FY2022

Community Behavioral Health Plan

Mid Shore Planning Collaborative (MSPC)

CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

DORCHESTER
water moves us
DORCHESTER COUNTY MARYLAND

THE COUNTY OF KENT
IN THE PROVINCE OF MARYLAND

MID SHORE
BEHAVIORAL HEALTH

QUEEN ANNE'S COUNTY
1706

TALBOT COUNTY HEALTH DEPARTMENT

ACKNOWLEDGEMENTS

The FY2022 mid-shore Community Behavioral Health Plan represents the work of many individuals and their commitment to the Mid Shore Planning Collaborative (MSPC). MSPC engaged with partners, persons in recovery, family members, natural supports, providers, and community leaders to develop the plan for FY2022. During the past year, MSPC has focused its work on the behavioral health integration process at a local level, responding to our community and providers with support throughout the COVID-19 pandemic, strengthening partnerships with stakeholders, and nurturing wellness of the community. MSPC prides itself on the inclusion, leadership, and commitment of our partners in supporting the work that is done on behalf of our mid-shore community.

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

MSPC is grateful to all who contributed to the development of the mid-shore FY22 Community Behavioral Health Plan and is enthusiastic about continued collaboration as we proceed with our goals and future endeavors in its implementation.

ACRONYMS

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

ACRONYMS FY2022

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

ACRONYMS FY2022

CLINICAL SERVICES GUIDE

Level 0.5 – Early Intervention

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

Level 1 – Outpatient Treatment

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

Level 2.1 and 2.5 – Intensive Outpatient Treatment and Partial Hospitalization

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

Level 3.1 – Clinically Managed Low-Intensity Residential Services

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

Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services

(Long Term Residential Care) – A structured environment with 24-hour care in combination with residential services and group treatment to support and promote recovery.

Level 3.5 – Clinically Managed High-Intensity Residential Services (Adults)

(Therapeutic Community) – A structured environment with 24-hour care in combination with a full active milieu to support and promote recovery and prepare for outpatient treatment.

Level 3.7 – Medically Monitored Intensive Inpatient Services (Adults)

(Intensive Inpatient/Residential) – A medically monitored intensive inpatient treatment program with 24-hour nursing care, 16-hour counseling and physician availability. Patients entering Level 3.7-WM require medication and have a recent history of withdrawal.

A. INTRODUCTION

The FY2022 Community Behavioral Health Plan (CBHP) is representative of the collaborative and integrated work of the six local authorities responsible for managing Maryland's Public Behavioral Health System (PBHS) for the mid-shore counties of Maryland: Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. The FY2022 Community Behavioral Health Plan is a product of the following local authorities' partnership and dedication to completing the first regional behavioral health plan representative of the mid-shore:

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

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

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

An essential process for the Workgroup members was determining a group name that would be respective of the collaboration contributed to the development of the CBHP, while remaining respectful of the existing autonomy that each local authority has at this early stage of local integration in the region. The Workgroup determined that the six entities represented would be named the "Mid Shore Planning Collaborative" or MSPC. MSPC is representative of regional collaboration on each element of the CBHP and initiatives that will be universally endorsed, supported, reflected, and driving the work of the group. In the document, when MSPC is referenced, please note that this indicates a mid-shore region collaboration, not a single local authority. Additionally, with the FY2021 CBHP representing the first annual plan for the region, the partners recognized that there remained a need at to note local authority-specific initiatives, experiences, or strategies that remain prescriptive to a county or to the regional CSA. The distinct contributions and unique systems management by county specific Local Addictions Authority and the regional Core Service Agency remains, as a means of presenting the content of the CBHP for several parts of the FY2022 CBHP.

The FY2022 Annual Community Behavioral Health Plan represents a continued commitment and process that has afforded the mid-shore region with the opportunity to address the needs of the region as a whole, evaluate the resources currently serving the jurisdiction, identify gaps and assess the future planning required for a strategic plan and successful implementation of an integrated structure. The primary goal with the development of the CBHP is to address both the mental health and substance related disorder (SRD) needs and services throughout our region, as well as the gaps in the behavioral health system and opportunities for increased collaboration across systems. MSPC is committed to enhanced relationships across local authorities and with our stakeholders to address our region's current capacity, disparities, and opportunities for growth for behavioral health.

Each section of the CBHP contributes to an overarching understanding of the mid-shore region's PBHS, offering the following: a detailed description of new developments and challenges in the region, a review of the previous year's accomplishments, presentation of behavioral health services and recovery supports, analysis of Maryland's Behavioral Health Indicator Data with specific mid-shore PBHS and specific priority area data analysis, history and current FY2021 landscape of local authority structures, implementation progress with local behavioral health systems management integration, FY2022 systems goals, objectives and strategies and FY2022 projected budgets and program service and deliverable planning.

MSPC recognizes that behavioral health is essential to achieve overall health and many domains of life contribute to one's behavioral health. As such, MSPC seeks to address the needs of the whole person and collaborates to improve the systems of care of the whole community throughout the region. Through the work of developing our FY2022 plan, MSPC is committed to addressing determinates of overall health and wellness through resources that offer interventions and supports to our region in hopes of improved quality of life and wellness of our

community. This year, MSPC has and will continue to remain committed to addressing the impact of the COVID-19 pandemic on mental health, suicidal ideation, substance use, the impact of unrest in our nation, addressing systematic racism, prioritizing undoing racism in our communities, addressing disparities in services, internal agency inclusion work, seeking to grow culturally sensitive practices, addressing stigma and its impact on access to supportive resources, enhancing integrated systems oversight, and emphasizing collaboration across systems providers to influence and steer planning and collaboration in our work in FY2022.

The mid-shore region of Maryland's Eastern Shore: Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties, is rural and approximately 2710 sq. miles with a population of approximately 171,904. With a population density of 85 people per square mile compared to 594 per square mile statewide, access to care is the primary health challenge in this rural region. Due to limited transportation options, compounded by the insufficient number of behavioral health providers, the county health departments play a key role in filling the healthcare delivery gaps in the region where medical services are sparse. Telehealth, mobile community health initiatives, care coordination, community health outreach workers and peers represent critical efforts to overcome the isolating distances and chronic health issues. Many of the behavioral and somatic health deficits are chronic and link directly with the region's social determinants: poverty/lack of personal and community financial resources, lack of affordable housing and healthy food, as well as social supports for those in need and seeking health care. Addressing these social determinants constitutes one of our biggest challenges and focus many of the new developments in the region.

Additional trends to note for the mid-shore include: all five counties have more people over age 65 than the state average; the population in the mid-shore has a lower income and a higher percentage of residents living in poverty than the state average; the number of residents with a disability and the number of residents who are uninsured in this region are slightly higher than the state average. Transportation and access to health care and treatment services as well as a dearth of behavioral health providers and workforce are major contributing factors to the wellness and health disparities in the region. Unstable and limited internet access is a major barrier to supporting access to services in the region. With most of the behavioral health care services now being rendered virtually with the pandemic, access to Wi-Fi and stable internet has inhibited this mode of treatment to be available to a significant portion of our community and consumer population due to the mid-shore's rural landscape and limited broad band.

Priority populations for MSPC include but are not limited to: young children (0-3 years), pregnant women and children, transitional-aged youth, school-aged children, adolescents, overdose survivors and families, individuals with chronic diseases, individuals experiencing homelessness or at-risk of homelessness, disparities in access to care, persons of color with mental health and substance use needs, intensive need consumers, consumers with and in need of entitlements (TCA, Medicaid, Medicare, SSI/SSDI), Deaf and Hard of Hearing individuals, consumers with complex and high service needs, Veterans, LGBT+, seniors/aging population, farmers-agriculture

workers, the criminal justice system, forensic or incarcerated individuals, and individuals that have high ratings of adverse childhood experiences (ACES).

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

Over the last year, MSPC has supported the provider community with the onboarding and transition of Administrative Service Organizations to Optum Maryland, effective January 1, 2020. The ASO transition has presented a compounding impact on the provider and consumer community of the region due to the disorganized structure. The transition has challenged ASO to support the PBHS to its fullest capacity and reimbursement support. This transition has impacted providers on all levels of care ranging from residential, outpatient, and Psychiatric Rehabilitation Services, to those recently added to the fee-for service structure such as the Recovery House community. Providers have been stressed financially and administratively while also managing the impact of the COVID-19 pandemic on services and client needs. MSPC is committed to advocating for the improvement of Optum Maryland and its support and responsibility to the PBHS.

MSPC has supported expanded funding and reimbursement structures for our providers and expansion of our grant-based services for the behavioral health community. MSBH endorsed Maryland General Assembly's passing of Maryland's Heroin and Opioid Prevention (HOPE) Act (HB1329/SB967) of 2017, which supports the expansion of treatment options for consumer access to mental health, substance related, and opioid specific needs. In support of the Keep the Door Open Act, the HOPE Act endorses fiscal supports expanded for providers. MSPC has worked collaboratively with the Eastern Shore Behavioral Health Coalition to advocate for full implementation of the HOPE Act support in the 2020 legislative session, with a focus on expanded funding to support behavioral health services. The KTDO provisions required the first-ever set of mandated rate increases for community behavioral health providers. These increases were carried over into the minimum wage bill (SB280/HB166) of 2019, including a 4% increase for FY

21 and 3.5% for FY22. MSPC is grateful for the support of the 4% increase for this current fiscal year (FY2021) and the support of the increase on January 1, 2021, an early adoption of the support for the provider community which, considering the increased demand for mental health and substance use disorder services created by the COVID pandemic, has yielded great support for our PBHS.

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

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

Crisis Services remains at the forefront of MSPC work as the mid-shore and Eastern Shore Crisis Response group work to implement the Crisis Strategic Plan of 2017. The primary goal for expansion of crisis services was the expansion of mobile crisis services to include 24/7 access to mobile crisis teams, enhancement of our Eastern Shore Crisis Response call center, and continued advocacy for our community stakeholders in our Wellness and Recovery Center and our Crisis Intervention Team programming for first responders. Initiatives to address the ever challenging and growing opioid epidemic are two new Adolescent Clubhouses, implementation of overdose review board activities in the mid-shore, expansion of Safe Stations in the mid-shore, expansion of crisis bed capacity, and enhancement to overdose response activities. All are a focus for FY2022.

Peer support specialists and the peer model of care has been a service of major growth and positive community partner planning in the mid-shore region. Peers are now staffed to be on call 24/7 to support responding with EMS in the community or meeting the individual in the emergency department for support, responding to emergency room visits. This model of response and support has yielded positive outcomes for individuals seeking ongoing recovery

supports, transition to inpatient care, and allowed for the resource of a peer to be made available as soon as the individual is ready to receive help.

The psychiatry/prescriber and behavioral health workforce crises remain a priority for MSPC and the behavioral health provider network. The shortage of psychiatrists and behavioral health providers is not unique to the mid-shore region, but is a growing crisis facing Maryland as a whole. Mid-shore providers lack the capacity to support the current demands of individuals seeking behavioral health services, primary care providers are currently not integrated to adequately serve behavioral health needs, and lack of efficient access is a barrier to ensuring community-based services. The mid-shore region has continued to support providers who are impacted by turnover of psychiatrists, nurse practitioners, and the credentialing issues with reimbursement outside of the PBHS system. The needs of the community are growing and highlighted because of the COVID-19 pandemic. Working to advocate for access and to combat stigma, providers need enhanced support to be equipped to serve and allowed opportunities to operate as this workforce crisis evolves. MSPC remains committed to supporting and addressing our network capacity with our work with BHA and our legislators, in addition to enhancing our regional collaboration across care providers and models.

MSPC remains steeped with regional and state-led initiatives that are addressing the health and wellness of the region. Senate Bill 1056 created The Rural Health Collaborative for the five Mid-Shore counties (Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties) to operate as an independent unit under the Maryland Department of Health, reporting directly to the Secretary. The Rural Health Collaborative (RHC), representing the mid-shore to improve the access and delivery of health services in a rural area, is a group that MSPC is supporting and mindful of with the development of priority goals for the region. Integrating healthcare delivery and efficiencies, coordination with clinical and proper access to community resources, as well as the universally noted barrier to access to and utilization of services, transportation, are all areas of focus for MSPC.

In addition to regional activities to evaluate behavioral health services, MSPC has participated and contributed to the Commission to Study Mental and Behavioral Health in Maryland. The commission, which is chaired by Lt. Governor Rutherford, has been tasked with studying mental health in Maryland, including access to mental health services and the link between mental health concerns and substance use disorders. In 2020, MSPC members assisted with the development of the plan for the Maryland Commission to Study Mental and Behavioral Health: Sequential Intercept Model Summit and participated in the November 17th and 18th 2020 Summit. MSPC continues to be involved with the planning for the implementation of this model in the state. MSPC and the Eastern Shore Behavioral Health Coalition will be presenting FY2022 and 2021 behavioral health legislative priorities to the Eastern Shore Delegation on March 12, 2021.

The FY2022 Community Behavioral Health Plan demonstrates a tremendous dedication of the MSPC partnership and drive to serve and improve the wellness of the mid-shore community of Maryland's Eastern Shore. The planning and collaboration that contributed to the goals and objectives for MSPC over the course of FY2021, FY2022 and in the three- to- five years to follow are priority areas that have been developed and endorsed by regional partners, advisory and leadership. The FY2022 Goals reflect five priority areas: Community, Social Determinants of Health and Addressing Disparities, Services, Local Systems Integration, and Workforce. The FY2022 Goals have been received by the mid-shore local governing and advising bodies, but most importantly, have been universally agreed upon by the MSPC team that will support the implementation of the priorities with our mid-shore consumers, stakeholders, and mid-shore community.

B. NEW DEVELOPMENTS and CHALLENGES

A responsibility of behavioral health systems management is the necessity to prioritize and address new developments and challenges impacting the region. This year has required MSPC to focus primarily on meeting the needs of the communities served, the provider network, and addressing the overwhelming impact of the COVID-19 pandemic on mental health and substance abuse in the region. MSPC prides itself on the responsiveness to the community and the ability to serve as local authorities supporting the health, wellness, and resources for the mid-shore region.

COVID Challenges: New Developments and Opportunities

Behavioral Health Systems Impact: COVID-19, Workforce, Provider Sustainability, and Regulatory Impacts:

MSPC prioritizes contact and relationships with our provider network and stakeholder groups. MSPC has enhanced this relationship with the support and communications that have been necessary to response to the COVID-19 pandemic. MSPC is sensitive to the impact of the pandemic on the provider community while remaining apprised and involved with the impact on several state and system level changes and proposed changes that will be impacting our PBHS. The provider network of the mid-shore has been subject to several challenges historically, and the events of the past year have compounded the challenges. Several areas have been impacting our providers over the course of the year and will continue to impact our providers in FY22. The impacts range from COVID-19, ASO transition, new proposed regulations, enhanced restrictions and monitoring of the Psychiatric Rehabilitation Program services, and the wavering and limited psychiatric workforce on the Eastern Shore.

The COVID-19 pandemic has challenged the already stretched behavioral health workforce and has created new costs for providers as they modify service delivery. Compliance with social distancing, quarantine standards, and sanitation guidelines, has been difficult to manage and costly to the providers. The rapid onset of the pandemic and the need to respond and adapt to avoid disruption of services has been a complex experience. The provider network responded beautifully to transitioning service delivery structures in response to the pandemic initiating in March of 2020. The provider network has been supported locally by our local health department leadership and the support of MSPC during the response and throughout the State of Emergency. Support from the Behavioral Health Administration with communications, transparency regarding regulatory accommodations and changes, in addition to the support of the acquisition of Personal Protective Equipment in April of 2020, was tremendously helpful.

Most providers in our mid-shore region were able to remain operational as soon as the impact of the pandemic hit. For our outpatient providers, transitioning to a virtual platform took ingenuity and some creative structuring of service platforms, and yielded successful and sustained services for our mid-shore consumers. For our residential providers, the impact of the

pandemic was more complex in nature, managing and assuring infection control and risk management practices of care with in-person and residential supports. The mid-shore and the Eastern Shore region of the state were impacted with a period in April-May 2020, when all residential substance use treatment providers were offline due to the impact of managing in absence of being equipped with the proper PPE and testing capacities. The development of admission protocols and accommodation changes for social distancing impacted the census capacity in the region for residential substance use treatment.

A major resource and provider in the mid-shore and supporting the Eastern Shore of Maryland is the A.F. Whitsitt Center located in Chestertown, MD, Kent County. The impact of COVID-19 on this facility has been significant, impacting the operations of the facility, ability to support residential substance use, opioid crisis beds, and the mental health residential crisis beds capacity. During the period of March 23, 2020 through July 6, 2020, all beds at the Whitsitt Center were offline for admissions. Since, March 23, 2020, the mental health residential crisis beds have remained offline and will not resume being housed or operated from the Whitsitt Center moving forward. The impact of the limited census and operations of the Whitsitt Center coupled with the loss of four mental health crisis beds on the Eastern Shore has been substantial. MSBH has been working closely with the leadership team of the Kent County Health Department and the Whitsitt Center to strategize resumption and maintenance of operations for all substance use residential and crisis services since the beginning of the pandemic. In addition, MSBH has been working with BHA and the Whitsitt Center team to plan for the discontinuation of the mental health crisis beds being managed and operated by the Whitsitt Center and to recruit and support a new provider for this resource. The recruitment and start-up of a new mental health residential crisis vendor and the support of onboarding a new provider will occur during the remaining part of FY21.

The psychiatry and behavioral health workforce crisis remain an issue for the mid-shore and Eastern Shore region. The shortage of psychiatrists and behavioral health providers is not unique to the mid-shore region, and is a growing crisis facing Maryland as a whole. Our providers lack the capacity to support the current demands of individuals seeking behavioral health services. The lack of efficiency with access is a barrier to ensuring community-based services. Our primary care providers are limited with integrated models and lack the providers to adequately serve behavioral health needs. The mid-shore region has continued to support providers who are impacted by turnover of psychiatrists, nurse practitioners, and the credentialing issues with reimbursement outside of the PBHS system. A recent development is the impact of noncompete agreements with hospital-based services that has impacted the psychiatry workforce from sustaining relationships with multiple outpatient networks and providers. This impact has been felt with several of our Outpatient Mental Health Clinic provider groups in the mid-shore region. A Federally Qualified Health Center in the region has recently moved to committing to adding behavioral health as a service line which will hopefully support the recruitment of psychiatry and psychiatric nurse practitioners into the region within the year as the services are set to launch in the second half of calendar year 2021.

The behavioral health provider network in the state of Maryland has been impacted this year with several systems driven oversight and management issues. The Administrative Services Organization (ASO)/Optum Transition has been a significantly challenging process for the provider network. Providers have had to pull staff time and attention away from clinical issues to deal with the shortcomings of the new ASO. Optum took over as the ASO in January 2020, and was unable to authorize services or pay claims, requiring the Maryland Department of Health to authorize estimated payments to providers. This experience spanned eight months of estimated payments and underwent a reconciliation period layered with complex communications and submission processes from Optum Maryland. Providers were left without access to necessary reports detailing claims processing and payment histories. New Proposed Regulations under COMAR 10.63 were released for comment in July 2020. The proposed regulations will add to provider costs and require additional demands of the behavioral health workforce. These regulations are in addition to new accreditation requirements that cost providers in both staff time and money. Psychiatric Rehabilitation Program (PRP) and Residential Rehabilitation Program (RRP) Restrictions have required new medical necessity criteria of providers rendering this service, coupled with Optum Maryland authorization and claims payment delays as well as requirements in the proposed regulations - all threaten access to, and the viability of, rehabilitation and residential programs. The Rate Study that is currently underway for providers will not adequately reflect the impacts of COVID and the additional costs to providers of the ASO transition and any new regulatory requirements. The study also creates an additional demand on overworked and understaffed billing departments for providers.

The behavioral health needs of the community have grown. With the impact of COVID-19, behavioral health providers are essential and critical resources for the wellness and health of our region. Providers are managing the trauma and disruption caused by the coronavirus, in addition to the crisis resulting from fragmented and fractured system supports in Maryland. MSPC continues to advocate for the removal of barriers to access and works to combat stigma. Providers need to be equipped to serve and allowed opportunities to operate and be supported as this workforce crisis evolves. MSPC will remain committed to supporting and addressing our network capacity through our work with BHA and our legislators, in addition to enhancing our regional collaboration across care models with growing partnerships and seeking out sustainability and quality resources for support.

Due to the challenges associated with COVID and school closures, many families lack the support and resources to manage their child with exceptionally high mental health and co-occurring health needs in their homes and communities. Many families are stretched to their limits financially, stressed beyond their limits in providing 24/7 care for their children with behavioral health challenges, and lack availability of community support to provide childcare or support services. The lack of break times for families/caregivers during the school day has put additional stress and pressure on families to provide care around the clock, when their child/youth used to attend school during the day. Virtual school platforms do not address the significantly challenged children's needs and do not provide respite for caregivers. Community resources are more

limited due to the risk of exposure to COVID by those who used to provide in-home supports and services, again adding to the burden on families and caregivers. Limited access to additional supports and services during the time from mid-March 2020 through the present adds additional stressors maintaining the children/youth in their homes with increasing behaviors. Many areas of the rural mid-shore do not have reliable internet service to access virtual school and/or telehealth providers. Many children and youth are not engaged in virtual learning, which has impacted depression, anxiety, and feelings of social isolation. Children and youth who were previously engaged in school-based mental health are having a much more difficult time engaging in tele mental health. Many are not seeing their therapists at all or at best on a very sporadic basis. Families seeking higher levels of services, such as residential treatment with capacity to meet co-occurring medical needs, have increased. It has been extremely difficult to identify residential treatment facilities capable of meeting the needs of these children/youth.

Mental Health and Substance Use Impact of COVID-19 and Wellness Initiative of the Mid-Shore
MSPC recognizes that behavioral health is essential to achieve overall health and that there are many domains of life that contribute to one's behavioral health. The COVID-19 pandemic has presented a collective traumatic impact and challenges resulting in increased rates of depression, anxiety, overdoses, and suicidality. As such, MSPC seeks to address the mental health and wellness needs of the community throughout the region and State of Maryland. MSPC hopes to address wellness by supporting training resources that offer interventions, insights, and professional education to enhance quality of life and wellness of our community during COVID-19 and beyond.

This year, MSPC has prioritized addressing access to treatment and enhancing relationships with local, regional, and state partners invested in the behavioral health of our community. MSPC recognizes the impact of wellness in our region and has been particularly informed of the need by way of the Centers for Disease Control and Prevention Morbidity and Mortality Report from August 14, 2020. The CDC highlighted the impact of the COVID-19 Pandemic on Mental Health, Substance Use, and Suicidal Ideation.

<u>Among the key findings from the CDC of a survey taken June 24th-30th, 2020:</u>

- 40.9% of respondents reported experiencing one or more adverse behavioral health conditions.
- 30.9% reported symptoms of an anxiety or depressive disorder.
- 26.3% reported trauma related to COVID-19.
- 13.3% reported having started or increased substance use to cope with stress of COVID-19.
- 10.7% reported having seriously considered suicide in the previous 30 days.

<u>At least one adverse behavioral health symptom was reported by:</u>

- 74.9% of respondents aged 18-24

- 51.9% of respondents aged 25-44
- 52.1% of respondents of Hispanic ethnicity
- 66.2% of respondents with less than a high school diploma
- 54% of respondents who identified as essential workers.
- 66.6% of respondents who identified as unpaid caregivers for adults.

The percentage of respondents who reported having *seriously considered suicide* in the previous 30 days (10.7%) was significantly higher among respondents aged 18-24 (25.5%), minority racial/ethnic groups (Hispanic respondents, 18.6%; non-Hispanic Black respondents, 15.1%), self-reported unpaid caregivers for adults (30.7%) and essential workers (21.7%). This data is unquestionably alarming and serves to reinforce the need for increased collaborative efforts to assure access to quality behavioral health services in the State of Maryland.

Since September 2020, MSBH has been meeting with stakeholders to address the recent trends of increased suicidality and overdoses in our community. A new partnership has formed with MSBH and Anne Arundel County LBHA leadership around suicide attempt activities on the Chesapeake Bay Bridge. Out of the partnership to enhance crisis response efforts and the impact on the community and stakeholders to address the alarming uptick in visible distress with the activities noted on the Bay Bridge, MSBH and Anne Arundel LBHA identified the need to partner and conceptualize a training cooperative to address wellness and suicide prevention in our communities.

Out of the training cooperative, MSBH has identified interested provider parties in the mid-shore region, as well as several local authorities, to collaborate and address wellness in the light of COVID-19 in our communities. The training cooperative identified renowned speaker and motivational leader in mental health, Kevin Hines, as a resource to engage in training, supporting, and reaching our community members. Kevin Hines has committed to a seven-part series scheduled for the spring of 2021 to address suicide prevention and wellness with focused presentations for the following groups: First Responder and Clinicians, Youth/Adolescents, Impacted Families of Suicide and Mental Illness, People working from home, Men/The Male Perspective, Older Adults, and General Public Community.

Serving the homeless population with COVID challenges

Since the start of the pandemic, there have been numerous challenges that have impeded on the ability to properly serve those experiencing homelessness. Due to the incredible financial hardships COVID-19 has caused, many people have suffered great loss, including ability to pay rent and utilities. Unfortunately, we have seen an increase in homelessness and as a result a lack of shelter capacity. Lack of shelter capacity is a result of both the increase in demand for shelter and the implementation of safety protocols and procedures to limit the spread of the virus. As emergency shelters are congregate living spaces, providers have had to act quickly and aggressively to restructure their shelter space for guest and staff safety, while working to avoid

turning away individuals and families in need of shelter. Luckily, providers have been able to place people in hotels and motels quickly, but due to the higher associated cost, it is not a long-term solution.

Additionally, the nature of the pandemic has made it difficult to get those living in emergency shelters rapidly rehoused due to the lack of movement in housing. The eviction moratoriums have been beneficial in that people are able to stay housed where they currently are. However, for those currently homeless, it has made finding available housing that much more difficult. There has been a severe shortage of affordable housing prior to this global pandemic, and the need has only increased while the availability has decreased. The needs for this population are growing rapidly and while there has been a great amount of emergency funding released, it does not adequately address the issues of available housing and shelter capacity.

Challenges presented to the Forensic Mental Health Program (FMHP)

The COVID pandemic significantly impacted the services the FMHP was able to provide to consumers this year. With the closing of the courts, delays in trials and sentencing, our stream of referrals was placed on hold. Clients who were referred could not have their mental health assessments completed in probation offices because of restrictions on gathering. Videoconferencing was made available, however most of our clients did not have the technological resources or understanding to participate in this manner. It was not until late summer when face to face meetings could take place for mental health court assessments. Case management services were similarly impacted, however the FMH Case Manager was able to provide support and maintain contact with clients over the telephone.

One positive change that resulted from limited court functioning was that some judges, concerned about housing people in jail during the pandemic, made efforts to create community based pre-trial plans. At times this involved the FMHP's help in linking these clients to behavioral health resources in the community and monitoring their compliance with routine reporting to the court.

Mental Health Crisis Beds

The four Mental Health Crisis Beds have been awarded to the AF Whitsitt Center (AFWC) for at least the last ten years. In May of 2020, MSBH was made aware that the AFWC no longer wanted to contract with BHA to house the beds. There had been no increase in the award since its inception and the AFWC stated they could no longer financially afford to provide this service. After much discussion between AFWC, MSBH and BHA, BHA was willing to renegotiate the contract. AFWC has been unable to secure staffing due to COVID-19 issues and other personnel changes and therefore can no longer provide this service. BHA asked MSBH to create an RFP for

four-eight beds, to secure a new provider on the mid-shore. BHA will provide startup funds and then the beds will be set up on a on a Fee for Service Structure. The hope is to have a new provider before the end of FY21.

Telehealth and Virtual Systems: Connecting and Serving the Community in the "New Normal"
A silver lining to the COVID-19 pandemic has been the expansion of virtual and telehealth platform use for the provision of behavioral health services. Since the determination of the need for a declaration of a Public Health Emergency on January 27, 2020 as a result of the COVID-19 pandemic, Alex M. Azar II, Secretary of Health and Human Services, in interpretation of section 319 of the Public Health Service Act, supported healthcare services including behavioral health, to be expanded to be provided and reimbursed for if rendered by way of telehealth. Several expanded and supported activities for behavioral health were added in March-May of 2020 with the support of the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) and have remained in effect to date in response to the pandemic.

Telehealth is traditionally defined as a "mode of delivering health care services through the use of telecommunications technology by a health care practitioner to a patient in a different physical location from a health care practitioner." Platforms for telehealth may include both synchronous and asynchronous interactions and exclude telephonic/audio only interactions. During the state of emergency, BHA allowed for providers who would normally be eligible for telehealth to use audio telephone for almost all clinical services. The addition of audio delivered services has been extremely helpful for consumers in the rural areas of Maryland, inclusive of a significant portion of the mid-shore region, due to unstable and unavailable internet access. In addition, the transition and utilization of telehealth for services is challenging to those individuals that do not have access to a smart device, smart phone, or tablet/computer in the home. The complexities and newness of managing the virtual platform for some consumers also has contributed to lack of access and engagement in virtual sessions which has been compensated by the telephonic/audio allowance for care.

The Maryland Department of Health (MDH) and CMS have continued to support expanded allowances regarding telehealth and telephonic services. HHS waived potential penalties for HIPAA violations against health care providers using telehealth platforms not traditionally recognized as HIPAA compliant, and supported audio-only permissions. MSPC has been working collectively with the mid-shore providers to assess the need for expanded equipment resources and internet needs to support the most compliant and confidential platforms and virtual settings for services.

There are some populations that have been well served by way of telehealth and some that have been challenged and not responsive to this mode of delivery behavioral health services. Concerns

with acute and chronically ill individuals as well as our child and adolescent population have been noted, as well as consideration for technology and compliance, privacy impacts. On the positive side, the allowance for the telehealth has been a tremendous resource and access has been uninterrupted during such a critical time to support access to services. Support groups, new virtual roundtables, Alcoholics Anonymous/Narcotics Anonymous, our wellness and recover and recovery centers, and additional networks of support pivoted to cultivate and create online groups virtually.

A focus of MSPC is to advocate for continuation of telehealth as it is a vital means of reaching those with behavioral health needs in the mid-shore region. The Eastern Shore Behavioral Health Coalition developed a telehealth survey in preparation for a presentation to our Eastern Shore Delegates and Senators on September 24, 2020. The survey specifically targeted the utilization of telehealth in practice on the Eastern Shore.

The survey concluded on September 22, 2020 with 29 provider respondents based on the Eastern Shore:

- 26 providers average 71% of clients using telehealth services.
- 17 providers average 27% clients using telephonic services.
- Roughly, 2/3 of clients use one of the two alternatives to face-to-face.

Additional surveying by the Behavioral Health Administration and Maryland's Association of Behavioral Health Authorities (MABHA) has been supported and responded to with information regarding the ability to administer and support consumers with telehealth. Providers were surveyed in five jurisdictions in Maryland (concluded January 28, 2021) that volunteered to participate in a pilot telehealth equipment program with BHA. The survey collected information specific to the needs of consumers and telehealth device needs, as well as internet/Wi-Fi access. The mid-shore region volunteered to be a participant in this pilot equipment and internet project and will be supporting funding distribution to all nine counties of the Eastern Shore in hopes of expansion of the technology and internet service to broaden access to care. The financial support that the pilot program will bring to the Eastern Shore provider network will be greatly beneficial as the equipment and technology expenses have historically been barriers to quality delivery of telehealth services in the region.

Telehealth services, especially for psychiatric care, remains an urgent need in the mid-shore region. Due to the lack of adequate services and the multiple barriers to hiring and maintaining quality staff, telehealth is critical in providing well-rounded care for those who are served.
Telehealth capability has historically enabled the mid-shore jurisdictions to have the ability to see more Mental Health and MAT-SUD clients, as a response to the provider desert that otherwise currently exists. Current contracted provider relationships with University of Maryland, Sheppard Pratt, and other inpatient facilities, have made it possible for enhanced behavioral health service delivery throughout the mid-shore.

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

Dorchester County has a contract with a telehealth service provider to enable Dorchester County Behavioral Health (DCBH) the ability to better provide psychiatric SUD services for its residents. DCBH has two psychiatrists available via telehealth to prescribe medications to treat SUD. These services include psychiatric medications as well. Services will be available for the local detention center and individuals receiving treatment through the Dorchester County Problem-Solving Court.

The Eastern Shore Behavioral Health Coalition will be closely following the activities of the 2021 legislative session with particular interest in the bills supporting expansion and permanency of telehealth access. The following bills will be followed in hopes of endorsement: The Preserve Telehealth Access Act of 2021 (SB 3/HB 123) Medicaid – Psychiatrist and Psychiatric Nurse Practitioner Telemedicine Reimbursement – Sunset Termination (SB 56/HB 191) Coverage for Mental Health and Substance Use Disorder Telehealth Benefits.

Transition of the Management of Maryland's Administrative Service Organization:
The transition of Maryland's Administrative Service Organization (ASO) was a change that the MSPC anticipated and had hoped would bring more efficient and quality oversight and support to our Public Behavioral Health System. The transition from Beacon Health Options to Optum Maryland occurred on January 1, 2020. The preparation for the transition was swift, with only a few months to prepare the provider network and the local authorities of Maryland. This limited window of transition preparation coupled with a year of complexities ranging from provider payment issues, to a complicated and inconsistent online billing platform, limited provider support with provider relations issues, and communication delays and issues, has created a very frustrated and fragile environment for the behavioral health provider network of Maryland.

MSPC takes pride in upholding our local responsibilities with quality oversight, in particular, that of the local oversight of the ASO. MSPC is responsible for maintaining relationships with our providers and the ASO concurrently and addressing any issues related to provider performance or management, as well as ASO responsiveness and support issues. The role of MSPC in FY20-FY21 with the issues stemming from Optum Maryland has been insurmountable and presented with impacts that quality management at the local level surpassed. The financial impact of the transition to Optum Maryland has exposed several mid-shore providers to financial distress and threats to sustainability and operations. MSPC has refined our local role to support the ASO issues as a primary demand over the course of the year all the while managing the impact of the pandemic simultaneously.

MSPC and systems managers in the state are peripheral supports and authorities for the ASO while supporting the provider community and providing quality oversight and consumer access to the PBHS. The transition to Optum Maryland has presented several challenges on the local level with onboarding to the new system for reimbursement, enrollment, claims management, an increase administrative time commitment, and consumer enrollment in the data platform.

Over the course of 2020-2021, MSPC has dedicated an exorbitant amount of time to supporting our providers impacted by the subpar support and transition issues related to Optum Maryland. Several providers in the mid-shore region have been impacted by delayed payments, the need to resubmit claims, and administratively have had to reallocate staff time from services to allow for the submission of supporting documentation for reimbursement and in several situations, resubmit claims for several months as a means of confirming receipt on the online platform, Incedo.

MSPC has established relationships with the provider network supports at Optum Maryland through the state Provider Relations representatives and has elevated our advocacy with the mid-Atlantic regional Provider Relations leadership in hopes of resolving the issues with Optum. In addition, MSPC is in frequent contact with the Behavioral Health Administration (BHA) leadership team, Community Behavioral Health Association of Maryland, Mental Health Association of Maryland, and the State Behavioral Health Coalition to share real-time provider experiences and concerns, as well as strategize the best approach to manage the velocity of the impact of Optum Maryland. Despite all efforts, the circumstances remain very poor for the providers engaged in rendering services under the PBHS and the need for improvement remains paramount. Provider moral and trust has been tested and, in some cases, expressed as reprehensible in the eyes of the providers. The resolution and restoration of faith in Optum Maryland and the ASO structure in Maryland is needed and is overdue. This will be a complex process and MSPC's continued role with the advocacy and support of our mid-shore providers will remain a top priority and is necessary. This system change has impacted the work of the MSPC and the morale of our mid-shore behavioral health provider community on several levels.

Hospital Transitions and Surge Capacity Management:

The COVID-19 pandemic has impacted and increased community's mental health and substance use issues and, on many levels, has presented added stress on our treatment providers, acute hospital settings, residential treatment providers, and community transition supports. The COVID-19 pandemic challenged providers to meet the needs of infection control of clients and staff, and pivot to supporting and treating a population that has been more acutely impacted by the stress and trauma of the pandemic. In some cases, the complexities of accessing help in the pandemic contributed to individuals not being treated at all or relapsing due to the impact of the delay of or lack of access to help during the pandemic. In the Maryland, the impact of the stress

on the hospital providers and acute inpatient providers to meet the needs of the community has been very complicated.

In the mid-shore region, outpatient providers, residential treatment settings, shelters, and community support networks have been strained and stretched to remain open and accessible to meeting the needs of those in need of help and services. Several community providers, shelters, and homeless services were able to extend access throughout the course of the warmer months and have access to more financial resource as result of relief options in response to the pandemic. This extended and expanded support did not alleviate the obstacles to remaining operational and open to service the community and remaining free of the virus. Some shelters continued to be more restricted to serving individuals with mental health or substance use needs due to the greater risk that this population presented with in managing and mitigating infection control measures.

The residential treatment providers and mental health crisis bed offline status, limited capacity, and census because of the pandemic have been a barrier to hospital transition and discharge planning in the region. The primary inpatient hospital provider in the mid-shore region is under The University of Maryland's Shore Regional Health system. With residential substance use treatment providers tightening admission and referral procedures and census, and no access to residential crisis beds for primarily mental health stabilization needs since March 23, 2020, the census in the acute hospital has been high and length of stay has been impacted. The surge in the needs for acute beds for the treatment and management of COVID-19 has also impacted the availability of acute beds and highlighted the need to support the transition and alternative placement of individuals with substance use and mental health needs as a primary admission need. There is a need for a short-term transitional resource for individuals discharging from inpatient facilities. Shore Behavioral Health has had significant difficulty with discharging patients into safe placement over the course of the pandemic.

MSPC has increased partnership and communications with Shore Regional Health's clinical team members, leadership, and transition care managers over the course of the pandemic. Discharge and treatment planning needs have been supported on a case-by-case basis depending on needs and supports in the community post-discharge. MSPC has routinely addressed capacity needs and provider vacancy and availability for treatment during the Eastern Shore Provider Network meetings. Active and engaged representation of residential, RRP, recovery housing, and shelter service providers on the provider calls has supported real-time availability and client need response.

Mobile Treatment Unit (MTU)

Caroline County's Mobile Treatment Unit continues to successfully provide MAT service delivery to the community. Since its inception two years ago, the MTU team has provided MAT services to 200+ clients, which also includes peer support and SUD counseling. Currently, the MTU team is providing services to approximately 85 active clients with new clients coming on-board weekly.

The MTU continues to provide services four days per week to scheduled clients and those new clients who may walk in. Consideration is being given to expanding its services to neighboring counties as time and scheduling will allow. In addition, we continue to evaluate the possibility of adding harm reduction approaches, such as a syringe exchange program, in the future. COVID-19 was especially a challenge for the team on the MTU. As they are in the community each day working face-to-face with clients without all the protections available in a brick-and-mortar building, the team was challenged to deliver services while aligning and complying with COVID-19 restrictions. The MTU was only parked for 1.5 weeks when COVID-19 first began while the team prepared a plan for a safer re-opening. A safe approach was developed to protect the staff with PPE, a cleaning process, as well as taking client temperatures and only allowing one client at a time on board. The MTU resumed delivering MAT in Caroline County throughout 2020 during the pandemic which may have helped to minimize OD's in the jurisdiction.

MAT in Detention Centers

University of MD MACS program is actively in process of developing a MAT pilot at the Caroline County Detention Center. The focus will be to continue MAT for those inmates already involved in a MAT program prior to incarceration which will offer inmates continuity in treatment and recovery. This pilot will also be supported by Caroline County Behavioral Health's SUD counselor who provides re-entry planning to refer inmates back to a MAT program in the community upon their release.

Faith-based Initiative

Caroline County has been fortunate to receive SOR funds to begin an initiative with the faith-based community in the jurisdiction by the MOTA-led Arc of Hope. This service will work with those minority populations who have an opioid or other drug SUD who is seeking help and support. Through their Peer Recovery staff, they make referrals to the Caroline County MTU and outpatient clinics as well as other recovery assistance as needed. This effort is a collaboration between several Caroline County churches and utilizes primarily Peer Recovery Specialists to provide recovery support and referral assistance, including transportation. One of the Peer Recovery Specialists' native language is Haitian Creole, helping with the large Haitian population in Caroline County.

COVID Challenges, new developments, and opportunities:

Dorchester County has negotiated many challenges related to the COVID-19 pandemic. These challenges have ranged from staffing to the ability to provide consistency during difficult times. As state facilities closed their doors and started to telework in response to the pandemic, Dorchester County Behavioral Health Services (DCBHS) began to strategically plan how to provide therapeutic, recovery, and harm reduction services in a COVID-19 environment. DCBHS staff supported the local health department in its COVID-19 testing efforts, obtained PPE for staff and direct consumers, and developed a hybrid procedure and schedule to provide continuity of care for our consumers. This was done across the continuum of services provided in the treatment,

recovery, and harm reduction systems. It is notable that there has been a cost associated with the challenge of providing services during a pandemic, but it has also yielded new developments regarding the ongoing provision of care for Behavioral Health consumers.

