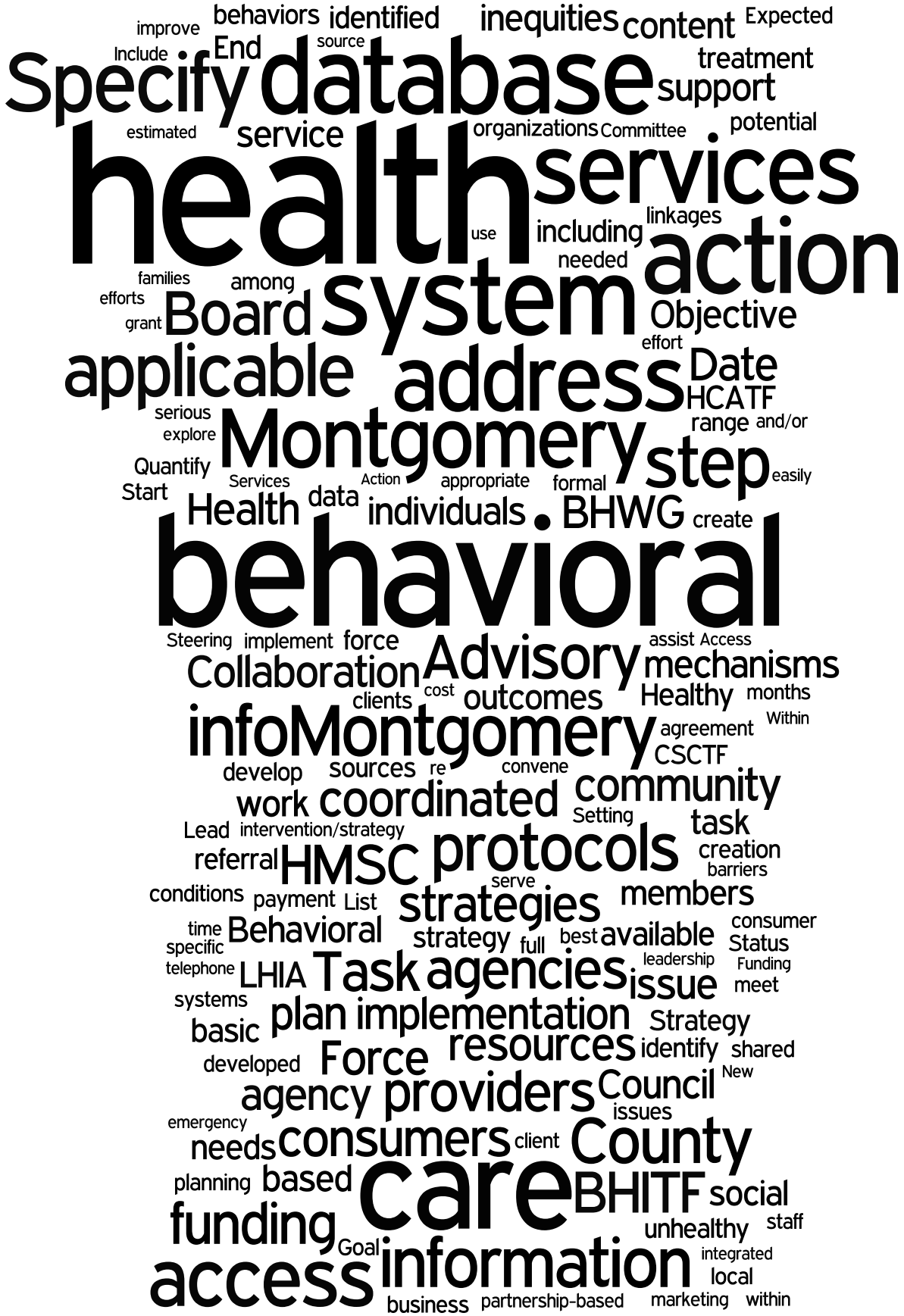
D R A F T

September 5, 2013

Healthy Montgomery
Behavioral Health Action Plan Report

Table of Contents


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

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Each hospital by name with HMSC/WG reps in parens

Key DHHS staff invested substantial efforts in developing the contents of this report under the direction of Dourakine Rosarion, Manager of the DHHS Healthy Montgomery Team:

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Healthy Montgomery Interns (list alpha (with contributions in parens))

Executive Summary

Executive Summary

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

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

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

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

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

Actionable Strategies

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

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

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

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

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

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

Implementing the Behavioral Health Action Plan

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

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

Section 1: Introduction

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

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

Healthy Montgomery History
Prior to the launch of Healthy Montgomery in 2008, the most recent Montgomery County Department of Health and Human Services (DHHS) community needs assessment was completed in 2001. Since then, DHHS and its diverse community partners have recognized the need to conduct timely, comprehensive, data-based health needs assessments across sectors, using data that identify health and human services needs in the various communities and populations in the County. This type of data-based needs assessment identifies disparities in health status among the County's communities and populations, identifies unmet needs, develops and implements strategies across all sectors to meet the needs, and evaluates the effectiveness of the strategies.

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

All the brain-storming work groups identified the "need for a mechanism to coordinate the efforts of public and private organizations to identify and address health and health-related issues in the County."[2] Additional areas for improvement included:

- Community-wide use of community health assessment or community health profile data;
- Establishment of a community health improvement committee;
- Review of community partnerships and strategic alliances;
- Review of public health policies;

[1] Visit http://www.healthymontgomery.org/index.php?module=htmlpages&func=display&pid=5000 for a list of the current Healthy Montgomery Steering Committee members.
[2] Local Public Health System Performance Assessment: Report of Results, Local Public Health System Assessment Retreat, June 10, 2008. Accessed at http://www.healthymontgomery.org/javascript/htmleditor/uploads/Montgomery_County_LPHSA_Combined_Report_FIN_5_14_2009.pdf on September 5, 2013.

- Establishment of a community health improvement process;
- Implementation of strategies to address community health objectives; and
- Use of the Local Public Health System Assessment evaluation to guide community health improvement activities.
- Healthy Montgomery was designed to respond to these needs.

The Healthy Montgomery Steering Committee

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

Affiliations on HMSC include:

- The four hospital systems in the county
- The three DHHS minority health initiatives
- Health insurance
- Behavioral health
- Persons with disabilities
- Schools
- The aging community
- Veterans
- Academia
- County government
- Recreation
- Parks and Planning
- Homeless Services
- Public Health
- Social Services for Children and Adults
- DHHS Advisory Committees

The HMSC identified its overarching mission, goals and objectives to carry out its community health improvement work.[3]

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

[3] Visit http://www.healthymontgomery.org/javascript/htmleditor/uploads/HM_Overview_Dec_13_2010.pdf for the an overview of Healthy Montgomery: The Montgomery County Community Health Improvement Process.

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

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

The Healthy Montgomery objectives are to:

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

Process

The Healthy Montgomery community health improvement process is based on four phases[4]

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

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

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

Phase 4: Monitoring and evaluation, preplanning for next iteration of the process.

All four phases of work are supported by the data systems and related infrastructure. The Healthy Montgomery process relies on techniques that are sustainable and adaptable to the

[4] www.healthymontgomery.org

growing and changing needs of the community over time. Healthy Montgomery builds efficiencies into its multi-disciplinary approach by aligning partners to eliminate redundancies and maximize returns on investment.

The Healthy Montgomery Timeline

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

* Project was interrupted due to staffing issues (Retirement, long term leave, restructuring contractual support)

Environmental Scan

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

Needs Assessment

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

Priority Setting Process

[5] 2010 Environmental Scan Updated Nov2010:URL to be provided.
[6] Healthy Montgomery 2011 Needs Assessment. Available at: http://www.healthymontgomery.org/index.php?module=InitiativeCenters&func=display&icid=7. Accessed on September 5, 2013.

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

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

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

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

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

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

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

The Work Groups continued to meet regularly until February of 2013. Each Work Group analyzed existing data bases to create indicator tables focusing on each of their issue areas, created an inventory of resources, reviewed the status of activities, policies, etc., including

[7] http://www.healthymontgomery.org/index.php?module=InitiativeCenters&func=display&icid=2
[8] Healthy Montgomery Priority Setting Tool. Available at: http://www.healthymontgomery.org/javas.cript/htmleditor/uploads/HM_PSP_tool_FINAL.pdf. Accessed on September 5, 2013.
[9] Healthy Montgomery Priority Setting Tool: Summary of Results. Available at: http://www.healthymontgomery.org/javascript/htmleditor/uploads/HM_OnlinePSP_tool_Group_Results__October_23_2011.pdf. Accessed on: September 5, 2013.

identifying gaps in resources, data and in coordination of activities. By February, each Work group was writing their respective Action Plan Reports.

In February, the Work Groups activities were suspended due to staffing issues, most prominently a reassignment of staff to develop a bi-county screening, outreach and enrollment program (Connector Entity) to health insurance for individuals and families through Maryland's Health Insurance Exchange (Maryland Health Connection) under the Affordable Care Act.

Staff work on the Reports began again in June 2013 with meetings with the Behavioral Health and Obesity Work Group Co-Chairs. Drafts are being updated for presentation to the Work Groups beginning in August 2013 (Behavioral Health) and September (Obesity Prevention).

