February webinars will feature national experts to discuss best practices for integrating behavioral health into rural primary care settings and in positioning health and wellness programs as a priority in behavioral health organizations.

Check out CIHS' **archived webinars** for past presentations on a variety of integrated care topics. Financing webinars include a focus on financing the health home and billing for integrated services.

Have a topic you'd like CIHS to explore on a future webinar? Let us know, email **Integration@TheNationalCouncil.org**.

More than a Group: Making Wellness an Agency Priority

Date and Time: *Wednesday, February 25, 2015, 3:00-4:30pm Eastern*
Register for free at www.integration.samhsa.gov/about-us/webinars

If you have ever started a diet and didn't stick with it, then you know how difficult it can be for good intentions for wellness to become habit. This is not only common for individuals, but also for organizations trying to implement wellness programming. It is not enough to simply offer a wellness program or group; you need to actively promote wellness throughout your agency.

Organizations can apply the stages of change model for wellness – to organizational life and to the interventions you choose for individual participants. Join this webinar to explore how to apply the stages of change model to implementing wellness, learn how one organization made changes to focus on wellness, discuss organizational and practice initiatives for each stage of change and get strategies for funding wellness initiatives.

Presenters: Joan Kenerson King, Senior Integration Consultant, The National Council for Behavioral Health; Paula Beaulieu, Project Director, Stanley Street Treatment and Resources.

Remote yet Resourceful: Integrating Behavioral Health in Rural Primary Care

Date and Time: *Thursday, February 26, 2015, 2:00-3:30pm Eastern*
Register for free at www.integration.samhsa.gov/about-us/webinars

Workforce shortages. Transportation barriers. Remote access. Rural primary care providers face unique challenges in meeting the behavioral health needs of their communities. However, rural primary care providers integrating behavioral health services also have opportunities to address these barriers through the community collaboration and partnership models integration brings. Join this webinar, from the SAMHSA-HRSA Center for Integrated Health Solutions, to get an overview of integration models used in rural settings, planning best practices, financing considerations, and implementation strategies for primary care and behavioral health providers to collaborate and better meet the behavioral health needs of their communities. Learn how one rural primary care provider successfully collaborated with a behavioral health organization and the local Medicaid plan to improve the health status of the community, including reducing depression and substance abuse.

Presenters: Donald Simila, Upper Great Lakes Family Health Center; and John Gale, Maine Rural Health Research Center, Muskie School of Public Service, University of Southern Maine

Closed Captioning Available Upon Request.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

No, we're not advertising the next season of House of Cards (and we really hope you don't aspire to be Frank Underwood).

But, if you are an executive aspiring to build stronger teams, develop new leadership skills and maximize your effectiveness, the National Council wants you to apply for the 2015 Executive Leadership Program.

This program is a unique offering designed for a diverse group of CEOs, COOs, CFOs, medical directors and other C-suite executives working in the mental health and addiction treatment fields.

A 10-month program that kicks off in March 2015, this program will give you the opportunity to:

- **Interact with national thought leaders and peers** on transformational leadership, business strategies, best practices and quality improvement.
- **Learn how to best work with your direct reports and your leadership team** through individualized coaching, which will lead to increased understanding, productivity and boost morale.
- **Develop an individualized "leadership stretch project,"** and with the assistance of faculty, implement this project throughout the program year.

If you are ready to become a more confident and inspired leader, hop off your rowing machine, put down the Freddy's BBQ and submit your application today for the 2015 Executive Leadership Program by **February 16**.

To learn more about the National Council Executive Leadership Program, visit our website or contact Kirsten Reed, Senior Policy Associate at KirstenR@TheNationalCouncil.org.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
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National Behavioral Health Network
For Tobacco & Cancer Control

Jointly-funded by the Centers for Disease Control and Prevention's Office on Smoking & Health and Division of Cancer Prevention and Control, the National Council for Behavioral Health established the National Behavioral Health Network's Tobacco & Cancer Control Community of Practice to support organizations that provide direct services in enhancing their tobacco and cancer control practices for people with mental illness and addictions.

We are pleased to announce the 10 organizations that the National Council selected to participate in its new community of practice:

- American Samoa Community Cancer Coalition, American Samoa
- Arapahoe/Douglas Mental Health Network, Colorado
- CODAC, Inc. (dba CODAC Behavioral Healthcare), Arizona
- Coleman Professional Services, Ohio
- CommuniCare, Inc., Connecticut
- Credo Community Center, New York
- Mirror, Inc., Kansas
- Northern Lakes Community Mental Health, Michigan
- Pittsburgh Mercy Health System, Pennsylvania
- Way Station, Inc., Maryland

Want to learn more about how your own organization can help individuals quit smoking or the importance of cancer control and prevention among individuals with mental illness and addictions? Visit BHtheChange.org, the National Behavioral Network for Tobacco and Cancer Control's new website containing the resources you need to eliminate cancer and tobacco disparities for the people you care for and join the Network today. "Network Insiders" gain free access to tobacco and cancer control and prevention toolkits, workforce development and trainings, information and more—with new content added regularly.

Learn more at BHtheChange.org and follow #BHtheChange on Twitter to get the latest news.

The National Behavioral Health Network for Tobacco and Cancer Control, operated by the National Council for Behavioral Health in partnership with the Smoking Cessation Leadership Center, Behavioral Health and Wellness Program and Centerstone Research Institute, is one of the eight CDC National Networks addressing cancer and tobacco use disparities among CDC's priority populations.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
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Stronger Together.

Michael Botticelli Unanimously Confirmed as New Director of National Drug Control Policy

A Statement by National Council CEO Linda Rosenberg

Last night, the U.S. Senate unanimously confirmed Michael Botticelli as the Director of the Office of National Drug Policy (ONDCP) in a 92-0 vote. Director Botticelli brings more than two decades of experience and leadership in supporting people struggling with addiction, their families and their communities.

Dominating American headlines, the recent spike in opioid and heroin addictions and deaths makes the tasks of prevention, treatment and intervention critical in communities in every corner of our country. The National Council strongly supported Botticelli's confirmation. His vision and passion prepared him for the principal task of successfully implementing the National Drug Control Strategy.

Director Botticelli had dedicated his life and career to combating addictions and ensuring access to treatment for those in need. As Director of the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health, he expanded the range of innovative and nationally recognized prevention, intervention, treatment and recovery services. The range of innovative programs he helped create include expanded treatment systems for adolescents, early intervention and treatment programs in primary healthcare settings, jail diversion programs, re-entry services for those leaving correctional facilities and overdose prevention programs.

Director Botticelli has long asserted the notion that people *can and do recover from addictions*, going on to lead successful lives. We congratulate him on his confirmation, applaud him for his commitment and look forward to continuing to work with him in his role leading our nation's efforts to reduce the impact of drugs and drug addictions.

Follow the **National Council** on

Weekly Inspiration