OUTPATIENT SERVICES (Hybrid Model)

Outpatient services provided by Dorchester County Behavioral Health was not prepared for the COVID-19 pandemic, as it required major changes in the way the program provided services. The March 2020 closure of treatment programs to comply with the Governor's order prompted an immediate response to minimize the uncertainty and lack of recovery support consumers would experience from abruptly becoming disconnected from treatment services. The pandemic precautions calling for social distancing and, in some cases isolation, had a negative effect on many consumers with a Substance Use Disorder (SUD).

In response to the pandemic restriction, DCBH adapted its operations forming a hybrid model to avoid a total disruption of services. This hybrid model joined an in-person platform with a virtual platform which enabled consumers to receive treatment more consistently. When consumers that were not able to receive in-person services, a virtual platform was utilized. In cases where SUD consumers did not have the equipment to utilize the virtual platform, DCBH provided the equipment and space for them to take part in the telehealth service. This was done with minimum contact, implementing safety protocols such as observing social distancing and disinfecting the area between everyone using the space. This was particularly helpful when providing services for the homeless SUD population. During the period where facilities were closed due to COVID-19 restrictions, DCBH maintained therapeutic contact via phone and stayed connected by mail when there was no other way to communicate.

In addition, it is essential to maintain treatment for individuals that are being prescribed SUD medications during the opioid epidemic compounded with the COVID-19 pandemic restrictions. DCBH hired a physician to provide SUD and psychiatric services for its consumers. The physician is available in-person and via telehealth to prescribe medications to treat SUD. These services include psychiatric medications as well. DCBH maintained this treatment during the closure via telehealth, using the program physician. Services will be available for the local detention center and Individuals receiving treatment through the Dorchester County Problem-Solving Court.

Conducting treatment services in this COVID-19 pandemic environment has resulted in increased cost as it mandates smaller group sizes and compliance with social distancing, quarantine standards, and sanitation guidelines. All of which comes with an increased cost to the provider but provides necessary supports within the community for those experiencing trauma and disconnection from behavioral health services.

CORRECTIONAL SERVICES (DART)

Treatment services at the Dorchester County Detention Center (DCDC) continue to be an important element in addressing SUD consumers that have been incarcerated. There have been a few interruptions in services due to pandemic restriction and quarantine standards. The clinical staff at the CARF accredited treatment program, Drug and Alcohol Recovery Treatment (DART), within DCDC have complied with the detention's protocols for safety and COVID-19 pandemic precautions. Individual treatment and SBIRT screening have continued using the virtual platform. All services were conducted using evidence based best practice curriculums such as "A New Direction" that focused on the individual in the criminal justice system and "Seeking Safety," a trauma focused approach.

RECOVERY COMMUNITY SERVICES

Despite the COVID-19 Pandemic, Dri-Dock Recovery and Wellness Center staff still endeavored to address the many complex issues related to the Opioid Epidemic. Despite having limited resources and opportunities for face-to-face contact due to COVID-19 restrictions, Dri-Dock's peers have been the boots on the ground, prepared to serve anyone seeking help for an opioid/substance use disorder. Community outreach is a tool Dri-Dock's peer staff have used to reach individuals with a SUD and community members. Community outreach allows peers to advocate, educate, and support the community for those who have loved ones or themselves suffer from an untreated opioid/substance use disorder. Other services that are provided by Dri-Dock Recovery and Wellness Center staff are one-on-one peer support, group peer support, peer support groups, referrals to outpatient/residential treatment, referrals to community services, job search assistance, computer stations for internet access, and special events.

The community recovery support services at Dri-Dock Recovery and Wellness Center have been challenged due to the pandemic, as have the other services provided by DCBHS. Complying with social distancing guidelines has made it difficult to provide peer support services such as one- on-one supports and transportation. Many of the individuals that typically utilize peer services do not have the equipment to engage in virtual communication for virtual support. To address this problem, peers equipped with proper PPE have gone into the community and distributed information regarding recovery as well as health information on the coronavirus and vaccine. Peers have also been available by appointment to meet with individuals one-on-one while maintaining the six feet social distancing policy. Peers are also providing phone support to individuals that call in for services. Peers have provided limited transports to residential treatment programs while adhering to COVID-19 precautions for transportation of consumers. Unfortunately, peer services have declined as consumers have been less likely to visit the recovery center due to the pandemic and Dri-Dock has not been able to sponsor its' monthly activities.

ACCESS TO HARM REDUCTION

The Harm Reduction Program in collaboration with DCBH, the HIV Department at the Dorchester County Health Department, and Johns Hopkins Hospital have been providing HIV and HCV testing

and treatment for individuals having a SUD. DCBH has incorporated the testing protocol into the intake process and will offer testing for all current consumers. Testing will also be available for individuals that visit Dri-Dock Recovery and Wellness Center. Peers will encourage participants to be tested. All individuals tested that are positive for HIV and/or HCV will get treatment through the Dorchester County Health Department and Johns Hopkins Hospital.

A Narcan Trainer is regularly available for walk-in Narcan training at Dri-Dock Recovery and Wellness Center. Peer recovery specialists have joined with harm reduction staff to distribute Narcan in the community to address the increase in overdoses seen during the pandemic. Harm reduction staff have also begun distributing fentanyl test strips with Narcan kits to individuals in the community using and known to use opioids. Narcan training continues to be conducted using a virtual platform and contactless delivery has become the norm.

START COLLABORATION

The Start program has been a great challenge in Dorchester County, as there has been very few candidates suitable for the peer mentor position. Dorchester County has advertised for the position five times and has not been able to hire a peer mentor. Health Department staff and representatives from the Department of Social Services are set to meet and review the process. The meeting will be focused on identifying problems and/or issues in the process that has hindered hiring and finding a suitable resolution.

Queen Anne's County continues to provide support and services to mothers, newborns who were exposed, and their families through peer outreach, clinical referrals, and close relationships with DSS and local providers. Queen Anne's County is not formally participating in the START program due to low potential case numbers, and current services available being adequate to serve the jurisdiction.

OOCC FUNDING

In FY 2020, Dorchester County experienced eighty-two (82) overdoses with sixteen (16) fatalities. Peer Recovery Specialists were notified of sixty (60) overdoses and responded to fifty-eight (58) of the call. Of the sixty (60) overdose notifications, two (2) individuals were transported to a hospital out of Dorchester County. From the sixty (60) overdoses, thirty-six (36) were opioid, eleven (11) were non-opioid drug/alcohol and thirteen (13) were categorized as other drugs. Due to COVID-19 precautions instituted by the local hospital, peers were not allowed to enter the hospital to respond to twenty-two (22) of the overdoses that happened in FY 2020. Peer Recovery Specialists conducted follow-up calls in all overdose cases in FY 2020 to include the ones not allowed to visit at the local hospital. In addition, DCBH clinical staff conducted a second follow-up call to the individuals based on information obtained from peers in the Overdose Response Program. Follow-up calls are focused on meeting individuals where they are and motivating them to seek treatment and/or assessing and referring them to a treatment program residential or outpatient.

The Youth Action Council (YAC) is composed of middle and high school students in Dorchester County. YAC gives kids a voice by addressing substance abuse issues they see in their community. The YAC has been limited in the activities that they have been able to conduct due to the pandemic, but they maintain communication and continue to distribute prevention information in the community.

During FY 2020, there were 796 individuals screened using the SBIRT screening tool (Screening and Brief Intervention and Referral to Treatment). There were 539 individuals that screened positive for a SUD. Staff at the local detention center conducted 1032 brief interventions and referred 267 individuals to treatment. Of the 267 individuals referred to treatment 149 were admitted into a treatment program.

Avenues Recovery

MSBH was contacted by Avenues Recovery in June of 2020 to sign an Agreement to Cooperate. Avenues Recovery was planning on opening a new SUD residential treatment facility in Cambridge, MD. Avenues initially applied for SUD outpatient treatment, partial hospitalization, SUD inpatient beds, and Mental Health Crisis Beds. There was a great deal of coordination, including many emails and phone calls, between MSBH, BHA and Avenues staff. Staff from MSBH, BHA, and the Dorchester County LAA conducted an initial site visit on Aug. 20, 2020. Avenues was not prepared for the visit and there were many tasks noted that needed to be completed before a future site visit was conducted. The Mental Health Crisis beds have very strict COMAR requirements and this was creating obstacles with the SUD beds residing in the same building. Avenues later decided, they were no longer going to get licensed for the MH crisis beds. They then requested 104 residential treatment beds. After much confusion with the catering contract and assuring the requested tasks were completed, another site visit was conducted on Sept. 17, 2020. This site visit went very well and MSBH signed the Agreement to Cooperate on Oct. 1, 2020. Avenues did not include OMHC in their original Agreement to Cooperate, so an additional Agreement to Cooperate was signed Nov. 19, 2020. Avenues Recovery is planning to start providing services on Dec. 22, 2020.

Adolescent Clubhouses

MSBH was offered an opportunity to solicit proposals for two Adolescent Clubhouses on the Eastern Shore. These Clubhouses would enhance the availability of recovery-oriented services to better address the needs of youth (12-17) impacted by, affected by, or diagnosed with an opioid use disorder (OUD) as well as their families. These efforts are also aimed to decrease future opioid related deaths in the population. The goal of this funding for BHA/MDH is to increase availability of evidence based or promising practices to support community outreach and family engagement. This initiative supports the early identification of youth who are at risk

of, impacted by, diagnosed with, or in recovery from an OUD, as well as providing a Family Peer Support Specialist to help engage their families. The funding intends to increase family involvement in the youth and family's wellbeing and recovery support network. MSBH is currently in the process of soliciting proposals for two Clubhouses and will be meeting to review proposals on December 21, 2020 with anticipated awards to follow. It is the goal of MSBH to have both Clubhouses operational within 6 months of the award.

Closure of substance use residential treatment for Youth

There are no substance use treatment centers in the state of MD for adolescents, which creates a hardship for families in seeking treatment for their adolescent. There is also a shortage of outpatient substance use treatment for adolescents, which causes concerns while attempting to provide needed services in the community due to no residential treatment in-state options.

Maryland Recovery Network (MDRN)

Starting in FY21, non-housing recovery support services transitioned into MDRN Substance Use Disorder (SUD) client support services funding. Beginning July 1, 2020, MDRN eligible individuals had to access MDRN Substance Use Disorder funds through their Local Behavioral Health Authority (LBHA) or Local Addiction Authority (LAA). The purpose of these funds is to enable an individual to access or retain community-based behavioral health services and to be linked to the individuals' clinical and/or recovery support plan goals. Individuals applying to access these support services must meet MDRN eligibility criteria. In the spirit of integration, BHA suggested that the mid-shore counties collaborate and have one award for all five counties. MSBH offered to manage this award with the assistance of the LAAs. Caroline, Kent, and Queen Anne's Counties agreed to integrate this award with MSBH. Dorchester and Talbot decided to manage their own county's award. MSBH developed the MDRN applications and after all five counties edits and approval, the applications were finalized. Although MSBH is managing 3 of the counties, all 5 are using the same application.

Teleworking

On March 16, 2020, MSBH implemented a teleworking policy in response to Governor's State of Emergency because of the COVID 19 pandemic. Corsica Technologies installed VPN connection on all staff devices allowing secure connection to the organization's server. MSBH provided full support to all employees to ensure the work of MSBH continued as seamlessly as possible despite challenges presented by the pandemic. MSBH adopted online platforms (GoTo Meeting and Zoom) to facilitate critical meetings while tele-working. One staff person a day reported to the office to check the FAX and general voice mail messages to ensure responsiveness to incoming referrals and general messages.

Forensic Case Management Services

It has been truly unique this year. When the country went "home on break" back in March of this year, a whole new working world began. An asset for our program has been the ability to collaborate more spontaneously with community partners. For some clients, the normal planning process had to take a back seat to being able to work in the moment, this made a strong partnership between MSBH's Forensic Program and the Neighborhood Service Center. We have several joint clients that needed, housing resources, emergency food, urgent placement and help with managing finances. These urgent needs had to be handled via Zoom platform or on conference calls to work out details for the client's best interest in a quick turnaround time. MSBH and the NSC have several joint clients that needed, housing resources, emergency food, urgent placement and help with managing finances. These urgent needs had to be handled via Zoom platform or on conference calls to work out details for the client's best interest in a quick turnaround time. Together we were able to provide temporary shelter for a family for six weeks by collaborating weekly to come up with the right strategy until more permanent housing is available.

MSBH Forensic Services also partnered closely with the Problem- Solving Courts by making more phone contact with case management clients and outside/inside visits at local Recovery Houses. Some clients were able to come to our office directly in a clean environment to have court required evaluations completed. The courts were closed for a while to in person appearances and some are still meeting on a virtual platform.

Some struggles have been that clients have not received the face-to-face contact that is needed to assure they are making healthy transitions and positive engagements. Many partnering agencies are short staffed and have limited hours of operations. Clients are struggling to find urgent resources they need to help with activities of daily living. Because of this, some of the same agencies such as ours are being compounded with more complex case management needs to help problem solve with clients throughout the day. Clients have access to the Forensic Mental Health Cell phone to reach the case manager in the need of an immediate resource. This has been utilized to the full potential.

Youth Outreach Coordinator -Mid Shore Behavioral Health, Inc.

The Youth Outreach Coordinator position is new to Mid Shore Behavioral Health. This position was created during the COVID-19 pandemic and as a result is not without its challenges. A key part of the plan for this position is community outreach and education. However, due to the pandemic, we find that there are fewer events where we can present the program. Additionally, the peer support aspect is also challenged by the virtual setting. Meetings with youth must be set up on a virtual platform as well. Another challenge we face is the rural setting in which our

programs exist. In speaking with other providers and professionals about setting up groups for youth in their respective counties, it has been expressed that such groups created in the past have limited attendance due to transportation issues and lack of public transportation, thus, causing these groups to close. Another challenge we will face is referring youth to care. Currently there are limited outpatient substance treatment services for youth and no inpatient substance treatment facilities in the state of Maryland.

Despite the challenges listed above, we have made a lot of developments with this program thus far. We are continuing outreach on the virtual platform to providers and educators to generate referrals for youth assistance. We have created forms associated with this position including consent and referral forms and have virtual marketing in place as well. Currently, we are working on upcoming educational presentations for families and youth, and we are seeking to partner with the local Chambers of Commerce in each of the five mid-shore counties to generate attendance at these events. Additionally, these events will be shared with providers, school systems, and other community partners to generate attendance and referrals for the program.

Personal Protective Equipment (PPE) for Providers

Mid Shore Behavioral Health, Inc. (MSBH) served as the BHA PPE Distribution Hub for the following counties: Caroline County, Cecil County, Dorchester County, Harford County, Kent County, Queen Anne's, Somerset, Talbot, Wicomico, Worcester. MSBH participated on a planning call with MABHA leadership on April 10, 2020 and welcomed the responsibility of serving as a hub for PPE distribution for ten counties in Maryland. On April 13, 2020, MSBH received the shipment of PPE at the MSBH office located in Easton, MD. On April 14, 2020, MSBH held an internal planning meeting to determine logistics for the distribution planning for the PPE materials. On April 14, 2020, MSBH also hosted a phone conference with leadership from all ten counties involved in the hub shipment. Directors from each local LBHA, CSA, and LAA were represented on the phone conference. On the phone conference, a distribution plan and determination of priority groups were reviewed and confirmed. The three priority groups for distribution of the PPE were identified as: Crisis Services Providers, Residential Rehab Programs (RRP), and Residential Substance Use Treatment Centers (3.5-3.7WM). The group reviewed the provider types by jurisdiction and agreed that the distribution algorithm would be determined by provider type and capacity/operational status, number of RRP beds in the jurisdiction, and if the current provider groups were equipped with PPE to date. An algorithm was developed to assign PPE by type per bed to provide adequate PPE to the RRP Providers in event of an outbreak in a house or surge in COVID-19 in the staff.

Distribution to jurisdictions took place on April 16, 2020 and April 17, 2020. Each jurisdiction out of the mid-shore region presented to pick up PPE and were provided with an invoice for the

jurisdiction and invoice for the deemed provider distribution sites. Mid-shore providers picked up and signed for all PPE on April 17, 2020. MSBH team member delivered the PPE for reserve to the A. F. Whitsitt Center, located in Kent County, on April 23, 2020. The result for this endeavor was the timely and successful distribution of over 25,000 pieces of needed PPE to the providers in our community and surrounding 10 county area.

Behavioral Health Integration:
MSPC continues to work on the strategic planning needed to progress to an integrated systems management and authority structure in the mid-shore region. This year has presented with many challenges to uphold the originally intended goals and strategies identified in the first integrated plan for MSPC for FY21 specifically regarding local integration with the intent to address integrated structural needs. Instead, this year has focused on working to support the behavioral health community in the mid-shore because of the need to prioritize the COVID-19 pandemic response.

MSPC has experienced a more organic integrated presence over the course of 2020-2021 in our efforts across entities to support the mental health and substance use needs of our community and our provider networks. There has been enthusiastic willingness to partner and collaborate on several response efforts, for example: The Behavioral Health Services on the Eastern Shore Provider Meetings, Personal Protective Equipment distribution initiative, integrative messaging and stakeholder engagement, and our awareness campaigns during Recovery month with our "Going Purple Together" community event and campaign.

MSPC successfully collaborated on the annual Local Systems Management Self-Assessment Tool for the second year in a row (see full results and description in Section C. of this document). MSPC identified that the dedicated and integrated efforts to support stakeholder engagement with providers is enhanced and moving to a fully integrated response to our community. This responsibility is critical as the provider network is essential to support serving the community members in need and supporting a no wrong door and open access and availability philosophy of care. MSPC contributed to offering responses to the draft form of the Local Public Behavioral Health Systems Management Roles and Responsibilities Framework (January 2021) and remains active in the Learning Communities with BHA. Mid-shore MSPC members hold two seats on the statewide Local Systems Integration Workgroup Advisory Committee (MSBH and QACLAA).

The mid-shore local systems management workgroup has had limited formal meetings during FY21 due to COVID-19. Engagement on behalf of the local addictions authority's health officer leadership has been impacted by the focus of pandemic response efforts. The ability to meet with all leadership at once due to scheduling limitations has been challenging. The hope is to revisit the timeline for local systems integration and revive the mid-shore integration workgroup for the remaining portion of FY21 and in FY22. MSPC remains committed to all responsibilities to serve

our community and is enthusiastic of the progress and partnerships that have been an outcome of the need to come together during the COVID-19 pandemic crisis.

SORII and OOCC Funds

MSBH received FY20 Funds from the Opioid Operation Control Center for an expansion project for the A.F. Whitsitt Center. This funding was to open the dormant "Brown Unit" and renovate it to house a 12 bed Opioid Crisis Unit. Challenges associated with the OOCC FY20 expansion project included the State of Emergency due to COVID-19. This made it difficult to complete the expansion in a timely manner and to open as an independent 12 bed unit. Staffing constraints at the A.F. Whitsitt Center made it difficult for them to maintain the 12-bed unit. The A.F. Whitsitt Center has struggled with hiring during COVID-19 due to the competitive salaries. Also, there are pre-COVID-19 staff that were unwilling to return to their previous positions due to the high-risk nature of the environment.

Early in 2020 the OOCC released a request for proposal for the OOCC FY21 Funding. MSBH applied and submitted a request for a Youth Outreach Coordinator, funding towards the two lower shore Safe Stations, and administrative funding for the Behavioral Health Coordinator position. MSBH was officially notified in April 2020 that the funding that was asked for was approved. MSBH began advertising and interviewing for a Youth Outreach Coordinator immediately.

The Youth Outreach Coordinator was interviewed and hired during the COVID-19 Pandemic. Since this is a new position at MSBH there have been many start up challenges such as the need to educate the mid-shore about the position, to create a network of referral sources, develop consent forms, outreach material, educational materials, program brochure, etc. This creates challenges while teleworking and not being able to meet with youth and community partners in person.

SOR II

Early in 2020 MSBH submitted a request for proposal for SOR II Funds. MSBH requested funding to continue all activities currently being funding through the SOR I Funds and some funding for additional expansion projects. The request was approved for funding to continue the two lower shore safe stations, one recovery house, the Crisis Beds at A.F. Whitsitt Center, and MSBH Coordination Administration. In addition, the award included funds for SOS-MAT a program for the mid-shore that would provide bridge MAT prescriptions to consumers while they are waiting to get into a medical provider.

The original proposed plan for SOS-MAT with the Kent County Health Department presented with too many barriers to be able to support the concept. After further discussion with BHA about these barriers it was suggested that MSBH reach out to Caroline County with their already existing Mobile Treatment RV. Following several meetings with Caroline County it was determined that because they are already receiving HRSA funding and were currently working towards expanding throughout the Mid Shore the SOR II funds were not necessary at this time. Simultaneously while MSBH was trying to reallocate the funds for SOS-MAT there had been discussions with the Caroline County Sheriff's Department about launching a safe station in Caroline County. The current plan with BHA's approval will be to reallocate funds to support two FTE Peers for the Caroline County Safe Station.

Opioid Crisis Beds

In early February MSBH received notification of being awarded FY20 OOCC Funding. This funding was for the expansion of the current eight opioid crisis beds to a 12-bed independent unit. Historically the opioid crisis beds have been comingled with the traditional residential 3.7 substance treatment beds. The projected date for opening the "Brown Unit" was June 2020.
On March 05, 2020 due to the COVID-19 pandemic, Maryland entered a State of Emergency. With the high demand for PPE equipment and concern for staff and consumers' safety, the A.F. Whitsitt Center stopped accepting inpatient admissions in mid-March. Not long after, Warwick Manor and Hudson Health stopped accepting admissions as well.

The COVID-19 pandemic and all three inpatient substance treatment facilities on the Eastern Shore closed temporarily, created new challenges. Due to additional stressors from the pandemic, Opioid use was on the rise it left leaving no inpatient substance treatment facilities on the Eastern Shore. This created the need to travel further to access treatment when transportation is already an issue due to the rural nature of the Eastern Shore.

After obtaining adequate PPE supplies and training staff the A.F. Whitsitt Center began accepting admissions again on July 13, 2020. However, they made the decision upon reopening they would change their policy to being a non-smoking unit. This was primarily due to research showing that people that smoke are at higher risk of contracting COVID-19 and having increased complications due to an already compromised respiratory system. With the three months of no admission, followed by two months of the non-smoking policy, referral sources began to refer to other programs.

Oxford House

The Oxford House contracted with MSBH in early 2020 to start three Recovery Houses in Queen Anne's County using SOR 1 Funding. Due to the late execution of the Oxford House contract, it

limited the timeframe in which they could use their funding. Once the State of Emergency was declared in early March it limited what the Oxford House Outreach Worker could do since they are considered non-essential workers. The Governor declared the stay-at-home order for all non-essential workers before the Oxford House had secured their first home in QAC. The Outreach Worker had to do everything remotely which significantly delayed them establishing their first home. This also impacted their ability to use their allotted funding.

CARES funding, CDBG

COVID 19 has brought many new developments and challenges to every aspect of our lives and work. To quickly help people impacted by loss of income due to COVID-19, national funds were repurposed, and new funding was made available to try to help. Two new funding streams that came to the Roundtable on Homelessness were repurposed CBGD funds and new CARES ESG Funds which supplemented our annual Homeless Solutions Program Funds.

The Roundtable on Homelessness partnered with the Department of Housing and Community Development and Caroline County Government to quickly repurpose current Community Development Block Grant (CDBG) funding for emergency homelessness needs. The funding covered emergency hotel placements, emergency shelter, staff costs, and supplies costs due to increased shelter needs from the COVID 19 pandemic. This funding allowed our winter shelters to extend services through the summer increasing the capacity of our system. It also allowed for safe operations of shelters in motels/hotels when needed.

CARES ESG Funding was awarded to the Roundtable on Homelessness by the Department of Housing and Community Development as a supplement to the annual Homeless Solutions Program Funding. As the Homeless Solutions Program includes services for Emergency Shelter, Street Outreach, and Housing stability – homeless prevention and rapid rehousing, it is a major need for those impacted by COVID 19. The CARES ESG funding allows us to increase service in these needed areas and allows for several additional services not included in general Homeless Solution Programs.

These funds have been extremely beneficial to our region during these difficult times, allowing us to get new services to people in need.

Caroline County Safe Station

When the Governor of Maryland declared an Opioid Crisis in 2016, the Caroline Local Drug and Alcohol Council (LDAAC) expressed being at a loss and unsure of how to best serve individuals with an opioid addiction. Since then, the LDAAC partners have worked together to support treatment, to educate the community and to spread prevention information across several

domains (ex. school system and law enforcement). This year, the Caroline County Sheriff's Department expressed exuberant interest in creating a Safe Station Program. The program will be accessed in their new office building, located on Route 404 in Denton, MD. Sheriff Randy Bounds and Captain James Henning requested to meet with MSBH staff in October 2020, to plan the best way to implement the Safe Station model in the county. The virtual meetings have included representation from the sheriff's office, staff from the Eastern Shore Crisis Response, the local State's Attorney, and the Director of the Local Addiction Authority from the Health Department. These agencies are dedicated to facilitating a Peer-led Safe Station Program in Caroline County that will begin receiving clients in February 2021. MSBH has advocated with BHA to support this new program with OOCC and SOR II funding through the end of FY21. Although a new development and challenge for FY21, MSBH is positive about promoting the ongoing success of the Caroline County Safe Station Program.

Site visits-new facilities and ongoing Behavioral Health Administration Requirements
(BHA) has policies that guide the ongoing operation of behavioral health facilities. MSBH is tasked with conducting initial inspections and yearly site visits of these locations in the mid-shore region, in particular the local Residential Rehabilitation Psychiatric (RRP) programs. This year, being mindful of COVID restrictions, BHA provided revised guidance for virtual site visits. MSBH was able to communicate with the RRP Program Directors and to have virtual site visits for 23 of the houses in the counties of the mid-shore region. The RRP Program staff were very receptive and coordinated logistics and were able to go from house to house, for MSBH staff to record the meetings. In addition, RRP residents from each house were enthused to be surveyed about their experience in the house.

Behavioral Health Services on the Eastern Shore: Provider and Stakeholder Engagement
In response to the rapid flow of information and systems impact of the COVID-19 pandemic, MSPC organized and has been the responsible administrator of the Behavioral Health Services on the Eastern Shore Provider and Stakeholder meetings (virtual meetings/conference calls) since the inception of the pandemic response in March of 2020. The network has been meeting since March 18, 2020, and to date (at the time of this plan submission 2/19/21) has met 34 times.

In March, the meetings were hosted twice a week. As the pandemic progressed, the meetings occurred once a week and more recently have decreased to every other week. From March 18th, 2020 to April 10, 2020, the regional calls were in support primarily of the mid-shore counties. A meeting was hosted on April 7, 2020 with all nine counties of the Eastern Shore local authorities represented. It was decided at that time, that the meetings would move from a mid-shore call to an Eastern Shore call. All nine counties LBHA/CSA/LAA affiliated logos were collected and are represented on the Agenda and meeting materials. The Eastern Shore network meeting has represented all nine counties since the meeting held on April 14, 2020.

The meetings have an agenda and are representative of all systems impacting and integrated with the behavioral health provider network on the Eastern Shore. Each meeting has time allocated for a BHA report out, Optum Maryland Provider Relations updates and receipt of questions and concerns, State updates provided by Maryland State Senator Addie Eckardt, capacity updates and issues. The meetings have a roll call reporting structure for all provider sectors ranging from acute hospitals, case management, OMHC, wellness and recovery centers, residential services, homeless services, and recovery housing, to Safe Stations. The participation averages 50-70 participants per meeting and participation is engaged and supportive. The peer support of the network has yielded positive problem solving, networking, referral resource information, and a platform of support for all participants and systems managers during the complicated and stressful times of COVID-19.

MSPC intends to continue to support and administer the provider network meetings beyond the COVID-19 pandemic. The peer support element and information sharing of systems changes with the provider connection across counties and services has been outstanding to witness, and MSPC desires to continue to support the partnerships that have grown out of this meeting platform. The collective problem solving, and resource sharing is a unique trait of the Eastern Shore, and the provider network meetings embody the spirit of this strength and support.

Implementing the FY21 and Creating the FY22 Community Behavioral Health Plan Virtually

When the MSPC agreed to meet for the duration of FY20 to plan for implementation of the FY21 plan, we could not foresee that these meetings would be held via virtual platform. After submitting the plan on February 4, 2020, the MSPC team met on March 30th to discuss the process and how to implement the FY21 Goals (Community, Social Determinants, Services, Integration and Workforce). The MSPC met with BHA April 21st for the official CBHP approval. BHA offered compliments and a few minor changes. MSPC met again on April 28th, May 12th, and June 16th to discuss plan implementation, with restrictions of the pandemic. We received notification on June 9th that our FY2021 CBHP was approved!

We launched the plan July 1st by posting on our website, sharing in the newsletter and with community partners via email. MSPC agreed that our FY21 CBHP Goals needed to be planned in more detail, especially regarding Goal #4 (Integration). Members of MSPC joined meetings during the week of July 6-10, to discuss each of the Goals in detail and how we could implement them during FY21. One specific outcome of the Goal meetings was to garner interest for a *Recovery House Workgroup* (Goal 2, Strategy 4I). Recovery House Mangers have since met three times during FY21.

The MSPC invited the mid-shore county Health Officers (August 11th) to discuss the process of implementing the plan (giving special attention to the Integration Goal) and preparing for the Local Systems Management Integration Self-Assessment due to BHA. During this meeting we shared that the MSPC would be meeting quarterly re the FY21 CBHP and would begin to construct the FY22 plan once we received the guidelines from BHA (usually November).

Once we received the CBHP Guidelines, MSPC began to schedule meetings based on the plan sections, through virtual platforms. We were mindful to update Performance Measures based on the pandemic restrictions now that we have learned the benefits of virtual workgroups and conferences. The MSPC team members are truly dedicated to the well-being and overall progress of an integrated behavioral health system, as we continue to improve services for consumers, to advocate for telemedicine for consumers and to ensure culturally competent services in the region.

Local Systems Management Administrative Concerns:
The local systems management and administrative responsibilities of local authorities in the state of Maryland continue to expand, which is a compliment to the local authorities, but has presented challenges as well. This year, the local authorities have been responsible for increased correspondence, surveying, engagement, and oversight of the behavioral health provider and systems response to the pandemic. The Behavioral Health Administration has relied heavily on the local systems managers and authorities and have increased collaboration, communications, and correspondence to the locals to share and promote in their jurisdictions.

The local behavioral health systems managers have also noted increased responsibilities with oversight with the transition of the Administrative Service Organization and the impact of the pandemic on service capacity. This increased responsibility has been complimentary to the footprint of the local authorities and the MSPC group but has been overwhelming at times with limited expansion to the administrative resources at the local level. Enhanced relationships across the mid-shore counties local authorities have allowed for peer support with administrative oversight but has no alleviated this issue.

Growth with grant dollars and new programming has been consistent despite the impact of the COVID-19 pandemic. The State Opioid Response Grant has presented opportunities for the communities served but is an example of a complicated administrative responsibility to manage locally. In addition, local authorities are working to pivot and manage new reporting and monitoring expectations from BHA. For the FY22 planning process, local authorities are required to support all legacy conditions of award/grant activities into a new more formalized format of a condition of award and statement of work. This has been a cumbersome process with tracking historical and new award documentation.

Funding delays are an additional administrative concern with new and expanded grant activities. Locally, MSPC has demonstrated strength with swift response to new funding opportunities and demonstrated the capacity to procure and identify local responsible providers for the award activities. The issue of delays with procurement from the state level have been challenging and impacted the local providers to start up and initiate the new programming. MSPC is mindful of the impact with delayed grant funds and prioritizes this transparency with local vendors as a possible delay when entering a new service or project. MSPC is sensitive to barriers to program and contract implementations including delayed receipts of COA's which impact the jurisdictions ability to contract and implement programs accordingly. The administrative oversight of the system is complex work in nature, and when systems are delayed and communication is inhibited, this impacts quality of services for our community. MSPC is hopeful that with enhanced relationships of our mid-shore providers and with BHA enhanced processes, the mid-shore region will benefit from new programming and activities not impacted by such delays.

Data and Reporting Management

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

Harm Reduction:

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

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

Education about Harm Reduction is critical for medical providers, business owners, faith-based agencies, and the public to support the acceptance of harm reduction strategies as well as successful implementation. The MSPC is dedicated to identifying strategies for implementation on the Shore to save lives and help our communities recover.

Across the mid-shore region, MSPC has been working to bring Harm Reduction initiatives to the community. Most of the Local Addictions Authorities in the mid-shore have enhanced their distribution of Narcan, training of community members and stakeholders, in addition to welcoming new initiatives such as Fentanyl testing strips and mobile treatment units for the screening and prescribing of MAT to the region. The mid-shore region has been recognized for the Mobile Treatment Unit in Caroline County that is working to expand their reach in the county for mobile MAT screening and treatment and is a partner for some new grant activities targeting at risk farming and agricultural workers. In Kent County, the implementation of the "No Harm In Helping" mobile unit is a new initiative to provide outreach, screening, prescribing, and administration of MAT, as well as mobile Narcan training and Fentanyl distribution.

Education of the mid-shore stakeholders remains a priority for the MSPC group. The buy-in of community partners and providers to move towards a system that embraces a harm-reduction philosophy, and desires to enhance harm-reduction and implement the harm-reduction priorities is a challenge in the mid-shore. Partners are often more conservative with services and initiatives, so education remains at the forefront of the work. In March of 2020, MSBH hosted an all-day Harm Reduction training presented by Maryland's Harm Reduction Training Institute. The hope of this training was to educate partners and identify new harm-reduction priorities that can be introduced and advanced existing initiatives in the mid-shore.

Limited MAT Providers

Over the past three years, the mid-shore has experienced the unexpected closure of two MAT providers that were both located in Queen Anne's County. These abrupt closures placed hundreds of clients in a position where they faced challenges in obtaining their medication. Once the leadership on the mid-shore was notified, a plan was crafted to ensure all affected clients were offered an alternative medical professional. However, there are limited providers on the Eastern Shore to assist with this process. For example, in Queen Anne's County, there is only one provider currently. Recruitment and training for additional prescribers for the region remains a priority of MSPC.

Outreach: COVID-19 Harm Reduction

The Opioid Intervention Team from Kent County has been doing community outreach in many ways over the last few months. We utilize the Recovery in Motion van to go to different communities throughout Kent Co. We have been to many of the local housing developments that we think could use our help or that have requested us to come there. We have participated in community events such as the Kent County Local Management Board event located at the Driftwood Inn, targeted towards the homeless population. We served 14 people and handed out 32 boxes of Narcan which totaled to 64 doses. We did a Holiday themed outreach and went to Woods Edge, Brittany Bay, Knights Landing, Calvert Heights, Dollar General, Big Mixx's Beautiful Beginnings, High Street businesses, local volunteer fire departments and the recovery houses.

OIT has begun doing virtual events such as going Facebook live, we have had 672 views thus far which is a great thing due to not everyone being comfortable with strangers approaching them. When we go live on Facebook it gives the audience an opportunity to interact with us and ask questions and provide comments if they have them. It also is beneficial for people who are not aware of what Narcan is or how to get it. This year has been hard with the pandemic, it has prevented us from doing a lot of the events we would normally do. We also hold a group with the patients in Whitsitt about Narcan.

Kent County has not seen as many overdoses in our community recently which leads us to believe that the outreach we are doing is helping. Every time that we do go out in our area, we run into at least one or two people who thank us for what we are doing, tell us how great of a job our organization does, and tells us how bad our area continues to need this kind of support. RIM, OIT and Overdose to Action Grant (OD2A) all work together to get Narcan on the streets and in the hands of our Kent county community members.

Queen Anne's county continued education in the community surrounding harm reduction strategies such as Naloxone, fentanyl test strips, and peer support. These efforts have been opened to increased community exposure due to COVID. For example, in Queen Anne's County, the peer support specialists have partnered with Haven Ministries food bank drive-through events, providing education, treatment information, as well as Naloxone training. During the months of April, May, and June approximately 500 doses of Naloxone were distributed within the community, and 500 community residents trained how to use it properly.

Risk Fatality Review Board:

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

MSPC partners are hopeful that the work to implement the Review Board in Queen Anne's will be complemented throughout the region in FY2022.

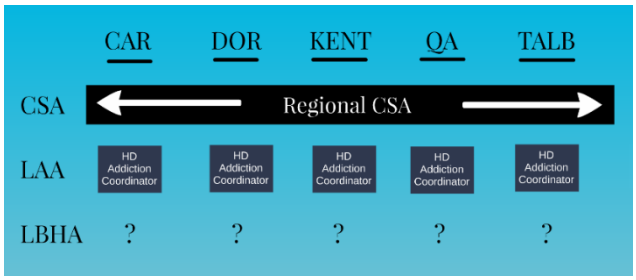
Chesapeake Bay Bridge Initiative

In late August 2020, in response to several individuals presenting in crisis and attempting suicide on the Chesapeake Bay Bridge, a regional and State partnership was initiated to address these crises and critical incidents, work to prevent incidents, and instill suicide awareness and prevention to the community. MSBH in partnership with the Behavioral Health Administration, Anne Arundel Mental Health Authority and Local Addictions Authority, Maryland's Department of Transportation, Anne Arundel Crisis Response, Eastern Shore Crisis Response, and the Mental Health Association of Maryland, formed the Bay Bridge Response group. The Bay Bridge Response group has convened since early September. Initially meeting every three weeks, recently the group has met monthly, and will move to once every other month in March 2021. The group has been successful with establishing and strengthening the collaboration with crisis response providers serving each side of the bridge (Anne Arundel county and Queen Anne's county), in addition to illuminating the need to work on a warm-hand-off initiative for crisis responders in the state. Representatives from Maryland's Department of Transportation who are primarily responsible for the Bay Bridge management and critical incident response, have enhanced their network of partnerships with crisis response and representatives from local authorities and BHA. This relationship has allowed for strategic planning for suicide prevention initiatives in the state, addressing stigma and social media issues with visibility of crisis and individuals in need of help, strengthening the collaboration across leadership groups, and communicating needs and areas for support to serve our communities.

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

Local Systems Management Integration

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



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

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

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

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

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

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

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

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

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

In FY2019 and FY2020, and FY2021 MSBH has sustained contracted responsibilities with Dorchester County to serve as the partial LAA for systems management and oversight functions and intends to continue this support in FY2022. MSBH continues to serve Caroline County Local Government and Caroline County Health Department with the role of LDAAC/Drug Free Caroline management and administrator for strategic planning, regional provider meeting support, and county awareness initiatives.

In FY2020, MSPC was presented with an opportunity to collaborate and partner for the oversight of an integrated new award from the Behavioral Health Administration. The Maryland Recovery Network (MDRN) award was presented to the local authorities in June 2020 as a new award activity for FY2021 (formerly the Recovery Housing award) to support of enabling individuals to access or retain community-based behavioral health services and be linked to the client's clinical and/or recovery support plan goals. MDRN SUD Client Support Services funds are used as funding of last resort for one-time only expenditures for the purchase of emergency goods and the provision of time-limited services.

The MDRN funding was initially individually allocated to each of the five mid-shore LAAs for oversight and distribution in their respective counties. On July 13, 2020, MSBH and each of the

five LAAs met to discuss and determine if MSBH would support the oversight of the MDRN funding given the similarity in process and procurement of the Mental Health Consumer Support Funds (overseen by MSBH historically). Discussion of the movement of consumers and individuals in need throughout the mid-shore region reinforced the consideration to make this award management be housed with MSBH. Three out of the five mid-shore LAAs determined to collaborate with MSBH for the oversight of the MDRN funds, with the understanding that each LAA and the care coordinator designee would be in contact with MSBH routinely. The following counties elected to integrate for this award activity: Caroline, Kent, and Queen Anne's. Dorchester and Talbot counties elected to remain independent with management of the funds, however, agreed to use the tools for solicitation of the funds that MSBH developed for ease with universal formatting of the forms to manage and request the funds in the mid-shore.

An additional integrated award in FY2021 was the support of MSBH procurement of new Federal Block grant funding for the Caroline County School-Based Program funds. Caroline county LAA developed a request for additional funding to support the expansion of Mental Health Services in all schools, to allow for dedicated full-time therapists skilled and trained in trauma and undoing racism and support the coordination of services provided in the county. Funds were allocated for training and to offset non-billable services for the coordination of care for the children in the school setting and lessen the financial impact on the agency. This award was submitted to BHA by Caroline County in support of MSBH procuring and supporting the funding management.

MSBH has been honored to support the LAA integrated functioning in several parts of the jurisdiction, and in FY2022, MSPC will continue assess and plan for integrated responsibilities for the mid-shore region. MSPC aspires to support our region by enhancing oversight and collaborative systems managers, with the goal of working towards an integrated region/jurisdiction.