Reports are scheduled to be finalized in early to mid fall of 2013

Section 2: Data Summary

Summary Table of Healthy Montgomery Behavioral Health Indicators

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

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

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

INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
Schizophrenia and Other Psychotic Disorders Discharge Rate per 10,000 population (20+ years) (MHSCRC, 2009)	11.9								
Schizophrenia and Other Psychotic Disorders Readmission Rate per 10,000 population (20+ years) (MHSCRC, 2009)	1								
Children (Ages 10-19 Years)									
Mental Disorders Discharge Rate Per 10,000 population (MHSCRC, 2009)	34.1								
Mental Disorder Readmission Rate Per 10,000 population (MHSCRC, 2009)	1.6								
Mood Disorders Discharge Rate Per 10,000 population (MHSCRC, 2009)	24.3								
Bipolar Disorders Discharge Rate Per 10,000 population (MHSCRC, 2009)	14.3								
Depressive Disorders Discharge Rate per 10,000 population (MHSCRC, 2009)	10								
Schizophrenia and Other Psychotic Disorders Discharge Rate per 10,000 population (MHSCRC, 2009)	3.2								
Hospital Discharges Rate due Substance-Related Disorders (10-19) per 10,000 population ((MHSCRC, 2009)	1.2								
Attention Deficit, Conduct, and Disruptive Behavior Disorders Rate for Ages (10-14 years) per 10, 000 population (MHSCRC, 2009)	1								
Montgomery County Maryland Medicaid Recipients Who Received Outpatients, Inpatients, and/or Professional Services									
ADHD and ADD (MDHMH, 2011)	1.5%	3%	BETTER						
Episodic Mood Disorders (MDHMH, 2011)	3.5%	6.0%	BETTER						

INDICATORS (SOURCE/YEAR)	COUNTY BASELINE	MARYLAND BASELINE	COUNTY COMPARED TO MARYLAND	MARYLAND SHIP 2014 TARGET	COUNTY COMPARED TO MARYLAND SHIP TARGET	UNITED STATES	COUNTY COMPARED TO UNITED STATES	HEALTHY PEOPLE 2020	COUNTY COMPARED TO HEALTHY PEOPLE 2020
Depression (MDHMH, 2011)	1.7%	3.1%	BETTER						
Substance Abuse (MDHMH, 2011)	0.7%	2.4%	BETTER						
Tobacco Abuse (MDHMH, 2011)	0.1%	0.2%	BETTER						

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

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

Healthy Montgomery Needs Assessment

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

2012 Behaviroal Health Data Profile Update

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

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

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

Mental Health and Mental Disorders

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

Substance Abuse

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

2012 Behavioral Health Data Profile Findings

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

Hospital Utilization Trends in Montgomery County, 2000-2009

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

Mood Disorders

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

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

Bipolar Disorders

- The rate of hospital discharges for adolescents, ages 10-19, with a **principal diagnosis of bipolar disorders** per 10,000 County residents **increased** from 6.9 discharges per 10,000 County residents in 2000 to 14.3 discharges per 10,000 County residents in 2009.
- The rate of hospital discharges with a principal **diagnosis of bipolar disorders** for adults, ages 20 and older, per 10,000 County residents **increased** from 9.7 discharges per 10,000 population in 2000 to 13.6 discharges per10,000 population in 2009.
- The rate of hospital discharges with a **principal diagnosis of bipolar disorders for adults, ages 20 and older, who were readmitted within 31 days** of a previous hospital inpatient service, per 10,000 County residents **rose over two-**fold from 0.5 to 1.2 admissions per 10,000 residents during the period 2000-2009.

Depressive Disorders

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

and/or an increase in the availability of non-hospital treatment modalities for adolescent depression[1].

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

Psychotic Disorders

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

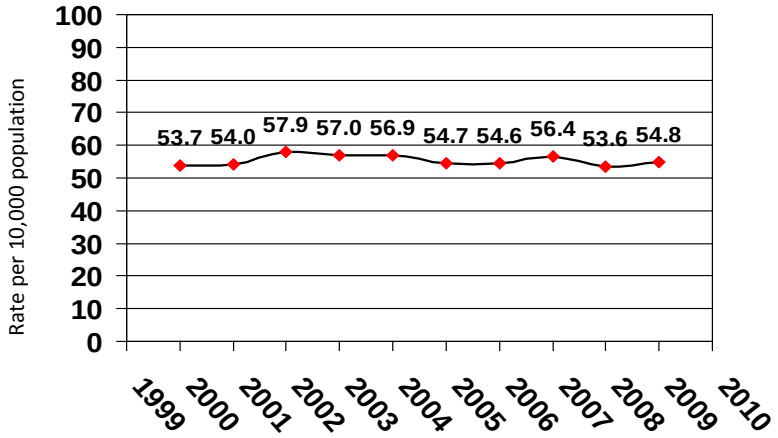
Alcohol-Related

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

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

Behavioral Health Chartbook

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



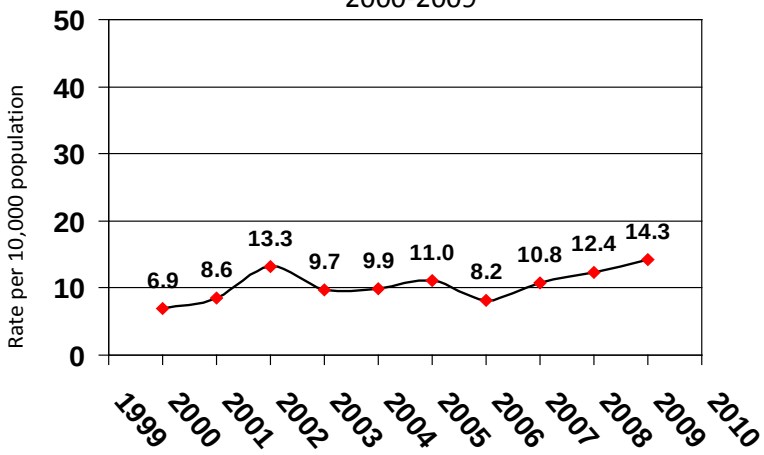
Mental Disorders Hospital Discharges: Young Adults (10-19)

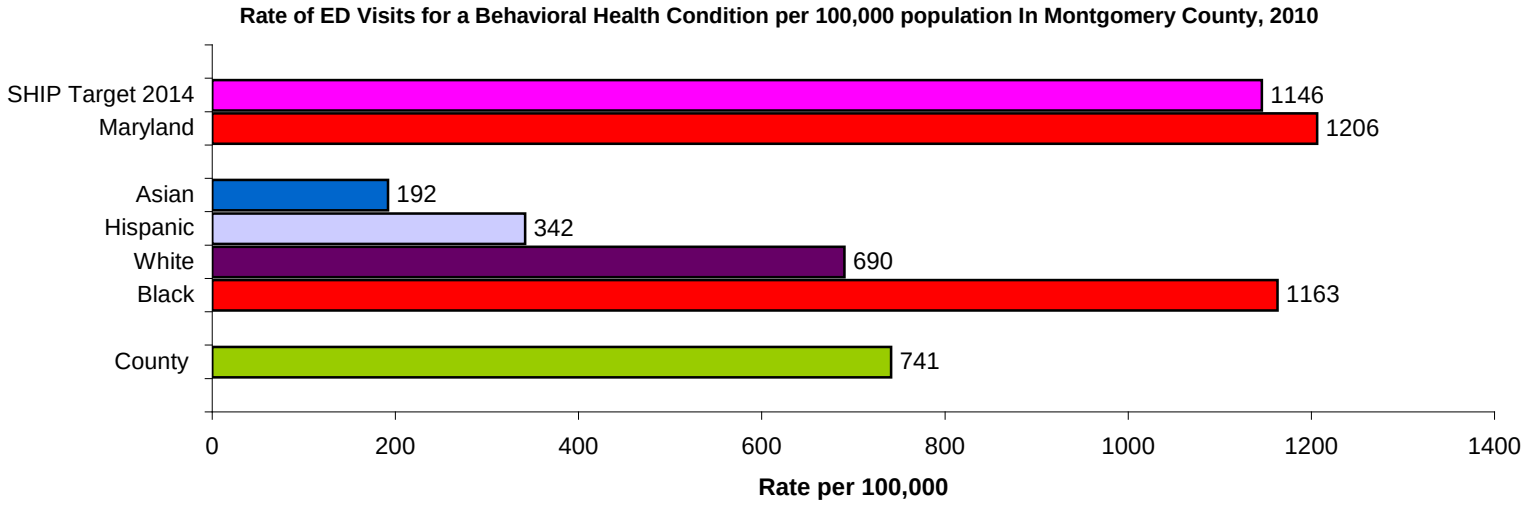
Trends: In Montgomery County, the rate of hospital discharges with a principal diagnosis of any mental disorder for adolescents 1019 years has doubled from 6.9 in 2000 to 14.3 per 10,000 County residents in 2009.

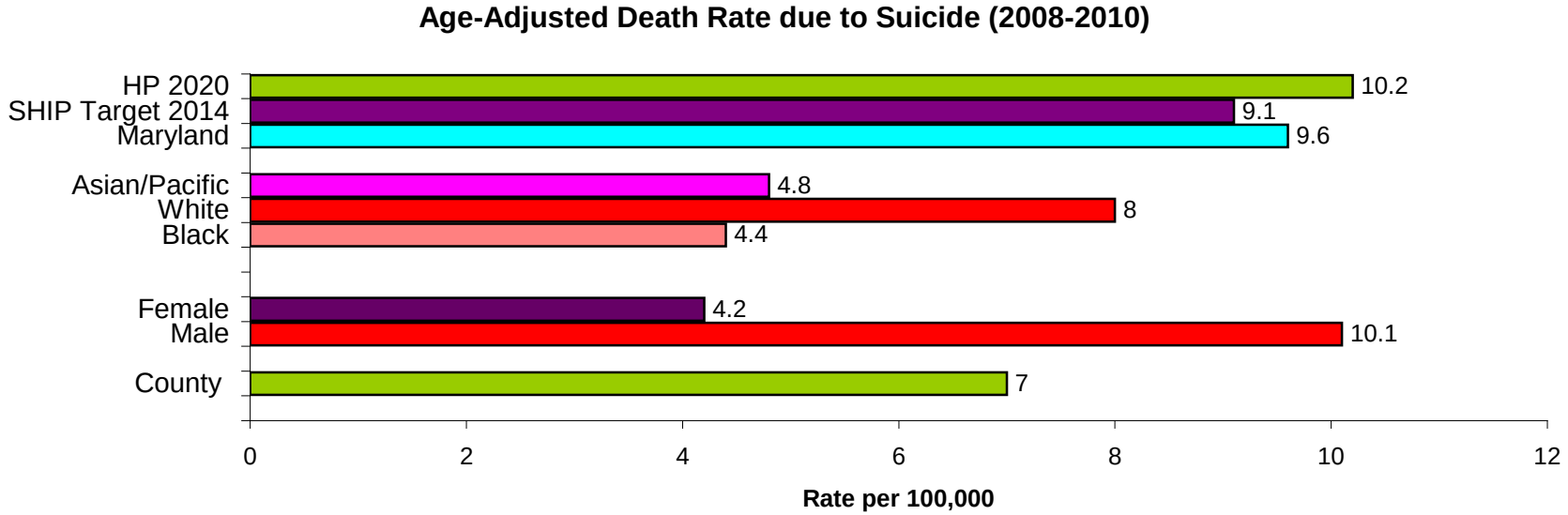
Mental Disorders Hospital Discharges: Adults (20+ years)

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

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




Rate of ED Visits for a Behavioral Health Condition per 100,000 population In Montgomery County, 2010
SHIP Target 2014
Maryland
Asian
Hispanic
White
Black
County
1146
1206
192
342
690
1163
741
0
200
400
600
800
1000
1200
1400
Rate per 100,000


Age-Adjusted Death Rate due to Suicide (2008-2010)
HP 2020
SHIP Target 2014
Maryland
Asian/Pacific
White
Black
Female
Male
County
10.2
9.1
9.6
4.8
8
4.4
4.2
10.1
7
0
2
4
6
8
10
12
Rate per 100,000

Data Sources

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

References

[1] Healthy Montgomery 2011 Needs Assessment, Healthy Montgomery. Accessed on the Healthy Montgomery website on April 5, 2013 at: http://www.healthymontgomery.org/index.php?module=InitiativeCenters&func=display&icid=7.