	FY2015 *1/2015-6/2015*	**FY2016** *7/2015-6/2016*	**FY2017** *7/2016-6/2017*	**FY2018** *7/2017-6/2018*	**FY2019** *7/2018-6/2019*	**FY2020** *7/2019-6/2020*	**FY2021** *7/2020-6/2021*
Caroline	5 functions	5 functions	LDAAC only	LDAAC only	LDAAC only	LDAAC only	LDAAC, MDRN, Fed Block
Dorchester	5 functions	5 functions	24 functions Partial LAA	24 functions Partial LAA	24 functions Partial LAA	24 functions Partial LAA	24 functions Partial LAA
Kent	5 functions	5 functions	No Integrated Agreement	No Integrated Agreement	No Integrated Agreement	No Integrated Agreement	No Integrated Agreement/MDRN
Queen Anne's	5 functions	5 functions	No Integrated Agreement	24 functions Partial LAA	No Integrated Agreement	No Integrated Agreement	No Integrated Agreement/MDRN
Talbot	5 functions	5 functions	24 functions Partial LAA	No Integrated Agreement	No Integrated Agreement	No Integrated Agreement	No Integrated Agreement

Mid-Shore Local Systems Management Planning:

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

The mid-shore is a unique region with MSBH remaining as the last regional local authority in the State of Maryland. MSBH as the Core Service Agency (CSA), has prioritized the relationship with and respect for the responsibilities of each Local Addiction Authority (LAA) in the mid-shore. The relationship and partnership with our LAA peers are paramount in the work that we are currently doing to meet the needs of the community, with the aspiration that through integration, the person-centered experience and "no wrong door" philosophy of care will be enriched.

MSPC has identified that behavioral health systems management integration is a top priority and has been a focus over the last several years within our regional systems management group. The FY2021 Integrated Community Behavioral Health Plan supported goals and strategies to assist MSPC with moving towards an integrated systems management planning and implementation process. The FY2022 Community Behavioral Health Plan supports Goal 4: Implement an Integrated Systems Management Structure, as an ongoing goal with several strategies to work thorough over the course of the next three-to-five years.

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

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

Caroline County Health Department:
Laura Fretterd Patrick RN, BSN, MS, Health Officer
Terri Ross, LCSW-C, C-ASWCM, Caroline County Behavioral Health Director and LAA
Dorchester County Health Department:
Roger Harrell, MHA, Health Officer
Donald Hall, MHS, LCADC, Dorchester County Behavioral Health Program Director and LAA
Kent County Health Department:
William Webb, MPH, Health Officer
Brenna A. Fox RPS, CPRS, LAA Director
Mid-Shore Counties Core Service Agency:
Kathryn Dilley, LCSW-C, Executive Director, Mid Shore Behavioral Health, Inc.
Patricia Doyle, Finance Director, Mid Shore Behavioral Health, Inc.
Kelley Moran, Administrative Director, Mid Shore Behavioral Health, Inc.
Queen Anne's County Health Department:
Dr. Joseph Ciotola, M.D., Health Officer and Medical Director
Maggie Thomas, MS, Director, Local Addictions Authority
Talbot County Health Department:
Dr. Maria Maguire, M.D. MPP, FAAP, Health Officer
Sarah Cloxton, LCADC, LGPC, RPS, Talbot County Addictions Program Director and LAA

The workgroup historically has met formally at a minimal quarterly, but with the impact of COVID-19 on the demands of the membership with attendance at priority emergency management meetings, the group only formally convened two times during FY2021 before the Community Behavioral Health Plan endorsement meeting on February 9, 2021. The LAA Directors and MSBH leadership and team members convened several times for local systems planning, annual integration self-assessment, and to complete the FY2022 Community Behavioral Health Plan. Meetings have been scheduled for the remainder of FY2021 and the group intends to meet quarterly as a whole in FY2022, with monthly and weekly engagement on standing meetings, and integration planning and systems management meetings in FY2022.

In February 2019, the group met and organized a group statement of purpose and integration plan intention to submit to the Behavioral Health Administration and Maryland Department of Health leadership.

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

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

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

Consensus

The workgroup members agree that it is our goal for the mid-shore counties' local authorities to work towards an integrated regional model of systems management. Further, members of the group agree that our vision of an integrated model will best serve the community if we demonstrate a truly integrated model reflecting not just a fiscal integrated model, but a model that is representative of addressing programmatic, community need, and person-centered integrated systems management.

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

Requirements for Success

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

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

Initial Joint Project

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

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

In addition to the workgroup's development of the integration plan, the workgroup has convened and collaborated to complete the Local Systems Management Integration Self-Assessment Tool annually. The self-assessment tool has been required to be completed by all of Maryland's local authorities due to BHA first in October 2018, and most recently in October 2020. MSPC submitted individual self-assessments in 2018 (FY2019) and a combined response representative of all six local authorities in 2019 (FY2020), and one MSPC integrated response in 2020 (FY2021). Each jurisdiction was tasked with measuring progress on the seven domains of integration:

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

Fiscal Year Response	Domain(s)	Leadership & Governance	Budgeting & Operations	Planning & Data Driven Decision Making	Quality	Public Outreach, Individual and Family Education	Stakeholder Collaboration	Workforce
FY2019	Caroline County LAA	1	1	1	1	1	1	1
FY2019	Dorchester County LAA	2	2	2	2	2	2	2
FY2019	Kent County LAA	2	1	1	1	2	1	1
FY2019	Queen Anne's County LAA	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response	Pending BHA Response
FY2019	Talbot County LAA	1	1	1	1	1	1	1
FY2019	MSBH CSA	1	1	1	2	2	2	1
FY2020	Integrated Self-Assessment Response	2	1	2	2	2	2	2
FY2021	Integrated Self-Assessment Response	2	1	2	2	2	3	2

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

MSPC has demonstrated progress across the integration domains over the course of the last three years. MSPC has made significant progress demonstrated by the capacity and support to complete the mid-shore self-assessment as one group, as well as progress in three domains, Leadership and Governance, Planning and Data-Driven Decision Making, and Workforce in FY2020. In FY2021, MSPC agreed that the collaboration and partnership to support the provider and stakeholder groups in the mid-shore region in response to the COVID-19 pandemic moved the group to the Integration Range Level 3: Integrated/Enhanced for Stakeholder Engagement. This is the first time the MSPC group evaluated work to be fully integrated. The MSPC group is very proud that the community, provider, and consumer focus is the area of the first achieved integrated domain. This progress reinforces the priority of the MSPC with supporting a no wrong door in the mid-shore community.

In FY2020, MSPC's demonstrated progress towards local systems management integration, and as a result, MSPC was asked by BHA to serve as a peer support to local jurisdictions for the following:

- Collective Experience with integrated crisis response systems
- Development of a regional annual behavioral health plan

- Contracting, contract monitoring, and regionalization of quality measure tool development

During FY2020 and FY2021, MSPC remained committed to supporting the local systems management peer groups as a resource with regional integrated efforts. MSPC served as a resource by sharing integrated bylaws for the Regional Behavioral Health Advisory Committee, tools for regional contract monitoring, and served as a panelist on two Local Systems Management Learning Community meetings: Learning Community 10: Data Analysis and the Annual Plan and Learning Community 13: Integrated Behavioral Health Advisory Councils.

Organizational Structure: Mid-shore Counties Current Structure

Caroline County Local Addictions Authority Organizational Structure:

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

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

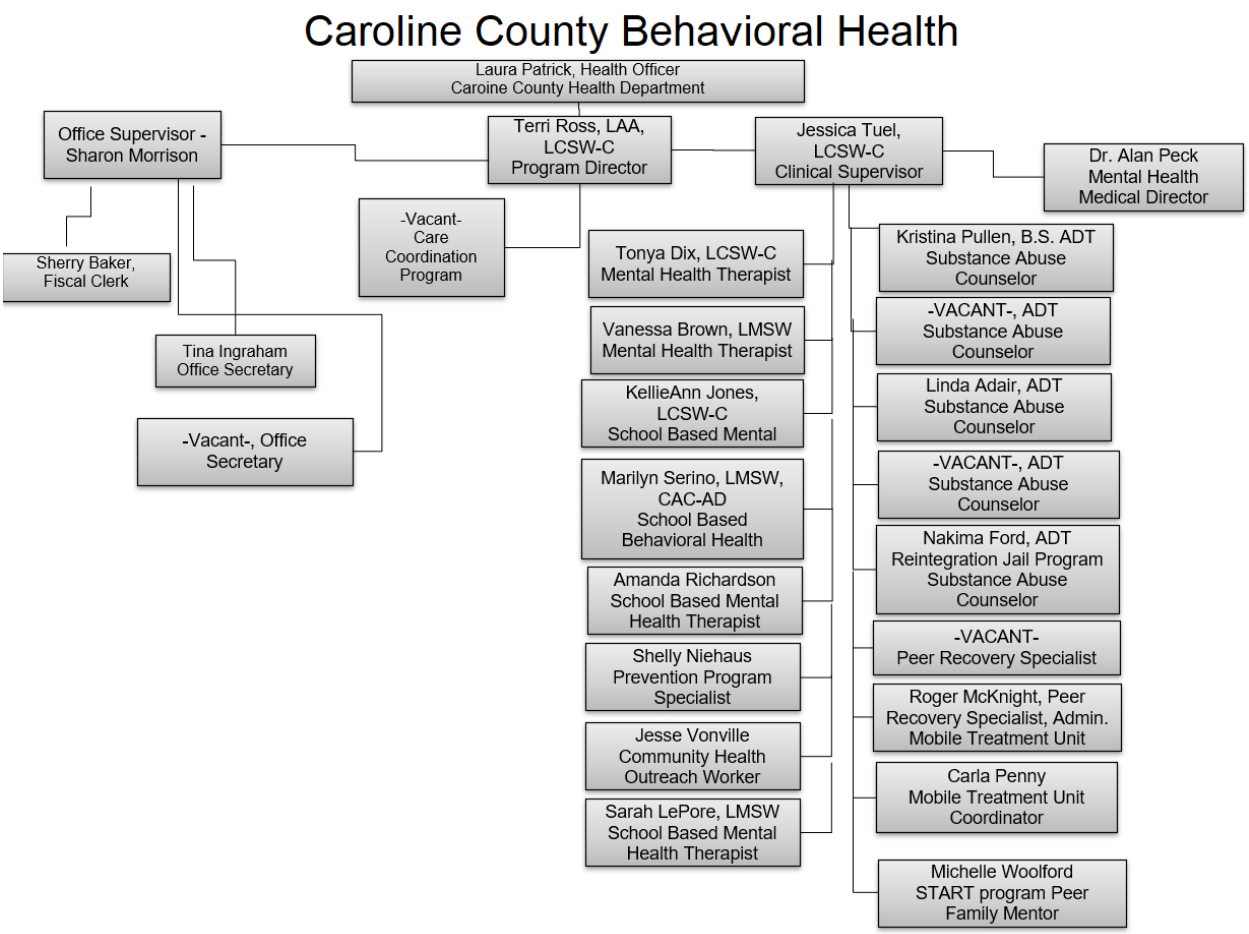
Caroline County's system program structure includes oversight of the following programs: Alcohol and other Drugs Prevention Program, outpatient Mental Health Disorders treatment,

School-based Mental Health treatment and SUD Assessment services, outpatient Substance Use Disorders treatment, Mobile Treatment Unit services for mobile outpatient tele-MAT, DWI Education Program, Medication Assisted Treatment (MAT) for Vivitrol and Buprenorphine, Tele-buprenorphine, tele-psychiatry, SUD and MH Client Transportation Program, Caroline Detention Center Program for SUD assessment and Peer Recovery Specialist Re-entry Program, SUD Assessment, Treatment, and Court status reports for the Caroline County Drug Court Program, Temporary Cash Assistance and START Programs Counselor and Peer for Department of Social Services, Community Health Outreach worker, Peer Recovery Specialists and Care Coordination for recovery housing. We also have the oversight of substance use disorder programs in our jurisdiction as the Local Addictions Authority (LAA).

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

Caroline County experienced a significant health officer transition this past year during the COVID-19 pandemic. Starting in December 2020, Laura Patrick was named the new Health Officer for Caroline County. Since she has been in her new position, Caroline has been largely focused on COVID testing and vaccinations for Caroline County residents during the pandemic. For Caroline Behavioral Health, staffing has largely remained stable and has even grown with the introduction of expanded services.

This past year we have added an additional therapist to our School-based Mental Health program to serve Denton Elementary students. We currently have full-time Mental Health clinicians in 4 of our jurisdiction's schools and caseloads continue to grow. We will continue to add additional clinicians as necessary to support the needs of the children in Caroline County. We have added a full time SUD Counselor to the team of the Mobile Treatment Unit to provide SUD counseling to the clients of the MTU when they come for their Physician visits, which now makes it a one-stop shop in providing evidenced based mobile treatment for opioid use disorders. In FY22 we will be hiring a clinician who can provide treatment to dually diagnosed clients, thereby increasing our staffing in this area to 2 clinicians—one in the school-based program and one in our adult clinic. Caroline County Behavioral Health continues to evaluate and respond to the needs of the community when it comes to Behavioral Health treatment and we look at creative, evidence-based, approaches to providing for these needs. We hope to continue to further expand services offered as the needs in the community increase.



Dorchester County Local Addictions Authority Organizational Structure:

In August 2014, the Dorchester County Health Officer, the Local Addictions Authority (LAA) / Behavioral Health Services and Mid Shore Behavioral Health, referred to as (MSBH) leadership convened to discuss the impending legislation requiring revision of Health General Article §10–1201 to 1203, the statute defining the Core Service Agency (CSA), expanding to include definitions for the local addictions' authority, and local behavioral health authority. In November 2014, BHA issued a letter to each county health department, allocating administrative funding for the first Substance Use Disorder related systems planning and management responsibilities of Local Addictions Authorities, for the second half of FY2015, beginning January 1, 2015. This letter clearly articulated the need to firewall systems planning and management functions from the provision of treatment, and strongly encouraged a partnership with the CSA in doing so. The CSA is now known as Mid-Shore Behavioral Health, Inc. (MSBH). For the second half of FY2015 to the present time, MSBH has executed the following functions for the Dorchester County Health Department:

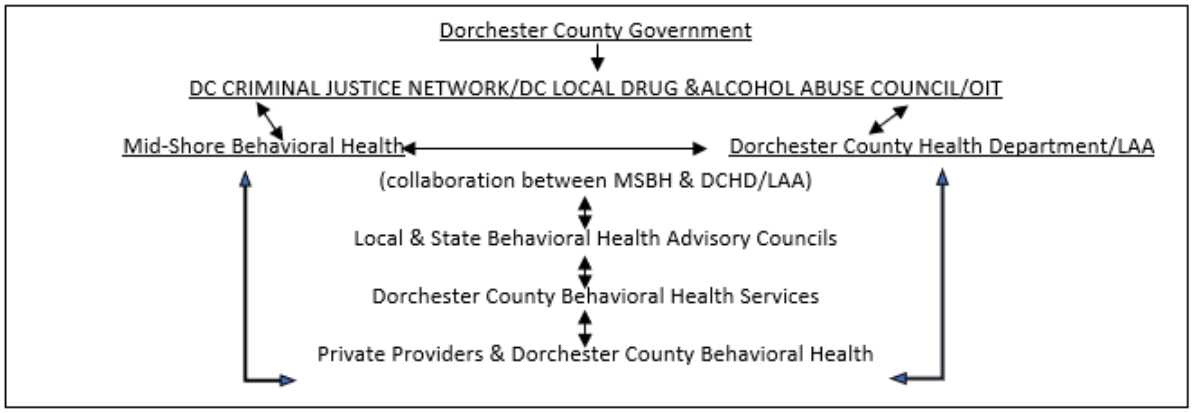
1. Investigate complaints regarding Public Behavioral Health System SUD treatment;

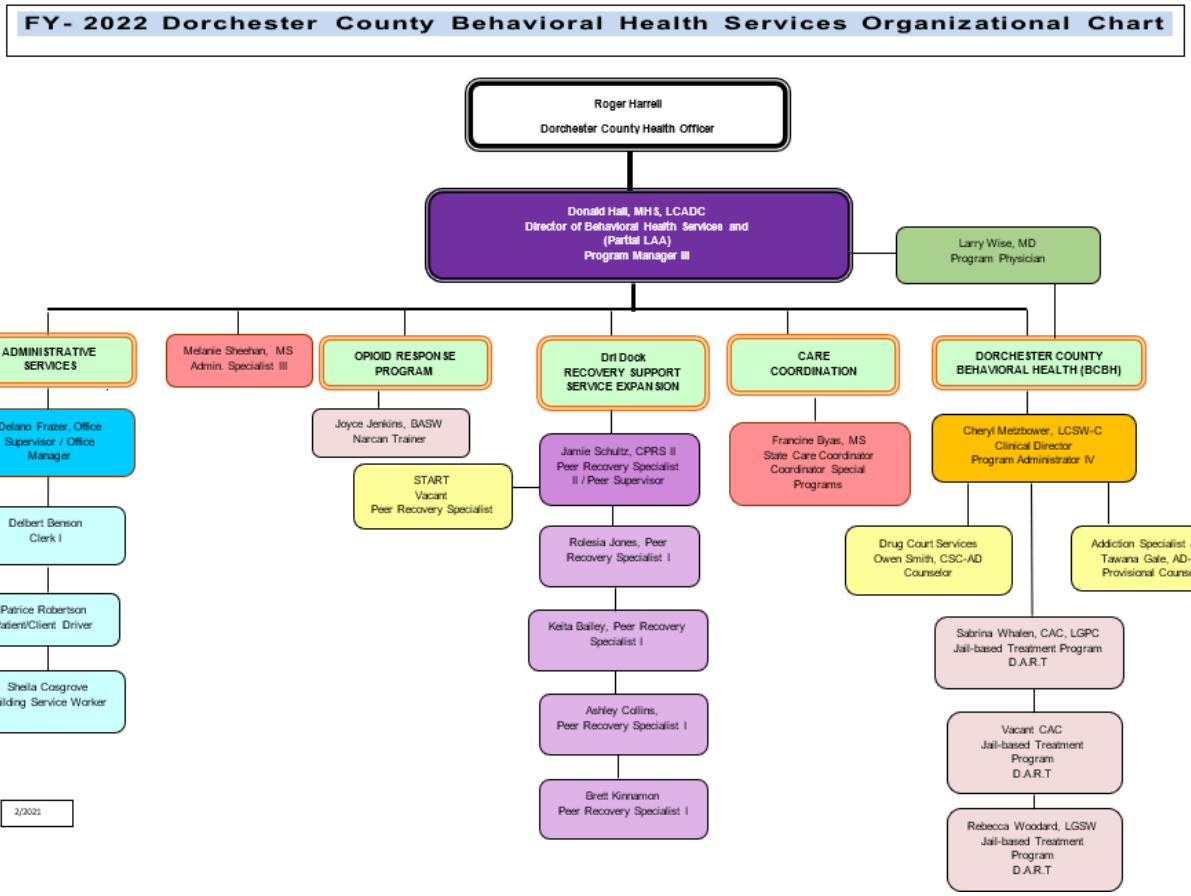
2. Monitoring and overseeing the correction of deficiencies in SUD treatment;
3. Problem solving difficult SUD patient situations;
4. Assisting BHA and the ASO in placing individuals in need of SUD treatment.

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

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

Figure 1. Organizational Structure of Local Behavioral Health Authority



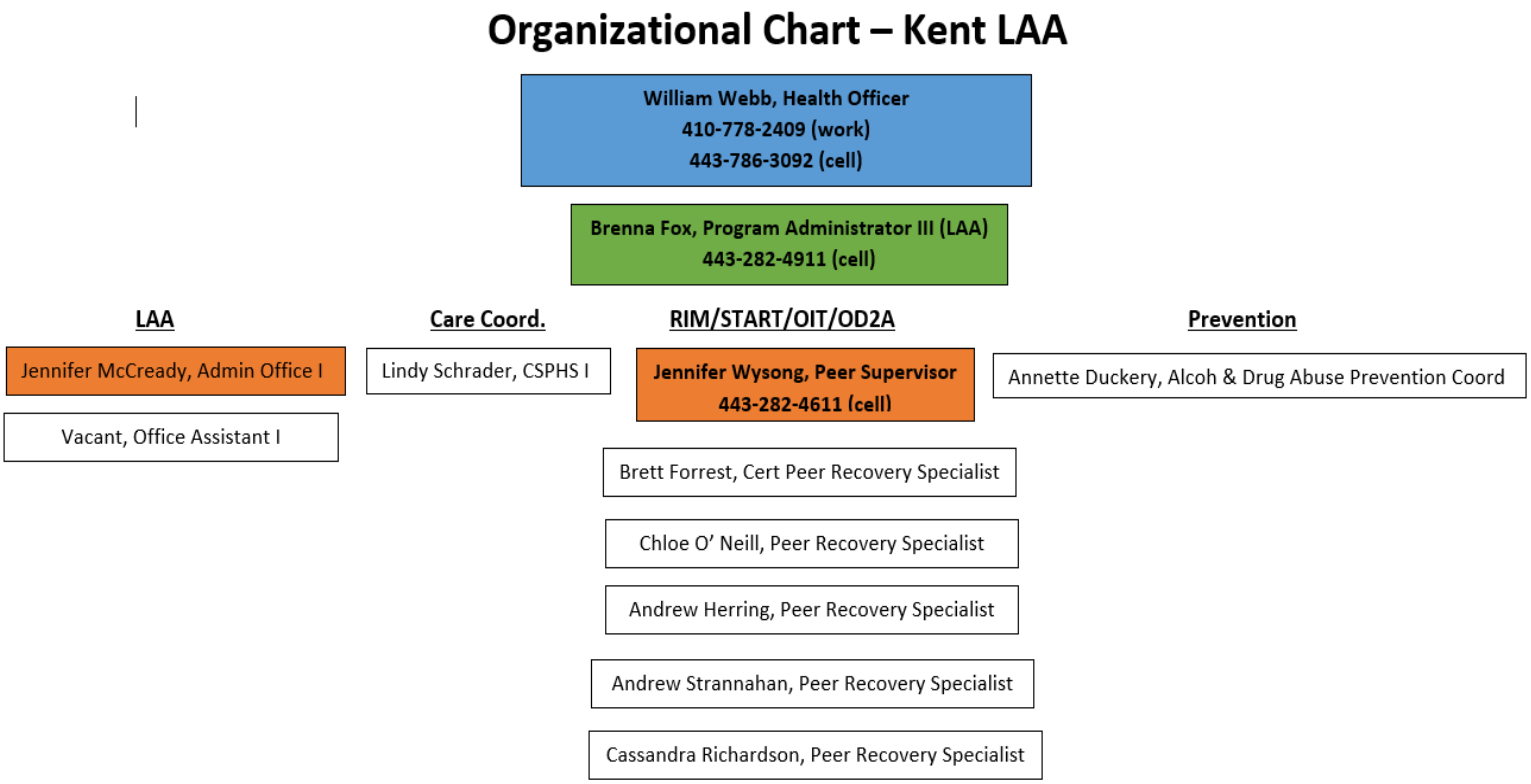


MSBH continues to work with the Dorchester County Behavioral Health Services to facilitate countywide provider meetings as a part of the LAA function partnership, collaboration, and integration. The provider meetings address concerns about the SUD/BH service systems, access, capacity, and quality of care in Dorchester County. There is at least one representative from MSBH serving on Dorchester County's DCCJN/LDAAC. There is cross-systems membership as several individuals serve on the LDAAC, RBHAC and the Local Management Board (LMB) providing

enhanced cross-systems collaboration and integration. In additional, Dorchester County Criminal Justice Network/Local Drug and Alcohol Council (DCCJN/LDAAC) and the Opioid Operations Command Center (OIT) share many of the same members offering increased inter-agency collaboration, planning and efficient use of resources.

Kent County Local Addictions Authority Organizational Structure:

The organizational structure of the Local Addictions Authority (LAA) for Kent County at present time is as follows:



There is a Memorandum of Understanding (MOU) with Caroline County LAA to mitigate conflicts of interest. Identified as conflicts of interest for Kent and Caroline County are: LAA exemption requests for treatment payment from ASO, critical incident reports, audits of providers in LAA's jurisdiction and investigations of programs in the LAA's jurisdiction. The Kent LAA will handle exemptions for Caroline County and vise-a-versa.

The Kent County Local Drug and Alcohol Council (LDAAC) and Opioid Intervention Team (OIT) are one in the same with representation on council's team members. The OIT addresses the same issues and the same population regarding the opioid epidemic. As we have limited resources and

time, Local Advisory Council members are also comprised of LDAAC and OIT members. This also gives us the opportunity to inform members of obstacles, new developments, and progress at the LDAAC/OIT Council meetings.

Organizational Chart LDAAC-OIT-Local Advisory Councils

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

Mid Shore Behavioral Health, Inc. Organizational Structure:

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

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

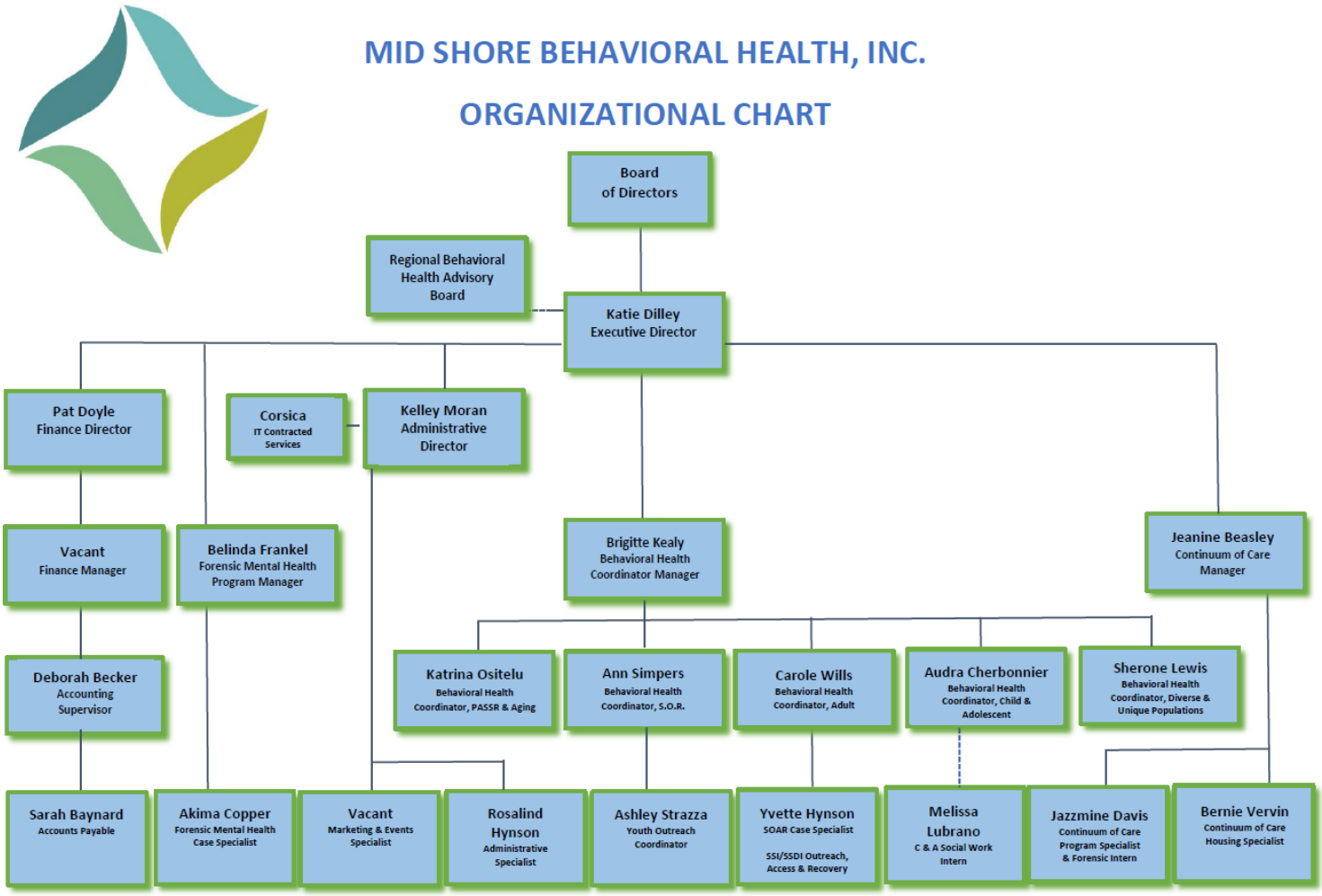
*The **vision** of MSBH is a rural behavioral healthcare delivery system that is clinically and culturally competent. This system will ensure access, have a community focus, be cost-effective, and be integrated to serve the community as a whole.*

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

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

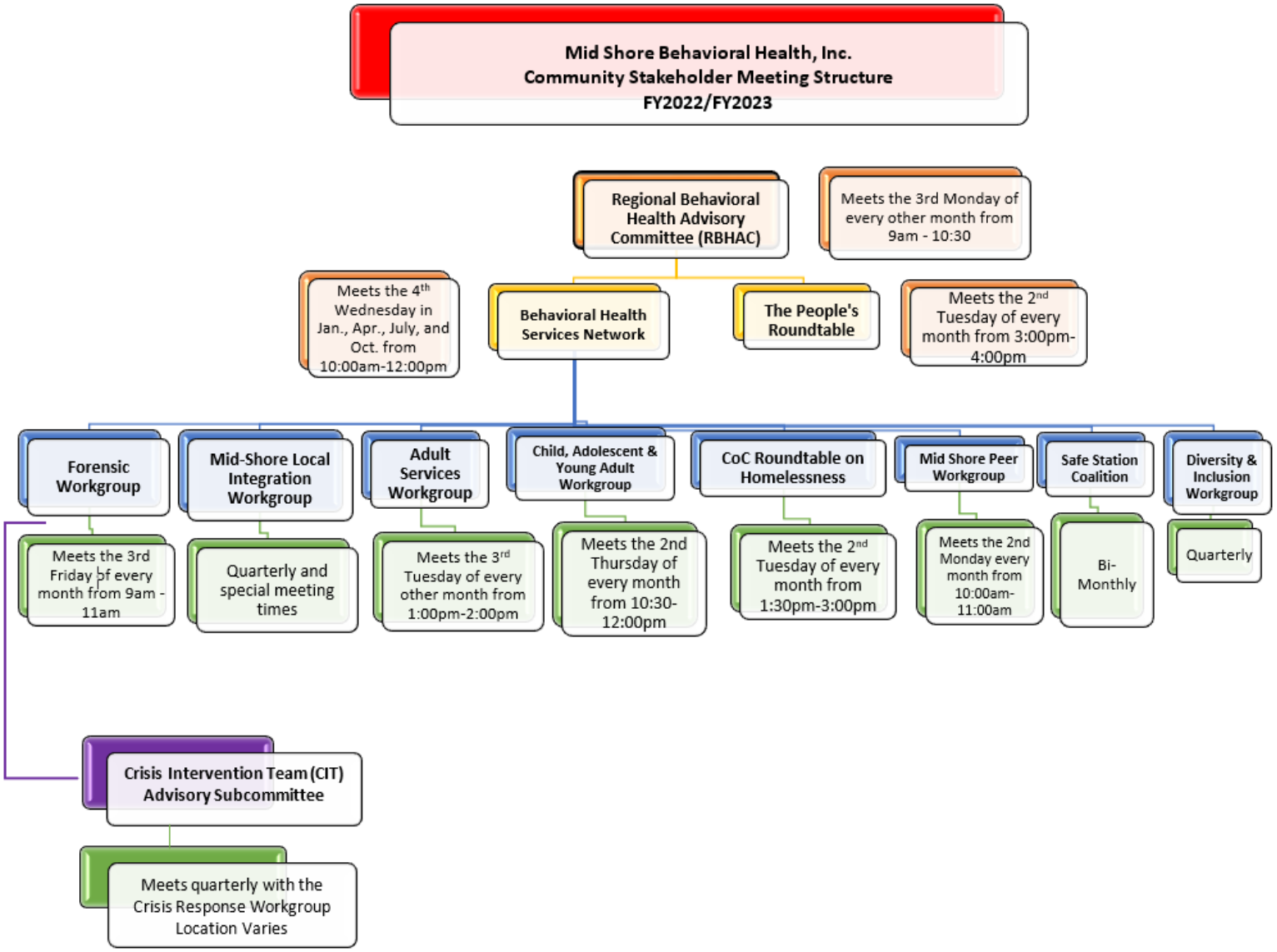
who are at risk for homelessness, access SSI/SSDI benefits. MSBH added a State Opioid Response (S.O.R.) Behavioral Health Coordinator in April 2019 to oversee the implementation and management of the activities supported by the S.O.R. grant, Safe Stations, Crisis Beds, and Recovery Housing initiatives. In October 2020, MSBH with the support of the Opioid Operational Command Center (OOCC), added a Youth Outreach Coordinator position. This position is a Peer Support position that serves all mid-shore counties with working with youth and providers serving children and young adults that may be at risk of opioid and/or substance use. MSBH supports two master's Level Social Work Interns from Salisbury University's School of Social Work program: one Forensic Mental Health Intern and one Child and Adolescent Intern.

MSBH is governed by a volunteer Board of Directors that is representative of the mid-shore region and is comprised of leaders in fields of healthcare, behavioral health, faith-based, education, community action, criminal justice, and county leadership.



It is important to note of the 21 positions on the organizational chart, several are funded in part by CSA Administrative support funding; one position is supported by BHA program funding; one position is supported by Federal Block Grant dollars; one position is supported by SAMHSA/SOR funding, three positions are supported by Housing and Urban Development (HUD)/Maryland Department of Housing and Community Development, and one position funded by the OOCC.

MSBH leads the Behavioral Health Services Network and Workgroup (BHSN) structure delineated in the chart below, with an expanded version in the Planning Section. Membership in these groups is open and anyone from our community is welcomed and encouraged to participate. MSBH prides itself on the oversight of the following groups and has noted that the availability of the following platforms for stakeholder engagement has supported our behavioral health and integrated systems planning:



Queen Anne's County Local Addictions Authority Organizational Structure:

Queen Anne's County is the hub for information, treatment services and support for all residents. The agency supports walk-in clients, although during COVID restrictions, the buildings are temporarily closed to the public, outside of necessary appointments. Phones are answered during normal business hours and staff are able to perform duties remotely. Clinicians and peer support staff are available to assist with referrals to all levels of treatment, 8-505s, TCA, Recovery housing, transportation, Care Coordination, and MAT program information and case management. Referrals for treatment are based on the needs of the client, level of care that is deemed appropriate, and client choice.

The peer specialist presence in Queen Anne's County has increased exponentially and positively impacted the care and services residents receive. The peers are involved in all local leadership committees and councils, providing their lived experience to ensure that the services and experiences are meaningful and well received.

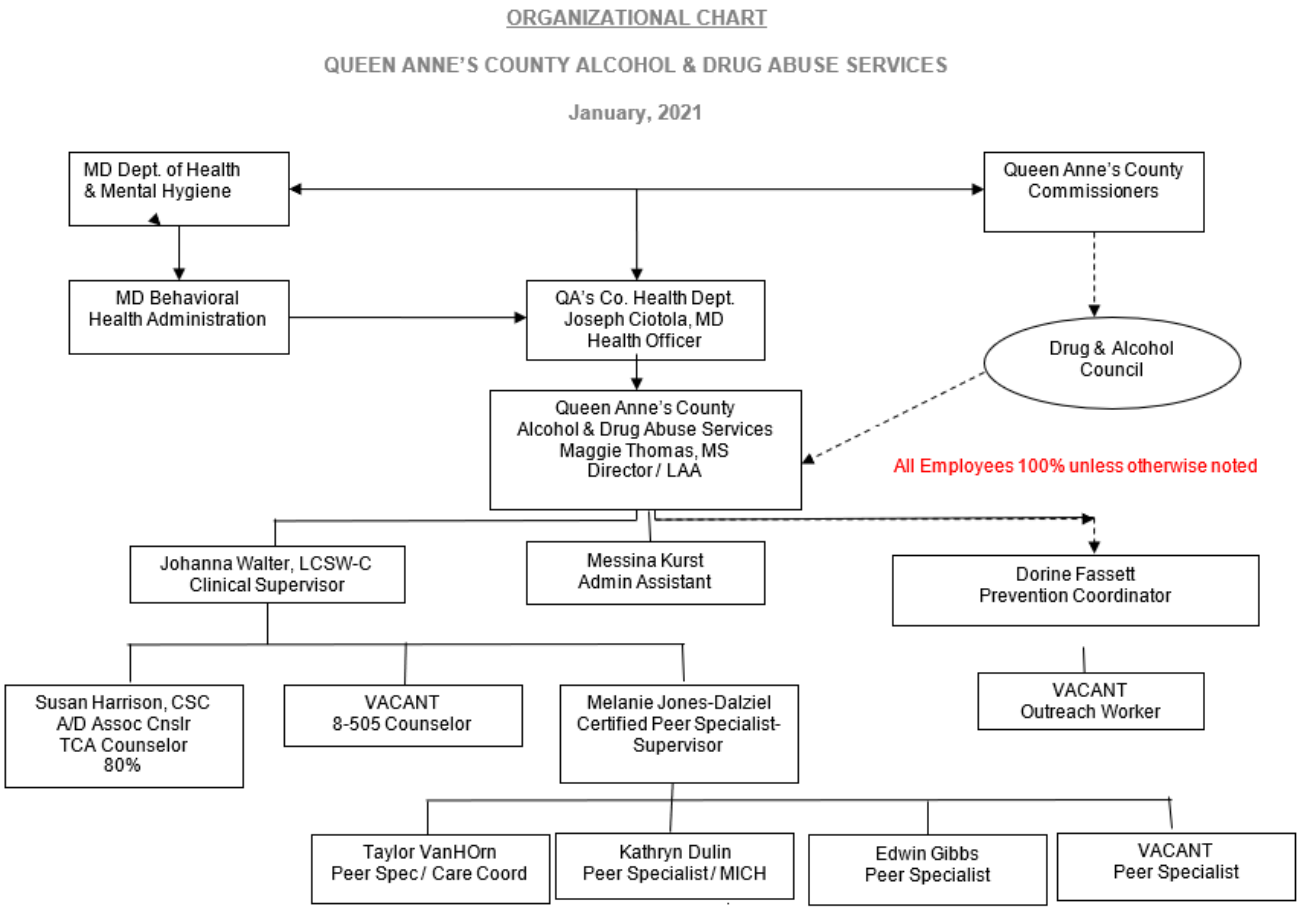
The focus of services for SUD in Queen Anne's County is on the person as a whole, meaning that the public health crisis of both somatic and behavioral health matter when supporting clients towards a life in recovery. With the move to tele-support for peer-based support groups, the need for additional groups arose. A support group focused on MAT recipients was created, which provides a space for those in recovery, who are not comfortable in a traditional 12 step group.

The peer overdose response has been successful in offering overdose survivors support and treatment options. While each survivor's path to recovery may look different, the peers support specialists provide knowledge of the treatment system and other available wrap around services, to support the person achieve their goals. While COVID has prevented the peer support specialists from meeting face to face with the survivors, both telephonic and following up after they are released from the ED continues to ensure that services are accessible. The peers are vetted through Shore Regional Health System as 'volunteers' and are allowed to enter the emergency department as a part of the 'care team'. This encompasses three locations: Chestertown, Queenstown ED, and Easton. As our county is located directly across from Anne Arundel Medical Center and is a different system than Shore Regional, our Mobile Integrated Community Health (MICH) team is able to reach out to those who are transported to that site for follow up and service assessment and provision.

Harm reduction efforts in Queen Anne's County began in the past two years through Naloxone distribution and the availability of Fentanyl Test Strips. Due to COVID and the anticipation of increased substance use, the peers partnered up with a local agency hosting food drive through events and offered Naloxone and CPR training – distributing approximately 500 doses in three months. In addition, safe disposal items, such as Deterra bags, along with educational materials were also provided to the public.

Queen Anne's County's Department of Health serves as the Local Addiction Authority. The responsibilities are for systems management for the county. Planning, overseeing programs both internal, and at partner provider sites, along with monitoring publicly funded SUD services in the county. In addition, investigation of complaints, participation in audit reviews and exceptions for needs requests that are for those who are uninsured are duties that are included.

The strategic plan for the county is created through the receipt of date from local councils and boards, as well as data from partner agencies. Planning together with partner agencies, councils, and committees form the outline for service provision. This plan is also adopted by the combination Local Drug and Alcohol Abuse / Opioid Intervention Team meeting as well. Entities that contribute to the information obtained for this plan is the local Drug Free Coalition, the Liquor Board, the Regional Behavioral Health Advisory Council, the Board of Education, and special committees that focus on needs identification, Wellness Coalition, the Judiciary system, Law Enforcement, Medical and Behavioral Health Providers, Emergency Services, OMPP, Addictions Consortium of the Eastern Shore, Child Fatality Team, and Department of Social Services.



Talbot County Local Addictions Authority Organizational Structure:

The Talbot County Addictions Program (TCAP), as part of the local Health Department, operates as the Local Addictions Authority (LAA) and is responsible for planning, managing, and monitoring publicly funded substance-related disorder services for Talbot County. This entails oversight of non-governmental entities providing direct SRD treatment services in the jurisdiction to ensure adequate supply and quality of services, financial management, and review and investigation of providers. The LAA, in reference to SRD services in Talbot County, receives and participates in audit reviews, complaint investigations, and exception of need requests (uninsured exception). Mid Shore Behavioral Health, Inc., a local private non-profit, serves as the regional Core Service Agency and manages publicly funded mental health services for Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties.

Since FY2017, TCAP's focus has shifted from delivering community-based SUD treatment to organizing patient care activities in the community and serving as a hub for issues relating to substance use and co-occurring concerns. TCAP continues to complete screenings and referrals to local private providers for SRD and co-occurring concerns and has received non-accreditation based licensure for assessment and referral only. TCAP promotes integrated care by collaborating with stakeholders to ensure access to treatment, referral for service and recovery support at all points in the PBHS including social services and through local hospitals. TCAP plans to and continues to have representation on the Local Care Team, Child Protection Team, Child Fatality Team, Local Drug and Alcohol Abuse Council, Behavioral Health Coalition of the Mid Shore, Addiction Consortium of the Eastern Shore, newly established Overdose Fatality Review Team, OMPP Coalition and Leadership Team as applicable, Opioid Intervention Team, MABHA, provider meetings, special initiatives, and representation or partnership in meetings among administrative agencies and those pertinent to the local PBHS and granting administrations. TCAP plans to and continues to have representation in membership to include both professionals and recovering participants including local behavioral health providers, the local recovery center, Community Supervision, peer support specialists, Department of Social Services, Care Coordinators, local Core Service Agency, substance abuse prevention coordinator, local court system/Re-Entry Program, Public School System, Federally Qualified Health Center, Department of Juvenile Services, local recovery house organizations, local shelters, Emergency Management Services, the local Hospital System, primary through tertiary providers, other public safety entities, and advocacy groups.

TCAP continues to provide onsite direct screenings and referrals for individuals referred by the Department of Social Services case managers including TCAP applicants/recipients and food supplement applicants and recipients convicted of a high-volume drug-related felony. TCAP provides assistance for Women and Children and other CPS cases and/or family identified as being in need of substance-related treatment services including screening, assessment, and

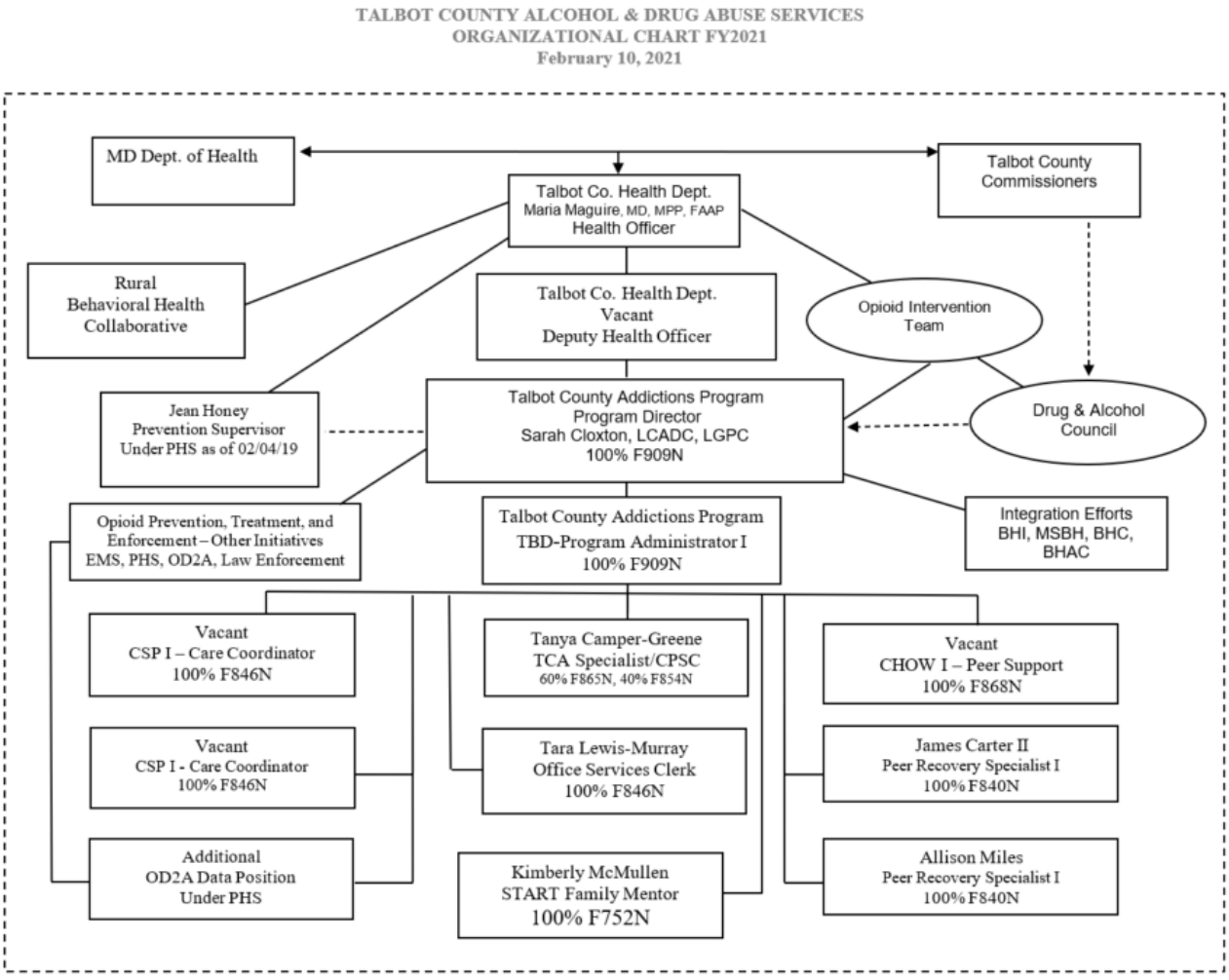
referrals at hospitals, during home visits and on site at the local Department of Social Services. TCAP plans to continue to participate in the multi-year effort of the Maryland Sobriety Treatment and Recovery Teams (START) Model in partnership with the local Department of Social Services. TCAP includes one (1) START Family Mentor that is collocated in the LDSS office where she shares parental SUD-related cases with LDSS caseworkers. TCAP will continue to assist pregnant women and women with children access residential treatment services through the BHA and provide guidance to local private providers regarding specialty residential treatment services and referral as needed.

TCAP continues to participate in recovery activities, offer Care Coordination and Peer Support services, and provides a counselor to participate with the Circuit Problem Solving Court (Drug Court Program), which is a unique partnership among team members including the designated court judge, attorneys, coordinators, parole and probation, and other service agencies that take an innovative approach to addressing substance use and/or serious mental health concerns.
TCAP Care Coordination is the orientation, enrollment and engagement of Talbot County residents consisting of at least bi-weekly visits/check-ins to ensure access to ancillary services, appropriate level of care and follow up with the next level of care as appropriate. Care Coordination is customized to regional and local factors and links physical and behavioral health while building bridges to other areas of need. TCAP's Care Coordinator meets with, engages and enrolls individuals in need of multiple ancillary services, those referred to inpatient treatment with public funding, and those enrolled in the Buprenorphine Initiative. Individuals entering recovery housing with MDRN funding are also enrolled in Care Coordination. Care Coordination continues to expand across populations and referral sources including the aging and elderly population, men and women returning to the community from jail, prison, or commitment under 8-507, individuals with complex social needs and comorbidity, overdose survivors, and those referred by the Peer Recovery Support Specialist.

TCAP Peer Recovery Support Specialist develops supportive relationships, provides recovery coaching, and engages members of the recovering community. Further support may be provided including items related to employment, education, recovery support meetings, housing, driver's licenses/identification, birth certificates, benefits, transportation, and the like. The Peer Recovery Support Specialist focuses on individuals with a history of unsuccessful attempts to establish recovery-oriented lifestyles and who may benefit from a peer's unique perspective and experience in accessing support services. Outreach to overdose survivors and other high-risk individuals in need of treatment and recovery support services are provided by the Peer Recovery Support Specialist in the community and through MOU and referral processes established with EMS, local law enforcement, the local hospital, and other agencies and initiatives.
Circuit Problem Solving Court (Drug Court Program) provides enhanced supervision of the Program's participants through ongoing judicial interaction and remote monitoring of participation and compliance. The Program offers linkages to services to promote recovery and safety, reduce rates of recidivism, and to ensure successful reintegration into the community.

The Program provides a system of accountability and support services to participants and is intended to create better transitions from incarceration to the community while also influencing productive adjustment with graduated sanctions and incentives.

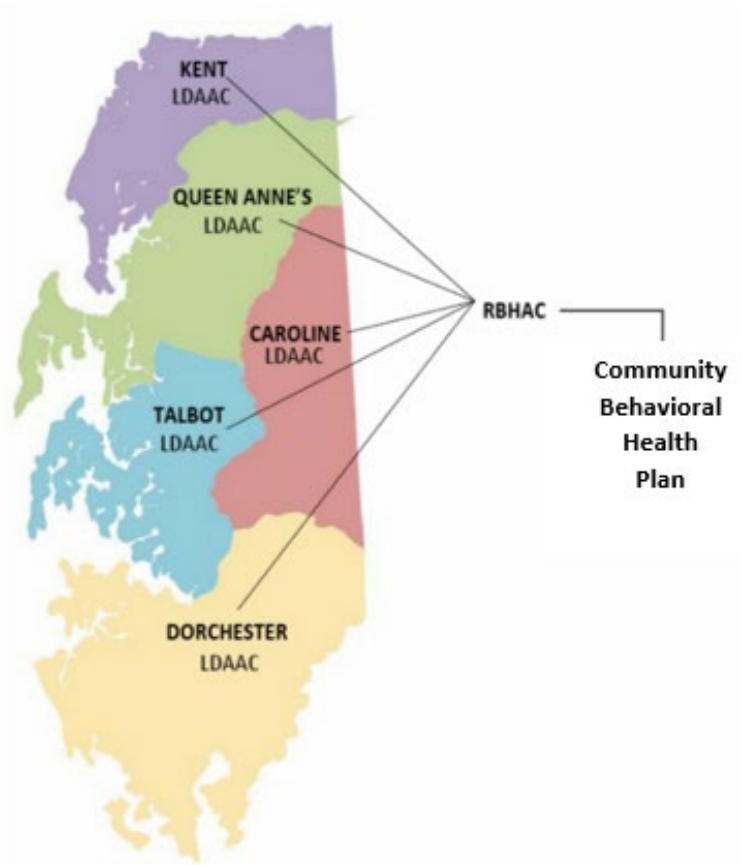
TCAP continues to assist other agencies in the jurisdiction with laboratory-based drug testing services at their expense, as well as MDRN SUD consumer support requests and providing office-based buprenorphine therapy with buprenorphine initiative funds. The Talbot County Health Department (TCHD) also acts as the primary provider of SRD prevention programming in the jurisdiction, frequently working with the Mid Shore Opioid Misuse Prevention Program (OMPP) and local law enforcement, completing needs assessment, and implementing environmental strategies to reduce incidences and prevalence of abuse and misuse of illicit and prescribed substances in Talbot County. Changes to this have been implemented and coincide with Public Health Services (PHS) who assumed responsibility of these areas during FY2020.



Mid Shore Planning Collaborative Relationship with Local Advisory and Governing Bodies

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

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



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

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

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

MSBH is responsible for the oversight and administrative function of the Regional Behavioral Health Advisory Committee (RBHAC). This committee is representative of an integrated advisory

committee. RBHAC has membership from all five counties, with predominant membership from the consumer and natural support community. RBHAC supports systems integration planning.

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

D. FY2020 HIGHLIGHTS and ACHIEVEMENTS

MSPC is proud to share highlights and achievements that were accomplished by the separate local authorities in FY2020, and some combined efforts and collaboration as a group. MSPC continues to acknowledge the unique greatness and commitment that we each possess as local authorities, along with the combined events that we support as a rural region.

Caroline County Local Addictions Authority

Caroline County Behavioral Health was on the road to doing exceptionally well strongly providing services to individuals in the community when COVID-19 hit. The team came together, and we were able to implement the provision of services to be provided via telehealth or by phone. This included school mental health and all clinic services. Our Medical Director continued seeing clients via telehealth or phone and no client was turned down for services during this time. The Mobile Treatment Unit which provides MAT in the community was only parked for about a week to implement safer techniques and COVID protocols to continue to see clients. Clients were given bridge prescriptions to carry them through this time. By ordering needed laptops, VPNs, cell phones, gloves, masks, cleaning supplies, etc. we were able to continue to offer ALL services via telehealth, telephone, or in person (on the MTU). For those clients who had no way to call in or use telehealth services, we set up a tablet in a private area in our waiting room where those clients could call in to their provider for sessions. While there were clients who chose not to participate, overall, our team was able to continue offering our services during 2020 and into 2021 by adhering to COVID-19 plan protocols that protected everyone's health and safety during this time.

Some new initiatives were not able to be started (including new hires) in 2020 due to the pandemic but we are hopeful that in 2021 we will be able to continue to expand services and new initiatives in Caroline County Behavioral Health. One area we will be planning for in 2021 is the expansion of school-based Mental Health services by adding new providers as needed. In addition, we will be expanding the reach of mobile MAT treatment on the Mid-shore, into Talbot County. Other areas may be added depending upon availability of the very busy Mobile Treatment Unit in 2020. Also, the Mobile Treatment Unit was featured in articles published in other states in the U.S. – Colorado and Massachusetts - in order to share its success with other states and jurisdictions. The Director and MTU team have met with individuals to share their knowledge in order to assist them in possibly implementing mobile MAT units in their areas.

Dorchester County Local Addictions Authority

In FY 2020, Dorchester County Behavioral Health Services (DCBHS) has continued its work to foster collaborative relationships with its stakeholders. DCBHS has collaborative relationships with agencies such as Dorchester County Parole and Probation, Dorchester County Detention Center, Office of Problem-Solving Courts, Department of Social Services, Dorchester County Circuit and District Courts, Emergency Management Service, and Dorchester Memorial Hospital. These relationships strengthen the countywide efforts to address the opioid epidemic and manage resources. DCBHS continues to manage a fee-for-service SUD treatment program and a correctional treatment program within the local detention center, accredited by the Commission on Accreditation of Rehabilitation Facilities, CARF. Having received a three-year accreditation in 2018, both treatment programs prepared and experienced a successful survey from CARF in January 2021, with a strong recommendation for re-accreditation. This was due to the extraordinary team efforts of the Administrative, Clinical and Management staff that were willing to commit to vigorous work to prepare for CARF Re-Accreditation.

In the fourth quarter of FY 2020, DCBH hired a program physician to provide SUD treatment to include medications, buprenorphine and Vivitrol, for individuals that are involved with the criminal justice system, both incarcerated and in the community. These medical services are essential in the treatment of SUD for this population as individuals with a SUD, released from incarceration, are at high risk for overdose. DCBH through its Jail-base component, DART, will be adding buprenorphine to the medications used at the detention center by March 2021. Currently, Vivitrol is available prior to release from the detention center and continued in the community. Screening Brief Intervention Referral to Treatment (SBIRT) screenings are conducted on a regular basis, and in FY 2020, 796 screenings were done. Of the 796 SBIRT screenings done 539 individuals screened positive for a SUD. There were 149 individuals that screened positive for a SUD that entered treatment.

DCBH is proud to have hired two new clinicians and now have a licensed social worker employed at the detention center and a licensed professional counselor at the fee-for-service program. Acquiring these licensed professionals in conjunction with the physician will help DCBH in its efforts to better service the co-occurring population in the detention center and in the community.

Dri-Dock Recovery and Wellness Center relocated as the COVID-19 Pandemic closure began. This was an extremely difficult task as the center was short staffed and required to comply with all COVID-19 restrictions. In the mist of the pandemic Dri-Dock has been able to hire three (3) new peer recovery specialists, one of which is a mental health peer. This is important as the SUD population served in Dorchester County is comprised of individuals with SUD and Co-Occurring

Disorders. The peer staff were instrumental in responding to the spike in non-fatal overdoses seen in FY 2020, and the follow-up referral to treatment. The dedicated Peer Recovery Specialists were willing to put on their PPE and respond to overdose calls over the past year and through the continued pandemic, offering support and making referrals to treatment. Peers and clinical staff engage overdose survivors and family members, contacting them after the emergency room visit and offer support, SUD Assessment/Treatment or referral to higher levels of care. In addition to the support offered during the pandemic, peers have provided transportation to residential programs for individuals that have no other means to get this essential treatment. In FY 2020, Peer Recovery staff served 790 individuals and an additional 454 individuals visited Dri Dock Recovery and Wellness Center for support groups and other activities.

The Access to Harm Reduction Program has formed a collaboration with DCBH, the HIV Department at the Dorchester County Health Department, and Johns Hopkins Hospital to provide HIV and HCV testing and treatment for individuals having a SUD. DCBH has incorporated the testing protocol into the intake process and will offer testing to all new and current consumers. Testing will also be available for individuals that visit Dri Dock Recovery and Wellness Center. Peers will encourage participants at Dri-Dock to be tested. All individuals tested, that are positive for HIV and/or HCV will get treatment through the Dorchester County Health Department and Johns Hopkins Hospital. In FY 2020, 627 individuals received Narcan training, to include a Narcan kit, and 49 trainings were conducted. The 49 trainings that were conducted included individuals suffering from a SUD, their family members, public agencies, and community members at large. Behavioral Health staff displayed commitment, creativity and dedication and were action-oriented from the onset of the Pandemic. DCBH's CQI team and clinical staff developed and implemented a telehealth clinical and medical service plan to meet needs of consumers during the pandemic. As pandemic restrictions changed, they assisted in a creative transition to a hybrid model and modified program schedule to provide safe in-person access to Level I SUD treatment. DCBH quickly prepared an emergency response to ensure all precautionary measures were taken to guarantee consumers received medications (Buprenorphine and Vivitrol) during the COVID-19 pandemic closure. DCBH established telehealth stations within the program, complying with safety precautions to serve consumers that otherwise would not be able to take advantage of telehealth services. DCBHS and DCBH staff also were actively involved in volunteering on multiple occasions to support Dorchester County Health Department's COVID-19 testing throughout Dorchester County.

Kent County Local Addictions Authority

The START program was implemented and fully operational in our County FY20. Kent START Program has become a model for a successful program for other local jurisdictions. The Family

Mentor has provided Parent Recovery Support, Coaching, Assistance with System Navigation, as well as promoting Child Safety and Wellbeing. All team members completed START Foundations Training. Ms. Richardson also received training regarding Peer Recovery standards as well as Child Welfare policies and procedures. The START team has developed working relationships with local providers for both inpatient and outpatient treatment.

Program Performance

Direct contact with individuals on Caseload: 100%-9 Families
Enter Data into DSS data system: 100%-9 Families
Enter data into Family Mentor Doc of Work: 100%-9 Families
Referrals to support/recovery resources: 100%-12 Referrals
Referrals needing treatment, sent to SUD programs: 100%-7 Referrals
Provide education to caseload: 100%-9 Families

Recovery in Motion

RIM staff attended 36 different trainings during FY20 for staff to obtain continuing education and CEU's, pertaining to Peer Recovery Specialist Certification. RIM staff held 37 trainings and events such as community Narcan distribution/education, sober socialization, etc. for the FY20 fiscal year. Our staff responded to 44 overdose calls from the Chestertown Emergency department and provided resources to consumers for treatment.

Care Coordination enrollments: 184

Program performance: Increased from FY19:

- # of consumers to housing for 42 day stay- 89
- Unduplicated served in recovery center- 2030
- # of peer contacts w/ participants- 3472
- # of facilitated peer support groups- 266
- # Referred to TX- 95
- # Referred to education- 313
- # Referred for employment- 35
- # Referrals for financial assistance- 204
- # Referrals for medical/dental- 12
- # Referrals for housing- 111
- # Referrals for nutrition- 17
- # Referrals for transportation- 93

Opioid Intervention Team (OIT)

Program performance: Increased from FY19:

Total # of Peer contacts with participants: 450

Total # of Unduplicated served by peers: 293
Total # of Peer facilitated support groups: 50
Total # of referrals to treatment: 88
Education: 32
Employment: 15
Transportation: 39

Prevention

- Prevention focused on both underage drinking and non-medical use of prescription drugs (NMUPD) during Fiscal year '20. We worked to prevent new cases of opioid and alcohol misuse and abuse among both adults and youth.
- We have forged new partnerships and adapted our strategies to coincide with the changing environment. One of the strategies implemented was prevention education in health class. The school was a huge partner this year as it has been in previous years. Due to their partnership, we were able to take students to a huge youth summit which included the first lady speaking.
- We were able to implement a new media campaign for prom that continued to reach the community. Implemented a social marketing campaign to target underage drinking.
- Prevention was also able to procure 1,000 more Deterra bags free of charge.

A.F. Whitsitt Center

During FY21 the AF Whitsitt Center (AFWC) was beginning a restructuring process when the pandemic began in March 2020. We suspended admission through July of 2020 to implement best practice recommendation of the CDC, train staff, obtain sufficient personal protective equipment (PPE) and develop new policy and procedures. Concurrently when reopening we also reduced our program capacity from a 44-bed facility to a 22-bed facility. A week later we reopened the eight State Opioid Response (SOR)-Crisis Opioid Beds (COB). The restructuring also included ending the 4-bed mental health crisis grant with the State of Maryland-Behavioral Health Administration (BHA) which had been open since 2010. This decision, as-well-as, the reorganization decision, which reduced our staffing from 84 employees to 42, was a difficult but necessary decision. Our program has suffered from: attrition due to private practice competitive pay, the Eastern Shore professional desert for attracting new hires to rural areas and overall attraction to the field of behavioral health professionals. The pandemic drove many or our retired contractual employees out of our schedule pool. We are fortunate to have train, reopened and been able to adapt to the new protocols and necessary adjustments for safety of staff and consumers. This was a costly endeavor. We received help in obtaining PPE from BHA and Mid Shore Behavioral Health (MSBH) and slowly gained the necessary PPE stock needed to reopen our doors for substance use disorder treatment of our community consumers on July 7, 2020. We also gained support from Opioid Operational Command Center (OOCC) funding with MSBH

oversight to make improvements to the SOR-COB program. AFWC is grateful for all the support and assistance from our partners in the mid-shore whom are battling the opioid epidemic in each and every jurisdiction only exacerbated by the COVID 19 pandemic.

Mid Shore Behavioral Health, Inc.

Enriching Access to Behavioral Health: A New Partnership with Shore Regional Health and Behavioral Health Leadership

In May of 2019, the University of Maryland's Shore Regional Health Hospital System (UM SRH), announced its intention to explore the relocation of the acute inpatient psychiatric treatment beds from their hospital in Cambridge, Maryland (Dorchester County) to Chestertown, Maryland (Kent County) in the summer of 2021. The proposed move stemmed from the planning and development that the UM SRH team their regional hospital development planning. The Cambridge hospital is slated to close and move to a free-standing Emergency Department in 2021. The closure of the facility initiated the evaluation of the transition of the inpatient psychiatric beds withing the UM SRH system.

The proposal to move the inpatient beds to the Chestertown Hospital location was endorsed by the UM SRH Board of Directors in August of 2019 to apply to the Maryland Health Care Commission (MHCC) for approval to relocate inpatient behavioral health beds to Chestertown, MD. As a result of this application and proposed move of the inpatient beds, the mid-shore provider community expressed concerns as well as outreach and outcry to state leadership in hopes of reevaluating this application for the movement of the beds.

As a result of the expressed concerns and need to ensure provider voice in the planning and impact to the behavioral health system of the region, MSBH initiated local advisory groups, MSBH Board of Directors and the Regional Behavioral Health Advisory Committee (RBHAC) to be a partner in forming a community forum group to focus on the needs that a transition in provider location and community impact in hopes of addressing the needs and gaps in services and community preparedness, prior to 2021. The formation of this group was an inclusive process with UM SRH leadership to ensure the support of both the providers in the region and the hospital in planning for and addressing the needs of our behavioral health system.

On February 27, 2020 UM SRH withdrew the request for exemption for Certificate of Need ("CON") to the Maryland Health Care Commission to approval to merge and consolidate UM SMC at Dorchester and UM SMC at Chestertown by relocating UM SMC at Dorchester's inpatient psychiatric services to UM SMC at Chestertown. The request highlighted the desire to support

the previously approved (April 2019) and existing exemption from Certificate of Need ("CON") review for the relocation of beds and services from UM SMC at Dorchester to UM SMC at Easton. On March 11, 2020 the first formal meeting of the Community Behavioral Health Partnership Committee convened. The first meeting focus was "Enriching Access to Behavioral Health: A Community Partnership Meeting". The meeting was attended by the leadership of most of the mid-shore region's outpatient mental health clinic directors, residential rehab leadership, mid-shore Local Addictions Authorities Directors, mid-shore counties Health Officers, MSBH leadership and Board of Directors representation, RBHAC Chair representation, and leadership from UM SRH.

The meeting addressed regional systems developments, service delivery needs and planning, gaps in access to adequate care, and group planning for short- and long-term goals, as well as meeting frequency. The group engaged in a rich discussion of all the topics, in addition to a robust and critical discussion regarding the COVID-19 pandemic and looming impact on behavioral health services and access. This meeting was the last in-person meeting that the leadership team of UM SRH system was permitted to attend in person with the newly enacted employee protocols with COVID-19 restrictions.

Since March 11, 2020, the Community Behavioral Health Partnership Committee has only met one time due to COVID-19 to review an application from UM SRH to Health Care Cost Review Commission for the behavioral health catalyst grant in support of for behavioral health crisis services expansion. MSBH intends on revitalizing the group in hopes of greater activities and continued collaboration in FY22 and beyond.

State Opioid Response Grant

Mid Shore Behavioral Health, Inc. was awarded the S.O.R. grant in January 2019. The award was designed to expand opioid services on the Eastern Shore, with the focus on expanding crisis bed services, recovery housing, and initiating safe stations. The purpose of a Safe Station is to have a place where anyone with a primary opioid misuse problem can walk in without an appointment, ask for help and begin the process to connect them to the treatment or resources they are ready to receive.

On August 1, 2019 two Safe Stations launched on the lower shore. The Worcester County Safe Station is located in the 15th Street Fire House in Ocean, City, MD. The Wicomico County Safe Station is located in the Recovery Resource Center in Salisbury, MD. Both Safe Stations utilize a peer led approach with Person Centered Care with availability 24/7 365 days a year. Combined, the two Safe Stations have served 181 consumers through the end of June 2020.

In Dorchester County a recovery house was established in 2019 with SOR Grant funding. Gratitude house is a five-bed male house. The recovery house setting allows the consumer time to focus on their recovery while slowly integrating back into society.

In early 2020 Oxford House had an executed contract with MSBH with plans to open 3 Recovery Houses in Queen Anne's County. They hired an Outreach Coordinator who has been reaching out to potential investors and looking for properties in the Queen Anne's County area suitable for a recovery house.

The A.F. Whitsitt Center, located in Kent County, is an inpatient substance use residential treatment facility. The A.F. Whitsitt Center continues to support an 8 Opioid Crisis Beds comingled within the tradition 3.7 treatment beds. However, with the support of the FY20 OOCC (Opioid Operations Control Center) Expansion Funding plans are to move from being comingled to becoming a separate Crisis Bed Unit with an increased 12 bed capacity.

Caroline County Summerfest 2019

MSBH attended the Caroline County Summerfest helping with the Caroline Goes Purple booth. There were all kinds of purple giveaways along with purple lightbulbs and t-shirts for sale. The Summerfest in Caroline County is an annual family friendly free event. Caroline Goes Purple was present at the Summerfest to educate and bring awareness the community about the opioid epidemic.

MSBH had a vending table at the North Caroline Goes Purple in September of 2019. There was a table with giveaways, resources, and educational material. The event was done to bring awareness to the opioid epidemic.

Safe Station Launch and Coalition meetings

On August 1, 2019 two Safe Stations launched on the lower shore. Worcester County Safe Station is located in the 15th Street Fire House in Ocean, City, MD. The Wicomico County Safe Station is located in the Recovery Resource Center in Salisbury, MD. Both Safe Stations utilize a peer led approach with Person Centered Care with availability 24/7 365 days a year. Combined the two Safe Stations have served 181 consumers through the end of June 2020.

MSBH developed the Eastern Shore Safe Station Coalition with the first meeting occurring in May of 2019. This meeting was designed to provide support and collaboration between the Safe Stations and MSBH. This meeting gives an opportunity to share resources, barriers, and accomplishments. Although the meetings began on a monthly, they have since moved to being a bimonthly event.

On September 26, 2019, the Worcester County Health Department held a recognition event at the 15th Street Fire Department in Ocean City. The WCHD recognized the efforts of recovery staff, first responders, behavioral health professionals and various local agencies that have partnered to make the program a reality. In addition they recognized the Ocean City Fire Department, Ocean City Police Department, Atlantic General Hospital, the Atlantic Club, the Worcester County Warriors Against Opiate Addiction, the Worcester County Sheriff's Office, the Worcester County State's Attorney's Office, the Worcester County Department of Emergency Services, Hudson Health Services, SUN Behavioral Health and Mid Shore Behavioral Health for their roles in establishing the local Safe Station program and helping those in need.

Stress Farmer Initiative: AmerisourceBergen Foundation Grant

In August of 2019, the Caroline Health Officer presented a grant opportunity to the Caroline County LDAAC. The AmerisourceBergen Foundation provided grant funds for a project to help individuals with Opioid use dependency. The partnership of the Caroline County Health Department, the Caroline County Public School System (Chesapeake Culinary Center), The Maryland Rural Health Association and MSBH created the *Stress Farmer Management Project*. This project is written to benefit, support and benefit the farmers, migrant worker and individuals who work in the agriculture field in Caroline County. The grant was approved for a program to facilitate events, to distribute literature about substance use and prevention, and to record interviews. The original project was scheduled to begin Spring 2020. Unfortunately, due to COVID, we requested from AmerisourceBergen to push the start date further out, based on COVID restrictions. The partners have since met to reconfigure the project slightly, with hopes to implement the Stress Farmer Project beginning Spring 2021.

Kevin Hines Collaboration

This event was hosted on September 19, 2019 successfully in collaboration with Channel Marker, Inc. This event showcased the Kevin Hines' Story: an evidenced based suicide prevention, free speaking engagement which was opened to the public. Kevin Hines is a national suicide survivor, public speaker, award winning documentary filmmaker, and best-selling author. In the year 2000, Kevin attempted to take his own life by jumping off the Golden Gate Bridge. Many factors contributed to his miraculous survival including a sea lion which kept him afloat until the Coast Guard arrived. Kevin now travels the world, sharing his story of hope, healing, and recovery while teaching people of all ages the art of wellness and the ability to survive pain with true resilience. This event was held at the Todd Performing Arts Center at Chesapeake College. MSBH honored CEUs for clinicians and social workers. We had over 100 Clinicians, peers, and guests in attendance. This event focused on Suicide Prevention, with hopes to reduce stigma around suicide and accessing mental health supports in the community.

Purple Events across the Mid Shore

As one of the county's "Going Purple" events, Kent County held a Jamboree on September 14th, 2019. The event consisted of several resource tables available to the county residents to learn more information about the services they can access. There were many faith-based organizations present as well. There were personal testimonies given by those with substance use disorder, in which they spoke about their journey through addiction and highlighted their recovery stories.

Along with the *Caroline Goes Purple* events, MSBH supported Purple Sunday, which shared substance use information in the faith-based community. Information for this event was dispersed via the Caroline Co LDAAC, through a list of churches from the Caroline County Taxation information and the Drug Free Caroline planning committee. On September 15th, churches shared messages of hope, recovery, and packets of information to their congregation. Many of those individuals are not part of the Caroline LDAAC meetings and ongoing planning.

Opioid Operational Command Center Regional Impact Presentations: 10/2/2019 & 2/21/20

Mid Shore Behavioral Heath, Inc. (MSBH) was invited to present to the Opioid Operational Command Center leadership two times during FY20; October 2, 2019 and February 21, 2020. The first request to meet was a special opportunity for each team member of MSBH to present their individual contributions to MSBH's operations and responsibilities. MSBH organized a presentation of the innerworkings of MSBH, the orientation and impact of the Eastern Shore Crisis Response System, and the expanded resources for opioid treatment on the Eastern Shore made possible by the State Opioid Response Grant (S.O.R).

For the October 2, 2019 presentation, MSBH organized the following "Snapshot" of activities and oversight of the organization, and financial growth over the course of FY17-FY20.

The MSBH team presented by concentrated oversight resposibilities ranging from Family and Youth, Forensic Services, Homeless and Housing Services, Crisis Response, Special Populations, and State Opiod Response actiteives. MSBH presented a financial growth and responsibility oversight and supported a dicussion regarding the regional oversight with contracting and procurement.

MSBH invited the leadership of the Eastern Shore Crisis Response Center and leadership of the A.F. Whitsitt Center and each Safe Station (Wicomico and Worcester County sites) to join with the MSBH for the meeting with Steve Schuh and team. All parties were able to present and orient the OOCC members to the regional impact that the collbaoration and oversight from a regional and multi-jusristictional structure has had on the mid-shore and Eastern Shore commuinities.
Following the October 2, 2019 presentation, a second invitation was received from the OOCC to travel to Western Maryland to present the regional impact model of MBSH to our peers in Allegancy, Garrett, and Washington Counties. MSBH Executive Director, Katie Dilley, Behavioral Health Coordinator Manager, Brigitte Kealy, and State Opiod Response Behavioral Health Coordinator, Ann Simpers, traveled to Western Maryland on February 21, 2020 for a presentation hosted at the Washington County Health Deparment.

MSBH team members presented to OOCC leadership and the Health Officers for each county, as well as representation from Local Behavioral Health Autorities for Allegany and Garrett counties and Local Addictions Authority and Core Service Agency leadership for Washington County. MSBH prepared and presented a more detailed presentation of the scope of services supported by MSBH; historical information on the regional structure as well as future planning and growth impact was dicussed. MSBH specifically highlighted the strength of the partnerships on the Eastern Shore and collaboration to support addressing gaps and limited resources in a rural region. MSBH has supported being a resrouce to our Western Maryland partners since the presentation in February and looks forward to supporting expanded regional iniatives across the state.

Healthy Transitions Grant

MSBH has contracted with Crossroads Community to provide expanded transition-age youth (TAY) programming, Healthy Transitions**,** to the five mid-shore counties. These services are provided to youth and young adults ages 16-25 who are eligible for the Public Behavioral Health System and meet TAY eligibility criteria. Healthy Transitions provides youth-driven, strengths-based, developmentally sensitive, non-stigmatizing, culturally competent, and appealing TAY services and supports. These services include developmentally tailored supported employment, competitive employment, supported education, and Family Psychoeducation. During the contracted period of October 2019-June 2020, thirty-one youth were served in the Mid-Shore.

Data Waiver 2000 Training

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

online. This has been an ongoing initiative to enlist primary care physicians to prescribe Buprenorphine.

Resilience: A Partnership with Health Tilghman

On November 13, 2019, MSBH in partnership with Healthy Tilghman, held a community event for the screening of the documentary Resilience, The Biology of Stress and The Science of Hope. The documentary focuses on the impact of Adverse Child Experiences (ACEs) and the impact of toxic stress, chronic environmental stress, and the relationship with the brain and behavior. The event was open to the public with special marketing efforts in the lower Bay-Hundred community of Talbot County.

Healthy Tilghman is a community collaboration and outreach led by the Tilghman United Methodist Church and For All Seasons Behavioral Health and Rape Crisis Center of Easton, MD, since the fall of 2016. It was begun initially to address the mental health and substance use needs of the residents of the Tilghman Island area. The originators were Pastor Everett Langdon, most recent Pastor is Rev. Herb Cain, For All Seasons, Inc. and Dr. Michael Flaherty, Ph.D. Pa. Clinical Psychologist. Healthy Tilghman is a collaboration of Faith and Secular Institutions and community leaders seeking to meet the mental health and substance use needs of the community in hopes to improve community health. Mariah's Mission Fund of the Mid-Shore Community Foundation, Phillips Wharf Environmental Center on Tilghman Island, and Mid Shore Behavioral Health, Inc. leadership are also members of the Healthy Tilghman group.

Since launching, Healthy Tilghman has helped train several local citizens as volunteer Peer Support Specialist, building a community safety net of those with first-hand knowledge of mental health or substance use and recovery. These committed volunteers reach out to the community in numerous ways to assist neighbors and residents in finding and sustaining help when needed, whether for an individual or a family, or by just sharing their lived experiences.

Community educational programs are regularly conducted as a mission of the work of Healthy Tilghman. The November 13th, 2019 program was specifically tailored for families living with challenges such as severe stress, mental health, or substance use and tools and community resources to build hope, wellness, and resiliency. The event was free to the public and offered free childcare for attendees. Food and drink were provided, and a host of several local mid-shore mental health, substance use, and crisis providers provided information tables for the event. Narcan training and distribution was offered by the Talbot County Health Department. MSBH facilitated the panel discussion and program management. Following the screening of the film Resilience, a panel discussion was conducted. Representatives from the treatment community, an individual with lived experience in recovery, and the Talbot County Health Officer Dr. Fredia

Wadley, MD comprised the panel. The event was well attended by community members and representatives of the provider community. The sponsors for the event were MSBH, Healthy Tilghman, For All Seasons, Inc, Tilghman Area Youth Association, The Family Tree, Phillips Wharf Environmental Center, and Mariah's Mission Fund.

Community Dinner with Knights of Columbus

The Mid Shore Roundtable on Homelessness and the Easton Chapter of the Knights of Columbus partnered together to hold a holiday meal for our community partners and people impacted by homelessness on Monday, November 25, 2019. The event took place at the Easton Fire House in the community room which was donated for the event. Over one hundred people attended and enjoyed a full holiday spread, including turkey, stuffing, mashed potatoes, mixed vegetables, and rolls. The meal was all prepared by volunteers from the Knights of Columbus. Desserts were provided by Roundtable on Homelessness partners and ranged from pumpkin pies to cakes and cookies. There was also a craft table set up for children who attended to create their own fall decorations. Guest from local homeless shelters attended along with other community members. It was a wonderful event filled with food, laughter, connection, and partnership.

Eastern Shore Behavioral Health Coalition events (MACO & Delegation meeting)

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

The Coalition presented at the Maryland Association of Counties (MACo) Winter Conference Briefing on December 4, 2019 at the Hyatt Regency in Cambridge, MD. Members met with county government officials across the Eastern Shore to discuss the needs of both behavioral health providers and consumers. The Coalition presented on barriers to credentialing, issues with network adequacy, and the importance of the Keep the Door Open Act. There was also timely discussion surrounding the critical infrastructural needs of the A.F. Whitsitt Center, which provides inpatient residential treatment for adults with a chemical dependency or co-occurring disorders. Although the facility is located in Kent County, individuals from across the state come to receive treatment services, which further emphasizes the need to keep the facility operational. Additionally, on February 14th, 2020, the Eastern Shore Behavioral Health Coalition presented in front of the Eastern Shore Delegation in Annapolis, MD. The meeting gave the Coalition the opportunity to review legislation and show their support and opposition for specific bills that were introduced in the 2020 Legislative Assembly.

Martin Luther King Event at Washington College

On January 20, 2020, at Washington College in Chestertown, MD, community members gathered to hear a presentation by the Racial Equity Institute. This event was sponsored by the Kent County Local Management Board, Talbot Family Network, and the Starr Center for the Study of the American Experience. The *Groundwater Approach* is the understanding of "how institutions and systems are producing unjust and inequitable outcomes". Racism is built into the policies that govern how these systems provide services in our communities. The education system, mental health, somatic care, and obliviously our *criminal justice* system, were not established with the thought that People of Color would positively utilize or be able to flourish within these domains. Participants are encouraged to begin creating or continue to support groundwater solutions against racism within their agencies and communities, in order to "unlock transformative change".

Sequential Intercept Map Conference -Human Trafficking

On January 28, 2020, the Forensic Mental Health Program hosted its 6th annual Sequential Intercept Mapping (SIM) conference. The SIM Map is a specific way of looking at the criminal justice process and where in that process diversions can made as well as where there are notable gaps in services. This year the focus was on Human Trafficking along the various intercepts of the SIM Map. The event was at full capacity (80 people) and we had a wide range of experts speak to the group including Katharine Petzold, the local Anti-Human Trafficking Program Coordinator with For All Seasons; Chris Heid and Pat Winn from the Maryland Child Exploitation Task Force; Cara Rose, Homeland Security Investigator, Heather Heiman from the Human Trafficking Prevention Project, and Julie Crain, founder of Harriett's House. The speakers were tremendously engaging, and lively discussion followed each topic. Many resources about Human Trafficking were distributed to all participants.