Section 3: Putting the Behavioral Health Action Plan in Context

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

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

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

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

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

The HMSC offered the following additional guidance:

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

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

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

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

[1] Healthy Montgomery Steering Committee Meeting, March 5, 2012. Online electronic handout packet, page 4. Accessed on April 5, 2013 at http://www.healthymontgomery.org/javascript/htmleditor/uploads/March_5_2012_HANDOUTS.pdf

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

Community Resources Related to Behavioral Health in Montgomery County

As part of an environmental scan conducted by the BHWG, an inventory tool (see Appendices) was utilized to document programs, services, and initiatives within Montgomery County. The tool was used to create a summary table of the individual-level and environmental and policy-based level interventions and best practices currently within Montgomery County. Included in the table are details on certain practices, networks, and partnerships that have made meaningful gains in the behavioral health system which informed the development of the Healthy Montgomery Behavioral Health Action Plan. Best practices or model programs of behavioral health services for which the County has been recognized are also highlighted.

Drawing from the literature on community health assessment and improvement processes as well as previously published community health improvement action plans, the inventory tool was designed to serve as a primary repository of both individual-based and environmental-based interventions within Montgomery County that have had a meaningful impact within the behavioral health system. Environmental-based interventions were any existing or proposed policies, regulations, or laws that create an environment where positive impacts can be made in behavioral health. (The inventory tool is included among the Appendices and is entitled "Inventory of Community-Based Interventions at the Individual Level, Systems Level, or Environmental Level.")

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

The foundational strategic planning-related documents that were closely reviewed by the BHWG include:

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

- Health Management Associates. *Accountable Care in the Safety Net* (Terry Conway, MD, Managing Principal & Pat Terrell, Managing Principal) Prepared for the Blue Shield of California Foundation, November 2010. (http://www.healthymontgomery.org/javascript/htmleditor/uploads/FINAL_Accountable_Care_in_the_Safety_Net.pdf)
- Montgomery County Public Schools, *Mental Health Task Force Report*, May 10, 2005 (http://www.healthymontgomery.org/javascript/htmleditor/uploads/mentalhealth_report_2005_MCPS1.pdf)
- *Developing a System of Care: Findings and Recommendations on the Public Mental Health System*, Blue Ribbon Task Force on Mental Health (Appointed by the Montgomery County Council), April 2002. (http://www.healthymontgomery.org/javascript/htmleditor/uploads/blue_ribbon_task_force_on_mh_2002.pdf)
- *Public Mental Health Services for Children and Adolescents in Montgomery County*, League of Women Voters of Montgomery County, Inc., Fact Sheet, April 2010. (http://www.lwvmd.org/mont/FS2010-04MentalHealth.pdf)
- *Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Health Care Approach: Consensus Statements and Recommendations*, Hogg Foundation for Mental Health, June 2012. (http://hogg.utexas.edu/uploads/documents/FinalReport%20-ConsensusStatementsRecommendations.pdf)
- *A Strategic Plan for Public Mental Health Services*, Montgomery County Department of Health and Human Services, July 2002. (http://www6.montgomerycountymd.gov/content/hhs/reports/Mental%20HealthSP_%20Aug02.pdf)
- *Progress on Building Brighter Futures*, 2009 Annual Report, Montgomery County Collaboration Council for Children, Youth and Families, Inc. http://collaborationcouncil.org/publications/annualreport09.pdf)

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

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

Federal and State Level Environment

Health Care Reform (Affordable Care Act)
Federal and state changes required by the Affordable Care Act (ACA) include increased access to health insurance as well as mandates that insurance cover behavioral health issues. These changes are scheduled to take effect January, 2014 and are predicted to reduce the number of uninsured in the County by 50% and begin to increase access to behavioral health. Additionally, the ACA includes measures that require integration of services and quality measures related to behavioral health. Despite increased access there will still be a population of uninsurable in Montgomery County as well as a predicted population that will 'churn' in and out of coverage or different types of coverage. This will lead to new issues for the health

and behavioral health care systems in terms of providing continuity of care for this population. Another likely issue will be the capacity of the current behavioral health care system and its ability to provide care to a much larger consumer population in a short period of time.

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

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

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

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

County Level Environment

Diverse Socio-Economic Climate
A county level environmental scan reveals that Montgomery County is the most populous county in Maryland with approximately 1,004,709 residents. Current county demographics show a growing low-income population, many of whom are first-generation immigrants. Currently, 18.3% of County residents are African American or Black; 14.7% are Asian; 17.9% are Hispanic or Latino; 23.5% are children under 18 yrs; 12.5% are 65 years and older; 31.4% are foreign-born; and 38.1% speak a language other than English at home. Over 100,000 residents do not have public or private health insurance (8.6% are children under 18 years); of those residents with health insurance coverage, 197,348 or 23.3% have public health insurance. Trend data show a widening gap between the affluent and the vulnerable in the county, with 6.3% of the population living below the poverty level.[2]

[2] U.S. Census Bureau: State and County QuickFacts. Accessed on September 3, 2013 at http://quickfacts.census.gov/qfd/states/24/24031.html; Source: U.S. Census Bureau, 2009-2011 American

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

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

Community and DHHS Jail Diversion Pilot (related to longstanding Criminal Justice Behavioral Health workgroup)
DHHS is trying to identify incarcerated individuals pre-trial or for brief sentences who are mentally ill and could benefit from community services.

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

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

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

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

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Community Survey. Accessed on September 3, 2013 at http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_3YR_DP03&prodType=table

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

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

Gaps Identified Through the Action Planning Process

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

Although the County has good resources there continue to be many gaps. These take a variety of forms but include types of service; certain providers including those with special language capabilities; the integration of related services such as mental health addictions treatment and primary care; adequate reimbursement for services to insured consumers; and financing for service to the uninsured.

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

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

The integration of services is also a gap. Only recently have behavioral health and primary care providers initiated partnerships to provide integrated care. People suffering from mental illness often get little primary care. Many report having no primary care provider or not having seen one in a period of years. Also, while discussions about the high frequency of dual diagnosis for mental illness and substance abuse have continued for many years, the level of integration of services remains very limited. This has multiple consequences. Patients do not thrive, with mentally ill adults dying more than 20 years earlier than others. Also, those who drop out of care or who fail to receive regular primary care services often end up in emergency departments and acute care settings that are costly to the system as a whole.

The lack of integration and the absence of financing for coordination of care contribute to a fragmented system for providers and one that is difficult for consumers to access. Not surprisingly, this contributes to

an overall lack of strong data collection that brings together, mental health, substance abuse, primary care, and hospital use. In addition, reimbursement rates from third party insurers are often woefully inadequate, Medicare co-payment requirements at times have exceeded the capacity of individual consumers, and the failure to factor into the public health mental health system no-show rates among a challenged population affect access, coordination, and sustainability.

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

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

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

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

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

- What percentages will be moved from Montgomery County agencies providing care to indigent and Medicaid/Medicare consumers? What percentages will remain within the current community of providers of indigent care but create new reimbursement opportunities/challenges?
- How will the characteristics of the remaining uninsurable change and how will the patterns of the population that "churns" in and out of health insurance coverage be affected?
- The impact of electronic medical record requirements will be substantial. Will the cost of compliance be wholly or partially reimbursable?

The next Section of this Action Plan describes the Local Health Issue Areas (LHIAs) chosen by the BHWG as priority areas of focus within the context of the complexity of the federal, state and local climate described above, the impending changes to the health insurance and behavioral health delivery systems, and the restrictive charge of the Healthy Montgomery Steering Committee to develop strategies that can be accomplished using existing financial and other resources. The LHIAs, by necessity, represent a systems approach that focuses on the needs of those with the most serious behavioral health problems

but which will also result in improved outcomes for other individuals who may have specific needs. Different priority areas may have been chosen if additional funding sources were available to enhance behavioral health in County.

Section 4: Local Health Issue Area Development

Local Health Issue Area Development

Summary

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

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

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

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

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

Recommendations

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

- **LHIA 1.** The need of consumers, families, referral agencies, etc., to have ready access to basic information about treatment protocols, the full range of available services, payment mechanisms, and how to access services;

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

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

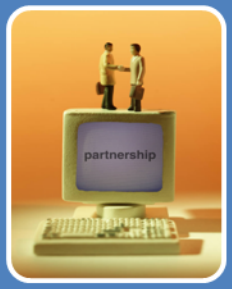
The Healthy Montgomery Behavioral Health Action Planning Work Group has devised the following strategies to:

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

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

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

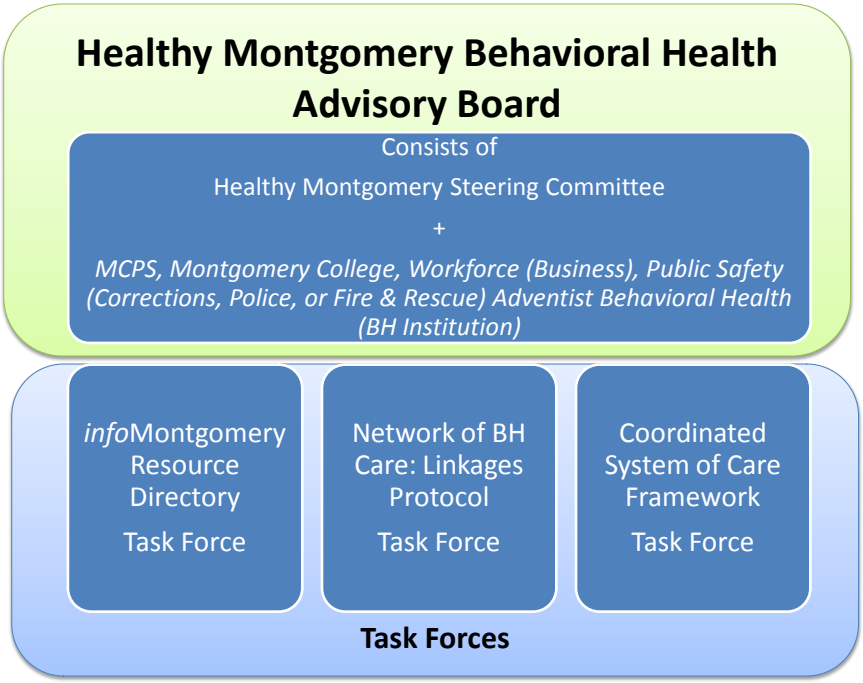
Long-range strategies include establishing adequate mechanisms for providers to communicate among themselves regarding shared clients and establishing client linkages to enable informed client intakes, coordinated care, and adequately supported discharges. The result will be a system that is conducive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



Formulate a framework to establish a Behavioral Health Coordinated System of Care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.