Caroline County Resource Day-Point in Time

The Mid Shore Roundtable on Homelessness partnered with the Local Caroline County Homeless Board to hold the annual Caroline County Community Resource Day on Wednesday, January 29, 2020. Resource tables are set up and services are offered for an array of things ranging from State Ids to cancer screenings. The event is held on the same day as the Annual Homelessness Point in Time Count in order to reach more people who are eligible for the survey. The survey seeks to find all people who are homeless, living in places not meant for human habitation or emergency shelters, on a single night in the last ten days of January. This survey is conducted nationally and impacts funding for homeless services annually. By partnering with the Caroline Community Resource Day, we have been able to find more people for the Point in Time and more importantly have been able to connect them to services.

Highlight from the Forensic Program

The Forensic Program has been working very closely with a client this year that has acute behavioral health needs along with a past of criminal charges and convictions. Client FABJ was incarcerated earlier this year and has a history of multiple arrests. He was detained in a local detention center for seven months beginning in January and was released in mid-July 2020. When he was released, he chose to move in with his wife and her mother. His wife vacated their residence in Cambridge due to not feeling safe there while he was in jail. This living arrangements with them staying with his wife's mother did not work, the client and his mother-in-law have a history of verbal disagreements and this time was no different. He was asked to leave by his mother-in-law. FABJ ended up homeless with nowhere to go. His wife chose to be homeless with him and this complicated matters some. His wife also struggles with mental health challenges and the two them "feed off" each other and often complicate matters that are not complex.

This writer was able to partner with a community provider to help with case management and provide temporary shelter. FABJ (along with his wife) stayed at various hotels in the Easton area over a six-week period. Some hotels they were asked to leave from due to conflict between the two of them. The conflicts and hotel evictions made finding a place to stay extremely hard. I was able to connect them to food pantries and they reached out to some local churches for assistance. They were finally accepted at one of the local shelters and this was looking to be a promising resource but the two them had a verbal fight at the shelter at 3:00 a.m., disrupting shelter rules. They were asked to leave the shelter and placed in a hotel once again.

When FABJ was incarcerated an application for residential placement was completed on him by the social worker at the detention center. That application was sent to our office and processed, and he was on the wait list for a residential placement. However, the client did not want to do this because he wanted his wife to be with him at all times, but she was not eligible for the program due to the fact that she has no forensic charges or need for this type of monitored and guided support. He was continuously updated on his residential waitlist status.

After weeks and now months of intensive case management, one of the RRP placements had an opening and called to interview myself and the client to determine his eligibility. The client was deemed eligible and was placed at a residential home early this month, December 2020. The update received is that the client is adjusting and doing seemly well. His medications are being administered and his nutrition is regulated. His personal goal is to be self-sufficient but without close supports this can be a hard task for him. We are pleased that he is doing well and look forward to hearing about of all the progress he is making. His wife was able to return home to her family and is adjusting to this transition.

Highlight from the Continuum of Care program

Joyce was born in a very dysfunctional family, experiencing early neglect, physical abuse, and was exposed to various illegal drugs. Joyce did not finish school and left her home to be with her male companion. Joyce continued to experience serious physical and emotional abuse from her partner and again moved away from everybody . . . She now was homeless in the street of a large city. Her use of illegal drugs increased and there was not one drug she had not tried according to her own words . . .

She was depressed and continued to move from an abusive relationship to another one that lead to receiving a serious brain injury. She was now having difficulties with caring for physical herself and experiencing poor emotional regulation. She continued to live in places not meant for human habitation.

Joyce was outreached and referred to a HUD housing program and received intensive Case Management services. She was linked to behavioral health services. Joyce has now earned her GED, reconnected to her daughter, and socializing again while being able to stay away from potential bad influences. Joyce is now happy and looking forward to pass her driver's license test.

Presentation of FY21 CBHP to Advisory and Governing Entities

The FY2021 Community Behavioral Health Plan, created by the five local addiction authorities and the mental health authority for the mid-shore region, was presented for review and approval on February 4th. We revealed the name of what we had agreed to call ourselves; the Mid Shore Planning Collaborative (MSPC). Representation from the MSBH Board of Directors, all five LDAAC's, MSBH Staff and the LAA Directors were all attentive, during the PowerPoint presentation. The audience was intrigued by the hard work of the LAA's and MSBH, creating this document, for the first time in mid-shore CBHP history. The opportunity to present and receive feedback from our community partners was critical to the revision process. The MSPC also agreed to implement the FY21 CBHP though ongoing meetings, beginning March 31st.

Continuum of Care Meeting with Chiefs

On February 19, 2020, the Mid Shore Roundtable on Homelessness met with Talbot County Sheriffs, Easton Police Chief, Maryland State Polices and Talbot County EMS Director to discuss and presented information about homeless services in the region. Pocket resource guides were reviewed and distributed to attendees to help them better serve those impacted by homelessness. Our daily emergency shelter availability google doc was presented to the group in order to help them when they encounter someone in need of shelter. Many of the attendees signed up to be on the Roundtable email distribution list. The meeting was productive, and partnerships were enhanced.

Keep the Doors Open, Rally in Annapolis

On February 27, 2020 beginning at 12:00 p.m., the Maryland Behavioral Health Coalition and the Mental Health Association of Maryland held a rally in Annapolis to advocate for consumers of the behavioral health system. During the rally, there were testimonies from individuals and families who have been impacted by the behavioral health system, as well as speeches from legislators and providers. It was a special day to advocate for the 1 in 5 Marylanders who are living with a mental health or substance use disorder. MSBH was one of over 50 organizations who endorsed the 2020 Keep the Door Open agenda, which focused on improving access to care, fully funding the behavioral health provider rate, keeping the minimum wage budget commitment, increase school behavioral health supports, expanding access to crisis services, and suicide prevention efforts.

March 2020-Suicide Prevention event at Eastern Shore Hospital Center

RRSR (Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians) in collaboration with BHA was held March 4th and 5th at the Eastern Shore hospital. MSBH helped facilitate, however Maryland's SPIN (Suicide Prevention and Early Intervention Network) honored CEUs. This event was capped at 50 participants, required to attend both days to qualify for CEU hours. Full day attendance was mandatory.

Out of the Darkness

MSBH Staff participated in the Out of the Darkness Walk hosted by the AFSP (American Foundation for Suicide Prevention). The event was a 5K walk through downtown Easton, MD. The agency raised money for Suicide Prevention and hosted a booth at the event. MSBH provided educational and resource materials to those attending the event.

Harm Reduction Presentation

On March 12, 2020, community members and service providers joined together for what would be the last in-person community event of 2020 at MSBH. Participants represented each of the five mid-shore counties, from mental health and substance use agencies. Sponsored by the Caroline County Human Services Council, MSBH and Behavioral Health Systems Baltimore, the event served to educate the participants about "Stigma, Trauma & People Who Use Drugs". Miera Corey with the Maryland Harm Reduction Training Institute shared a broad definition of harm reduction and how human and social service professionals can improve HR within their agencies. The topic of Harm Reduction (HR), across clinical and somatic domains is important to understand improving services. Principles of harm reduction include sociocultural factors, participant centered services, participant autonomy with a focus on health and dignity.

Behavioral Health Services on the Eastern Shore: Provider and Stakeholder Engagement

In response to the rapid flow of information and systems impact of the COVID-19 pandemic, MSPC organized and has been the responsible administrator of the Behavioral Health Services on the Eastern Shore Provider and Stakeholder meetings (virtual meetings/conference calls) since the inception of the pandemic response in March of 2020. The network has been meeting since March 18, 2020, and to date (at the time of this plan submission 2/19/21) has met 34 times.

In March, the meetings were hosted twice a week, and as the pandemic has progressed the meetings occurred once a week and have moved to every other week meeting that has remained. From March 18th, 2020 to April 10, 2020, the regional calls were in support primarily of the mid-shore counties. A meeting was hosted on April 7, 2020 with all nine counties of the Eastern Shore local authorities represented. It was decided at that time, that the meetings would move from a

mid-shore call to an Eastern Shore call. All nine counties LBHA/CSA/LAA affiliated logos were collected and are represented on the Agenda and meeting materials. The Eastern Shore network meeting has represented all nine counties since the meeting held on April 14, 2020.

The meetings have an agenda and are representative of all systems impacting and integrated with the behavioral health provider network on the Eastern Shore. Each meeting has time allocated for a BHA report out, Optum Maryland Provider Relations updates and receipt of questions and concerns, State updates provided by Maryland State Senator Addie Eckardt, capacity updates and issues. The meetings have a roll call reporting structure for all provider sectors ranging from acute hospitals, case management, OMHC, wellness and recovery centers, residential services, homeless services, and recovery housing, to Safe Stations. The participation averages 50-70 participants per meeting and participation is engaged and supportive. The peer support of the network has yielded positive problem solving, networking, referral resource information, and a platform of support for all participants and systems managers during the complicated and stressful times of COVID-19.

MSPC intends to continue to support and administer the provider network meetings beyond the COVID-19 pandemic. The peer support element and information sharing of systems changes with the provider connection across counties and services has been outstanding to witness, and MSPC desires to continue to support the partnerships that have grown out of this meeting platform. The collective problem solving, and resource sharing is a unique trait of the Eastern Shore, and the provider network meetings embody the spirit of this strength and support.

PPE Distribution throughout the Eastern Shore

Mid Shore Behavioral Health, Inc. (MSBH) served as the BHA PPE Distribution Hub for the following counties: Caroline County, Cecil County, Dorchester County, Harford County, Kent County, Queen Anne's, Somerset, Talbot, Wicomico, Worcester.

MSBH participated on a planning call with MABHA leadership on April 10, 2020 and welcomed the responsibility of serving as a hub for PPE distribution for ten counties in Maryland. On April 13, 2020, MSBH received the shipment of PPE at the MSBH office located in Easton, MD. On April 14, 2020, MSBH held an internal planning meeting to determine logistics for the distribution planning for the PPE materials. On April 14, 2020, MSBH also hosted a phone conference with leadership from all ten counties involved in the hub shipment. Directors from each local LBHA, CSA, and LAA were represented on the phone conference. On the phone conference, a distribution plan and determination of priority groups were reviewed and confirmed. The three priority groups for distribution of the PPE were identified as: Crisis Services Providers, Residential Rehab Programs (RRP), and Residential Substance Use Treatment Centers (3.5-3.7WM). The

group reviewed the provider types by jurisdiction and agreed that the distribution algorithm would be determined by provider type and capacity/operational status, number of RRP beds in the jurisdiction, and if the current provider groups were equipped with PPE to date.

The group determined that PPE was a priority need for the RRP provider community. Each jurisdiction reviewed RRP beds census capacity:

Cecil County: 38 Beds
Harford County: 59 Beds
Mid-shore Counties: 88 Beds
Wicomico County: 65 Beds
Worcester County: 10 Beds

An algorithm was developed to assign PPE by type per bed to provide adequate PPE to the RRP Providers in event of an outbreak in a house or surge in COVID-19 in the staff.

Distribution to jurisdictions took place on April 16, 2020 and April 17, 2020. Each jurisdiction out of the mid-shore region presented to pick up PPE and were provided with an invoice for the jurisdiction and invoice for the deemed provider distribution sites. Mid-shore providers picked up and signed for all PPE on April 17, 2020. MSBH team member delivered the PPE for reserve to the A. F. Whitsitt Center, located in Kent County, on April 23, 2020.

The result for this endeavor was the timely and successful distribution of over 25,000 pieces of needed PPE to the providers in our community and surrounding ten county area.

HB1092

The expansion of services provided by Affiliated Sante Group's (ASG) Mobile Crisis Team (MCT) now includes additional staff to provide services for children, youth and families in Caroline, Dorchester, Somerset, Talbot, and Wicomico counties. This expansion includes having a crisis and individualized service plan developed with input from outside stakeholders/providers. This expansion also includes the addition of a Peer Recovery Support Specialist (PRSS) in each team. From April through June the Child & Adolescent team worked with 12 families. Family peer support specialists and clinicians are working with care givers and children. Families are being contacted weekly and offered weekly dispatches in person and tele health as needed.

MSBH Caring Café

On May 7th, MSBH hosted a two hour-long discussion using GoTo Meeting, titled "Caregivers and Children's Stress: Coping in the New Norm." Facilitated by Audra Cherbonnier, BHC, Child & Adolescence, the Café was intended to be a warm, welcoming forum in which professionals provided tips and resources to help reduce stress related to the added stressors on families due to the pandemic.

Guest speakers were Jeri Jones, Program and Clinical Director for the Eastern & Mid-shore from Wraparound Maryland Inc., and Augustine Cook, Training Coordinator and Family Peer Support, from MD Coalition of Families. Over forty people participated including speakers and MSBH staff.

Children's Mental Health Matters Campaign

Mid Shore Behavioral Health's (MSBH) Child and Adolescent workgroup strives to raise awareness and to reduce stigma as a part of the Children's Mental Health Matters Campaign (CMHM). The 2020 campaign looked very different due to COVID-19 but was able to take place virtually. Children's Mental Health month kicked off with MSBH hosting a virtual Caring Café entitled Caregiver Stress and the New Norm. We hosted two speakers from community partnerships who spoke about how families with children can approach stress and take care of themselves during this pandemic. Questions were posed by participants and answers provided by speakers. Community participation was good for this first-time event. The team at MSBH observed CMHM month by wearing green and taking a virtual group picture and sharing it to the CMHM website as well as our FB and website. Many of the MSBH team also shared pictures of them celebrating CMHM. An article was written by Audra Cherbonnier, Child, and Adolescent Behavioral Health Coordinator for MSBH's newsletter addressing children's mental health and sharing resources for families. Audra also participated in the virtual Multicultural event by contributing a CMHM video.

9th Annual Across the Lifespan Conference

Due to the pandemic, MSBH's 9th annual Across the Lifespan Conference was split into two days, June 4th and 5th from 11:00 – 1:00 p.m. on Zoom. Each year, the conference has a topic of focus as it relates to consumers, "across the lifespan." This year's theme was "Resiliency in Birth to Older Adults" and provided 4 CEU's by Maryland Board of Social Work Examiners.

Dr. Ileana Lindstrom provided the opening keynote for both days. Conference speakers included representation from a variety of perspectives on the topic of resilience: Shawan Burke, Joan Smith, Jada Carrington, Brittany K. Lewis-Fooks, Tina-Marie Brown & Maria Daniels, Richard Lewis, Lynn Keckler, Maggie Black, and Beth Parker O'Brien. Each presenter shared insights, tips, resources, and relevant information regarding resiliency through all stages of life. There were over seventy participants.

2020 Caliber Awards

The MSBH Caliber Awards are usually held during the month of May, which is Mental Health Awareness Month. Due to the pandemic, we had to reschedule the event and have it on a virtual platform. The 9th annual Caliber Awards were held on July 10, 2020 via Zoom. The people recognized were:

His Hope Ministries - **Loge Knight & Desiree Jefferson**, *Achieving Excellence through Effective Programming*
Overflow Café - **Dudley & Anna Parr,** *Achieving Excellence through Empowerment of Consumers*
Local Care Teams for Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties- *Achieving Excellence through Interagency and Community Collaboration*
Recovery in Motion, *Special Recognition - Peer Support*
Debbye Jackson, *Special Recognition*
Kimberly Cook, *Special Recognition*
Carol Johnson, *Special Recognition*
Pastor Pete Smith, *Special Recognition-Unsung Hero*
Joan Smith, *Lifetime Achievement Award*
Bernadette Townsend, MARY BETH BRENNAMAN AWARD

MSBH hosted this event. Photos were taken of each person recognized. A press release was sent to further highlight the achievement of our champions. We look forward to hosting the 10th annual event this year in the month of May, if possible, in a hybrid format, online and with the awardees in person.

Sharing Cultural and Linguistic Competency Information in the Region

As part of the FY20 Cultural and Linguistic Competency Strategic Plan, MSBH fulfilled the commitment to share CLC information with various mid-shore agencies. The A.F. Whitsitt Center in Kent County was provided information about how to improve CLC throughout their agency. Two apartment facilities in Caroline County received information about mental health stigma and addressing trauma. CLC information was also shared during workgroups for providers who serve the Child & Adolescent and Forensic populations, as well as the Eastern Shore Safe Station Coalition. Participants were engaged and understand the importance of providing culturally competent services for their consumers. CLC best practices and articles about disparities were shared via the MSBH weekly e-newsletter. The Regional Behavioral Health Advisory Council participated in a CLC Self-Assessment and received ongoing reports on the CBHP planning process. MSBH will continue to broaden their cultural sensitivity with ongoing staff trainings and by sharing relevant CLC information with community providers and stakeholders.

Residential Services Committee Meeting and Adult Services Workgroup

MSBH offers the Residential Services Committee Meeting and Adult Services Workgroup for providers to attend to encourage collaboration on services and resources for consumers in the mid-shore region.

The Residential Services Committee meeting is held bi-monthly and serves those providers who generally provide services and resources to those consumers who need residential placement. This meeting is the central place for residential placement updates and changes that are occurring in the local community, region, and state. The RSC meeting is attended by the RRP providers in the region as well as several hospitals that refer to these providers for placement options.

The Adult Services Workgroup, formerly known as Aging with Behavioral Health Disparities, was completely revamped in 2020. Previously the workgroup focused on issues experienced by those with behavioral health disorder or disparities mainly for the geriatric population. The new Adult Services Workgroup focuses on the entire span of the adult population and is focused on core issues faced by consumers within the local community and region. Any organization that provides services to adults in the mid-shore region is welcome to attend. Meetings are attended by several agencies to include DSS, local health departments, community agencies, and more.

Behavioral Health Assisted Living Project

Resources for older adults with behavioral health conditions are generally scarce within Maryland, and even more so within the rural counties. Mid Shore Behavioral Health, Inc., (MSBH) is committing to develop a behavioral health assisted living program to address such concern on our Eastern Shore. In collaboration between MSBH and an assisted living service, behavioral health wrap around services will be provided to support older adults – while serving as a means

to prevent unnecessary institutionalization in nursing facilities. This program is expected to begin implementation during FY21 and continuing into FY22 as an ongoing annual program.

Queen Anne's County Local Addictions Authority

A Naloxone training and distribution program has been fully implemented that also includes training of hands-only CPR. All peers and most agency staff are all trained as trainers that are not only able to teach residents how to successfully use Naloxone, but to train partner agency leadership to train their staff as well.

The past success of acupuncture services combined with traditional therapeutic outpatient treatment has led to increased interest in participation. Additional funding was allocated to this service, however, due to COVID restrictions and all therapeutic treatment moving to virtual, these beneficial services are on hold until the restrictions lift.

The peer on call system is still operating at 100%, although telephonic at this time due to COVID restrictions. The peer continues to be notified by QAC DES dispatch as to which of the three facilities on the Shore the survivor will be transported to, and the peer responds via telephone to the emergency room. While the success rate of supporting survivors is lower, it appears that the face-to-face contact during this vulnerable time is critical to accepting help.

COVID has brought extreme challenges to all service provision – it has changed the way communication can occur between peer and recoveree, the participation level of recoverees in volunteer groups, as well as the increased mental health needs, in addition to increased substance use. In response to this, Queen Anne's County added two additional virtual groups, which will be added to the in-person schedule once guidelines allow. These two new groups are for those individuals in recovery who are utilizing MAT medications. Typically, in traditional twelve step support groups, there can be feelings of that someone is not in recovery, unless they are not taking any medications, which we know is simply not true. This group provides support for those not only enrolled in our agency's MAT program, but is open to anyone, in any MAT program who does not feel comfortable in a traditional program. The other new peer-led support group that was added during this past year is co-occurring. As it is known that most individuals who are beginning their recovery journey experience some sort of mental health struggle as well, whether it be depression, anxiety, or something more complex. This group is for both substance users as well as non-substance users to discuss their recovery, learn from peers who have successfully navigated the process and continue to do so. This brings the total peer-led group offerings to five: Coffee, Tea, and Recovery - a group that is peer-led and recovery based; Co-Occurring and MAT groups – as described earlier, Family Group – which is for adult family members of those either in active use, or in early recovery, and Anxiety & Depression – which is a peer led group specific to anxiety and depression, facilitated by staff from Chesapeake Voyagers.

Two large campaigns were launched in Queen Anne's County as well that address the stigma associated with MAT, as well as normalizing recovery. The first campaign, funded through Buprenorphine Initiative funds allowed for social media, print, and billboards to support the conversation between patient and doctor regarding MAT, specifically Buprenorphine. These attractive designs showed photos of multiple people and the accompanying text described that their doctor manages their diabetes, high blood pressure and their Buprenorphine. Its intended purpose is to spark a conversation between patients and their physicians on the use and management of Buprenorphine along with their other medications.

The other successful campaign launched was the 'don't label us'. This campaign's message is that there is no typical look of someone in recovery and those in recovery can go on to lead successful lives. The photo would show various individuals and a list of things they 'are', such as 'business owner, parent, homeowner' the word 'addict' would be crossed out and the bottom would direct the viewer to go to the website 'dontlabelus.org' where they receive information on MAT, and treatment and recovery services through the QAC department of health.

Talbot County Local Addictions Authority

During FY2020, over 3,500 support service activities were provided by the Talbot County Addictions Program. TCAP continues to increase in access to recovery support services in Talbot County including The START Family Mentor position which was filled in March 2020 and has allowed for the establishment of collaborative child welfare led interventions for families who are impacted by parental substance use disorders. Peers vetted with the local hospital provide

outreach to individuals that have presented at the ED due to drug/alcohol poisoning as well as individuals presenting at one of the two Safe Station locations in the county. TCAP also continues to provide outreach to overdose survivors that have been rescued with Narcan in the jurisdiction through agreements with EMS and local law enforcement. During FY2020, TCAP established peer support within the local Detention Center and transitional support upon release, including coordination of treatment services as well as access to funding for local and distant recovery houses for Talbot residents. TCAP also participated in the planning and expansion of medication-assisted treatment to inmates in the Talbot County Detention Center. By the end of FY2021, the University of Maryland under their existing FORE grant will provide telehealth services to inmates of the Talbot County Detention Center to ensure access to buprenorphine treatment for qualified individuals with opioid use disorders. During FY2020, TCAP provided a continuation to the State Opioid Response (SOR) Grant to expand recovery housing in Talbot County. TCAP also began developing an Overdose Fatality Review Team and participated in state OFRT and technical assistance calls for inception in FY2021.

E. PLANNING PROCESS

A "No Wrong Door" Experience

MSPC strives to support a no wrong door experience for the community members in the mid-shore and maintains this philosophy when addressing gaps in services and new programming in the region. MSPC believes that a no wrong door experience for consumers of the PBHS and our community is necessary to support the wellness of our region, and this quality focus and access of care priority drives the work of each local authority in the mid-shore. The COVID-19 pandemic reinforced the need to maintain addressing the accessibility and no wrong door experiences of our community members. COVID-19 challenged the ability for all service providers in the region to sustain a no wrong door open access in many levels. The pandemic illuminated the need for behavioral health services to be available with many new mental health and substance use needs emerging and the impact on wellness overall. Behavioral health providers had to adapt to the ability to continue to serve clients and support new referrals and growing demands for care, while shifting service delivery platforms and safety measures for clients and team members.

A significant portion of the mid-shore provider network shifted to telehealth platforms only for care, and some providers experienced periods of closure and suspended services due to lack of PPE and during periods of staff or consumer exposure to COVID-19. The transitions and ongoing changes with availability of "open door" providers presented a new challenge for MSPC in supporting the providers and community with awareness of availability of providers. In response to maintaining correspondence regarding real-time availability of providers, MSPC developed a Google Spreadsheet of the provider network in the region; all service types are represented: residential, inpatient psychiatric and substance use treatment, outpatient service, medication assisted treatment (MAT), recovery housing, and crisis response services. The Google Spreadsheet supports updates as they occur with provider correspondence regarding open access, waitlists, availability of services in-person or telehealth, in addition to provider access for Medicaid/PBHS, as well as private insurance carriers. In addition to the behavioral health provider Google Spreadsheet, a real-time Continuum of Care homeless services and shelter capacity Google form has been made live on the Mid Shore Behavioral Health, Inc. website (https://www.midshorebehavioralhealth.org/). Both Google Forms have been highly utilized by community members, emergency response providers and police, crisis services, behavioral health providers and integrated health care systems provider groups, and local Behavioral Health authorities in neighboring counties.

The COVID-19 pandemic reinforced the strength of the peer support specialist network in the region in supporting the no wrong door experience for our communities. The peer support networks are an essential component to actualizing a "no wrong door" experience for many of our consumers. The peer network can also add to the success of sustaining and engagement in services with the additional support component of a peer. Peers are an integral link to maintaining relationships and networks with individuals in need of behavioral health services, and these relationships were critical in supporting the community accessing services pre-COVID, as well as expanding the reach to the community during the pandemic. The mid-shore peer

network is complemented by peers embedded in each of the five health departments in the mid-shore, integrated peers in crisis response services, Wellness and Recovery Centers, Dri-Dock, Recovery in Motion, recovery houses, and at MSBH with the youth outreach coordinator position. Peers responded to the need to adapt their mode of contact with consumers during COVID-19. Access to providing groups, supportive meetings, and access to harm reduction services was challenging. Peers pivoted in many of the mid-shore counties to providing virtual meetings, door-to-door Narcan and fentanyl testing strips and sharing materials on new and available treatment services during the pandemic. Crisis response to overdoses is a peer response that has been maintained during the pandemic and adapted primarily to the mode of contact with the overdose survivor; services have been rendered primarily by phone and telehealth.

The pandemic highlighted the need to continue to make healthcare disparities, addressing racism in healthcare, and anti-stigma initiatives a priority for MSPC. The reinforced need to address access and "no wrong door" grounds the MSPC as local systems managers in the need to focus our efforts on seeking to have services that are accessible and rendering culturally sensitive practices. MSPC has made this a focal point of our work in FY21 and will continue to strengthen efforts in FY22 through the work of the newly developed Diversity and Inclusion Workgroup and partnership building with Georgetown University, Choptank Community Health, Inc., and the Eastern Shore Area Health Education Center (ESAHEC). These newly formed partnerships intend to enrich services in the mid-shore that will be serving the community as whole and work to address stigma and expand services that are tailored for the black and African American community.

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

A strength for supporting a no wrong door experience in the mid-shore region is the Eastern Shore Crisis Response structure supported by Affiliated Sante Group, Inc. The Eastern Shore Crisis Response network is responsible for the Easter Shore Operations Center, the 24/7 resources and referral and crisis hotline for the nine counties of the Eastern Shore (888-407-8018). ESOC is supportive of receiving and managing calls that may result in referral and appointment with an urgent care appointment, dispatch of a mobile crisis team, over the phone crisis support with follow-up, or resources information only. The crisis response network is structured by a no wrong

door philosophy provider, as crisis is defined by the individual and welcomed for support regardless of circumstance. Expansion to the Eastern Crisis Response Service provider group over the last three years has supported the ability to have crisis access responses that are timely and tailored by population. Recent funding expansion with the House Bill 1092 legislation has supported growing resources for the child and adolescent population. Continued growth to the crisis network for the development of substance use specific mobile crisis teams to be established in the region. All efforts to grow the crisis response system will support an enhanced no wrong door experience in the region.

The MSPC team generates a reference and resource guides that are county specific as well as regional. MSPC collaborates with MSBH to support the annually updated comprehensive Resource Guide that is used as a tool regionally across authorities and providers for behavioral health, housing, and community services resources. Since FY2018, MSBH has represented integrated providers to include substance use disorder resources and recovery house resources. The guide is available both in hardcopy and electronically at the MSBH website (https://www.midshorebehavioralhealth.org/). A goal for FY2022 is to publish the Resource Guide on the MSBH website that is interactive with category filters, such as county and presenting need, to allow for community members to reference and refine their resource searches. The mid-shore Resource Guide will support a data warehouse model of information that will be available and updated routinely to be tool for the community in navigating and accessing services.

Local Authority Complaint Investigation and Contract Monitoring Processes

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

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

FY2022: Conflict of Interest and Systems Management Integration by Agency

Agency/ County	Caroline LAA	Dorchester LAA	Kent LAA	Queen Anne's LAA	Talbot LAA	MSBH CSA

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

MSBH has supported the region's five Local Addiction Authorities (LAA) since FY2015 in some variation of contracted LAA responsibilities. There has been fluctuation of counties supported over the course of our work towards local integration during the course of MSBH LAA support. Complaint investigations have been a primary function of our role. Complaint investigation is a function that as a CSA, MSBH has supported since its inception in 1992, and identifies complaint investigations as an accomplishment of with quality management as an organization. Any time a complaint is filed with MSBH, the complaint is investigated, and the team works to resolve the issue with the provider or complainant group to improve service provision.

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

A complaint of criminal conduct will immediately be referred to the appropriate authority for investigation including, but not limited to: ASO grievances and appealing a clinical denial of service, suspected abuse and neglect reporting requirements to the Local Department of Social Services, reporting professional misconduct to the appropriate Professional Licensing Board, issues of billing irregularity and suspected fraud are referred to the Medicaid Fraud Unit or other entities as appropriate, and discriminatory practices and policies characterizing a federal criminal violation of an individual's civil rights that may require remedy by federal or local authorities. The Local Authority will also inform BHA Staff regarding major/serious complaints, especially if it is suspected that others may be exposed to risks.

The validity of non-criminal complaints will be determined by the local authority or authorities involved. Non-criminal complaints may include and may not be limited to safety, quality of care, access to services, unjustified adverse impacts, and medication. The Local Authority will document the information from the complainant including the specific nature of the complaint and any data supporting the complaint, the personnel involved and the complainant if needed using the CSA/LAA Complaint Reporting Form. The Local Authority will review, and document attempts made by a program or complainant to resolve the complaint including any internal filing

of a complaint within a program by a service recipient, barriers to resolving complaints internally by a service recipient, family member or guardian, and program awareness of complaint and any corrective actions implemented and outcomes. Supporting documentation may be appended including any relevant policies and procedures, correspondence including email, timelines of referenced events, and other content germane to the complaint. The Local Authority may investigate by visiting the facility, reviewing the patient record, reading, and reviewing program policies, procedures, interviewing staff, and observing staff delivering care. Attempts to settle the complaint at the local level will be made by factual analysis, mutual concession, and corrective actions as needed, including peer assignment. Once a complaint/concern is resolved, the Local Authority will provide the complainant appropriate feedback regarding the resolution of the complaint. Programs will be monitored for their compliance with COMAR 10.63, 42 CFR Part 2, The Federal Guidelines for Opioid Treatment Programs (Guidelines) as they align with Title 42 of the Code of Federal Regulations Part 8, DATA 2000 for patients receiving buprenorphine (approved by the FDA) for an opioid use disorder in an OTP and 21 USC § 802 restrictions.

MSPC participates on the ASO audits with all identified mid-shore providers, county-specific by LAA. Communication across loal authorities takes place to ensure that the LAA in the county and MSBH are represeted at an ASO audit if indicated by provider type. Audit participation allows opportunities to build relationships, reinforce quality of care standards, and remain apprised of situations in the mid-shore community. When Program Improvement Plans (PIP) are issued, a reviews of the plan takes place, and the identified local authority schedules follow-up with the provider to determine whether corrective actions are in place and to report progress to ASO.

MSPC has prioritized our complaint investigation process as a quality improvement initiative with the goal of manualization of our procedures. This includes dissemination of information, documentation, responsiveness, management and follow-up, involvement of accrediting bodies and supportive regulatory entities, as well as groupthink with best practices for complaint resolution. Leadership of MSPC has served on the Accreditation Implementation Sub Committee with BHA since January 2017 to present (February 2021). MSBH serves as one of two local authority representatives on the subcommittee. The Accreditation Implementation Sub Committee's primary task is to assist with the development of the guidelines from BHA to local authorities regarding complaint and critical incident investigation and update the Critical Incident management and reporting process. MSBH has extended support to this group with the development of the document: *Local Behavioral Health Authorities, Core Service Agencies and Local Addiction Authorities Guidance for Patient/Family Member/Guardian Incidents, Complaints and Concerns Regarding Substance Use Disorder and Mental Health Services* as well as the revised *BHA Critical Incident Report form*. MSPC abide by the provisions of Section 2180.04 of the Local Health Department Funding Systems Manual (LDHFSM) regarding the audits of sub-vendor cost reimbursement contracts as applicable. MSPC may also audit or cause to be audited each human service contract sub-vendor in accordance with the LDHFSM and MDH Audit Division's Policy and generally accepted auditing standards.

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

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

MSPC follows state procurement policy, local procurement policy, Local Health Department Funding Systems Manual (LHDFSM) including cost reimbursement agreements, Human Service Agreements Manual (HSAM), and/or a procurement policy approved by it's Board of Directors MSPC include Conditions of Award in funding agreements with providers for contracted services and may conduct comprehensive review of subprovider budgets and deliverables under contract.

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

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

Originally planned for FY2021, an initiative for FY2022 is to formalize cross-local authority agency workplans with contract monitoring, reporting, and BHA required monitoring as an exercise to enhance cross-authority processes orientation and streamlining and to assist with mitigating duplication of administrative functions.

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

Dorchester County Behavioral Health Services
SUD System Design Planning and Evaluation Process

Strategic Systems and Planning Process

The planning process that is utilized internally, is an adaptation of Philip Kotler and Alan R. Andreasen's Strategic Marketing and Planning Process (SMPP) to address Dorchester County's population-based approach to behavioral health and will be referred to as a Strategic Systems and Planning Process (SSPP), Figure 1, in this document. This approach is consumer centered taking into consideration the internal and external factors and influences that affect the service delivery system. The process is continuous and constantly fine-tuned. This planning process allows an organization to take advantage of its strengths and build to correct its weaknesses. Figure 1. illustrates the flow of the Strategic Systems and Planning Process. In the first step, an analysis is conducted of the two environments where the organization operates.

Examine the internal organizational system to include its mission, objectives, goals, culture, strengths and weaknesses to understand how it functions internally and in its macro environment. An examination of the external environment especially its target population, behavioral health consumers, the community and the positions and plans of stakeholders, advisory councils and boards are important the operational environment the organization faces. For continued success it is important to also analyze the behavioral health trends in the macro environment including social, political, technical and economic components.

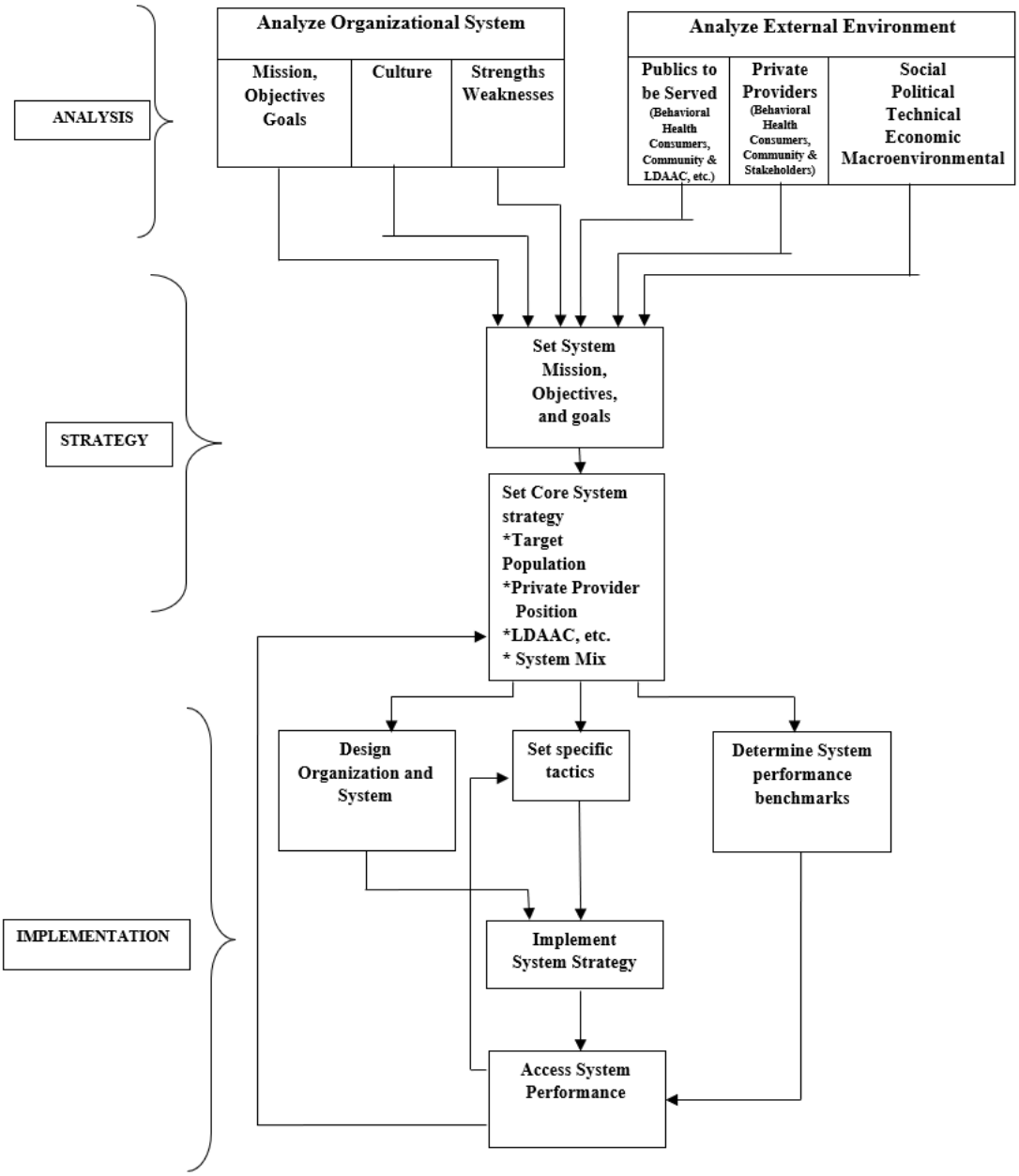
The next step to the SSPP will require two actions to develop the broad strategy to guide the System's progress. It requires setting the system goals and objectives, then clearly identifying the core system strategy. The next action is to identify specific system targets, understanding provider services and key elements in the system mix.

The third and major step of implementation has many subcomponents. The core system strategy must be broken down into specific tactics to be implemented and continuously monitored for evaluation. Prior to the implementation, the organizational system structure must be in place and has set specific system performance benchmarks.

DCBH continues to work cooperatively with MSBH in planning as well. MSBH includes stakeholders in the planning and evaluation program/jurisdiction services throughout the year. Members of the recovery community and their natural supports, formerly homeless individuals, representatives from the criminal justice system, and providers of services for the deaf and hard of hearing engage in all levels of the meeting structure and contribute to the successful development and implementation of the Community Behavioral Health Plan which includes Dorchester County. Organizational systems performance and plans are discussed with the

Dorchester Criminal Justice Treatment Network/Local Drug and Alcohol Council at the regular meetings for comment, recommendation and or approval.

Figure1. **Strategic Systems and Planning Process**



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

Intervention Teams, Local Drug and Alcohol Abuse Council(s), Regional Behavioral Health Advisory Committee, and our regional hospital provider, University of Maryland's Shore Regional Health System.

Through collaboration with partners and community members, MSPC is supported with assessing our unmet needs and gaps in services in the region. In addition to relationships in the region, data is a key element of confirmation of the needs in the region and trends with utilization and primary needs. Data comes from several origins, CRISP, OD statistics and overdose mapping, OIT, Opioid Task Force, SEADS study, ASO utilization, and provider/contract specific reporting. This year, MSPC referenced data from the Centers for Disease Control and Prevention (CDC) study on Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020, as a critical study highlighting the tremendous impact that the pandemic has made on wellness and behavioral health. This study reinforced MSPCs work to strengthen our behavioral health services and access in the mid-shore.

MSPC utilizes data that highlights that as a region, we are primarily in need of workforce to support our services gaps. In December of 2019, the Eastern Shore Behavioral Health Coalition supported an analysis of the Health Professional Shortage Area (HPSA) zones defined by the Health Resource and Services Administration, and the mid-shore and Eastern Shore are all indicated as disparity zones for primary care, and three of the five mid-shore counties are mental health disparity zones. This information is being used to highlight the needs of the region and support advocacy with workforce initiatives through legislation and grant initiatives. Telehealth expansion by way of the pandemic, has alleviated some of the disparities with access to prescribers/psychiatry time, in the mid-shore region and has supported access to care that has historically been limited due to transportation barriers.

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

MSPC references the Crisis Services Strategic Plan from FY2018 as a guiding document to continually improve the crisis response system in the mid-shore. The Crisis Services Strategic Plan was completed by all mid-shore local authority partners and is representative of a vision for enhanced crisis response services for the region. Participants informed MSBH of community needs, taking into consideration their unique region and community needs. This plan included adding crisis beds to the region, assessing the possibility of a crisis walk-in center, and moving to

a 24/7 mobile crisis response structure. MSPC has been able to enhance the crisis services in the mid-shore region due to additional funding made available through BHA, the State Opioid Response Grant and Opioid Operational Command Center. The mid-shore region assisted the A.F. Whitsitt center in structural improvements which allowed the expansion of 12 opioid crisis beds. The 24/7 mobile crisis system is fully implemented, and two successful Safe Stations to the Eastern Shore Region have been operating for two years. A Caroline County Safe Station is in development stages. This is another critical program that will assist in expanding crisis services.

A continual gap in the mid-shore region are crisis services to youth and adolescents. In addressing this issue, mobile crisis system has expanded to provide more crisis services youth and adolescents. In addition, MSPC has received SOR funding for two Adolescent Clubhouses in the mid-shore region. This is a program to serve adolescents who are experimenting with opioids or have been affected by family members with a substance use disorder.

MSPC is working to address increasing access to behavioral health services and recovery support systems wherever possible, and working to build an integrated, robust continuum of services. MSPC collaborates with a variety of stakeholders for input and provisions of recovery support services including DSS, Circuit Court and judiciary, public safety and corrections, community action agencies and coalitions, PBHS managers, recovery and wellness centers, care management programs, recovery residences, and 12-Step support. MSPC supports seeking out expanded resources and funding opportunities to support the mid-shore region. MSPC intends to expand the resources that are being identified for the region as we complete a more comprehensive regional needs assessment with the intention of utilizing this data to secure additional funding and support for service expansion in the region.

MSPC references the work of the Mid-Shore Rural Health Collaborative as a guiding group that is working in with the mid-shore counties to address healthcare access and challenges to delivery of care in the region. MSPC is represented on the Rural Health Care Collaborative by way of the five mid-shore county Health Officers. Identified priorities include addressing access to clinical services, transportation disparities, addressing social determinants of health, and enhancing coordination of services across providers and social services.

Stakeholder Engagement in Community Planning

Deliberate involvement of community stakeholders is an ongoing priority for the MSPC and is a point of the local systems behavioral health integration planning in which MSPC has excelled, in our integrated efforts. In October 2020, the MSPC group determined that out of the seven domains to assess the mid-shore region's progress towards integration, Domain #6 Stakeholder Collaboration, is an area where MSPC demonstrates enhanced integration with how meeting the needs and engagement with our local stakeholders and community members. In the mid-shore region, each county has established meetings and workgroups that engage stakeholders and yield community involvement with planning. In the mid-shore region, each county has a Local Drug and Alcohol Abuse Council (LDAAC) and has representation on the Regional Behavioral

Health Advisory Council (RBHAC). In FY2020, each county achieved the establishment of county specific provider meetings that engage providers across the integrated continuum. These provider meetings meet quarterly and compliment the mid-shore region's BHSN quarterly engagement with providers; each committee requires participation and representation from the consumer and community. Sustained meetings in Caroline, Kent, and Dorchester and highlight the regional Provider Meetings (ES). Since the onset of COVID-19, the collaboration and provider network engagement has been an integrated structure across the mid-shore counties and all nine Eastern Shore counties. The Behavioral Health Services on the Eastern Shore Provider and Stakeholder meeting is an expanded resource to the community providers that has supported open communication, partnerships, and collaboration to meet the behavioral health needs of the region during the pandemic and will continue to meet as a well-established provider resource beyond the pandemic.

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

MSPC participates on several BHA level committees and work groups. MSPC team members are represented at the following work groups at BHA: Older Adult/PASRR Work Group, Adult Services MABHA Subcommittee, RRP Process Work group, Child, Adolescent, and Young Adult MABHA Subcommittee Work Group, and Crisis Intervention Team Advisory Committee. MSPC prioritizes opportunities to be engaged in process related subcommittee opportunities in collaboration with BHA. MSPC leadership are all represented at the Maryland Association of Behavioral Health Authorities (MABHA) group, and the regional Addictions Consortium of the Eastern Shore (ACES) group. In July 2020, Kathryn Dilley of MSBH, was appointed Co-President of the Maryland Association of Behavioral Health Authorities for a three-year term.

MSBH and MSPC collaborate to be responsible for several population specific workgroups that meet over the course of the year. The workgroups are a key element of the work of MSBH and MSPC to interact with local providers and consumers. MSBH manages the following workgroups that meet at least six (6) times annually: Forensic Workgroup, Crisis Intervention Team (CIT) Advisory Subcommittee (meeting quarterly with the Forensic Workgroup), Child and Adolescent Workgroup, Mid-Shore Local Systems Management Integration Workgroup, Adult Services Workgroup, Continuum of Care Roundtable on Homelessness, and The People's Roundtable, formally Consumer Council, and the Eastern Shore Safe Station Coalition. MSPC proudly launched

The Diversity and Inclusion Workgroup during FY21. The Diversity and Inclusion Workgroup has convened four times since its inception in August 2020 and will be meeting at a minimum quarterly annually.

The Forensic Workgroup is composed of a wide range of stakeholders who touch the criminal justice system including court representatives such as public defenders, probation officers, judges, police officers and first responders; behavioral health providers and programs; and housing programs, shelters, and people impacted by homelessness: peer support programs and housing and consumers. The Workgroup addresses different topics and resources. During the past year speakers have presented on Mediation programs, Mobile Crisis, ACT team services, Prison Yoga, Treatment Courts, Cultural Competency, MD Coalition on Families. The Crisis Intervention Team joins the Forensic Workgroup on a quarterly basis. The FMHP will host its seventh Annual Sequential Intercept Model (SIM) conference on February 26, 2021. The theme of SIM meeting this year will be Veterans who enter the criminal justice system, with a specific focus on disparities.

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

MSPC strives to be inclusive of diverse and unique populations, including but not limited to deaf and hard of hearing, visually impaired, LGBTQ+, and Veterans, by way of stakeholder engagement. MSPC has prioritized improving and bringing awareness to racial equity and social justice in the mid-shore region. One priority is to have representation of marginalized populations on leadership teams and governing bodies. Through the Diversity and Inclusion Workgroup and the FY2022 Goals, MSPC will focus on addressing the impact of disparities within minority populations. How the MSPC will address disproportionalities is captured in the FY2022 CLC Strategic Plan.

In FY21, MSPC has identified groups serving the mid-shore that may benefit from enhanced partnership and group representation. MSPC supported the following groups: Recovery Housing and Treatment Workgroup for the mid-shore and the Peer Support Workgroup. The Recovery House workgroup has taken on leadership withing the Recovery House community and MSPC is welcomed as a guest twice a year moving forward. The Peer Support workgroup will be co-

facilitated in FY22 by the Youth Outreach Coordinator with MSBH as a peer support specialist lead.

Local and State Behavioral Health Advisory Councils

MSPC prides itself on the prioritization of inclusion of our local and state advisory counterparts as a part of our planning process. Throughout the course of the year, MSPC facilitates, as well as participates, in various local and state workgroups and advisory committees. As described in the Organizational Structure section of the plan, MSPC includes stakeholders in the planning and evaluation program/jurisdictional services. Input from consumers, natural supports, the provider community, legislative representatives, and local stakeholders is obtained throughout the year and contributes to the Annual Community Behavioral Health Plan.

MSPC is representative of six local advisory councils, with each county in pursuant with the Annotated Maryland Code Health General 8-1001- Local Drug and Alcohol Abuse Council (LDAAC), represented by each of the five mid-shore counties, and the Maryland Code Health General 10-308, Mental Health Advisory Committee represented by one Regional Behavioral Advisory Committee (RBHAC). RBHAC serves to represent our mid-shore counties to advise and assist in the planning and evaluation of the publicly funded mental health and substance related disorder services. The LDAACS serve to represent the substance use advisory and criminal justice advising for each county. Most LDAAC members are also representative of local Opioid Intervention Teams (OIT) pursuant with Inter-Agency Heroin and Opioid Coordinating Council 01.01.2015.13. These advisory entities review and evaluation of behavioral health needs of the local public health system, including quality of services, gaps in the system, and interagency coordination. Each advisory group is included in the integrated Community Behavioral Health Plan endorsement processes for the MSPC FY2022 Annual Plan.

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

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

local advising bodies by jurisdiction (estimated completion: February 2021) as a part of the data collection to inform the groups' recommendations in FY22.

MSPC is an active participant on the state level Behavioral Health Coalition as well as the Chair of the Eastern Shore Behavioral Health Coalition. MSPC remains abreast of the legislative impact on the delivery and access to the public behavioral health systems, as well as supporting the education of our regional legislative body by way of our activities supported by our local coalition. Due to the challenges of the pandemic, our legislative advocacy has become even more imperative to properly serving our communities. Areas such as the Keep the Door Open Act, provider credentialing and workforce, expansion of Psychiatric Nurse Practitioner scope, and telehealth allowances for rural communities continue to be of high priority. FY21 has also championed the Keep the Door Open Act, access to and inequities in care and telehealth service provisions, crisis services and strengthening suicide and overdose prevention efforts, as well as expansion of school-based behavioral health support services.

On September 24th and November 19th of 2020, MSPC met with members of the Eastern Shore Delegation to discuss the Budget Reconciliation and Financing Act, expansion of telehealth and telephonic services, credentialing barriers, and the overall impact the behavioral health system has faced due to the pandemic. The impacts named by our coalition as high priority were the transition of the administrative service organization, new proposed regulations, RRP and PRP restrictions, the rate study, and housing and shelter needs. The Eastern Shore Behavioral Health Coalition continues to advocate for these issues and develop collaborative partnerships to address the community needs. Our coalition will present in front of the Eastern Shore Delegation on March 12, 2021 to discuss the above priority areas in detail and solicit their support in important legislation as the Maryland General Assemble convenes. MSPC members continue to engage with and follow updates of the Lt. Governor's Commission on Mental and Behavioral Health, as well as with the System of Care workgroup.

Emergency Preparedness/County Specific Planning

Caroline County Local Addictions Authority:

Caroline County Behavioral Health will utilize our Emergency Preparedness Plan for our local Jurisdiction. Caroline County will coordinate with other nearby jurisdictions when an emergency arises to fill any gap services necessary. The need for substance-related disorders has exploded with the opioid epidemic. The mid-shore regional Public Behavioral Health System needs to look at ways to improve access to both mental health and substance-related disorders treatment across the spectrum. The integrated Eastern Shore Crisis Response System is growing exponentially, particularly with the continuous training of CIT officers. Both the helpline call center and the mobile crisis teams urgently need increased capacity to meet needs currently. During a disaster, these services would need to expand quickly and efficiently.

In Caroline County, where the health department is the largest single provider of behavioral health services, there has been limited provider expansion. A list of key staff contacts to be reached in case of emergency is included in the document. Caroline County implements a call-down tree within the Health Department for emergencies. Caroline County Behavioral Health also supports the Emergency Preparedness plan for the mid-shore and will work collaboratively with MSBH.

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

Kent County Local Addictions Authority (Planning and Emergency Preparedness):
Our jurisdiction is working with all providers to ensure no wrong door is a reality in all of our behavioral health programs. We continue to collaborate during our monthly provider meetings. The Provider Meeting includes Kent County Behavioral Health (KCBH), Local Addiction Authority (LAA), Post-Adjudication Supervision and Treatment (PAST) Program Coordinator, District and Circuit Court Judges, Maryland Coalition for Families (MCF), local recovery houses, Recovery in Motion (RIM), Mid-Shore Behavioral Health (MSBH), Sobriety Treatment and Recovery Teams (START), and Kent County Health Officer. During these meetings we share resources to ensure each consumer is able to access all services needed for optimal and holistic wellness. If a gap in any level of care is identified the LAA's duty will be to assess the resources and levels of funding to promote linkage of the needed service(s) within our jurisdiction.

The LAA educates providers regarding critical incident reporting criteria and investigation protocols. This ensures that everyone is aware of the expectations and reporting requirements. The LAA is available to address complaints regarding services in our jurisdiction.

It is also the duty of the Kent County LAA to provide resources to programs to ensure they can provide the services needed in the jurisdiction that enables them to provide no-wrong door services. This includes but is not limited to recovery supports, substance use disorders, mental health, COVID, and individual and family wellness.

The planning process for coordination and evaluation of care in Kent County is preformed through monthly Local Drug and Alcohol Counsel (LDAAC) meetings and bi-monthly Provider Meetings. During these meeting we are able to communicate, update, and network with various care providers in our region. Information shared during these meetings is essential to meeting the needs of the population we serve.

Kent County's emergency preparedness plan consists of the coordinated response of the department of emergency services and department of health personnel through the Kent County Department of Emergency Services, Kent County Health Officer, county officials, the public information officer, and close collaboration with other local state agencies and responders. The emergency plan is included in the Appendix section. Covid-19 pandemic emergency preparedness in Kent County will follow infectious disease protocol. This plan is attached in the Appendix section.

Mid Shore Behavioral Health, Inc.:
MSBH is guided in its emergency preparedness philosophy and procedures by a series of documents, created by MSBH staff and incorporating current research into organizational disaster readiness. These documents are updated annually to reflect, for example, changes in our organizational chart, internal procedures, or recommendations of emergency planners in our jurisdiction. The aforementioned documents are included in the Appendices of this plan. They are: MSBH Emergency Contact Plan, MSBH Emergency Operations Plan, and MSBH Disaster Preparedness Internal Evacuation Procedures.

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

<u>Responsibilities during an emergency are related to, but not limited to the following:</u>

- Ensure communication and response arrangements with the Eastern Shore Crisis Response system; Eastern Shore Operations Call Center, Mobile Crisis Teams, contact with Crisis Intervention Team response personnel.
- MSBH will be available for support to provider community with support with triage of individuals in need of mental health services and access to treatment.
- Communicate with Residential Rehabilitation Programs for confirmation of needs and emergency response.
- Provide counties with primary and alternate point of contact for mental health services, as well as a 24 hours/day, 7 days/week contact during emergencies.
- Assist with the assessment of mental health needs of staff, victims, and volunteers during and following a disaster.

- Assist Mental Health Team and Emergency Response personnel with the coordination and provision of mental health service support in clinics, and other designated areas such as triaging, debriefing, and the counseling of people, staff, and volunteers who are exhibiting signs and symptoms of stress and/or anxiety, or any other maladaptive symptoms, as a result of a naturally occurring or terrorist-initiated disaster.
- Direct mental health staff to report to specific locations, as determined in coordination with County Emergency Response Staff.
- Plan and assist in the coordination of follow-up services to ensure long-term recovery, such as additional community interventions, individual or family counseling, or community education.

With the onset of the COVID-19 pandemic in March 2020, FY20-FY21 provided opportunity to engage in real-time implementation of our emergency preparedness procedures. Following the orders and proclamations from the Governor's office, MSBH worked closely and collaboratively with BHA, providers, and elected officials throughout the mid-shore to support swift response to the pandemic and assist as needed. MSBH officially closed the office on March 16, 2020, supporting all employees for teleworking from home. A COVID-19 office safety protocol was implemented to ensure the safety of employees who were required to report to the office, or who chose to work designated hours at the office in part to ensure critical FAX communications were received and processed. MSBH developed a COVID-19 protocol to screen visitors to the office; all employees were required to sign in on a designated log. Both protocols allowed necessary documentation in the event contact tracing became necessary. MSBH developed a Telework Policy ensuring all employees were equipped to work safely from home. MSBH upgraded and purchased additional online platforms to support virtual meetings.

In April 2020, MSBH initiated and then provided ongoing coordination and facilitation of weekly Eastern Shore Provider Network meetings. These Network meetings provided a critical forum in which providers communicated needs, concerns, and challenges to ensure the safety of employees and consumers. The Network allowed MSBH to effectively advocate for and organize distribution of much needed PPE and support distribution of hand sanitizer when it was in short supply. MSBH also supported the transition from office-based and community-based services to use of telehealth, a pivot critical to help flatten the curve, reducing risk of COVID -19 transmission.

In addition to MSBH responsibilities with emergency preparedness, MSBH initiated requesting that all the sub vendor groups provide a copy of their agency COOP/Emergency Response Plan at the time of FY2021 contract site visits. This is a recurring requirement in response to MSBH Contracting requirements.

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

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

Talbot County Local Addictions Authority:
Talbot County Health Department Emergency Management Plan is included in the Appendix section of the Plan. The Plan addresses the coordination of emergency services and mobilizing emergency personnel under the Talbot County Department of Emergency Services, the TCHD Health Officer, County Officials, local Public Information Officer, and in collaboration with other State agencies and responders.

F. SERVICE DELIVERY AND RECOVERY SUPPORTS

1. Treatment Services

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

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

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

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

Special Population Groups bulleted below:

SRD Services

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

MSPC recognizes that many individuals with SRD in the mid-shore region are at risk of relapse due to unstable housing. Unstable housing is prevalent among injection drug users (IJU). At the A. F. Whitsitt Center (AFWC), SRD Treatment Center in the mid-shore, finds that those with unstable housing affects between eighteen and twenty-five percent of AFWC population. There is a high rate of mental health disorders and SRD/co-occurring disorders of those with unstable living arrangements or homelessness. Recovery residences (RR) can provide the stability and support for the co-occurring population without housing. With semi-structed recovery environments many behavioral health consumers are able to gain periods of recovery which allow for stabilization and self-improvement in many life areas. During the transition from inpatient treatment to community housing, the care coordinators and peer recovery specialists (PRS) assist in the stabilization process. They can assist with securing housing funding for up to sixty-days, transportation, and linkage to needed services and treatment. Kent County has

introduced the No Harm in Helping (No HiH) mobile MAT unit which provides monthly injections for RR consumers in the mid-shore and Cecil County area. This provides an option for RR owners to accept MAT referrals without the daily oversight and management obstacles that comes with daily MAT prescriptions. The one-time monthly injectable Vivitrol or Sublocade also eliminates the possibility of medication diversion, irregular patterns of administration, eases the consumers difficulties regarding refills and allows the RR house managers uncomplicated MAT process in the RR.

Opioid-related dx engaged with MAT

MAT along with counseling is considered the best-practice treatment of choice for these individuals with opioid-related disorders. There are limited options available on the mid-shore for those consumers seeking treatment. Due to the limited MAT providers on the mid-shore, many individuals seek services in surrounding areas outside of their County of origin. Transportation is also an ongoing issue in this area. Caroline County's Mobile Treatment Unit (MTU) has been very successful in addressing and meeting the treatment needs of individuals. Treatment is offered through the Caroline County outpatient clinic setting and on the Mobile Treatment Unit (Eastern Shore Collaborative in Caroline County). Mobile Treatment for these consumers brings MAT to their own community and addresses the transportation issue as well. MAT treatment may be provided in the form of a tele relationship with distant contracted providers, as is the case on the Mobile Treatment Unit, as well as our other treatment locations on the mid-shore, due to the lack of providers in the area. This enables more MAT treatment options for our consumers with an opioid diagnosis and additional treatment slots available for more consumers to be able to seek treatment.

In the coming months, the Mobile Treatment Unit (MTU) will continue its work to expand its services to other jurisdictions in the Mid-Shore. The MTU also provides overdose intervention to those individuals who have overdosed and their families. This is a partnership between the Caroline County MTU and Caroline County EMS. They receive OD reports shortly after the event and will track these events. The MTU team will reach out to every individual who has experienced a non-fatal overdose and provide support, education, and offer treatment. In addition, they have overdose prevention kits that contain the team's contact information, Narcan, and other information. They are instructed in the use of Narcan. They have been successful in getting several individuals into treatment after making an on-site visit shortly after the overdose occurs. Harm reduction interventions such as needle exchange, Hepatitis C/HIV testing, and counseling is targeted to be offered on the MTU in the near future.

Individuals Identified as IV drug users

Dorchester County Behavioral Health Services (DCBHS) continues its efforts to address opioid misuse by providing treatment and prevention services. DCBHS operates a CARF accredited outpatient program offering multiple levels of SUD treatment such as 0.5 Early Intervention, Level I Outpatient, and Level II.I Intensive Outpatient, with a clear focus on Opioid Use Disorder. DCBH also provides treatment for the process addiction of Problem Gambling. Individuals receive a

comprehensive assessment and are placed within a treatment tract, based on the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) and the American Society of Addiction Medicine Patient Placement Criteria (ASAM). Once assessed, documentation of medical necessity is completed, to reduce authorization denials and over-utilization of high-cost services. Individuals are assessed for co-occurring disorders to include the presences of trauma, noting that research clearly indicates that many individuals experiencing SUD commonly have a co-occurring behavioral health disorder, and have been victims of trauma. Once the assessment information has been reviewed, the individual is placed in the appropriate level of care. When a residential level of care is indicated, the individual is referred to the appropriate level of residential care by DCBH clinicians. DCBH often assists with transportation to SUD residential programs.

DCBH realizes the importance of employing evidence-based, best practices, and continues to use curriculums such as Hazelden's, "A New Direction," effective with the criminal justice population and with consumers diagnosed as having Opioid Use Disorder, as well as "Seeking Safety", for trauma-informed services. All treatment is provided by utilizing best practice approaches including Motivational Interviewing, Cognitive Behavioral Therapy, and Trauma Informed Therapy. A pharmacological approach in treating opioid addiction, Medication Assisted Treatment (MAT) is utilized when clinically appropriate. DCBH provides substance abuse/use education, individual therapy, family therapy, group therapy, toxicology screening and medical services, utilizing its program physician to provide psychiatric evaluations and evaluations for Medication Assisted Treatment. Behavioral health medications utilized include, but are not limited to Buprenorphine/Naloxone, Subutex, and Vivitrol.

To respond to COVID-19 safety precautions and restrictions, DCBH developed a hybrid model of service delivery to avoid a total disruption in treatment services. This hybrid model merges an in-person platform with a virtual platform and enables consumers to receive treatment more consistently. This model allowed consumers that were not able to receive in-person services to take advantage of a virtual platform. DCBH provided the equipment and space for consumers to utilize telehealth service. This was done with minimum contact, implementing COVID safety protocols such as observing social distancing and disinfecting the equipment and area between each individual use. This hybrid platform was particularly helpful in providing SUD services for the homeless consumer. To respond to facilities closures due to COVID-19 restrictions, DCBH maintained therapeutic relationships via smartphone/phone and stayed connected by mail.
Additionally, it was essential to maintain treatment for individuals that were prescribed SUD medications, as treatment facilities continue to address the opioid epidemic, through the COVID-19 pandemic. DCBH's physician provided SUD and psychiatric services for its' consumers in-person and via telehealth to prescribe medications to treat SUD. These services include psychiatric medications as appropriate. DCBH maintained this hybrid model during the closures via telehealth.

Prevention Services continue to serve as the lead representative for Dorchester County, participating on the Mid-Shore OMPP Leadership Team and the OMPP Coalition. Prevention Services are responsible for the continuous effort in collecting data, implementing a strategic plan, guiding the coalition, and working with the evaluation team to evaluate the program and its data. Through this process, decisions are made as to what types of educational materials are needed in the county and the region. The development of information to disseminate is collected from many sources such as the Substance Abuse and Mental Health Services Administration (SAMSHA), the State Behavioral Health Administration, Maryland Poison Center, local law enforcement data, MSBH data, information and questions posed at local public forums, and other state and national substance use data reports from universities.

When high risk and high-cost consumers are identified either by clinical staff, Peer Recovery Specialists, or referring agencies, they are assessed to determine level of care and support needs. Individuals appropriate for level III residential treatment programs are routinely referred to Care Coordination and to Dri-Dock Recovery and Wellness Center for peer support as well. Coordination of care for high risk and high-cost consumers, specifically consumers identified as IV drug users, is managed through a referral process to the local health department in Dorchester County, to Dorchester County Behavioral Health, or one of the local private providers. DCBH utilizes the A.F. Whitsitt Center for crisis beds specifically for individuals experiencing Opioid Use Disorder, Avenues Recovery, Warwick Manor Behavioral Health, and Hudson Health Services for Level III residential treatment. In Dorchester County, high risk and high utilization consumers are case managed by qualified clinical staff, with special attention from the clinical supervisor, an experienced LCSW-C, during any waiting period prior to admission to residential treatment. The Care Coordinator works with the individual to help ascertain resources to address primary needs prior to admission to residential treatment and upon discharge. Contacts are made with MSBH when appropriate for assistance with challenging cases.

Transitioning from incarceration to the community

CORRECTIONAL SERVICES (DART)

Treatment services at the Dorchester County Detention Center (DCDC) continue to be an important element in addressing the needs of SUD consumers who have been incarcerated. There have been a few interruptions in services due to Covid-19 pandemic restrictions and quarantine standards. The three clinical staff members, a Licensed Master's level Social Worker, a Licensed SUD Counselor, and a Certified SUD Counselor, at the CARF accredited treatment program, Drug and Alcohol Recovery Treatment (DART), within DCDC have complied with the detention's protocols for safety and pandemic precautions. Individual treatment and SBIRT screenings have continued using the virtual platform, when appropriate. The Screening, Brief Intervention and Referral to Treatment (SBIRT) is completed at the time individuals first enter

the detention center to identify those who would benefit from SUD services. If an individual presents with a positive toxicology screen, they may be referred to the DART Program for treatment as well.

All services are conducted using an evidence based best practice curriculum, "A New Direction", focused on the individuals in the criminal justice system and "Seeking Safety", a trauma focused approach. These evidence-based best practices are proven to be effective with the criminal justice population and with consumers who are diagnosed with Opioid Use Disorder, as well as "Seeking Safety", for trauma-informed services. All treatment is provided utilizing best practice approaches including Motivational Interviewing, Cognitive Behavioral Therapy, and Trauma Informed Therapy. The program physician for the DART program completes psychiatric evaluations and evaluations for Medication Assisted Treatment. SUD medications, Buprenorphine/Naloxone and Subutex will be introduced in the program in March 2021. Vivitrol is currently being prescribed and administrated to consumers inside the detention center, when appropriate, prior to release and continued in the community at DCBH or one of the private SUD providers for a seamless transition.

Individuals released from the Detention Center are given Narcan upon release. Participants in the DART program are referred to SUD treatment upon release from the detention center. The referral for outpatient treatment includes a contact person and an appointment time and date. DART staff members refer consumers to the State Care Coordinator for housing and consumer supports such as help with employment, transportation, and to obtain vital documents, etc. Consumers are also referred to Dri-Dock Recovery and Wellness Center for peer support services from a Certified Peer Recovery Specialist to help with the transition. If the individual chooses not to go to treatment, they will be connected with a Peer Recovery Specialist to provide recovery support resources to include housing information, employment help, and assistance with vital documents.

Regionally MSPC offers services through the detentions centers to assist with transitions into the community such as the Maryland Community Criminal Justice Treatment program (MCCJTP) and transitional housing.

Individuals who are HIV positive

The Dorchester County Health Department assists individuals who are HIV positive. Individuals can receive case management services, a referral to the local FQHC, as well as being eligible for Care Coordination and Peer Support services through their local jurisdiction. The Care Coordinator acts as the primary interface between ambulatory providers, community partners, and their consumers. Care Coordinators are responsible for conducting ongoing face-to-face or

telephone meetings with the consumer, bi-monthly or as needed. This will allow for coordination and support to access, participate, continue in, avoid duplication of services, and to update the consumer's plan utilizing positive goals and objectives. Peer Recovery Support Specialists may work closely with these individuals to assist in accessing treatment and support services within the community. Dorchester County Health Department has also partnered with Dorchester County Behavioral Health and Dri-Dock to provide HIV and HCV testing and treatment for those suffering from a SUD. Testing for HIV and HCV has been incorporated into the Intake and Assessment process at DCBH to increase the number of individuals in this at-risk population that are tested. All individuals that test positive will be able to receive treatment for either HIV and or HCV. The goal is to reduce the incidence and prevalence of communicable diseases transmitted through injection drug use, in Dorchester County.

Co-occurring Disorders

Caroline County Behavioral Health continues to fine-tune its integration of mental health and SUD programming for its clients. Clients with co-occurring disorders are referred for outpatient Mental Health treatment at Caroline County Behavioral Health. Staff work together to co-treat within groups. The SUD and Mental Health clinical team meets weekly to discuss and coordinate treatment for all clients when necessary and include the school-based therapists when treatment may be provided to members of the family. The intake assessment for new clients is integrated to include assessment for mental health and addictions, (as per the scope of the professional) and can identify those with co-occurring disorders. For those who can benefit from Peer Support, Chesapeake Voyagers Wellness and Recovery Center is utilized to assist those clients with specific needs. Currently, the clinic provides addictions and alcohol education, Narcan instruction and distribution, school-based therapy (elementary, middle, and high school), drug education (middle and high school), mental health therapy for adults, outpatient addictions treatment and counseling, MAT (Vivitrol, Suboxone, Subutex), and Peer Support along with Care Coordination.
Kent County works with local providers as well as surrounding counties to ensure all the needs of individuals are met for both substance use and mental health. Recovery in Motion a Wellness and Recovery Center, also offers various support groups (anxiety and depression, gender specific, employment and life skills, and social support events). Peers are also available to meet one-on-one with individuals to offer person centered care and linkage to other community resources as needed.

Queen Anne's County works with local providers for substance use and mental health disorders closely to ensure that all needs are met. Queen Anne's County itself provides wrap around services to those providers, such as MAT (Vivitrol and Buprenorphine), Fentanyl Test Strips, Naloxone, family support groups, Narcotics Anonymous, a peer-led recovery group, as well as hosts an anxiety and depression support group. Within the Center at Nielsen (located at the QADOH) a wellness center exists where peers can meet with their recoverees, assist in employment searching, access to the public behavioral health system, learn about the multiple treatment options available, as well as arrange for transportation to appointments.

Pregnant women and women with children

Last year, four out of the five mid-shore counties have initiated the START (Sobriety Treatment and Recovery Teams) Program. The four counties are in different stages of implementation. Kent County's program was initiated, and a Family Peer Mentor was hired. The START Program Model is a child welfare- based intervention that has been shown, when implemented with fidelity, to improve outcomes for both parents and children affected by child maltreatment and parental substance use disorders. The START Model, along with the family mentor has been able to decrease the negative stigma surrounding child welfare agencies and SUD providers. There are six main goals of the START Program:

1. Preventing Out of Home Placement
2. Child Safety and Wellbeing
3. Permanency for Children
4. Parental Recovery
5. Family Stability and Self Sufficiency
6. Improved System Capacity

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

Mental Health Services

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

Individuals with serious and persistent mental illness and co-existing conditions can attend the Psychiatric Rehabilitation Program (PRP) through mid-shore community providers, in addition to the Residential Rehabilitation Program; both programs build on recovery and independence. The mid-shore also has an inpatient psychiatric unit in Dorchester County for individuals diagnosed with a serious mental illness that require acute stabilization. Other community providers offer intensive outpatient treatment and referrals for linkage to services for persistent mental illness. In addition, Mobile Treatment programs are available and able to meet individuals in the community for crisis response services. Eastern Shore Crisis Response is a 24/7 call center that triages behavioral health crisis calls and can dispatch Mobile Crisis Teams to respond to individuals 24 hours per day if needed.

Peer Support is also available to support individuals on their path to recovery. Chesapeake Voyagers Wellness and Recovery has locations in all 5 counties. They offer support groups, and their peers offer guidance to individuals who are living with a behavioral health diagnosis.

Court and criminal justice involvement

DCBH collaborates with the Dorchester County Problem-Solving Court to provide SUD Drug Court and Veterans Court services. Defendants are referred from the Problem-Solving Court for an assessment to determine if they have a SUD. Defendants receive a comprehensive assessment, and if diagnosed with a SUD, are placed in the appropriate level of care, Level I Outpatient, and Level II Intensive Outpatient with a clear focus on Opioid Use Disorder. If the defendant requires residential treatment, Level III, they are referred with the courts' permission. All assessments screen for co-occurring disorders, trauma, and problem gambling.

Many defendants referred from court experiencing a SUD also have a co-occurring disorder and are victims of trauma. The defendant's trauma may have been from adverse childhood and life experiences, or from opioid or another type of drug overdose.

DCBH's Drug Court Service employs evidence based best practices and continues to use curriculums such as "A New Direction," effective with the criminal justice population and with consumers diagnosed with Opioid Use Disorder, as well as "Seeking Safety", for trauma-informed services. All treatment is provided by utilizing best practice approaches including Motivational Interviewing, Cognitive Behavioral Therapy, and Trauma Informed Therapy. A pharmacological approach in treating opioid addiction, Medication Assisted Treatment (MAT) is utilized when clinically appropriate. Services include SUD education, court consultation, toxicology screening, individual therapy, family therapy, group therapy and medical services, utilizing its program physician to provide psychiatric evaluations and evaluations for Medication Assisted Treatment. SUD medications used include, but are not limited to, Buprenorphine /Naloxone, Subutex, and Vivitrol. All necessary referrals for state care co-ordination and peer recovery services are made at the time of admission.

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

Traumatic brain injury (TBI)

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

Homelessness

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

Co-occurring Disorder

Mental health problems and substance use disorders often occur together, this is referred to as co-occurring. Mental health concerns may lead to alcohol use or the use of other substances, as a form of self-medication. More than one in four adults living with serious mental health concerns also have a substance use concern. An individual with co-occurring concerns who seeks treatment, must see a clinician who is versed in treating both in tandem. Treatment for co-occurring disorders may include rehabilitation, medications, support groups, and talk therapy. There are services throughout the Eastern Shore that provide the necessary services to treat co-occurring disorders. However, there remains a shortage of clinicians in the region. MSPC will support clinical trainings that educate mental health and substance use professionals about complexity of co-occurring disorders; including how to screen, assess and to provide ongoing treatment.

Victims of Trauma

MSPC promotes ongoing acknowledgement of the delicate needs of victims of trauma and educating providers and the community about trauma-informed services. This past fall, MSBH and community partners sponsored the virtual showing of three IndieFlix movies – Angst, Like and the Outstanders. The movies addressed anxiety, the impact of social media, resilience and bullying, each viewing was followed by a panel discussion facilitated by the producer including three community partners/family members. Following the panel discussion, resources were shared with viewers.

The death of George Floyd in May of 2020 once again brought to light the need for behavioral health providers to have specialized training to address racial, historical, and compound trauma within BIPOC (Black, Indigenous, People of Color) Communities. Facing two pandemics, racism and COVID-19, many individuals found themselves overwhelmed and seeking mental health

treatment via telehealth which came more readily available. To support this need, MSBH has partnered with Dr. Dionne Coker-Appiah and the Rural Mental Health Initiative to bring culturally competent providers and services to the region. Also, to note that many mid-shore providers have a variety of clinicians with specialized training and resources to address complex and various types of trauma in the client treatment world and the community at large.

Deaf and hard of hearing

MSBH continues to monitor the Deaf and Hard of Hearing contract through Arundel Lodge Inc. (ALI) and other private providers who serve the deaf population across the Eastern Shore. Because many deaf individuals who utilize behavioral health services were familiar with telehealth and using visual online platforms for their appointments, the contract continued serving this population. However, the private providers did not facilitate services in Quarter 4 of FY2020, assumedly due to COVID-19. MSBH reached out to the contracted private providers but no response was given. In alignment with the FY21 CLC Strategic Plan, Dr. Crowe with Gallaudet University will present at the MSPC Diversity and Inclusion Workgroup re deaf culture and best practices for deaf services.

Individuals transitioning from RRP to Supportive Housing

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

Individuals transitioning from RRP to independent living

Individuals transitioning from RRP to independent living are often successful when supportive services are put in place. Targeted Case Management, outpatient behavioral health treatment, Supported Employment and/or day programming such as Psychiatric Rehabilitation Programs are discussed and put in place prior to the transition out of the residential program. Often, goals are established between the provider and the individual detailing what services are needed. The residential programs work collaboratively with community providers to establish a stable and successful transition.

Forensically involved individuals who are ready to discharge from State Hospital

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

to needed services and supports. If the individual is on Conditions of Release, they will already be assigned a worker from the Office of Forensic Services.

TAY transitioning from treatment centers

Although MSBH does not provide direct services, Transition aged youth (TAY) transitioning back into the community are referred for outpatient mental health services, Local Care Teams to coordinate care and supports in their community, RRP, and the Healthy Transitions program which includes supported education and employment, PRP, Health Homes, and Family Psychoeducation.

b. Describe how you will develop and implement integrated behavioral health treatment services and recovery supports in collaboration with other local authorities, public and private service providers, state and local hospitals, human service agencies, and somatic care providers including long term care facilities.

Best Practices for evidence-based treatment for best outcomes

Kent County works side by side with local providers for SUD and MH disorders to ensure a person is receiving proper care for all their behavioral health needs. Recovery in Motion (RIM) Center takes a holistic approach with all consumers. RIM does an initial intake evaluation with a consumer to determine what support services they need in regard to MH, SUD, Physical, Social, Emotional and Spiritual Wellbeing. RIM is staffed with a Care Coordinator, Peer Supervisor and 5 Certified Peer Support Specialists. The Center hosts an array of support groups such as Anxiety & Depression, Teen-Changers, Men/Women, Spiritual Guide, Job Search Assistance, Etc. The Opioid Intervention Team (OIT) works with the local hospital and EMS department. The Certified Peers respond to all Overdose calls to promote treatment, education and prevention to the individual admitted. OIT also works with other local agencies to train and distribute Narcan to the community.

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

MSBH focuses on ongoing integration efforts with facilitation of BHSN workgroups, as well as attendance at existing workgroups in the community, including Healthy Tilghman in Talbot County, The Safety Net (previously Partnership for Suicide Prevention, now combined with the

Anti-Bullying Committee) in Queen Anne's County, and LDAAC participation in each of the five mid-shore counties. MSBH collaborates with local Departments of Social Services on high needs utilizers through regular participation at Multi-Disciplinary Meetings. In addition, the Forensic Mental Health Program and SOAR program work directly with clients to access benefits through DSS to assist clients in successful integration back into the community.

c. *Describe the behavioral health service needs for the system in your jurisdiction as well as any challenges and issues affecting your ability to provide or otherwise ensure access to a full continuum of care and support. How will you address gaps in the service delivery continuum?*

MSPC prioritizes contact and relationships with our provider network and stakeholder groups. MSPC has enhanced this relationship with the support and communications that have been necessary for during the management and response to the COVID-19 pandemic. MSPC is sensitive to the impact of the pandemic on the provider community, in addition to remaining apprised and involved with the impact with several state and system level changes and proposed changes that will be impacting our PBHS. The provider network of the mid-shore has been subject to several challenges historically, and the events of the past year have compounded the challenges. Several areas have been impacting our providers over the course of the year and will continue to impact our providers in FY22. The impacts range from COVID-19, ASO transition, new proposed regulations, enhanced restrictions and monitoring of the Psychiatric Rehabilitation Program services, and the wavering and limited psychiatric workforce on the Eastern Shore.

The COVID-19 pandemic has challenged the already stretched behavioral health workforce and has created new costs for providers as they modify service delivery. Compliance with social distancing, quarantine standards, and sanitation guidelines, has presented as difficult to manage and costly to the providers. The rapid onset of the pandemic and the need to respond and adapt to avoid the disruption of services has been a complex experience. The provider network responded beautifully to transitioning service delivery structures in response to the pandemic initiating in March of 2020. The provider network has been supported locally by our local health department leadership and the support of MSPC during the response and throughout the State of Emergency. Support from the Behavioral Health Administration with communications, transparency regarding regulatory accommodations and changes, in addition to the support of the acquisition of Personal Protective Equipment in April of 2020, was tremendously helpful. Most providers in our mid-shore region were able to remain operational as soon as the impact of the pandemic hit. For our outpatient providers, transitioning to a virtual platform took ingenuity, and some creative structuring of service platforms, and yielded successful and sustained services for our mid-shore consumers. For our residential providers, the impact of the pandemic was more complex in nature with managing and assuring infection control and risk management practices of care with in-person and residential supports. The mid-shore and the Eastern Shore region of the state were impacted with a period in April-May 2020, when all residential substance use treatment providers were offline due to the impact of managing and being equipped with the proper PPE and testing capacities. The development of admission

protocols and accommodation changes for social distancing impacted the census capacity in the region for residential substance use treatment.

A major resource and provider in the mid-shore and supporting the Eastern Shore of Maryland is the A.F. Whitsitt Center located in Chestertown, MD, Kent County. The impact of COVID-19 on this facility has been significant, and impacted the operations of the facility, ability to support residential substance use, opioid crisis beds, and the mental health residential crisis beds capacity. During the period of March 23, 2020 through July 6, 2020, all beds at the Whitsitt Center were offline for admissions. Since, March 23, 2020, the mental health residential crisis beds have remained offline and will not resume being housed or operated from the Whitsitt Center moving forward. The impact of the limited census and operations of the Whitsitt Center coupled with the loss of four mental health crisis beds on the Eastern Shore has been substantial. MSBH has been working closely with the leadership team of the Kent County Health Department and the Whitsitt Center to strategize resumption and maintenance of operations for all substance use residential and crisis services since the beginning of the pandemic. In addition, MSBH has been working with BHA and the Whitsitt Center team to plan for the discontinuation of the mental health crisis beds being managed and operated by the Whitsitt Center, and to recruit and support a new provider for this resource. The recruitment and start-up of a new mental health residential crisis vendor and the support of onboarding a new provider will occur during the remaining part of FY21.