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

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



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

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

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

Strategy	Resources/Assets	Short Term Outcomes	Long Term Outcomes
LHIA 1. Clear, basic behavioral health information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.			
1. *Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services payment mechanisms, and how to access services (on* *info*Montgomery, a collaborative effort of public and private agencies providing information about health, education, and human service resources).	• Extensive availability of public, non-profit and private behavioral health services • *info*Montgomery is operational. • *info*Montgomery Steering Committee is a broadly representative group of government and non-profit organizations • *info*Montgomery is managed by staff at the Montgomery County Collaboration Council for Children, Youth and Families, a member of the HMSC	Healthy Montgomery Behavioral Health *info*Montgomery Task Force is convened under the Collaboration Council auspices, it finalizes policies on scope, content, maintenance and support of the database; identifies resources needed for project. By July, 2014 the Collaboration Council submits funding proposals and then completes content of database. By March 2015 (or within 5 months of completing content) the database is launched.	Medicaid and Medicare eligible populations and the uninsured needing behavioral health services, social service and referral agencies readily utilize the behavioral health database to find and easily enroll in care services appropriate to the individual.
2. *Create hard copy documents about how to access behavioral health resources in Montgomery County as well as a supply and distribution system for the materials for use by consumers, their families, providers and other social service agency or referral source personnel in environments which do not have access to the Internet.*	• STRATEGY #1 must be completed first. The database and the knowledge of end user search options requirements established during the development of the database are the basis for properly designing the document-based system. • The BHWG did not have resources to research best practices and models for a telephone-based system, including maintaining the accuracy of the information in conjunction with the *info*Montgomery database.	**Barriers and challenges:** Leadership, funding and/or appropriate action steps cannot yet be fully developed. (See Resources/Assets)	This is a long-term strategy which must follow the creation of the *info*Montgomery behavioral health database.

Strategy	Resources/Assets	Short Term Outcomes	Long Term Outcomes
3. *Identify a telephone mechanism through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services payment mechanisms, and how to access service for use by consumers, their families, providers and other social service agency or referral source personnel (in environments which do not have access to the Internet).*	• STRATEGY #1 must be completed first. The database and the knowledge of end user search options are the basis for properly designing the telephone-based system. • The BHWG did not have resources to research best practices and models for a telephone-based system, including maintaining the accuracy of the information in conjunction with the *info*Montgomery database.	**Barriers and challenges:** Leadership, funding and/or appropriate action steps cannot yet be fully developed. (See Resources/Assets)	This is a long-term strategy which must follow the creation of the *info*Montgomery behavioral health database.
LHIA 2. Providers have inadequate mechanisms for communicating among themselves regarding shared consumers and consumer linkages (warm hand-offs), resulting in poorly informed client intakes, uncoordinated care, and inadequately supported discharges			
1. Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.	• This strategy can build on multiple existing efforts by various hospital and community level behavioral health providers collaborating on developing coordinated referrals. • Extensive availability of quality public, non-profit and private behavioral health services.	The protocols are adopted and used by the discharging institutional settings (hospitals, emergency rooms, correctional facilities) and the behavioral health providers initiating community level care for the discharged patients.	All Montgomery County behavioral health care institutions and community providers agree on a common policy for transfer/release of patients to the community and adopt and utilize a common transfer protocol.
2. *Establish adequate mechanisms for providers communicating among themselves regarding shared consumers and consumer linkages to enable informed client intakes, coordinated care, and adequately supported discharges; establish a system that is conducive*	• Completed strategy #1 as this (Strategy 2) will build on the protocols and automated system linkages for transferring clients from institutional settings to community behavioral health organizations. • This strategy needs further thought in aligning it with the next LHIA (LHIA 3 - Explore the creation of a coordinated system of care)	**Barriers and challenges:** •. Insufficient membership of somatic care providers •. Further thought needed on this strategy's alignment with the next issue area (LHIA 3.) •. The BHWG did not have resources to research best practices/models to	TBD

Strategy	Resources/Assets	Short Term Outcomes	Long Term Outcomes
to navigating between providers effectively, further contributing to coordinated care and preventing clients being lost to follow-up.	• A Task Force with former BHWG members and other experts can work on the further development of this strategy.	address a major component (shared electronic interface providing specific consumer information in real time).	
LHIA 3. Establish a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions.			
1. *Establish a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.*	• The national movement toward formal integrated systems, including coordinated systems of care; • The Affordable Care Act requires the integration of behavioral health services into the insured health care system. • Multiple existing local collaborative efforts among behavioral healthcare providers and hospital/somatic care providers in Montgomery County collaborating on integrating care. • Extensive availability of quality public, non-profit and private behavioral health services.	Grant applications are developed by either the HMSC(Advisory Board) or the Coordinated System of Care Task Force to secure funding to implement the Action Plan. The funding application includes funding for a leadership consultant.	Sufficient providers in all categories of care (somatic, mental health, substance abuse) and settings (hospital, emergency departments, somatic, behavioral health and corrections clinics) participate in a partnership based coordinated system of care or similarly organized entity to meet the needs of the target population.

Local Health Issue Area Development

Background and Detail

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

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

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

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

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

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

BEHAVIORAL HEALTH ACTION PLANS

LHIA 1. Clear, basic behavioral health information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.

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

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

Objective I.: By December 1, 2013, the Healthy Montgomery Steering Committee (Advisory Board) with the Behavioral Health and Crisis Services Access (Montgomery County Department of Health and Human Services) and the Montgomery County Collaboration Council for Children, Youth and Families (Collaboration Council) will convene a Behavioral Health Information Task Force (BHITF)of behavioral health and social services providers and consumers to advise the Collaboration Council staff on the development of more detailed search functions in the *info*Montgomery behavioral health database.

Objective II.: By May 31, 2014, the BHITF, working with Collaboration Council staff, will finalize and approve the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database, taking into consideration changes in Maryland Medical Assistance financing of services planned for the fall of 2013.

Objective III.: By July, 2014, the BHITF and Collaboration Council will identify the resources needed for programming, data collection and input, identify potential funding sources to revise *info*Montgomery, and submit a proposal for funding.

Objective IV.: Within 6 months of securing funding, identified staff will complete collection and programming the content of the database and the query functions.

Objective V.: Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery will launch the behavioral health database.

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

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

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

Strategy #1: *Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.* **GOAL:** infoMontgomery will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is persons who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.	**OBJECTIVE I**: By December 1, 2013, the HM Steering Committee (Advisory Board), Behavioral Health and Crisis Services Access and the Collaboration Council convene a Behavioral Health Information Task Force (BHITF). **OBJECTIVE II**: By May 31, 2014, the *BHITF* and Collaboration Council staff finalize the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database. **OBJECTIVE III:** By July 2014, the *BHITF* and Collaboration Council identify the resources needed and potential funding sources. **OBJECTIVE IV:** Within 6 months of securing funding,, social work interns at HHS BHCS Access and NAMI complete collection of the content of the database. Programming begins followed by testing **OBJECTIVE V:** Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery launch the behavioral health database. **OBJECTIVE VI**: Within 3 months of the launch of the database, the BHITF finishes training health and social services professional users on how to use the system.

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
1. Confirm that the Collaboration Council, Behavioral Health and Crisis Services Access (BHCS Access) and the National Alliance on Mental Illness (NAMI) are willing to lead this effort, including supporting the *BHITF*.	**Status:** New **Setting:** N/A **Start Date – End Date** Dec 1, 2013	**Lead agency:** HMSC(Advisory Board) **List other agencies and what they plan to do:** N/A **Include how you're marketing the intervention/strategy:** N/A	• **Specify how you will address access to care issue through this action step, if applicable:** N/A • **Specify how you will address inequities through this action step, if applicable:** N/A • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Quantify what you will do:** • **Expected outcomes:** Written Memorandum of Understanding among the three agencies.
2. Identify and contact individuals from behavioral and social services organizations and consumers to participate in the *BHITF* and convene.	**Status:** New **Setting:** TBD **Start Date – End Date** 12/2013- 01-2014	**Lead agency:** Collaboration Council/BHCS Access **List other agencies and what they plan to do:** HMSC(Advisory Board) assists with gaining commitments to populate the Task Force.	• **Specify how you will address access to care issue through this action step, if applicable:** N/A • **Specify how you will address inequities through this action step, if applicable:** N/A • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Quantify what you will do:** Contact 15-20 individuals to invite them to participate in the Task Force. • Expected outcomes: Task Force of approximately 10 individuals from diverse backgrounds and organizations.

Strategy #1: *Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.* **GOAL:** infoMontgomery will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is persons who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.	**OBJECTIVE I**: By December 1, 2013, the HM Steering Committee (Advisory Board), Behavioral Health and Crisis Services Access and the Collaboration Council convene a Behavioral Health Information Task Force (BHITF). **OBJECTIVE II**: By May 31, 2014, the *BHITF* and Collaboration Council staff finalize the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database. **OBJECTIVE III:** By July 2014, the *BHITF* and Collaboration Council identify the resources needed and potential funding sources. **OBJECTIVE IV:** Within 6 months of securing funding,, social work interns at HHS BHCS Access and NAMI complete collection of the content of the database. Programming begins followed by testing **OBJECTIVE V:** Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery launch the behavioral health database. **OBJECTIVE VI**: Within 3 months of the launch of the database, the BHITF finishes training health and social services professional users on how to use the system.

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
		Include how you're marketing the intervention/strategy: N/A		
3. a. Lead agency staff prepares draft policies on the scope of database, content of database and maintenance and support of the database. b. *BHITF* reviews and approves policies (may require several revisions.)	**Status:** New **Setting:** N/A **Start Date – End Date** 03/2014-05/2014	**Lead agency:** Collaboration Council/BHCS Access **List other agencies and what they plan to do:** *BHITF* prepares and reviews policies, provides feedback, and approves final policies. **Include how you're marketing the intervention/strategy:** N/A	• **Specify how you will address access to care issue through this action step, if applicable:** N/A • **Specify how you will address inequities through this action step, if applicable:** N/A • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Quantify what you will do:** N/A • **Expected outcomes:** Documented policies on the scope of the database, content of database, and maintenance and support of the database.
4. a. Determine the resources needed to revise *info*Montgomery.	**Status:** New	**Lead agency:** 4.a: Collaboration Council	• **Specify how you will address access to care issue through this acSpecify**	• **Quantify what you will do:** N/A

Strategy #1: *Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.* **GOAL:** infoMontgomery will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is persons who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.	**OBJECTIVE I**: By December 1, 2013, the HM Steering Committee (Advisory Board), Behavioral Health and Crisis Services Access and the Collaboration Council convene a Behavioral Health Information Task Force (BHITF). **OBJECTIVE II**: By May 31, 2014, the *BHITF* and Collaboration Council staff finalize the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database. **OBJECTIVE III:** By July 2014, the *BHITF* and Collaboration Council identify the resources needed and potential funding sources. **OBJECTIVE IV:** Within 6 months of securing funding,, social work interns at HHS BHCS Access and NAMI complete collection of the content of the database. Programming begins followed by testing **OBJECTIVE V:** Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery launch the behavioral health database. **OBJECTIVE VI**: Within 3 months of the launch of the database, the BHITF finishes training health and social services professional users on how to use the system.