The psychiatry and behavioral health workforce crisis remain an issue for the mid-shore and Eastern Shore region. The shortage of psychiatrists and behavioral health providers is not unique to the mid-shore region, but is a growing crisis facing Maryland as a whole. Our providers lack the capacity to support the current demands of individuals seeking behavioral health services, our primary care providers are limited with integrated models and providers to adequately serve behavioral health needs, and the efficiency with access is a barrier to ensuring community-based services. The mid-shore region has continued to support providers who are impacted by turnover of psychiatrists, nurse practitioners, and the credentialing issues with reimbursement outside of the PBHS system. A recent development is the impact of noncompete agreements with hospital-based services that has impacted the psychiatry workforce from sustaining relationships with multiple outpatient networks and providers. This impact has been felt with several of our Outpatient Mental Health Clinic provider groups in the mid-shore region. A Federally Qualified Health Center in the region has recently moved to committing to adding behavioral health as a service line which will hopefully support the recruitment of psychiatry and psychiatric nurse practitioners into the region within the year as the services are set to launch in the second half of calendar year 2021.

The behavioral health provider network in the state of Maryland has been impacted this year with several systems driven oversight and management issues. The Administrative Services Organization (ASO)/Optum Transition has been a significantly challenging process for the provider network. Providers have had to pull staff time and attention away from clinical issues to

deal with the shortcomings of the new ASO. Optum took over as the ASO in January 2020, and was unable to authorize services or pay claims, requiring the Maryland Department of Health to authorize estimated payments to providers. This experience spanned eight months of estimated payments and underwent a reconciliation period layered with complex communications and submission processes from Optum Maryland. Providers were left without access to necessary reports detailing claims processing and payment histories. New Proposed Regulations under COMAR 10.63 were released for comment in July 2020. The proposed regulations will add to provider costs and require additional demands of the behavioral health workforce. These regulations are in addition to new accreditation requirements that cost providers in terms of both staff time and money. Psychiatric Rehabilitation Program (PRP) and Residential Rehabilitation Program (RRP) Restrictions have required providers rendering this service with new medical necessity criteria, coupled with Optum Maryland authorization and claims payment delays, and requirements in the proposed regulations all threaten access to, and the viability of, rehabilitation and residential programs. The Rate Study that is currently underway for providers will not adequately reflect the impacts of COVID and the additional costs to providers of the ASO transition and any new regulatory requirements. The study also creates and additional demand on overworked and understaffed billing departments for providers.

The behavioral health needs of the community have grown, and with the impact of COVID-19, behavioral health providers are essential and critical resources for the wellness and health of our region. Providers are managing the trauma and disruption caused by the coronavirus, along with the crisis of the impact of fragmented and fractured system supports in Maryland. MSPC continues to advocate for the removal of barriers to access, and works to combat stigma, providers need to be equipped to serve and allowed opportunities to operate and be supported as this workforce crisis evolves. MSPC will remain committed to supporting and addressing our network capacity with our work with BHA and our legislators, in addition to enhancing our regional collaboration across care models with growing partnerships and seeking out sustainability and quality resources for support.

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

Transportation also remains a significant barrier to accessing treatment. Limited public transportation does exist, but transit rides can take an entire day both in town centers and rural areas, given that the mid-shore spans more than 2,200 square miles. Some providers offer limited transportation for clients, as do wellness and recovery centers in both Dorchester and Talbot Counties. Queen Anne’s County also offers limited transportation from its health department. MSBH continues to collaborate with providers to secure grant funding for vehicles and drivers,

however, those requests have been unsuccessful. In some counties, Medical Assistance (MA) transportation will not retrieve children from school and will only transport one guardian per child. MSBH continues to participate in regional groups tasked with addressing transportation issues. There are voluntary ride-sharing nonprofits, however, these are not available for individuals with behavioral health diagnoses. Peer-to-peer transport continues to be discussed but lack of funds to reimburse for mileage, gas, and repairs prohibit such an endeavor.

As with transportation, housing can be problematic due to cost, location, safety, and availability. Quality, affordable housing is limited in the few town centers where most services are located. Recovery housing has expanded over the last two years in the mid-shore region. A barrier remains with individuals receiving medication assisted treatment accessing the array of housing available. In addition, recovery housing remains a cost for some, and costs up to $150 to $200 weekly for a shared room. The movement of recovery housing into the fee for service structure in the Public Behavioral Health System/ASO has benefited the region and has supported more long term stays and the sustainability of Recovery Houses in the region.

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

MSPC coordinates and facilitates the Eastern Shore Behavioral Health Coalition and is an active member on the State Behavioral Health Coalition, which supports advocacy to state and regional legislators and raise awareness about gaps, barriers, and other system needs.

d. Describe what program or system management processes will be implemented to address the following areas:

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

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

MSPC coordinates care for high risk/high-cost individuals with a primary substance use diagnosis. Provider meetings are held in every county in the mid-shore. These meetings routinely include discussion about care coordination opportunities for individuals meeting criteria for Level 3.7 treatment. County provider meetings also highlight waitlists and unique programmatic interventions and barriers. Area crisis teams support individuals who are waiting for an available treatment bed. MSBH successfully secured funding from the State Opioid Response (SOR) grant

for twelve 3.7 crisis beds specifically for individuals presenting with an Opiate Use Disorder and expanding to individuals with a Cocaine or Methamphetamine drug use disorder. Priority is given to mid-shore residents although, if beds are available, individuals from the Eastern and Western shores may be placed. The S.O.R funding also allowed MSBH to support the continuation of two Safe Stations on the Eastern Shore and the implementation of a third Safe Station in Caroline County. The Safe Stations provide 24/7 access to treatment for consumers with substance use disorder (SRD), specifically opioid misuse disorder, expanding to Cocaine and Methamphetamine misuse disorder. MSBH will continue the quarterly Eastern Shore Safe Station Coalition. This coalition coordinates services for SRD consumers across the Eastern Shore.

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

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

Complex consumers, those who have somatic, behavioral health, and/or require physical assistance with daily living activities, are not appropriate for residential rehabilitation facilities. Assisted living facilities are prohibitively expensive without the Community Options Waiver which, because of long waiting lists, can only be accessed after a nursing home stay. Nursing homes are not prepared due to lack of staff, lack of staff training, and minimal behavioral health provider support to care for these individuals. Because of the chronicity of serious mental illness and the likelihood of exacerbations with transitions to such an unfamiliar and unsupported environment, those individuals who are accepted often need stabilization in an acute psychiatric unit. Despite the possibility of fines, a nursing home may not agree to have the individual return. These individuals are characterized as ‘stuck’ patients. To assist with these individuals, MSBH is initiating a new project for older adults to the Eastern Shore. MSBH will be supporting the placement of 4-6 older adults with behavioral health needs into Assisted Living Facilities. The PASRR specialist will assist in the intake, placement, and case management of the individuals. The PASRR specialist will also support the Assisted Living Staff with training. Funding will support these individuals who are placed until they obtain the Community Options Waiver.

The PASRR Specialist at MSBH, through informal relationships with the Eastern Shore Psychiatric Center, the local psychiatric inpatient unit, Adult Evaluation and Review teams, and interested nursing home administrators, has worked to characterize the issues that surround unsuccessful transitions. Assisting all parties to identify the information essential to person-centered and

facility-centered planning and providing on-going support as requested during the transition phase, has resulted in some success in reducing the traumatic cycle of acute psychiatric admissions.

ii. Assessment of training needs around accurate clinical application of the ASAM Patient Placement Criteria and documentation of medical necessity to reduce authorization denials and over-utilization of high-cost services.

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

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

iii. Needs and gaps in housing and whether you have considered applying for Community Bond Funds to address housing needs

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

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

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

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

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

MSBH continue promote the Buprenorphine training (Wavier 2000) for primary care providers in the mid-shore area. This project teams public and private providers with primary care providers to deliver SRD/BH treatment for those individuals needing SRD management medications. This is a unique opportunity to partner somatic care with behavioral health care further addressing the "no wrong door concept."

Currently there are five local providers that offer office-based Buprenorphine therapy services. The expansion of MAT continues been on our radar. Through our LDAAC and Provider meetings we are gathering information regarding gaps of service and plan on brainstorming on how to resolve them. We do have a grant, "No Harm in Helping" that we ran into some issues with and are reconfiguring that grant in order to provide mobile MAT in our jurisdiction.

Currently there are two methadone providers in the mid-shore region; however, there are multiple providers who prescribe Vivitrol and 12 providers prescribing Suboxone. Withdrawal management includes residential crisis beds at A.F. Whitsitt and step-down programs from in-patient, long-term treatment facilities for those interested in reducing or eliminating the use of MAT substances. Additionally, detention centers in the mid-shore region offer in-house MAT, as well as provision of MAT for individuals upon release.

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

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

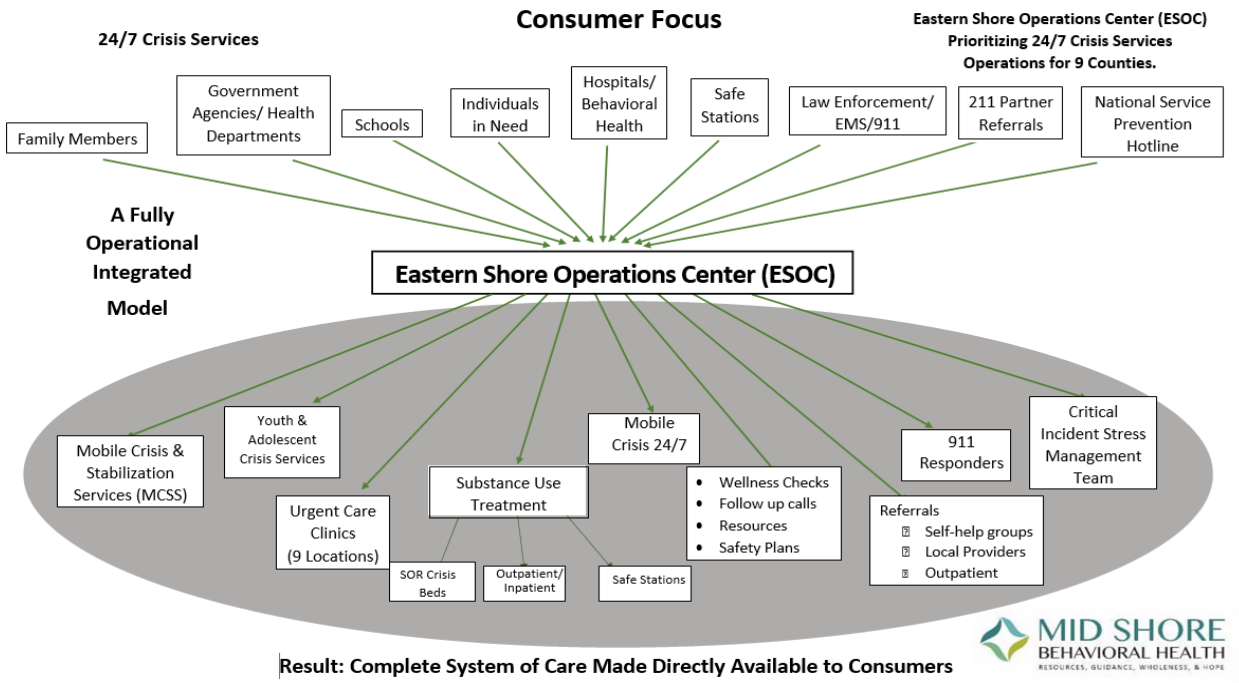
Local providers/programs treating co-occurring disorders include a psychoeducation component as part of the consumers treatment. Psychoeducation increases awareness of the symptoms of the disorder(s) and the relationship between mental disorders and substance abuse. Relapse-prevention education can also help consumers become aware of cues that make them more likely to abuse substances and help them develop alternative responses.

Integrated treatment often involves forms of behavioral treatment, such as cognitive behavioral therapy or dialectical behavioral therapy. The goal of therapy is to help improve coping skills and improve maladaptive behaviors. This is sometimes used in combination with medication. Comprehensive treatment includes collaboration between clinicians, physicians/psychiatrists/nurse practitioners, and other community services that offer support with issues related to housing, health, work, and other life skills.

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

g) *Crisis response services and diversion activities.*

MSBH and Cecil County CSA currently contract with Affiliated Santé Group (ASG) for Eastern Shore Crisis Response Services (ESCRS). ESCRS comprises the Eastern Shore Operations Center (ESOC), a 24/7 hotline, four Mobile Crisis Teams, and Crisis Intervention Team (CIT) coordination and training for Law Enforcement. ASG phone counselors hold bachelor's and master's level degrees in human services and are supervised by licensed mental health professionals. ESCRS programs are co-occurring capable and working toward enhanced. All staff are trained in conducting Crisis Risk and ASAM assessments. ESCRS are CARF accredited.



As seen in the diagram above, ESOC is the hub of the fully operational crisis system. ESOC's 24/7 crisis, resource and Urgent Care Clinic hotline serves all nine counties of Maryland's Eastern Shore. Phone counselors assess for safety, ascertain the crisis, provide support, complete a comprehensive clinical evaluation, and triage the referral options. Interventions included information and referrals; crisis plans; mental health, non-mental health, and substance use referrals; critical incident stress management; and calling 911.

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

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

In FY21, ESCRS received new contracts for two child and adolescent programs. The first is the Mobile Crisis Stabilization Services. This program is a 24/7 service in which a therapist, or MCT

team after hours, will respond to crisis issues of children in foster/kinship homes where Department of Social Services has placed the children or for children who continue to live with their families, but DSS is involved. Services are provided to the children to stabilize the placement and avoid disruption. The second program is a Crisis Service program. ESCRS provides services to children, you and their families who reside in Caroline, Dorchester, Somerset, Talbot, and Wicomico counties. The team will provide services to children, youth and their families with behavioral health needs who are in crisis in the community and/or school. MCT develops an individualized service plan with the child and/or family and then provides follow up services.
One of the main objectives of ESCRS is to divert consumers from unnecessary emergency department visits and reducing the response from law enforcement/EMS responders. ESCRS tries to effectively support individuals experiencing a behavioral health emergency in the least-restrictive environment. Along with the support provided from the phone counselors and the Mobile Crisis Teams, ESCRS links consumers to community behavioral health services to meet the emergent and general behavioral health needs of the consumer. The goal is to divert consumers from hospital and jail admissions.

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

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

Since April 2018, the Maryland Coalition of Families (MCF), in partnership with the University of Maryland Center Of Excellence on Problem Gambling, has sustained Program Coordinator for Problem Gambling position. This program offers support to families who have loved ones with gambling addiction. MCF uses a regional approach, with the five mid-shore counties being included in their Eastern region, along with Somerset, Worcester and Wicomico counties. Referrals are made through the 1-800-GAMBLER hotline, by warm line transfer. Unfortunately, referrals from the Eastern Shore have been limited since the program's inception. There is still limited data to illustrate concerns of gambling, as it is still socially accepted. In spite of the constraints of the pandemic, the Program Coordinator has been creative in sharing the program. She has created online workshops for family members, a profile of the target person who is calling the hotline, emotional and mental health referrals for families, "What the Gambler wishes the family would know", and a Facebook support group. Anticipated projects for this program include billboards (in partnership with MSBH) and television commercials to increase referrals from Eastern Shore residents.

i) Tobacco cessation services and activities

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

In Caroline County a prevention specialist is located within the behavioral health program and works in conjunction with the health department's prevention team to do tobacco cessation/prevention education and outreach, especially to school-aged adolescents, and other populations for wellness promotion in the community.

Queen Anne's County tobacco cessation is managed through the Prevention grant which is allocated through MDH. Queen Anne's county offers smoking cessation products, referrals for screening and counseling

The Kent County Health Department has local priorities of collaborating with schools and school systems to reduce tobacco use by raising awareness, strengthening policies, and training and educating staff, parents, and other community members. They also partner with schools and school systems to implement science-based prevention programs to educate students on the dangers of electronic cigarettes and vaping. If needed, they will connect students with available cessation services. As Kent's priorities have shifted away from adult cessation to youth prevention, the cost-effective Quitline 1-800-QUIT-NOW is promoted as an accessible and convenient alternative to in-person cessation groups through the health department. Kent continues to offer individual counseling to adults seeking service on an as-requested basis. Clients are offered counseling, a starter pack of NRT as supplies last, and referral to the Quitline. Kent County has been successful in helping organizations adopt smoke -free policies. There is opportunity to re-educate community leaders about the importance of smoke-free outdoor areas, especially considering the ESDs normalization.

DCBH has worked with the Health Education and Wellness Section of the Dorchester County Health Department to promote and address tobacco use. The Health Education and Wellness Program oversees the Tobacco Cessation Program available to residents in Dorchester County that have a desire to stop smoking or otherwise using tobacco products. This program works with BCBHS to offer Tobacco Cessation services to the treatment and recovery community upon request. Additionally, Tobacco Cessation presentations are provided to consumers having a SUD at DCBH multiple times per year. Upon demand classes are conducted at Dri-Dock Recovery and Wellness Center.

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

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

MSBH now has a Peer Support Specialist on staff to provide outreach to the community and offer support to youth, adolescents and their families who may be experiencing issues with Substance Use Disorders.

MSPC is also in the process of creating a Peer led Safe Station in Caroline County. An individual will present themselves at the Safe Station seeking treatment and they will meet a Peer Recovery Specialist, who will assist in securing treatment for the individual.

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

Queen Anne's County is the only jurisdiction in Maryland to support those who overdose on substances and take them to the emergency room, either on their own volition, or through an emergency petition, via the QA Sheriff's department. Over three years, that this has been in effect, only two survivors have chosen the emergency petition route. The rationale behind this is the medications that the survivors are ingesting are commonly used in surgical procedures, where once these are administered, the client is not allowed to make their own decisions. Once under the influence of strong opiate, especially Fentanyl, the client is not in a state where they are able to make clear and sound decisions for their best interests. The goal is to transport the survivor to a medical facility where they are evaluated beyond the obvious effects of an overdose and treat them medically if needed. The peers are able to alleviate the pressure on the nursing/medical staff at the emergency departments, be the liaison with local law enforcement, as well as ensuring that the survivor has contact information to someone who will be able to transport them to a safe environment.

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

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

2. Outreach and Public Awareness

a) Disseminate public awareness education and information.

Prevention staff from health department

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

Translation/Interpreters, information in other languages

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

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

MSPC's Peer Recovery Specialists attend outreach events throughout the mid-shore to introduce agency's services as well as provide education about SRD and Mental Health, recovery, and awareness. They have been instrumental in promoting Purple events, as well as various activities within the schools, American Legion and Wellness Days. They promote the Mobile Treatment Unit- MAT treatment, recovery resources available in the community, and outreach to the faith-based organizations. Peers and Prevention Specialists are able to provide Narcan education to the community and provide each person with a Narcan kit to keep. These Narcan kits are also distributed to law enforcement, the local library, town council members, and anyone who desires to receive one, along with training.

Behavioral Health Services on the Eastern Shore: Provider and Stakeholder Engagement

In response to the rapid flow of information and systems impact of the COVID-19 pandemic, MSPC organized and has been the responsible administrator of the Behavioral Health Services on the Eastern Shore Provider and Stakeholder meetings (virtual meetings/conference calls) since

the inception of the pandemic response in March of 2020. The network has been meeting since March 18, 2020, and to date (at the time of this plan submission 2/19/21) has met 34 times.

In March, the meetings were hosted twice a week, and as the pandemic has progressed the meetings occurred once a week and have moved to every other week meeting that has remained. From March 18th, 2020 to April 10, 2020, the regional calls were in support primarily of the mid-shore counties. A meeting was hosted on April 7, 2020 with all nine counties of the Eastern Shore local authorities represented. It was decided at that time, that the meetings would move from a mid-shore call to an Eastern Shore call. All nine counties LBHA/CSA/LAA affiliated logos were collected and are represented on the Agenda and meeting materials. The Eastern Shore network meeting has represented all nine counties since the meeting held on April 14, 2020.

The meetings have an agenda and are representative of all systems impacting and integrated with the behavioral health provider network on the Eastern Shore. Each meeting has time allocated for a BHA report out, Optum Maryland Provider Relations updates and receipt of questions and concerns, State updates provided by Maryland State Senator Addie Eckardt, capacity updates and issues. The meetings have a roll call reporting structure for all provider sectors ranging from acute hospitals, case management, OMHC, wellness and recovery centers, residential services, homeless services, and recovery housing, to Safe Stations. The participation averages 50-70 participants per meeting and participation is engaged and supportive. The peer support of the network has yielded positive problem solving, networking, referral resource information, and a platform of support for all participants and systems managers during the complicated and stressful times of COVID-19.

MSPC intends to continue to support and administer the provider network meetings beyond the COVID-19 pandemic. The peer support element and information sharing of systems changes with the provider connection across counties and services has been outstanding to witness, and MSPC desires to continue to support the partnerships that have grown out of this meeting platform. The collective problem solving, and resource sharing is a unique trait of the Eastern Shore, and the provider network meetings embody the spirit of this strength and support.

b) *How will you reach out to/engage culturally linguistically diverse individuals?*

Out of the FY21 MSPC CLC Strategic Plan, came the Diversity and Inclusion Workgroup. In June 2020, MSPC created an online survey to garner interest for the Workgroup. MSPC hosted the first workgroup on August 25th with discussion about the workgroup purpose and review of the CLC Strategic Plan. A distribution list was created from the survey response. The meeting agenda allowed for participants to share their agency's CLC progress, what they hope to gain from the workgroup and any participants grassroots racial equity efforts in the region. The second workgroup in October featured the Kent and Talbot County Local Management Boards sharing how their agencies integrate racial equity in their strategic planning and funding requests. Also,

during the October workgroup, the Upper Bay Counseling & Support Services shared their increased efforts to discuss and understand racial equity among their staff, in order to better serve their clientele. The December Workgroup featured LGBT services on the Eastern Shore. Presenters from PFLAG Chestertown, the ESPS TransLiance Group and Chase Brexton shared their breadth of services for individuals who identify as LGBT+. Rebecca Hutchison LCSW-C, who has a private practice, shared the majority of her clients identify as LGBT+ and have shared concerns of discrimination and competent services in the region. The workgroup will continue to meet, at least quarterly, covering Linguistic and other cultural concerns with meeting participants.

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

Choptank Community

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

Caroline Health Department moved into one location

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

Provider meetings and workgroups include MH and SRD Providers

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

BHSN – MH and SRD related topics

MSBH hosts a quarterly Behavioral Health Services Network meeting, which comprises provider and consumer representation. Staff takes into consideration challenges and changes at the regional, state, and national levels and works to address behavioral health issues while anticipating how change may impact the system of care. During 2020 BHSN quarterly meetings, MSBH welcomed presenters from various agencies, throughout the mid-shore region, to share the services that they provide to in the community. The following presentations were presented during the 2020 meetings:

- Arundel Lodge-Deaf and Hard of hearing services
- Mentor Maryland
- CLAS, Cultural &Linguistic Competency
- MD Commitment to Veterans
- Mid Shore Roundtable Point in Time results
- LGBT-On Our Own
- Presentation from DDA and DORS
- Warm Hand-Off Initiative
- Healthy Transitions Grant
- Awaken Recovery
- Mid Shore Community Mediation Center
- Self-care during COVID-19
- Mid Shore Pro Bono
- Mid Shore Council on Family Violence

Safe Stations

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

LDAAC

Health General 8-1001- Local Drug and Alcohol Abuse Council, requires that each county in Maryland have a Local Drug and Alcohol Council (LDAAC). Each of the county LDAAC's is served by the local addiction authorities (LAA). The purpose of the LDAAC is to present information about issues of substance use and to problem solve how to address those issues within the county. MSBH supports each of the mid-shore region LDAAC's, serving in various capacities in each county. For example, in Caroline County, MSBH has an administrative role with the LDAAC, scheduling the meetings, creating the agenda and facilitating guest speaker presentations. Although separate in function, the LDAAC's members come support county "Go Purple" efforts during the month of September. The activities for Recovery Month, are coordinated through each county LDAAC, beginning August 31st.

START

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

Trauma Informed Care Trainings

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

use trauma informed care principles to support their work with individuals. The overall framework of this training will help to strengthen the breadth of knowledge and skills supporting recovery for those individuals in need.

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

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

d) MH and SRD prevention promotion and awareness activities in FY 2020.

Each year, Go Purple campaigns in the five mid-shore counties continue to grow in size and scope and regional participation. On September 25, 2020, MSBH launched the first Going Purple Together Event. Following the example of the Mid-Shore Planning Collaborative with the CBHP all five mid-shore counties decided to host an event together-Going Purple Together. The Going Purple Together was one of the final events to close out Recovery Month. The event was held on Facebook live and had 823 views during the live stream event. Recovery stories were shared that offered hope and inspiration. Peers from each county highlighted events and/or services offered in their county for those seeking substance related recovery. The event ended with a local band sharing a beautiful music video they created in support of Recovery Month. This event united the mid-shore counties in educating and supporting the community.

Dorchester County's community recovery support services at Dri-Dock Recovery and Wellness Center have been focused on addressing the complex issues related to the Opioid Epidemic and most recently this has become a major challenge due to the COVID-19 Pandemic. Complying with social distancing guidelines has made it difficult to provide peer support services such as one- on-one supports, peer lead support groups and transportation. The core services provided at Dri-Dock are individual peer support, assisting with recovery related issues, referrals for SUD assessment and to community service agencies, job search assistance, housing, medical,

transportation, and assistance with obtaining vital documents. Dri-Dock also provides computer stations to access internet to support participants that have no internet access, sponsors SUD support group meetings such as Narcotics Anonymous and Alcoholics Anonymous and has monthly recovery events. Annually, Dri-Dock recognizes Recovery Month, Overdose Awareness Day and sponsors activities for holidays allowing participants to experience traditional celebratory events without the use of mind and mood-altering substances.

Peer Recovery Specialists perform community outreach where peers advocate, educate, and provide support within the community for those who suffer or have loved ones who suffer from an untreated SUD. Many of the individuals that are usually serviced by Dri-Dock do not have the equipment, such as smartphones, to engage in virtual communication for virtual support. To reach these individuals during the pandemic, Peer Recovery Specialists, equipped with proper PPE, have continued their community outreach. The peers distribute information regarding recovery and health information on the coronavirus and vaccines. Peers have posted flyers to let community members know that they are available by appointment to meet with individuals one-on-one, while maintaining six feet social distancing and mask protocols. Peers also provide phone support to individuals that call in for services. Peers have provided limited transportation to residential treatment programs while adhering to COVID-19 precautions for the transportation of consumers.

Unfortunately, at present, the volume of individuals seeking peer recovery services has decreased, as consumers have been less likely to visit the recovery center due to the pandemic. Dri-Dock has complied with the limited gathering mandates. Dri-Dock will resume sponsoring its' monthly recovery activities when COVID-19 pandemic restrictions are lifted, and it is safe to gather in groups.

A Naloxone training program has been fully implemented in Queen Anne's County that also includes training of hands-only CPR. All peers and most agency staff are all trained as trainers that are not only able to teach residents how to successfully use Naloxone, but to train partner agency leadership to train their staff as well.

The past success of acupuncture services combined with traditional therapeutic outpatient treatment has led to increased interest in participation. Additional funding was allocated to this service, however, due to COVID restrictions and all therapeutic treatment moving to virtual, these beneficial services are on hold until the restrictions lift.

The peer on call system is still operating at 100%, although telephonic at this time due to COVID restrictions. The peer continues to be notified by QAC DES dispatch as to which of the three facilities on the Shore the survivor will be transported to, and the peer responds via telephone

to the emergency room. While the success rate of supporting survivors is lower, it appears that the face-to-face contact during this vulnerable time is critical to accepting help.

COVID has brought extreme challenges to all service provision – it has changed the way communication can occur between peer and recoveree, the participation level of recoverees in volunteer groups, as well as the increased mental health needs, in addition to increased substance use. In response to this, Queen Anne's County added two additional virtual groups, which will be added to the in-person schedule once guidelines allow. These two new groups are for those individuals in recovery who are utilizing MAT medications. Typically, in traditional 12 step support groups, there can be feelings of that someone is not in recovery, unless they are not taking any medications, which we know is simply not true. This group provides support for those not only enrolled in our agency's MAT program, but is open to anyone, in any MAT program who does not feel comfortable in a traditional program. The other new peer-led support group that was added during this past year is co-occurring. As it is known that most individuals who are beginning their recovery journey experience some sort of mental health struggle as well, whether it be depression, anxiety, or something more complex. This group is for both substance users as well as non-substance users to discuss their recovery, learn from peers who have successfully navigated the process and continue to do so. This brings the total peer-led group offerings to five: Coffee, Tea, and Recovery - a group that is peer-led and recovery based; Co-Occurring and MAT groups – as described earlier, Family Group – which is for adult family members of those either in active use, or in early recovery, and Anxiety & Depression – which is a peer led group specific to anxiety and depression, facilitated by staff from Chesapeake Voyagers.

Two large campaigns were launched in Queen Anne's County as well that address the stigma associated with MAT, as well as normalizing recovery. The first campaign, funded through Buprenorphine Initiative funds allowed for social media, print, and billboards to support the conversation between patient and doctor regarding MAT, specifically Buprenorphine. These attractive designs showed photos of multiple people and the accompanying text described that their doctor manages their diabetes, high blood pressure and their Buprenorphine. Its intended purpose is to spark a conversation between patients and their physicians on the use and management of Buprenorphine along with their other medications.

The other successful campaign launched was the 'don't label us.' This campaign's message is that there is no typical look of someone in recovery and those in recovery can go on to lead successful lives. The photo shows various individuals and a list of things they 'are', such as 'business owner, 'parent, 'homeowner' the word 'addict' would be crossed out and the bottom would direct the viewer to go to the website 'dontlabelus.org' where they find information on MAT, and treatment and recovery services through the QAC department of health.

In addition to partnering with Haven Ministries food drive throughs for Naloxone and CPR training, the Queen Anne's County Peer Support Specialists held a 'Narcan Drive Through' in the parking lot of the agency. Residents could drive through, speak with peer support specialists, and learn how to administer Naloxone and perform hands only CPR. They also received educational materials from the prevention department on safe storage, disposal (Deterra Bags), and treatment and recovery support information.

The local Sheriff's office along with Kent County Health Department held a drug take back, where consumers could safely dispose of unwanted medications. The annual "Backyard Bash" was cancelled due to COVID-19. The Backyard Bash has been an annual event bringing community resources both local and surrounding together in an informal family style event. Individuals and/or families can enjoy sober social support while getting acquainted with various resources promoting overall well-being (Mental health services, recovery housing, medical assistance, family services, Narcan training and kits).

Community Events

Harm Reduction

MSPC has been working to bring Harm Reduction initiatives to the community. Most of the Local Addictions Authorities in the mid-shore have enhanced their distribution of Narcan, training of community members and stakeholders, in addition to welcoming new initiatives such as Fentanyl testing strips and mobile treatment units for the screening and prescribing of MAT to the region. The mid-shore region has been recognized for the Mobile Treatment Unit in Caroline County, that is working to expand their reach in the county for mobile MAT screening and treatment and is a partner for some new grant activities targeting at risk farming and agricultural workers. In Kent County, the implementation of the "No Harm In Helping" mobile unit is a new initiative to provide outreach, screening and prescribing, administration of MAT, as well as mobile Narcan training and Fentanyl distribution. Education of the mid-shore stakeholders remains a priority for the MSPC group. The buy-in of community partners and providers to move towards a system that embraces a harm-reduction philosophy, and desires to enhance harm-reduction, and implement the harm-reduction priorities is a challenge in the mid-shore. Partners are often more conservative with services and initiatives, so education remains at the forefront of the work. On March 12, 2020, MSBH hosted an all-day Harm Reduction training presented by Maryland's Harm Reduction Training Institute. Participants represented each of the five mid-shore counties, from mental health and substance use agencies. Sponsored by the Caroline County Human Services Council, MSBH and Behavioral Health Systems Baltimore, the event served to educate the participants about "Stigma, Trauma & People Who Use Drugs". Miera Corey with the Maryland Harm Reduction Training Institute shared a broad definition of harm reduction and how human and social service professionals can improve HR within their agencies. The topic of Harm Reduction (HR), across clinical and somatic domains is important to understand improving services. Principles of harm reduction include sociocultural factors, participant centered services, participant autonomy with a focus on health and dignity.

The Access to Harm Reduction Program, in collaboration with Dorchester County Behavioral Health, the HIV Department at the Dorchester County Health Department, and Johns Hopkins Hospital, are providing HIV and HCV testing and treatment for individuals having a SUD. DCBH has incorporated the testing protocol into the Intake and Assessment process and will offer testing for all current consumers. Testing will also be available for individuals that visit Dri-Dock Recovery and Wellness Center. Peers will encourage participants to be tested and provide support. All individuals whose test results indicate the presence of HIV and/or HCV will get treatment through the Dorchester County Health Department and Johns Hopkins Hospital.

Narcan Training is regularly available at Dri-Dock Recovery and Wellness Center. All individuals trained are issued a kit containing the medication, Narcan, and for active opioid users, Fentanyl Test Strips. Peer Recovery Specialists have joined with harm reduction staff to distribute Narcan in the community to address the increase in overdoses seen during the pandemic. An increased effort is made prior to all holidays as Dorchester County has identified a spike in overdoses around the holidays. Harm reduction staff have also begun distributing fentanyl test strips with Narcan kits to receptive individuals in the community including consumers known to use opioids or reporting use. Narcan training continues to be conducted using a virtual platform with contactless delivery becoming the norm.

Kent County held a community virtual event titled, "Hope for the Holidays" which featured Colicchie who was born Chas Smith in Pittsburgh, Pennsylvania. He began experimenting with drugs in his early teens and was fully immersed in heroin and crack addiction by the end of high school. Years of substance abuse led Smith to a dangerous life on the streets and multiple overdoses, all bracketed by short-lived attempts to give drugs up. In 2005 he began rapping, using the creative outlet to support his efforts to stay clean. Performing around Pittsburgh and working toward recording music, Smith drew content for his songs from his own harrowing experiences with addiction and recovery to promote and motivate individuals.

Kent County also initiated "Narcan from a Van." Prior to the holidays, the peers from Recovery in Motion and the OIT team provided training and distribution of Narcan to hot spots in Kent County. In addition to providing training and providing Narcan to the community, the gave out masks and hand sanitizer.

Across the Lifespan

9th Annual Across the Lifespan Conference

Due to the pandemic, MSBH's 9th annual Across the Lifespan Conference was split into two days, June 4th and 5th from 11:00 – 1:00 p.m. on Zoom. Each year, the conference has a topic of focus as it relates to consumers, "across the lifespan." This year's theme was "Resiliency in Birth to Older Adults" and provided four CEU's by Maryland Board of Social Work Examiners. Dr. Ileana Lindstrom provided the opening keynote for both days. Conference speakers included representation from a variety of perspectives on the topic of resilience: Shawan Burke, Joan

Smith, Jada Carrington, Brittany K. Lewis-Fooks, Tina-Marie Brown & Maria Daniels, Richard Lewis, Lynn Keckler, Maggie Black, and Beth Parker O'Brien. Each presenter shared insights, tips, resources, and relevant information regarding resiliency through all stages of life. There were over seventy participants.

Resilience Screening

Resilience: A Partnership with Health Tilghman

On November 13, 2019, MSBH in partnership with Healthy Tilghman, held a community event for the screening of the documentary Resilience, The Biology of Stress and The Science of Hope. The documentary focuses on the impact of Adverse Child Experiences (ACEs) and the impact of toxic stress, chronic environmental stress, and the relationship with the brain and behavior. The event was open to the public with special marketing efforts in the lower Bay-Hundred community of Talbot County.

Healthy Tilghman is a community collaboration and outreach led by the Tilghman United Methodist Church and For All Seasons Behavioral Health and Rape Crisis Center of Easton, MD, since the Fall of 2016. It was begun initially to address the mental health and substance use needs of the residents of the Tilghman Island area. The originators were Pastor Everett Langdon, most recent leadership, Pastor is Rev. Herb Cain, For All Seasons, Inc. and Dr. Michael Flaherty, Ph.D. Pa. Clinical Psychologist. Healthy Tilghman is a collaboration of Faith and Secular Institutions and community leaders seeking to meet the mental health and substance use needs of the community in hopes to improve community health. Mariah's Mission Fund of the Mid-Shore Community Foundation, Phillips Wharf Environmental Center on Tilghman Island, and Mid Shore Behavioral Health, Inc. leadership are also members of the Healthy Tilghman group.

Since launching, Healthy Tilghman has helped train several local citizens as volunteer Peer Support Specialist, building a community safety net of those with first-hand knowledge of mental health or substance use and recovery. These committed volunteers reach out to the community in numerous ways to assist neighbors and residents in finding and sustaining help when needed, whether for an individual or a family, or by just sharing their lived experiences. Community educational programs are regularly conducted as a mission of the work of Healthy Tilghman. The November 13th, 2019 program was specifically tailored for families living with challenges such as severe stress, mental health, or substance use and tools and community resources to build hope, wellness, and resiliency.

The event was free to the public and offered free childcare for attendees. Food and drink were provided, and a host of several local mid-shore mental health, substance use, and crisis providers provided information tables for the event. Narcan training and distribution was offered by the Talbot County Health Department. MSBH facilitated the panel discussion and program management. Following the screening of the film Resilience, a panel discussion was conducted. Representatives from the treatment community, an individual with lived experience in recovery,

and the Talbot County Health Officer Dr. Fredia Wadley, MD comprised the panel. The event was well attended by community members and representatives of the provider community. The sponsors for the event were MSBH, Healthy Tilghman, For All Seasons, Inc, Tilghman Area Youth Association, The Family Tree, Phillips Wharf Environmental Center, and Mariah's Mission Fund.

Children's Mental Health and Film series

Due to the impact of COVID, MSBH participated during the month of May in numerous virtual events to bring awareness to children's mental health. The purpose of the Children's Mental Health Matters Campaign is to help defeat the stigma associated with children's mental health and substance use, and to connect families to resources throughout the state that can assist families in receiving services. A video clip was shared during the virtual MultiCultural Festival to speak to the benefits of having conversations and seeking help early on with children. MSBH sponsored a virtual Caring Café with two guest speakers to discuss mental health concerns and resources for families with children and youth. As an extension of Children's Mental Health Matters campaign, MSBH and community partners sponsored in the fall the virtual showing of three IndieFlix – Angst, Like and the Outstanders. The movies addressed anxiety, the impact of social media, resilience and bullying, each viewing was followed by a panel discussion facilitated by the producer including three community partners/family members. An average of fifty people attended each viewing. Following the panel discussion, resources were shared with viewers.

3. Sub Grantee Monitoring

MSBH Sub Grantee Monitoring Processes

It should be noted that last year COVID-19 resulted in a Maryland State of Emergency in the middle of MSBH and vendor site visits, which take place between February and April. Some of the site visits were completed in person and some of them were completed virtually. FY22 will most likely take place virtually as Maryland is still in a State of Emergency. All meetings listed below will be held virtually at this time.

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

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

MSBH values the importance of a meaningful site visit. On-site, virtual, and desk-top audits are completed with vendors throughout the year. MSBH uses templates for site visit monitoring reporting in contract management to provide consistency to the process. Site visits are scheduled with providers on a mutually agreed upon date and time. Once scheduled, MSBH sends a site visit confirmation that includes requests for file access, documentation, and other pertinent information. An agenda for the visit is also included. During the visit, monitors are looking at internal controls, contract deliverables, scopes of work, provider policies, and the conditions of ward as outlined by BHA. Site visit reports are forwarded to the sub-vendor within thirty days of the visit. MSBH staff works closely with the sub-vendor to correct any findings.

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

MSBH is responsible for the monitoring of Residential Rehab Programs (RRPs), Group Homes for Adults with mental health needs, and Residential Crisis services. The Residential Rehabilitation Program currently has 18 small group homes with a total of 88 beds across the mid-shore region. The site requirements are monitored annually using the Residential Rehabilitation Program Housing Inspection Form. This objective is to provide a safe, comfortable, healthy, and recovery-oriented environment to RRP residents. The COMAR regulations 10.63.04.07 are used as guidelines for inspection purposes. Upon completion of inspection the provider is issued a Certificate of Approval for each year of compliance with the regulations depicted in COMAR 10.63.04.07. The Residential Specialist is required to attend BHA's Annual Mandatory Fire and Environmental Safety Training for Residential Specialists. The Residential Specialist also supports the monitoring of the Residential Crisis beds for mental health needs to ensure compliance with licensure and accreditation. MSBH operates from a streamlined internal process for efficiency and consistency in contract management. This approach, allows for our sub vendors to have a consistent experience across multiple contracts regardless of the behavioral health coordinator responsible for the monitoring. Most Conditions of Award (COA) for MSBH are encompassing of all five mid-shore counties, some COAs covering all nine counties of the Eastern Shore. MSBH behavioral health coordinators are assigned a county to serve as a point of contact and support for resources, guidance, and mediation if needed.

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

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

Local Addictions Authorities Sub Grantee Monitoring Process:

Contracting volume varies by Local Addictions Authority (LAA) in the mid-shore region. Sub-grantee monitoring standards are outlines as follows: The LAA contracts and develops scopes of work with sub grantee with language that is respective of the Conditions of Award (COAs) offered by BHA. COAs and compliance with the scope of work are reviewed at the time of the site visit with the sub-grantee. The Behavioral Health Administration Grant Monitoring tool is used along with the Behavioral Health Administration Provider Record Review Form. Any areas of non-compliance are followed by a corrective action plan and quarterly site visits are put in place to monitor progress.