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
b. Identify sources of funding to include the behavioral health database in *info*Montgomery. c. Submit a proposal for funding .	**Setting:** NA **Start Date – End Date** 02/2014-07/2014	4.b: *BHITF* **List other agencies and what they plan to do:** DHHS Grants Office (recommends funding sources) HMSC/(Advisory Board) (recommends funding sources) **Include how you're marketing the intervention/strategy:** N/A	• **Specify how you will address access to care issue through this action step, if applicable: N/A** • **Specify how you will address inequities through this action step, if applicable:** N/A • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Expected outcomes:** 4. a. and b: Budget to modify and maintain *info*Montgomery and possible funding sources. 4. c: Grant proposal. Desired outcome: grant award.

Strategy #1: *Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.* **GOAL:** infoMontgomery will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is persons who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.	**OBJECTIVE I**: By December 1, 2013, the HM Steering Committee (Advisory Board), Behavioral Health and Crisis Services Access and the Collaboration Council convene a Behavioral Health Information Task Force (BHITF). **OBJECTIVE II**: By May 31, 2014, the *BHITF* and Collaboration Council staff finalize the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database. **OBJECTIVE III:** By July 2014, the *BHITF* and Collaboration Council identify the resources needed and potential funding sources. **OBJECTIVE IV:** Within 6 months of securing funding,, social work interns at HHS BHCS Access and NAMI complete collection of the content of the database. Programming begins followed by testing **OBJECTIVE V:** Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery launch the behavioral health database. **OBJECTIVE VI**: Within 3 months of the launch of the database, the BHITF finishes training health and social services professional users on how to use the system.

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
5. a. Identify social work interns from HHS BHCS Access and NAMI to collect information about behavioral health services. b. Conduct an orientation session for interns explaining the type of data needed, and the guidelines for searching viable data from reliable sources to build the content of the database. c. Interns collect data.	**Status:** New **Setting: N/A** **Start Date – End Date** 07/2014-09/2014 (or 3 months after funding secured)	**Lead agency:** HHS BHCS Access and NAMI **List other agencies and what they plan to do:** N/A **Include how you're marketing the intervention/strategy:** N/A	• **Specify how you will address access to care issue through this action step, if applicable: N/A** • **Specify how you will address inequities through this action step, if applicable: N/A** • **Specify how you will address unhealthy behaviors through this action step, if applicable: N/A**	• **Quantify what you will do** 1-3 potential interns to be assigned the collection of data. • **Expected outcomes:** A confirmed number of interns able to collect valid and reliable data for the content of the database.
6. **This and subsequent steps are dependent on receiving funding for the programming.** a. Collaboration Council staff program *info*Montgomery behavioral health database b. *BHITF* members review and	**Status:** New **Setting: N/A** **Start Date – End Date** a. 10/2014-01/2015 (or 6 months after funding secured)	**Lead agency:** Collaboration Council and *BHITF* **List other agencies and what they plan to do:**	• **Specify how you will address access to care issue through this action step, if applicable:** Having this information available and providing the ability to sort through it, based on the individual's needs, will support access.	• **Quantify what you will do** 1-3 potential interns are assigned to the collection of data. • **Expected outcomes:** A confirmed number of interns able to collect valid

Strategy #1: *Create a Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services.* **GOAL:** infoMontgomery will host an easily understandable and accessible centralized Internet database of basic information about behavioral health services available in the County that can be sorted by payor, provider, location, specialty, languages spoken, and target population. The primary target audience is persons who have Medicare and/or Medicaid or are uninsured, but does not exclude other individuals.	**OBJECTIVE I**: By December 1, 2013, the HM Steering Committee (Advisory Board), Behavioral Health and Crisis Services Access and the Collaboration Council convene a Behavioral Health Information Task Force (BHITF). **OBJECTIVE II**: By May 31, 2014, the *BHITF* and Collaboration Council staff finalize the policies on the scope of the database, the content of the database, and the requirements for maintenance and support of the database. **OBJECTIVE III:** By July 2014, the *BHITF* and Collaboration Council identify the resources needed and potential funding sources. **OBJECTIVE IV:** Within 6 months of securing funding,, social work interns at HHS BHCS Access and NAMI complete collection of the content of the database. Programming begins followed by testing **OBJECTIVE V:** Within 5 months of the completion of data collection and input, the Collaboration Council and Healthy Montgomery launch the behavioral health database. **OBJECTIVE VI**: Within 3 months of the launch of the database, the BHITF finishes training health and social services professional users on how to use the system.

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
approve content. C Identified staff inputs data into *info*Montgomery. d. *BHITF* members test the *info*Montgomery behavioral health database with staff and clients in their organizations. *info*Montgomery staff make changes as necessary e. Healthy Montgomery and the Collaboration Council launch the *info*Montgomery behavioral health database.	b. 05/2015 – 06/2015 c and d. 11/2013—1/2014 d. 7/2015 (may vary depending on date funding is acquired. See 6.a, above)	**Include how you're marketing the intervention/strategy:** a. The content of the database will be published on the *info*Montgomery website and a link will be added to the Healthy Montgomery website. b. There will be a public launch of the *info*Montgomery behavioral health database. c. There will be training for staff of health, behavioral health, social service agencies and other organizations/individuals, such as clergy and school counselors, who refer individuals for behavioral health services.	• **Specify how you will address inequities through this action step, if applicable:** Having this information available and providing the ability to sort through it based on the individual's needs will support equitable access • **Specify how you will address unhealthy behaviors through this action step, if applicable**: N/A	and reliable data for the content of the database. Staff identified to input data (from lead agency, task force member agencies or as funded by grant); database and query functions finalized; database launched

Long-Term Action Planning Considerations for Behavioral Health Strategies

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

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

Local Health Issue Area 1: Clear, basic behavioral health information about treatment protocols, the full range of available services, payment mechanisms, and how to access services.

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

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

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

Barriers/challenges to implementation:

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

- There is no known existing resource/entity that can invest the workforce support and financial resources to compile and update the printed materials once the database is operational within *info*Montogmery; no cost estimates on this effort were available to apply to the implementation planning of this strategy.

- Also, the BHWG did not have the resources to research best practices for cataloging and tracking the distribution of the documents and the difficult task of maintaining documents distributed widely in the community.

Next steps recommended by BHWG to HMSC and partners:

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

Long-Term Action Planning Considerations for Behavioral Health Strategies

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

LHIA 1. Clear, basic behavioral health information about treatment protocols, the full range of available services (including payment mechanisms), and how to access services.

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

Recommended Approach to Strategy: The BHITF will create a telephone-based system described in Goal #3.

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

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

Barriers/challenges to implementation

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

- The BHWG did not have resources to research best practices and models for a telephone-based system, including maintaining the accuracy of the information in conjunction with the *info*Montgomery database.

Next steps recommended by the BHWG:

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

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

LHIA 2. Providers have inadequate mechanisms for communicating among themselves regarding shared clients and client linkages (warm hand-offs).

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

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

Objective I: By December, 2013, the Healthy Montgomery Steering Committee (Advisory Board) will convene a Hospital/Community Agency Task Force (HCATF) which includes the Montgomery County hospitals, others providing institutional services, and community agencies that serve as sources of referral for hospital behavioral health consumers.

Objective II: By July 2014, the HCATF will define specific protocols that will improve the transfer of patients from a hospital's ED, inpatient services, outpatient Behavioral Health and Crisis Services, Department of Corrections, and school-based counselors to appropriate community resources.

Objective III: By March, 2015, participating hospitals, others providing institutional services and community agencies that serve as sources of referral for hospital behavioral health consumers will officially adopt and implement the developed protocols.

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

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

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

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

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

Strategy #1: *Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.* **GOAL #1**: Consumers with behavioral health diagnoses who receive services at a local emergency department (ED), Department of Correction, Crisis Services or who receive inpatient behavioral health services will be successfully linked to appropriate behavioral health services, thereby reducing repeat ED visits or hospitalizations that occur when patients do not successfully transfer to appropriate care.	**Objective I**: The HMSC(Advisory Board) will convene a Hospital/Community Agency Task Force (HCATF) by December, 2013.. **Objective II:** By July 2014 the HCATF will define specific protocols that will improve the transfer of patients from hospital EDs, Crisis Services and other inpatient services to appropriate community resources. **Objective III:** By March 2015, 90% of all hospital and community agencies that serve as sources of referral for hospital behavioral health consumers will officially adopt and implement the developed protocols. **Objective IV:** Within 18 months of the adoption of the protocols, the protocols will be disseminated to community providers and social service agencies to serve as a model for communication and linkages within the entire behavioral health system.

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

Specify anticipated Sources of Funding: To be determined.

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
1a. HMSC(Advisory Board)will convene the Hospital/Community Agency Task Force (HCATF) leadership to identify potential members and hold an initial meeting by February 2014.	**Status:** New **Start Date – End Date** 12/2013-2/2014	**Lead agency:** Suburban Hospital **List other agencies and what they plan to do:** Adventist Hospital Family Services, Inc. HMSC(Advisory Board) All will assist in identifying and enrolling members.	• **Specify how you will address access to care issue through this action step, if applicable:** End result will improve access for clients. • **Specify how you will address inequities through this action step, if applicable:** Standard protocols lessen potential for inequities based on a client's demographic information and/or where they receive care. • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Quantify what you will do:** Number of meetings and attendance at workgroup meetings. • **Expected outcomes:** Approved protocols.

Strategy #1: *Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.* **GOAL #1**: Consumers with behavioral health diagnoses who receive services at a local emergency department (ED), Department of Correction, Crisis Services or who receive inpatient behavioral health services will be successfully linked to appropriate behavioral health services, thereby reducing repeat ED visits or hospitalizations that occur when patients do not successfully transfer to appropriate care.	**Objective I**: The HMSC(Advisory Board) will convene a Hospital/Community Agency Task Force (HCATF) by December, 2013.. **Objective II:** By July 2014 the HCATF will define specific protocols that will improve the transfer of patients from hospital EDs, Crisis Services and other inpatient services to appropriate community resources. **Objective III:** By March 2015, 90% of all hospital and community agencies that serve as sources of referral for hospital behavioral health consumers will officially adopt and implement the developed protocols. **Objective IV:** Within 18 months of the adoption of the protocols, the protocols will be disseminated to community providers and social service agencies to serve as a model for communication and linkages within the entire behavioral health system.

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

Specify anticipated Sources of Funding: To be determined.

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
2. a. HCATF will identify all the specific agencies in the County that would use the protocols and the specific areas/types of protocols that are needed. b. Assign members task of developing specific protocols in their area of expertise. c. HCATF will review and approve all protocols.	**Status:** New **Setting:** N/A **Start Date – End Date** 3/2014 - 7/2014	**Lead agency**: Hospital Community Agency Task Force (HCATF) **List other agencies and what they plan to do**: HCATF Subcommittee will develop protocols. **Include how you're marketing the intervention/strategy:** N/A	• **Specify how you will address access to care issue through this action step, if applicable:** End result will improve access for clients. • **Specify how you will address inequities through this action step, if applicable:** Standard protocols lessen potential for inequities based on a client's demographic information and/or where they receive care. • **Specify how you will address unhealthy behaviors through this action step, if applicable**: N/A	• **Quantify what you will do:** Subcommittees created; members assigned • **Expected outcomes:** X number of protocols

Strategy #1: *Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (hospitals, emergency rooms, correctional facilities) to community behavioral health organizations.* **GOAL #1**: Consumers with behavioral health diagnoses who receive services at a local emergency department (ED), Department of Correction, Crisis Services or who receive inpatient behavioral health services will be successfully linked to appropriate behavioral health services, thereby reducing repeat ED visits or hospitalizations that occur when patients do not successfully transfer to appropriate care.	**Objective I**: The HMSC(Advisory Board) will convene a Hospital/Community Agency Task Force (HCATF) by December, 2013.. **Objective II:** By July 2014 the HCATF will define specific protocols that will improve the transfer of patients from hospital EDs, Crisis Services and other inpatient services to appropriate community resources. **Objective III:** By March 2015, 90% of all hospital and community agencies that serve as sources of referral for hospital behavioral health consumers will officially adopt and implement the developed protocols. **Objective IV:** Within 18 months of the adoption of the protocols, the protocols will be disseminated to community providers and social service agencies to serve as a model for communication and linkages within the entire behavioral health system.

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

Specify anticipated Sources of Funding: To be determined.

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
3. a. Hospital/Community Agency Task Force (HCATF) will identify and recruit additional workgroup members that can assist with implementation and training. b. HCATF will officially ask and invite leadership of every identified agency to adopt the protocols. c. Identified agencies will adopt and incorporate the protocols into their internal protocols. d. HCATF will develop training materials to assist with implementation and offer this training and materials to agencies. e. Protocols will be implemented by front line providers in theagencies and disseminated widely to serve as a model	**Status:** New **Setting:** N/A **Start Date – End Date** 8/2014 - 3/2015	**Lead agency:** HCATF **List other agencies and what they plan to do:** N/A	• **Specify how you will address access to care issue through this action step, if applicable:** End result will improve access for clients. • **Specify how you will address inequities through this action step, if applicable:** Standard protocols lessen potential for inequities based on a client's demographic information and/or where they receive care. • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Quantify what you will do:** The number of agencies that implement the protocols. • The number of people/agencies trained in protocols. **Expected outcomes:** The rate of repeat ED visits and hospitalizations within 30 days of referral will measurably decline for successfully linked Medicaid/Medicare consumers and uninsured.

LHIA 2. Providers have inadequate mechanisms for communicating among themselves regarding shared consumers and consumer linkages (warm hand-offs).

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

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

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

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

Barriers/challenges to implementation:

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

Recommended Approach to the Long-Term Strategy:

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

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

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

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

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

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

Objective I: By January 2015, the HMSC(Advisory Board)/ will create a Coordinated System of Care Task Force (CSCTF) to explore the creation of a coordinated system of care in the County to increase cost-effectiveness and improve client outcomes.

Objective II: By October 2015, the CSCTF will commission a white paper on viable partnership-based business agreements to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County.

Objective III: By October 2016, the CSCTF will research, identify, and apply for grant funding to aid in the infrastructure and support systems necessary to support the proposed partnership based business agreement.

Strategy #1: Establish Coordinated System of Care Task Force (CSCTF) to formulate framework to establish a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.	**OBJECTIVE I:** By January 2015, the HMSC(Advisory Board establishes a Coordinated System of Care Task Force (CSCTF) to increase cost-effectiveness and improve client outcomes.
GOAL #1: Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.	**OBJECTIVE II:** By October, 2015 the CSCTF will commission a white paper on viable partnership-based business agreements to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County. **OBJECTVIE III**: By October 2016, the CSCTF will research, identify and apply for grant funding to aid in the infrastructure and support systems necessary to support the proposed partnership based business agreement.

FUNDING STATUS: *Funding required.*

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

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
1.HMSC/(Advisory Board) recruits and establishes a Coordinated System of Care Task Force (CSCTF) that will inform, formulate and implement the strategic plan to establish a collaborative behavioral health coordinated system of care; CSCTF members will represent major providers of somatic, mental health, and substance abuse services in the County (including emergency departments, hospitals, safety net clinics, and corrections clinics).	**Status:** new **Setting:** not applicable **Start Date – End Date** 1/2015	**Lead agency:** Healthy Montgomery Steering Committee(Advisory Board) **List other agencies and what they plan to do:** HMSC(Advisory Board) assists in gaining commitments to populate the task force **Include how you're marketing the intervention/strategy:**	• **Specify how you will address access to care issue through this action step, if applicable:** End result will improve access for clients. • **Specify how you will address inequities through this action step, if applicable:** An integrated system will lessen potential for inequities based on a client's demographic information and/or where they receive care. • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	• **Quantify what you will do** Recruit and convene CSCTF. • **Expected outcomes:** Seat a composition of members to inform consultant on strategic plan for a behavioral health collaborative that follows a coordinated system of care framework.
2. CSCTF through its work with a consultant, commissions white paper	**Status:** new **Setting:** not applicable	**Lad agency:** CSCTF	• **Specify how you will address access to care issue through this action step, if**	• **Quantify what you will do** Draft White Paper that outlines

Strategy #1: Establish Coordinated System of Care Task Force (CSCTF) to formulate framework to establish a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.	**OBJECTIVE I:** By January 2015, the HMSC(Advisory Board establishes a Coordinated System of Care Task Force (CSCTF) to increase cost-effectiveness and improve client outcomes. **OBJECTIVE II:** By October, 2015 the CSCTF will commission a white paper on viable partnership-based business agreements to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County. **OBJECTVIE III**: By October 2016, the CSCTF will research, identify and apply for grant funding to aid in the infrastructure and support systems necessary to support the proposed partnership based business agreement.
GOAL #1: Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.	

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
to develop a strategic plan to establish a feasible coordinated system of care agreement that links County emergency departments, hospitals, safety net clinics, and corrections clinics in a collaborative network through both technology (emergency medical records), best practices (such as health homes), and systems-wide cost containment measures.	**Start Date – End Date** 1/ 2015- 10/2015	**List other agencies and what they plan to do:** HMSC(Advisory Board) Providers/Stakeholders, Consultant **Include how you're marketing the intervention/strategy:** N/A	**applicable:** N/A • **Specify how you will address inequities through this action step, if applicable:** N/A. • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	strategic plan to implement a coordinated system of care in Montgomery County • **Expected outcomes:** Montgomery County will have framework to seek grant funding to actualize a coordinated system of care.
3. CSCTF leverages findings from white paper's strategic plan framework to develop grant applications to secure funding for implementing the strategic plan through leadership from national consultant who will actualize plan.	**Status:** new **Setting:** N/A **Start Date – End Date** 10/2015-10/2016	**Lead agency:** CSCTF **List other agencies and what they plan to do:** HMSC/(Advisory Board), Providers/Stakeholders, consultant assist with identifying grant sources, developing grant application **Include how you're marketing the intervention/strategy:** N/A	• **Specify how you will address access to care issue through this action step, if applicable:** End result will improve access for clients. • **Specify how you will address inequities through this action step, if applicable:** An integrated system will lessen potential for	• **Quantify what you will do** Apply for grant funding to implement strategic plan. • **Expected outcomes:** Grant funding to implement plan; national consultant to lead implementation effort.

Strategy #1: Establish Coordinated System of Care Task Force (CSCTF) to formulate framework to establish a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.	**OBJECTIVE I:** By January 2015, the HMSC(Advisory Board establishes a Coordinated System of Care Task Force (CSCTF) to increase cost-effectiveness and improve client outcomes. **OBJECTIVE II:** By October, 2015 the CSCTF will commission a white paper on viable partnership-based business agreements to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County. **OBJECTVIE III:** By October 2016, the CSCTF will research, identify and apply for grant funding to aid in the infrastructure and support systems necessary to support the proposed partnership based business agreement.
GOAL #1: Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.	

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

ACTION STEPS	SETTING & TIMEFRAME	COMMUNITY PARTNERS' Roles and Responsibilities	ADDRESSING ACCESS TO CARE, HEALTH INEQUITIES AND UNHEALTHY BEHAVIORS	PLAN HOW YOU WILL EVALUATE EFFECTIVENESS
			inequities based on a client's demographic information and/or where he or she receives care. • **Specify how you will address unhealthy behaviors through this action step, if applicable:** N/A	

Section 5: Evaluation Planning Using Logic Models

Healthy Montgomery Behavioral Health Action Plan
Logic Model for Local Health Issue Area 1

Behavioral health information about treatment protocols, range of available services, payment mechanisms, and how to access services is not easily accessible by clients, providers social service or referral personnel.

GOAL: *info*Montgomery will host a centralized Internet database of basic information about available behavioral health services in Montgomery County, sorted by payor, provider, location, specialty, languages spoken, and target population, especially for those with Medicaid coverage, Medicare coverage, and the uninsured (no coverage).

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

Logic Model	Description	Possible Evaluation Measures
Target Population *Who will directly benefit?*	Medicare, Medicaid and uninsured patients and their families and support system Referral agencies and the providers who currently or could potentially serve them	Number of residents uninsured, with Medicare, with Medicaid Number of providers that accept referrals to deliver behavioral health (BH)-related services to Montgomery County residents
Inputs *Resources, workforce, costs?*	HMSC (Advisory Board)	Meeting schedule, attendance and minutes
	Creation of a group with authority and resources to create and maintain an interactive BH informational database available and easily useable by the target populations	Budget, annual cost, cost per resident Charter of HMSC (Advisory Board); with formal formation of task force in charter
	Existing *info*Montgomery database and technical staff to complete revisions	Letter of support from Collaboration Council Director with commitment of *info*Montgomery database, technical staff, and anticipated costs for revisions to HMSC
	Task Force members with technical knowledge to support activities	Letter of support from Task Force co-chairs which lists list members interested in providing the necessary technical support to project to HMSC
Activities *What we do- quantified terms. (What will produce measureable results)*	Prepare and adopt MOU among the Collaboration Council, MCDHHS BHCS and NAMI to lead the effort	Signed MOU between Collaboration Council, MCDHHS BHCS, and NAMI
	Create and support the HMSC (Advisory Board); HMSC establishes task force to lead implementation of expanded *info*Montgomery database development	Charter of HMSC; with formal formation of Task Force in charter
	Task Force implements scope of services from MOU	Quarterly progress reports from task force to HMSC
Outputs *Direct products of activities. (How will strategy be counted? What portfolio of services will produce desired change?)*	Updated *info*Montgomery publicly accessible centralized Internet-based database of basic information about available behavioral health services in Montgomery County, sorted by payor, provider, location, specialty, languages spoken, and target population; Contents of platform will be reviewed and updated to ensure content is on a schedule established by the Task Force and the host agency, the Collaboration Council.	Revised data dictionary of portal's data elements that includes: payor, provider, location, specialty, languages spoken, and target population Percent of listed attributes added and maintained within *info*Montgomery Stats on use of added elements in search functions Dissemination materials that convey new elements to target audiences
Short Term Outcomes *Initial changes in condition, attitude, knowledge beliefs, skills. (Who or what would change and how? Accountable for what outcomes?)*	By Dec. 1,2013 HM BH*info*Montgomery Task Force is convened under the Collaboration Council auspices, with authority to identify detailed search functions in *info*Montgomery	Membership for Task Force, charter/charge of Task Force
	By May 31, 2014 Task Force finalizes policies on scope, content, maintenance and support of the db; identifies resources needed for project; by July, 2014 resources needed and potential funding source is identified	Agenda, minutes, materials from meetings held, policies on scope, content, maintenance and support of the database; Budget reflecting cost of construction and ongoing maintenance; funding proposal
	Wwithin 6 mos of securing funding content of database is completed	Budget with sources and amounts identified and scheduled for payment; contracts/MOUs with funding amounts and payment schedule
	Within 5 mos of completing content the database is launched	Dissemination materials promoting launch date Usage statistics on new features upon activation
Intermediate Term Outcomes *Resulting behavior change. (Who or what would change and how? Accountable for what outcomes?)*	Publicly insured, uninsured people, their advocates, providers and referral agencies become aware of the database and the availability/quality of care available to diverse populations	Website utilization patterns of residents by coverage group to detect improvement over time for Montgomery County residents Designed, administered, and analyzed pre- and post-implementation survey to partnering providers that captures pre/post use of *info*Montgomery; and assessment of HM BH care delivery system's integration defined parameter (TBD) to convey effectiveness, timeliness and monitor over time, **(Needs to be included in Action Plan**).
	Care will extend to higher percentages of those in need	
	Also, the behavioral health care services community will acquire elements of a system, which will foster additional linkages, coordination and collaboration (i.e., the field will move toward becoming an integrated system.)	
Long Term Outcomes *Changes in policies, programs and practices. (What's possible, who cares? Accountable for what outcomes?)*	Medicaid, Medicare eligible populations and the uninsured needing behavioral health services, readily utilize the behavioral health *info*Montgomery database to find and easily enroll in care services appropriate to the individual.	Enrollment patterns for most needed/utilized services and percent improvement
Anticipated Impacts *Longer term indicators of impact. "If we got it right, in 10 yrs…"*	Usage and feedback data shows that all residents and BH providers have the information they need to easily access care at an early stage and/or immediately upon release from receiving acute care services. ER visits for BH conditions decrease significantly for target population.	ER and inpatient utilization rates for preventable BH conditions that directly benefit from successful referrals (TBD by Task Force experts) Reduction in self reports of days of poor mental health in BRFSS and other surveillance system reports

Healthy Montgomery Behavioral Health Action Plan
Logic Model for Local Health Issue Area 2:

Providers have inadequate mechanisms for communicating among themselves regarding shared consumers and consumer linkages (warm hand-offs), resulting in poorly informed client intakes, uncoordinated care, and inadequately supported discharges

GOAL: Patients who receive services at a local emergency department (ED), Department of Correction, Crisis Center or who receive inpatient behavioral health services will be successfully linked to appropriate behavioral health services, thereby reducing repeat ED visits or hospitalizations that occur when patients do not successfully transfer to appropriate care.

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

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

Healthy Montgomery Behavioral Health Action Plan
Logic Model for Local Health Issue Area 3:

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

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

STRATEGY: Establish task force to formulate framework to establish a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions living in Montgomery County.

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

Section 6: Appendices

Appendix I:
Behavioral Health Glossary of Terms

Healthy Montgomery Behavioral Health Work Group Glossary[1]

Access to Care: The ability to obtain wanted or needed services in a timely manner. An individual's ability to access care is influenced by:

- The availability of services (providers, facilities, etc.);
- The availability of appointments;
- The cultural competency of providers, including language capabilities and cultural understanding;
- The ability to pay for services, either through health insurance or out-of-pocket; and
- The individual's understanding of how to access care.

Action Step: The specific action(s) that will be taken to achieve each stated objective and strategy.

Age-adjustment: Age-adjustment is a method of adjustment applied to data estimates to control for differences due only to differences in age composition; usually done when comparing two or more populations (such as race/ethnic groups) at one point in time or one population at two or more points in time.

Behavioral Health: For purposes of Healthy Montgomery, behavioral health refers to mental health, abuse of illegal and legal substances, and tobacco use.

Benchmark: Originally, benchmark meant the real best performance level, somewhat like "best of breed" in dog shows. Usage has evolved to mean a standard or reference to which an outcome is compared. Examples include Healthy People 2010 goals, the state of Maryland, or peer counties.

Community: For the purposes of this process, community is defined as not only the collective community of county residents, but also the various constituent communities defined by geography, language, race, ethnicity, gender, age, sexual orientation, health status, disability status, or a combination of these attributes.

Contributing Factor: A scientifically established factor that directly affects the level of a risk factor.

Data Sources:

- Primary data: Data that are collected by Healthy Montgomery or a contractor directly from the source, such as data from health records and data collected from interviews with individuals.

[1] This is a living document. Send recommendations for additions, revisions, and deletions to Healthy.Montgomery@montgomerycountymd.gov

- Secondary data: Data that are collected, compiled, and/or analyzed by other organizations, such as the Centers for Disease Control and Prevention. The majority of data sources available for the first cycle of Healthy Montgomery are secondary sources but a compilation of primary data collection needs will also be produced to inform future cycles of Healthy Montgomery.

Determinants of Health: "Factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature."

- Biology and genetics (e.g., sex and age)
- Individual behavior (e.g., alcohol use, injection drug use (needles), unprotected sex, and smoking)
- Social environment (e.g., discrimination, income, and gender)
- Physical environment (e.g., where a person lives and crowding conditions)
- Health services (e.g., access to quality health care and having or not having health insurance)

(*CDC and Healthy People*)

Dimensions: Divisions of the data into sub-groups. For example, age, race/ethnicity, or geographic area.

Environmental Scan: Review of data sources and past needs assessments in Montgomery County.

Health: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. (*WHO*)

Health Equity: Absence of systematic disparities in health (or in the major social determinants of health) between groups with different social advantages/disadvantages (e.g. wealth, power, prestige).

Health Inequities: Differences in the health status, morbidity, and mortality rates that are systematic, avoidable, unfair, and unjust whereby certain segments of the population fare better or worse than others. These differences do not occur randomly as they are caused by systems of power and privilege, policies and the implementation of those policies.

Indicator: A measurement that reflects the status of a social, economic, or environmental system. For purposes of the Healthy Montgomery Website Community Dashboard, an indicator must be valid, reliable, relevant, specific, and sensitive. It must also have a reference group, such as the Maryland Statewide average or the performance of all other Maryland counties.

Indirect Contributing Factor: Community-specific factor that directly affects the level of the direct contributing factors.

Mental Health: is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." It is estimated that only about 17% of U.S adults are considered to be in a state of optimal mental health. There is emerging evidence that positive mental health is associated with improved health outcomes.[2]

Objective: A specific, measurable change in health status or behavior; objectives add specificity to goals by stating "**who, what, when,** and **where**," and by stipulating "**how many, by how much,** and **how often**." They typically begin with active verbs such as "**increase, decrease, reduce, create,** and **establish**."

- **Impact Objective:** a goal for the level to which a direct determinant or risk factor is expected to be reduced. An impact objective is intermediate (one to five years) in length of time and measurable. These are statements about how much and when the program should affect the determinant.

- **Outcome Objective:** a goal for the level to which a health problem should be reduced within a specific time period. It is long-term (within five years) and measurable. These are statements about how much and when the program should affect the health problem.

- **SMART Objective Characteristics:**
  Specific - What will change and for whom?
  Measurable – Is it quantifiable and can we measure it?
  Attainable/**A**ttainable – Can we accomplish this in the time-frame with the resources we have?
  Relevant - Is it directly related to the underlying causes or problem we are trying to change?
  Time-Specific - Have we defined when this will be accomplished?

Risk Factors: Direct causes and determinants which, based on scientific evidence or theory, are thought to relate directly to the level of a specific health problem. A health problem may have any number of risk factors associated with it. *(CDC)*

Social Determinants of Health: Complex social and economic circumstances, in which people are born, grow up, live, and work. These circumstances are shaped by a wider set of forces including economics, social policies, and politics. Examples of social determinants of health include socioeconomic status, discrimination, housing, physical environment, food security, child development, culture, social support, healthcare services, transportation, working conditions, and democratic participation. (*CDC and others*)

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[2] World Health Organization. Strengthening Mental Health Promotion. Geneva, World Health Organization (Fact sheet no. 220), 2001; U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Accessed from CDC website: (http://www.cdc.gov/mentalhealth/basics.htm) on August 3, 2012.

Strategy: The method, approach, or process that will achieve the stated goal(s) and objective(s). It describes how you will go about accomplishing your action plan and specifically answers the question, "**How can we get from where we currently are to where we want to be?**"

Substance Abuse: is defined by Merriam-Webster as "excessive use of a drug (as alcohol, narcotics, or cocaine): use of a drug without medical justification."[3] Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems.[4]

Tobacco Use: is defined by the National Institutes for Health as "any habitual use of the tobacco plant leaf and its products. The predominant use of tobacco is by smoke inhalation of cigarettes, pipes, and cigars. Smokeless tobacco refers to a variety of tobacco products that are either sniffed, sucked, or chewed.[5]

Unhealthy Behavior– A patterned behavior regarded as detrimental to one's physical or mental health.

[3] Accessed online (http://www.merriam-webster.com/dictionary/substance%20abuse) on August 3, 2012.
[4] Healthy People 2020: Substance Abuse | Overview. Accessed online from website: (http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=40) on August 3, 2012.
[5] National Institutes for Health, National Center for Biotechnology Information. Chapter 40. Tobacco Use. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Walker HK, Hall WD, Hurst JW, editors. Accessed online from website: (http://www.ncbi.nlm.nih.gov/books/NBK362/) on August 3, 2012.

Appendix II:
Inventory of Community-Based Interventions at the Individual Level, Systems Level, or Environmental Level

Inventory of Community-Based Interventions at the Individual Level, Systems Level, or Environmental Level

Individual Level Intervention

List any individual level interventions are already addressing behavioral health issues in Montgomery County. Broadly defined, individual strategies are short-term actions focused on changing individual behavior)

Title of Activity/Program	Brief Description	Main Contact	Target Population					Does this specifically target health disparities?	Progress to Date	Member Providing the Information
		(Include Name, Title, Phone Number, and Email)	Age		Race/Ethnicity		Sex (M/F/Both)	Y/N		
			(X)	*(Choose All that Apply)*	*(X)*	*(Choose All that Apply)*				
Ex. Critical Time Intervention	*Intervention program designed to prevent recurrent homelessness and other adverse outcomes among persons with severe mental illness. The intervention, which lasts roughly 9 months, involves: (1) strengthening the individual's long-term ties to services, family, and friends; and (2) providing emotional and practical support during the transition. Postdischarge services are delivered by workers who have established relationships with patients during their institutional stay.*	*Sarah Conover, M.S.* *Critical Time Intervention* *(212) 543-6244* *saconover@hotmail.com*		*Infants*	*X*	*White, Caucasian*	*Both*	*Y*	*More than 92 counselors in 22 outpatient substance abuse treatment programs have been trained on the use of the CASPAR software suite to assess and arrange treatment services, and a total of 351 clients have been assigned to CASPAR-trained counselors.*	IPHi
				Children	*X*	*Black, African American*				
				Adolescents	*X*	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	*X*	*American Indian or Alaska Native*				
			X	*Adults*	*X*	*Asian, Native Hawaiian or Other Pacific Islander*				
			X	*Older Adults*		*Other:*				
	(X) *Implementation Site/Setting:*			*Seniors*						
				Other:						
	School-Based									
	X *Community-Based*									
	Business-Based									
HHS Access to BH "transitonal psychiatrty or safety net" med service	HHS provides brief psychotherapy and psychiatric medication eval and supervision for patients in danger of relapsing due to gap between hospital or jail serivces and OP services.	Access to BH 240.777.1770		*Infants*	*X*	*White, Caucasian*	Both	Y		Gene Morris
				Children	*X*	*Black, African American*				
				Adolescents	*X*	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	*X*	*American Indian or Alaska Native*				
			X	*Adults*	*X*	*Asian, Native Hawaiian or Other Pacific Islander*				
			X	*Older Adults*		*Other:*				
	(X) *Implementation Site/Setting:*		*X*	*Seniors*						
				Other:						
	School-Based									
	X *Community-Based*									
	Business-Based									
Crisis Intervention Unit (CIU)	Provides for mental health evaluation and treatment for detainees at the Montgomery County Correctional Facility.	Anthony Sturgess, MSN, CRNP, Health Services Administrator (240) 773-9830 Anthony.sturgess@montgomerycountymd.gov		*Infants*	*X*	*White, Caucasian*	Both	Y	Mental health staff receive and respond to over 2,200 mental health referrals per year. Therapist provide initial and ongoing treatment for those housed in the 40 bed male unit and 15 bed female unit.	Anthony Sturgess
				Children	*X*	*Black, African American*				
				Adolescents	*X*	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	*X*	*American Indian or Alaska Native*				
			X	*Adults*	*X*	*Asian, Native Hawaiian or Other Pacific Islander*				
			X	*Older Adults*		*Other:*				
	(X) *Implementation Site/Setting:*		*X*	*Seniors*						
				Other:						
	School-Based									
	X *Community-Based*									
	X *Business-Based*									
Jail Addiction Services (JAS)	Substance abuse treatment services for individuals incarcerated at the Montgomery County Correctional Facility, Boyds, Maryland. JAS in partnership with the Department of Corrections and Rehabilitation offers Addiction Treatment and Education. Participants reside in therapeutic housing units separate from the general population in MCCF. Treatment involves an eight (8a ten (10) week education phase and an ongoing aftercare phase. Therapeutic activities include community meetings, task, education and therapy groups, peer counseling, self-help meetings and cognitive	Larry Wilson (240) 773-9732 Larry.wilson@montgomerycountymd.gov		*Infants*	*X*	*White, Caucasian*	Both	Y	Program started in 1990. The program is designed to: • Encourage and increase the offender's willingness to participate in addictions treatment while in jail and in the community; • Provide assessment of drug/alcohol use and criminal thinking;	Anthony Sturgess
				Children	*X*	*Black, African American*				
				Adolescents	*X*	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	*X*	*American Indian or Alaska Native*				
			X	*Adults*	*X*	*Asian, Native Hawaiian or Other Pacific Islander*				

Inventory of Community-Based Interventions at the Individual Level, Systems Level, or Environmental Level

Individual Level Intervention

List any individual level interventions are already addressing behavioral health issues in Montgomery County. Broadly defined, individual strategies are short-term actions focused on changing individual behavior)

Title of Activity/Program	Brief Description	Main Contact	Target Population					Does this specifically target health disparities?	Progress to Date	Member Providing the Information
		(Include Name, Title, Phone Number, and Email)	Age		Race/Ethnicity		Sex (M/F/Both)	Y/N		
			(X)	(Choose All that Apply)	(X)	(Choose All that Apply)				
	groups, peer counseling, self-help meetings and cognitive behavior skill-building.		X	Older Adults		Other:			criminal thinking. • Increase access to community based addiction treatment services to offenders released from MCCF; • Reduce the recidivism rate of program participants;.	
	(X) Implementation Site/Setting:		X	Seniors						
	School-Based			Other:						
	X Community-Based									
	X Business-Based									
Clinical Assessment and Transitional Services (CATS)	Provides mental health and substance abuse screening and evaluation for individuals detained at the Montgomery County Detention Center, Rockville, Maryland	Athena Morrow (240) 777-9847 Athena.morrow@montgomerycountymd.gov		Infants	X	White, Caucasian	Both	Y	Program began in 2001 as the Clinical Asesment and Triage Services (CATS). Serves more than 2,200 clients per year. Provided reentry services in FY12 to 391 clients. In FY12 30% of the clients evaluated were recommended for diversion.	Anthony Sturgess
				Children	X	Black, African American				
				Adolescents	X	Hispanic, Latino, Spanish				
			X	Young Adults	X	American Indian or Alaska Native				
			X	Adults	X	Asian, Native Hawaiian or Other Pacific Islander				
			X	Older Adults		Other:				
	(X) Implementation Site/Setting:		X	Seniors						
	School-Based			Other:						
	X Community-Based									
	X Business-Based									
ReEntry's Collabortive Case Management Team (DOCR)	Provides case management services for individuals incarcerated at the Montgomery County Correctional Facility and/or Detention Center with mental illness/substance abuse problems who are sentenced and being released back into the community.	Gale Starkey (240) 773-9769 Gale.starkey@montgomerycountymd.gov		Infants	X	White, Caucasian	Both	Y	To date has served close to 1,800 clients (since February 2006).	Anthony Sturgess
				Children	X	Black, African American				
				Adolescents	X	Hispanic, Latino, Spanish				
			X	Young Adults	X	American Indian or Alaska Native				
			X	Adults	X	Asian, Native Hawaiian or Other Pacific Islander				
			X	Older Adults		Other:				
	(X) Implementation Site/Setting:		X	Seniors						
	School-Based			Other:						
	X Community-Based									
	X Business-Based									

Inventory of Community-Based Interventions at the Individual Level, Systems Level, or Environmental Level

Policy or Environmental Level Change

List any policy or environmental level changes that are already addressing behavioral health issues in Montgomery County. Environmental strategies involve longer-term, potentially permanent changes that have a broader reach (e.g., policies and laws that affect all members of society).

Title of Activity/Program	Brief Description	Main Contact	Target Population					Does this specifically target health disparities?	Progress to Date	Member Providing the Information
		(Include Name, Title, Phone Number, and Email)	Age		Race/Ethnicity		Sex (M/F/Both)	Y/N		
			(X)	*(Choose All that Apply)*	*(X)*	*(Choose All that Apply)*				
Health Care Reform	Federal state changes likely to take effect 1/204 should reduce by 50% the number of uninsured in County and begin to improve BH tx quality by integrating services and including quality measures.		X	*Infants*	X	*White, Caucasian*	Both	Y		Gene Morris
			X	*Children*	X	*Black, African American*				
			X	*Adolescents*	X	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	X	*American Indian or Alaska Native*				
			X	*Adults*	X	*Asian, Native Hawaiian or Other Pacific Islander*				
			X	*Older Adults*		*Other:*				
	(X) *Implementation Site/Setting:*		X	*Seniors*						
	X *School-Based*		X	*Other:* The Uninsured						
	X *Community-Based*									
	X *Business-Based*									
Hospital "Diversion "and Discharge Efforts and conversations	Varioius community hospital, OP provider and HHS efforts to provide more appropriate BH services at key points of ER visits and discharge from inpatient psych services.			*Infants*	X	*White, Caucasian*	Both	Y		Gene Morris
				Children	X	*Black, African American*				
				Adolescents	X	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	X	*American Indian or Alaska Native*				
			X	*Adults*	X	*Asian, Native Hawaiian or Other Pacific Islander*				
				Older Adults		*Other:*				
	(X) *Implementation Site/Setting:*			*Seniors*						
	School-Based		X	*Other:* High users of						
	X *Community-Based*			hospital, urgent, and						
	X *Business-Based*			emergency services.						
Community and HHS Jail diversion pilot (related to longstanding Criminal Justice Behavioral Health workgroup)	HHS is trying to identify individuals who are incarcerated pre-trial or for brief sentences who are mentally ill and could benefit from community services.	Arthur Wallenstein (Director DOCR) and Athena Morris, CATS 240.777.9847		*Infants*	X	*White, Caucasian*	Both	Y		Gene Morris
				Children	X	*Black, African American*				
				Adolescents	X	*Hispanic, Latino, Spanish*				
			X	*Young Adults*	X	*American Indian or Alaska Native*				
			X	*Adults*	X	*Asian, Native Hawaiian or Other Pacific Islander*				
			X	*Older Adults*		*Other:*				
	(X) *Implementation Site/Setting:*		X	*Seniors*						
	School-Based			*Other:*						
	X *Community-Based*									
	Business-Based									


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