Graduated monitoring Processes:

Step I: First year of public funding, program receives quarterly monitoring.
Step II: Monitor twice in a fiscal year if no corrective action plan required for one full year and no change in clinical supervisor within the past year.
Step III: Monitor one time during the fiscal year if no corrective action plan was required for two consecutive fiscal years.

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

MSPC Sub Grantee and the ASO

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

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

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

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

G. DATA and PLANNING

Introduction

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

The FY22 Community Behavioral Health Plan presented a unique data analysis opportunity in the absence of regional Administrative Service Organization (ASO) claims/service expenditure data and consumer counts. This year MSPC evaluated the Behavioral Health Indicator Data provided by BHA, in addition to an analysis of priority areas of focus: COVID-19 impact on wellness, Health and Behavioral Health Disparities, Crisis Response and Prevention, Suicide Deaths and Ideation, and Overdose Events and Deaths.

The data analysis section is organized as follows:

- Important Information about the data being reviewed
- Overview: Population, Poverty Levels, Medical Assistance Data, Unemployment
- Consumer and Expenditure data – Medically Assisted Mental Health and Substance Use Disorder
- COVID Impacts – Housing, Child/Adolescent Population, Previously Diagnosed Anxiety and Depression, Suicide Ideation and Opioid Overdose Presentation
- Special Areas of Analysis:
    I. Health and Behavioral Health Disparities Response
    II. Crisis Response and Prevention
    III. Overdose events

<u>Important information about the data being reviewed</u>

Data references:

- Mid-shore refers to the data for five counties: Caroline, Dorchester, Kent, Queen Anne's, and Talbot
- Statewide refers to data for the State of Maryland. This data includes expenditures for Maryland residents that were treated in other states where Maryland Medicaid pays for the out of state services.
- The data marked 'Mental Health' or 'MH' pertains to data provided to MSBH. The data marked 'Substance Use Disorder' or 'SUD' relates to data provided to mid-shore county LAA's. As noted above, data draws from MSBH and LAA records will be noted accordingly.
- The analysis is a review of the five mid-shore county combined data unless specifically noted to be an analysis of a specific county's data.

- Demographic data was obtained from the MSBH FY2019 Continuum of Care Notice of Funding Availability (NOFA) Internal Data.

Data used for the analysis:

The following analysis utilizes the Behavioral Health Indicator Data provided by the Behavioral Health Administration (BHA) which included:

- ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) are data from Maryland's Emergency Departments (EDs) and selected Urgent Care facilities that log individuals presenting in the EDs with defined syndromes, or chief complaints. Surveillance data can be used to monitor and detect changes in disease frequency and guide preventive measures in an attempt to reduce or eliminate morbidity and mortality.

  Note on actual verses projected:
  - Where calendar year 2020 includes claims filed through October 31, 2020 –if applicable for comparative purposes, November and December 2020 data was extrapolated using a straight-line method averaging the prior actual monthly results.
  - Regarding ASO data, the actuals recorded as of October 31, 2020 are not final as claims may be submitted up to twelve months from data of service.
  - Overdose data for the mid-shore counties for calendar year 2020 included actual events through December 31, 2020.
  - If the number of persons served is less than 11, the data is suppressed and not available to protect personally identifiable information (PHI).
- Mental Health (MH) and Substance Use Disorder (SUD) MARF (Maryland Financial Report) data – this data was limited due to change in ASO. Consumer counts may be duplicated across coverage and service types; however, the consumer count totals represent unduplicated counts.
- BHA recommended websites – there were numerous health websites utilized in the analysis and the specific site is referenced for information utilized in MSPC analysis. This information also allowed for additional analysis of the impact from COVID 19.
- Mid Shore Planning Collaborative (MSPC) – to further support a more comprehensive analysis, data collected by MSBH and our five LAA partners operations was utilized.

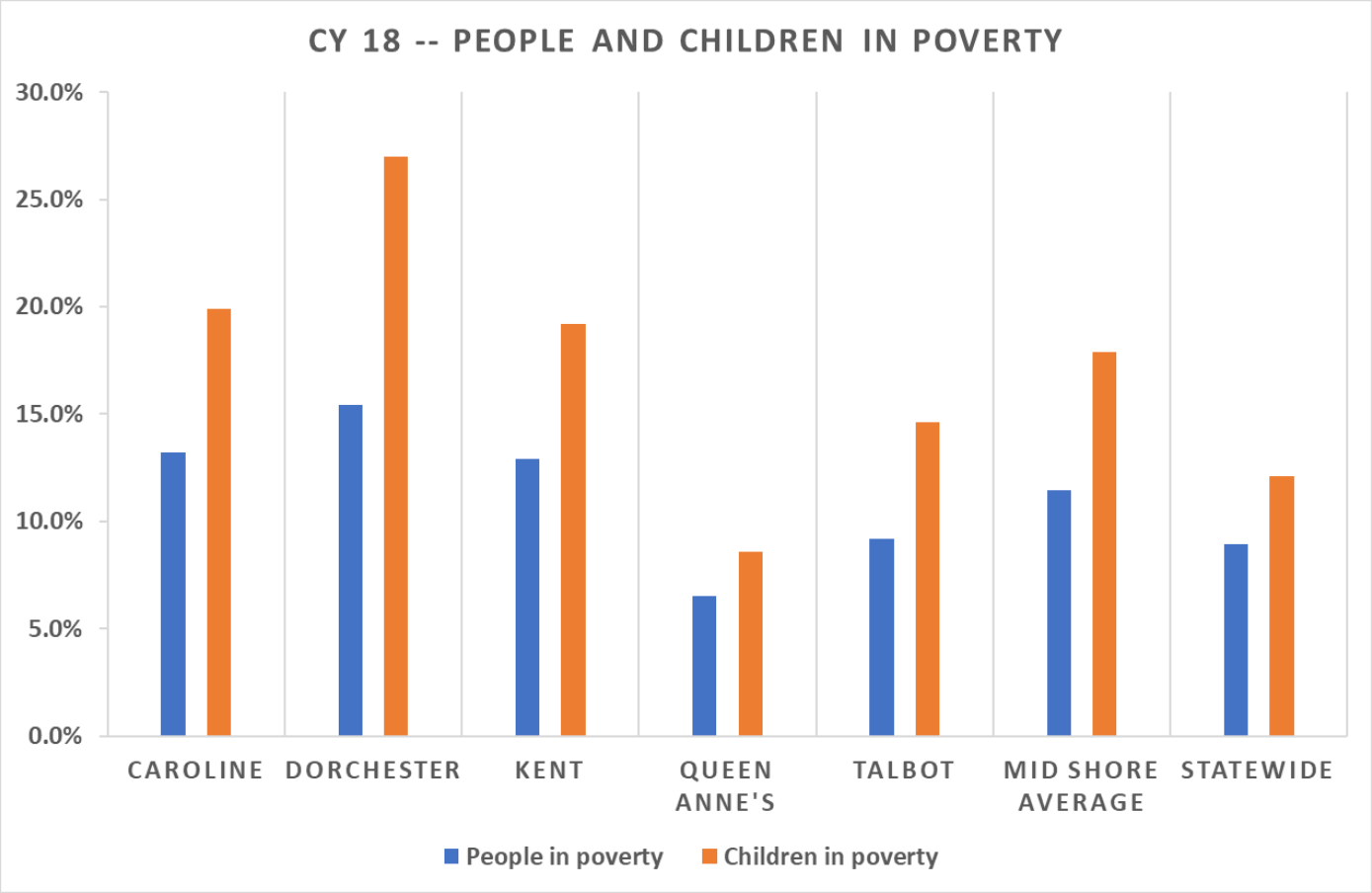
Overview

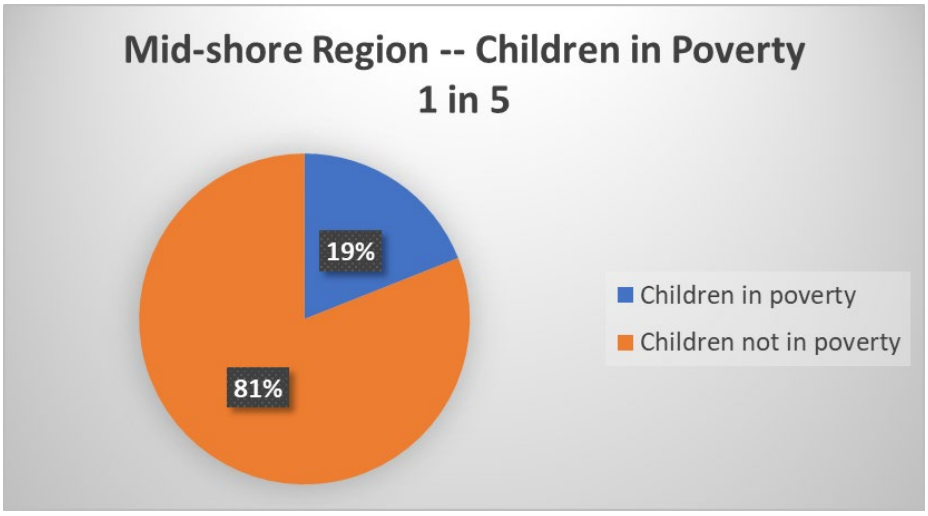
Mid-shore Demographics – 'Rural Nature of the Mid-Shore Region'

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

The following charts are reflective of the challenges that the mid-shore region is confronted with in providing for the behavioral health services to meet the needs of the community.

In comparison with statewide data, the mid-shore poverty rates for adult and children are among the highest in the state.

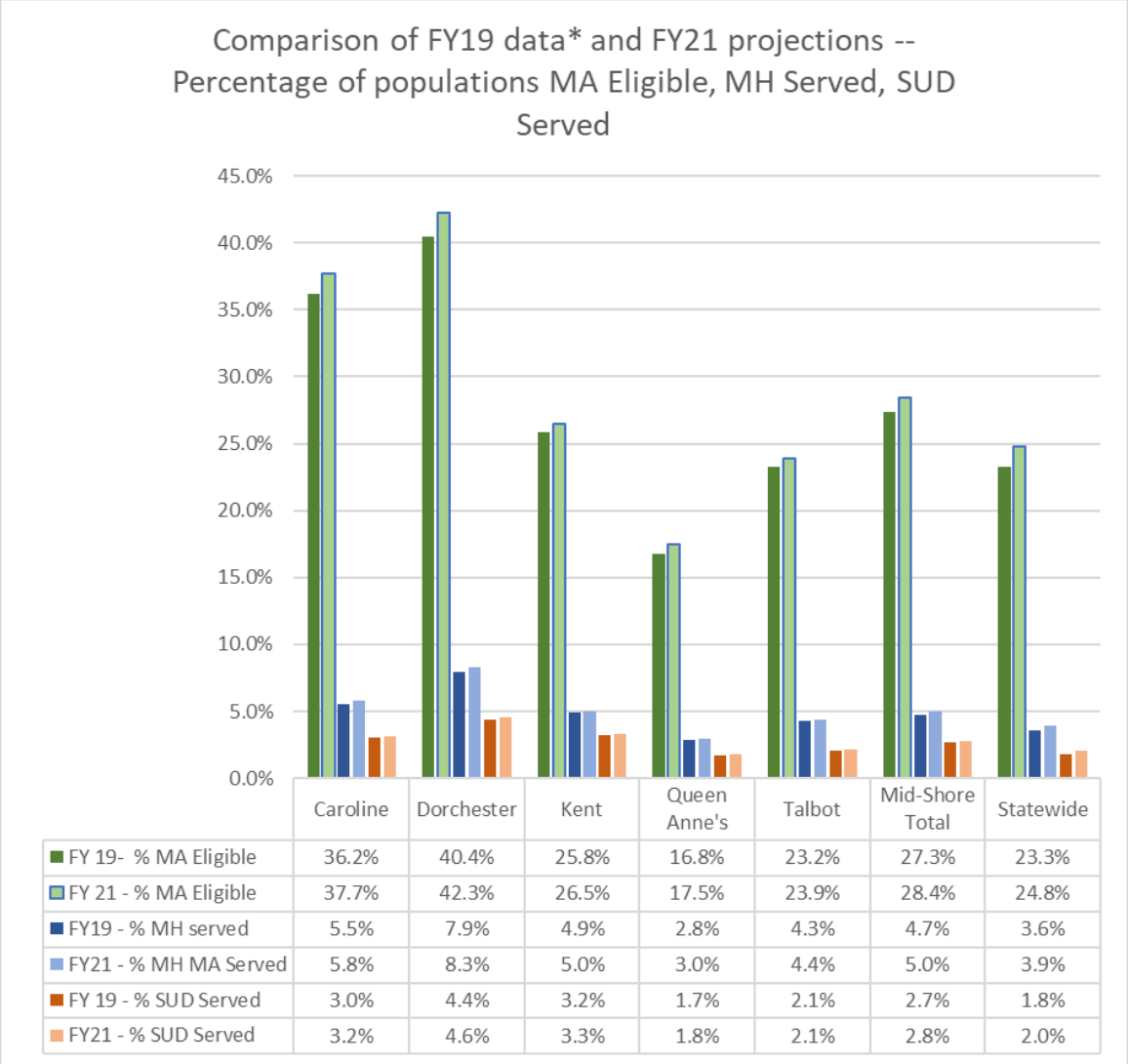




BHA provided statistics from the U.S. Department of Agriculture and Economic Research Service 2018 data – percent of total population in poverty.

The following charts show a large portion of the mid-shore population as eligible for medical assistance. In review of FY19 data as compared to FY21 data there is an increase across each county and the state in MA eligible, MH served, and SUD served. These charts also identify a larger MA eligible population in the mid-shore region as compared to statewide data.

FY 21 Compared to FY19 -- Medical Assistance Eligibility and MH/SUD Served



	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid-Shore Total	Statewide
FY 19- % MA Eligible	36.2%	40.4%	25.8%	16.8%	23.2%	27.3%	23.3%
FY 21 - % MA Eligible	37.7%	42.3%	26.5%	17.5%	23.9%	28.4%	24.8%
FY19 - % MH served	5.5%	7.9%	4.9%	2.8%	4.3%	4.7%	3.6%
FY21 - % MH MA Served	5.8%	8.3%	5.0%	3.0%	4.4%	5.0%	3.9%
FY 19 - % SUD Served	3.0%	4.4%	3.2%	1.7%	2.1%	2.7%	1.8%
FY21 - % SUD Served	3.2%	4.6%	3.3%	1.8%	2.1%	2.8%	2.0%

Notes -- Population statistics – Maryland vital statistics, estimate July 2018

FY 21 Projections	Total Population	Avg MA Eligible	MH MA Served	SUD MA Served
Caroline	33,304	12,549	1,918	1,053
Dorchester	31,998	13,528	2,657	1,465
Kent	19,383	5,131	977	641
Queen Anne's	50,251	8,790	1,487	889
Talbot	36,968	8,845	1,630	791
Mid-Shore Total	**171,904**	**48,843**	**8,669**	**4,839**
Statewide	**6,042,718**	**1,497,036**	**235,035**	**122,757**

--Average MA Eligible supplied by UMEC Hilltop Institute

-- MH and SUD served represents penetration rate based on PBHS Service Utilization

The mid-shore has a large MA eligible population. In review of the percentages, the difference between percent MA served and the percent MH or SUD served represents a larger population percentage than the state differential. This may represent that residents are not receiving needed services possibly due to:

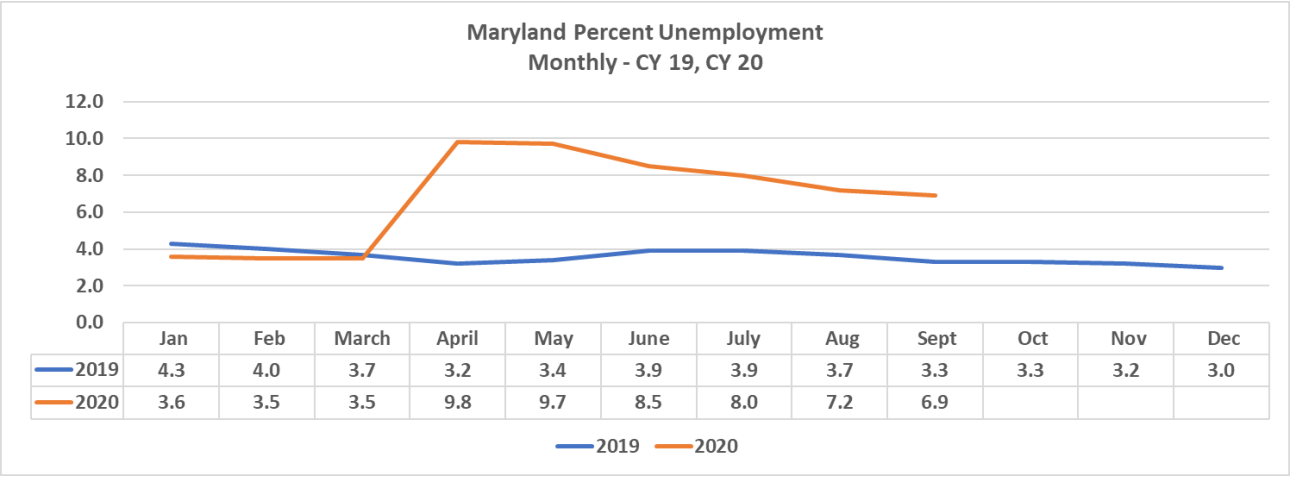
- Lack of a transportation systems along with longer distances to travel to receive care.
- High unskilled labor population where workers must choose between attendance at work or seeking needed healthcare treatment.
- Lack of needed providers and services.
- Economic barriers limiting gainful employment,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

The increase in MA eligible populations for all regions for FY21 over FY19 may also represent the impact of COVID-19.

Unemployment Data – State of Maryland and Mid-shore Counties

The following three charts are sourced from: Bureau of Labor Statistics (BLS) Publisher: MD Office of Workforce Information & Performance Release date: 10/28/2020

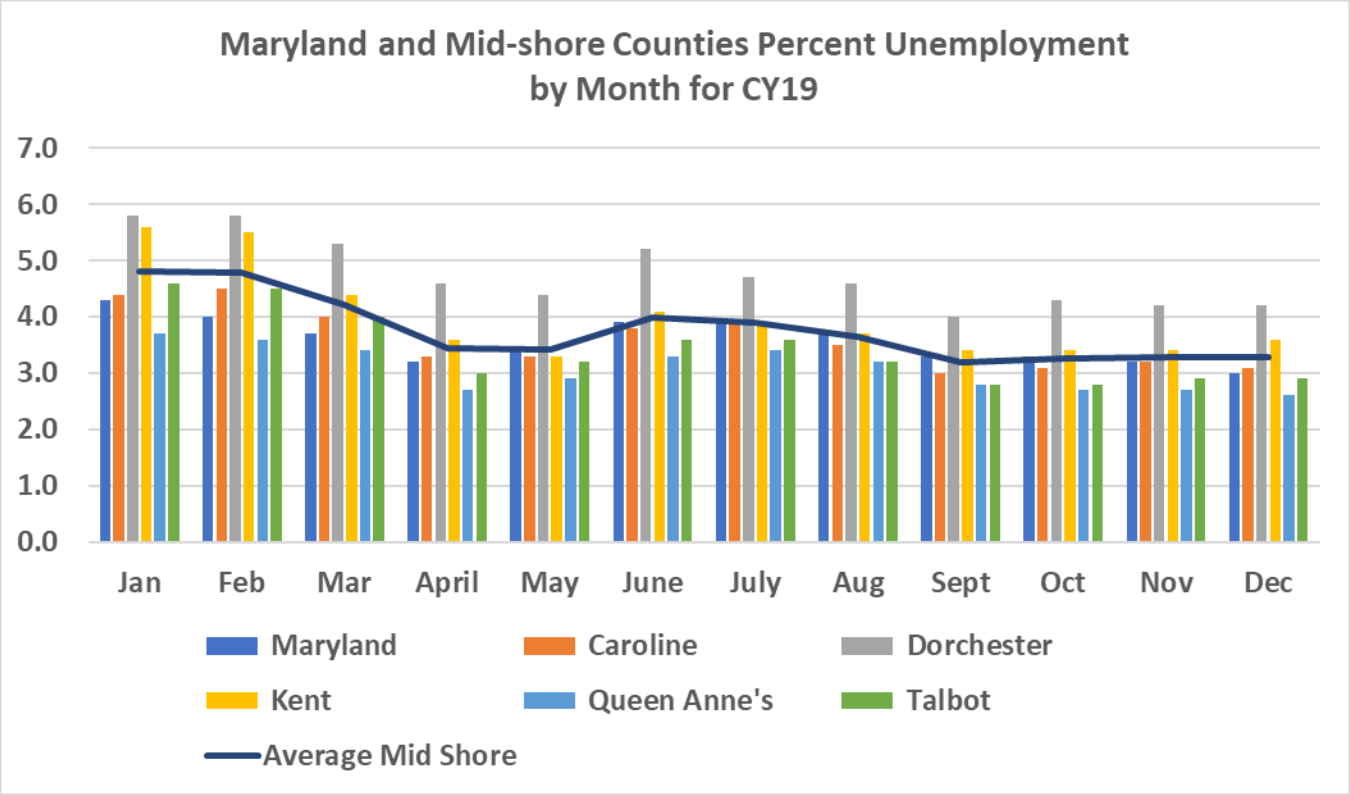
Maryland Percent Unemployment – Monthly for 2019 and 2020



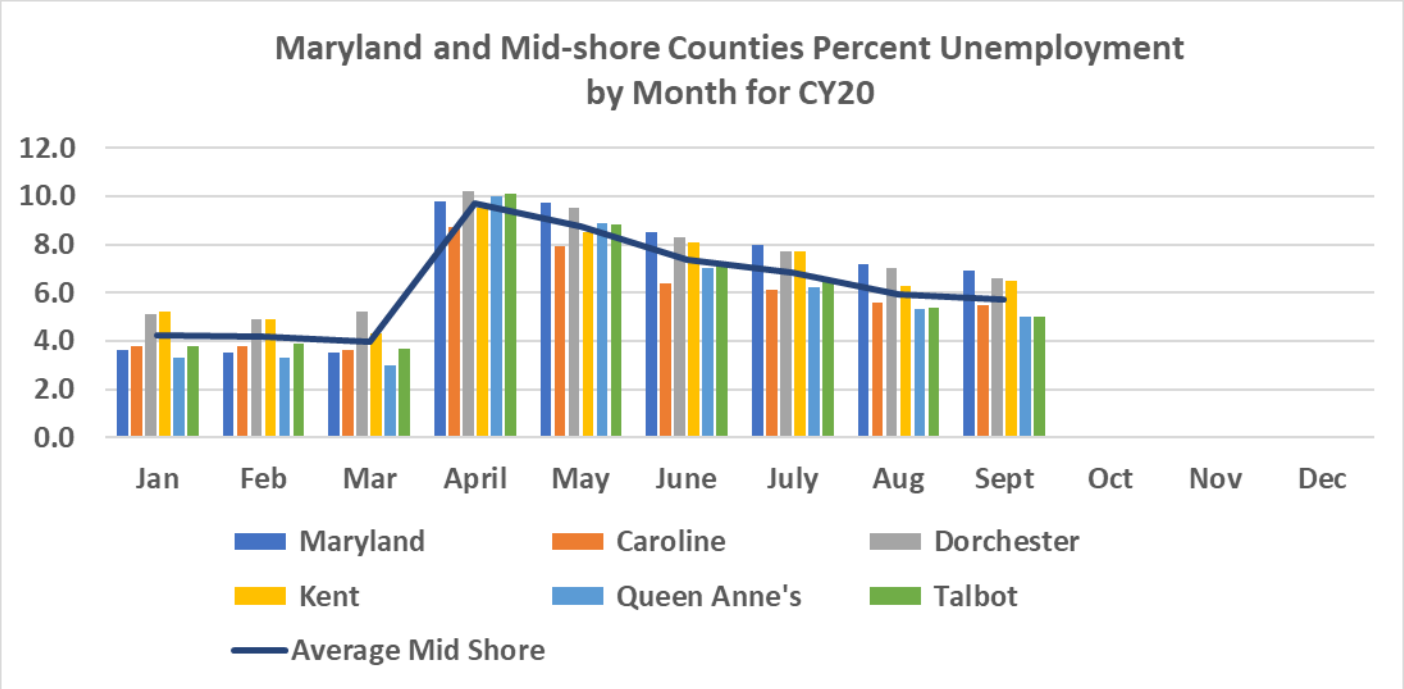
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2019	4.3	4.0	3.7	3.2	3.4	3.9	3.9	3.7	3.3	3.3	3.2	3.0
2020	3.6	3.5	3.5	9.8	9.7	8.5	8.0	7.2	6.9			

The COVID impact on unemployment is clearly demonstrated in the following chart with the rise in April 2020 rate. Maryland was experiencing 3% to 4% unemployment from January 2019 through to March 2020. Note the jump in April to 10% when actions were implemented to mitigate the effects of the pandemic which correspondingly impacted economic conditions. The following months show some improvement. A further analysis with more current data is provided in the Special Analysis section 'Health and Behavioral Health Disparities Response.'

Maryland and Mid-shore Counties – Percent Unemployment 2019



Maryland and Mid-shore Counties – Percent Unemployment 2020



The 'average Mid-shore' unemployment data shows a COVID 19 impact in April similar to the state. The 'average mid-shore' unemployment data also shows an unemployment rate higher at the start of 2019 than the state. It improves later in the year through March where the rate more closely approximates the state rate. Following the COVID impact in April, the mid-shore unemployment showed more favorable unemployment rates than the state.

On a per county basis, Dorchester has the highest unemployment rate; it also has the highest poverty rate, pointing out the relationship with unemployment and poverty. Caroline had the second highest poverty rates; however, the unemployment data shows more favorably overall when compared to the state and other mid-shore counties with the exception of Queen Anne's and Talbot.

Queen Anne's and Talbot had the lowest rates, these are also the counties with the lower poverty rates in the mid-shore region.

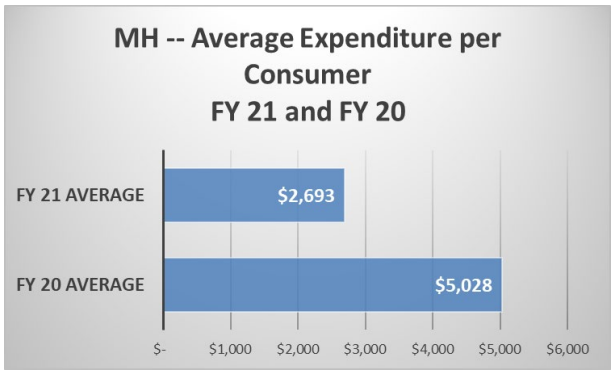
From a health disparities perspective, earlier it was reviewed that the counties with higher poverty rates also had higher needs for medical assistance. We include the above unemployment data and we see the relationship to unemployment rates. Improvements in employment and building the economy in the mid-shore region would help positively impact poverty levels and need for medical assistance. Further matters specific to health disparities are addressed in the Special Analysis section.

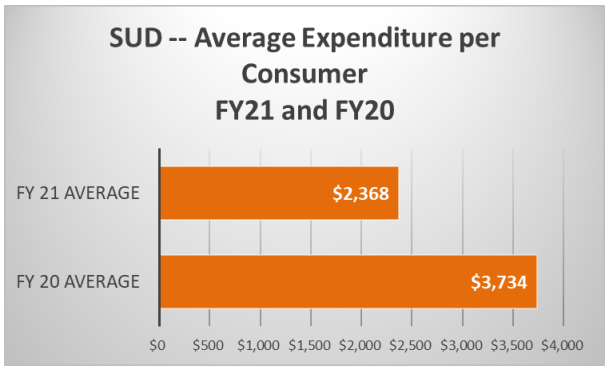
<u>Consumer and Expenditures Data</u> – Medically Assisted Mental Health and Substance Use Disorder

The data available for review is significantly limited. The following provides a general overview of utilization and expenditures for MH and SUD.

Expenditures per Person Served

For FY20 the average expenditures for both mental health and substance use disorder are materially higher than the average projected expenditures for both services.

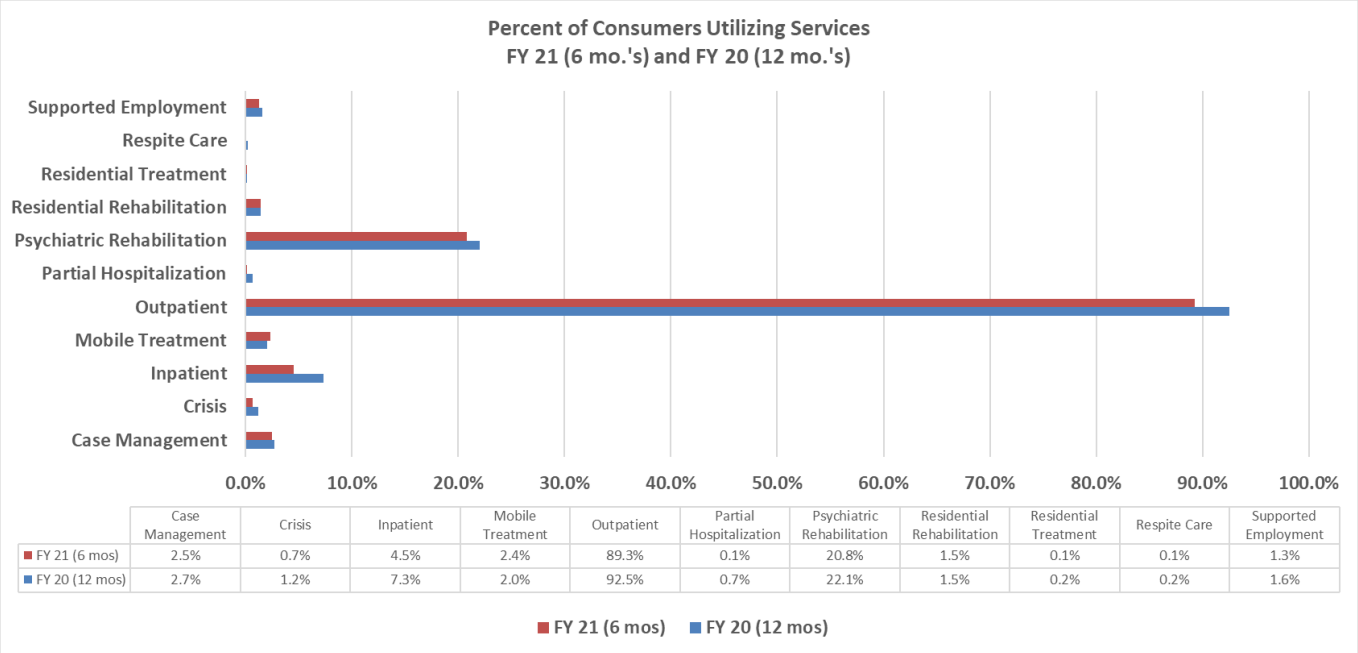




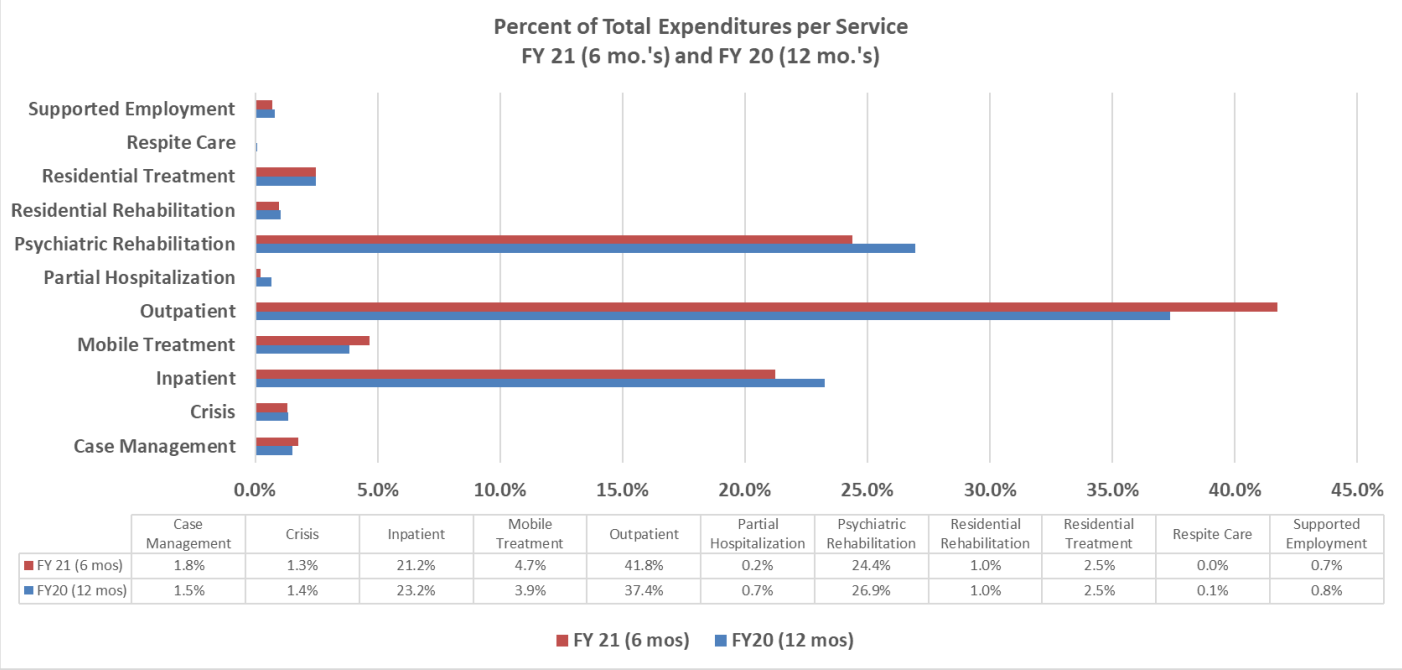
NOTE – Source MARF -- FY20 (June 30, 2020 yearend) data averages 12 months of data, and FY21 averages six (6) months of data. These time periods are not complete since providers have twelve months from which to submit a claim for payment. FY20 data was as of Dec 31, 2020.

The averages would be expected to be closer in expenditure per consumer. This differential may be significantly due to new ASO provider processes which have resulted in long delays in claims filing and payment experienced by MH and SUD providers across the state. As reflected in the following charts 2C-2D-2Eand 2F, a portion of the differential may be due to a reduction in services and reduction in the more costly services.

Mental Health



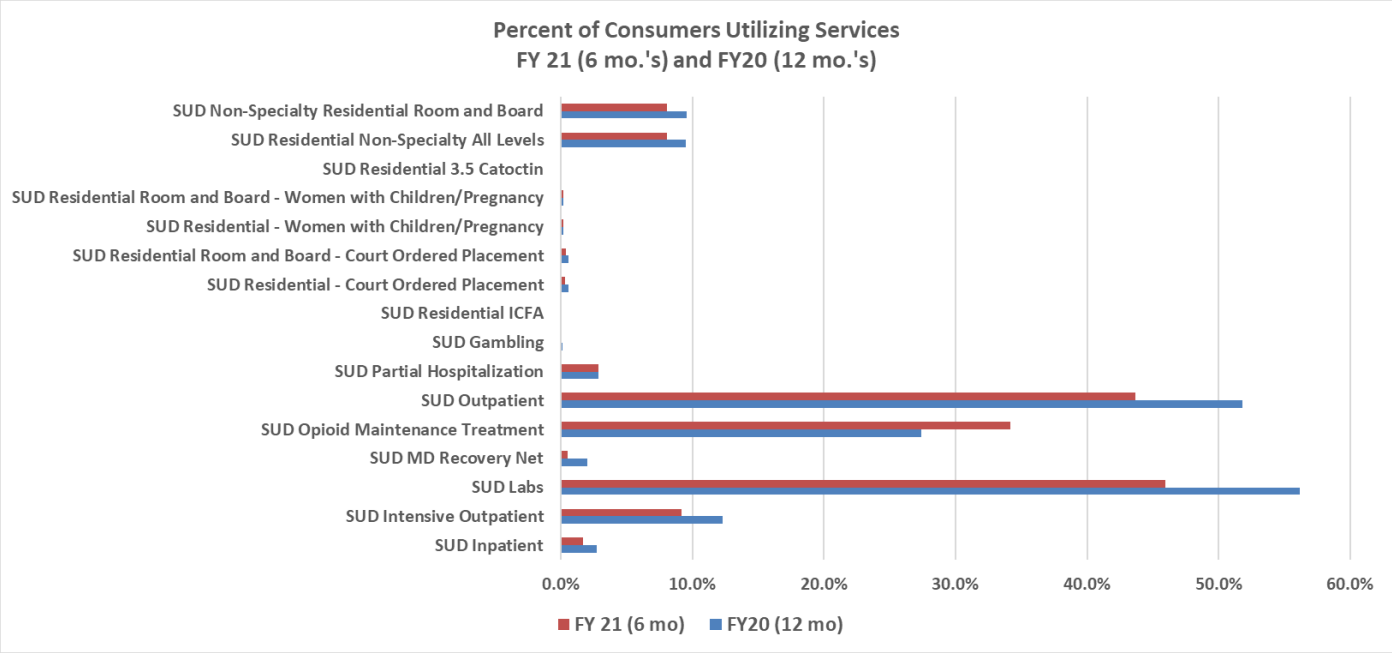
	Case Management	Crisis	Inpatient	Mobile Treatment	Outpatient	Partial Hospitalization	Psychiatric Rehabilitation	Residential Rehabilitation	Residential Treatment	Respite Care	Supported Employment
FY 21 (6 mos)	2.5%	0.7%	4.5%	2.4%	89.3%	0.1%	20.8%	1.5%	0.1%	0.1%	1.3%
FY 20 (12 mos)	2.7%	1.2%	7.3%	2.0%	92.5%	0.7%	22.1%	1.5%	0.2%	0.2%	1.6%

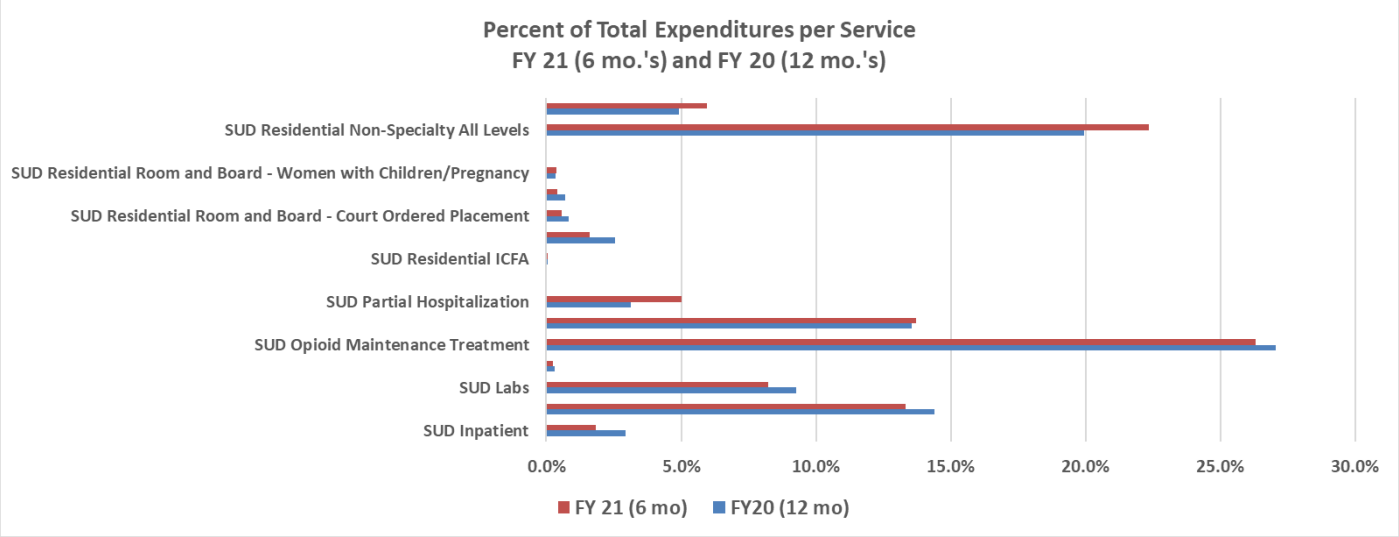


	Case Management	Crisis	Inpatient	Mobile Treatment	Outpatient	Partial Hospitalization	Psychiatric Rehabilitation	Residential Rehabilitation	Residential Treatment	Respite Care	Supported Employment
FY 21 (6 mos)	1.8%	1.3%	21.2%	4.7%	41.8%	0.2%	24.4%	1.0%	2.5%	0.0%	0.7%
FY20 (12 mos)	1.5%	1.4%	23.2%	3.9%	37.4%	0.7%	26.9%	1.0%	2.5%	0.1%	0.8%

Source - MARF

Substance Use Disorder





Source – MARF

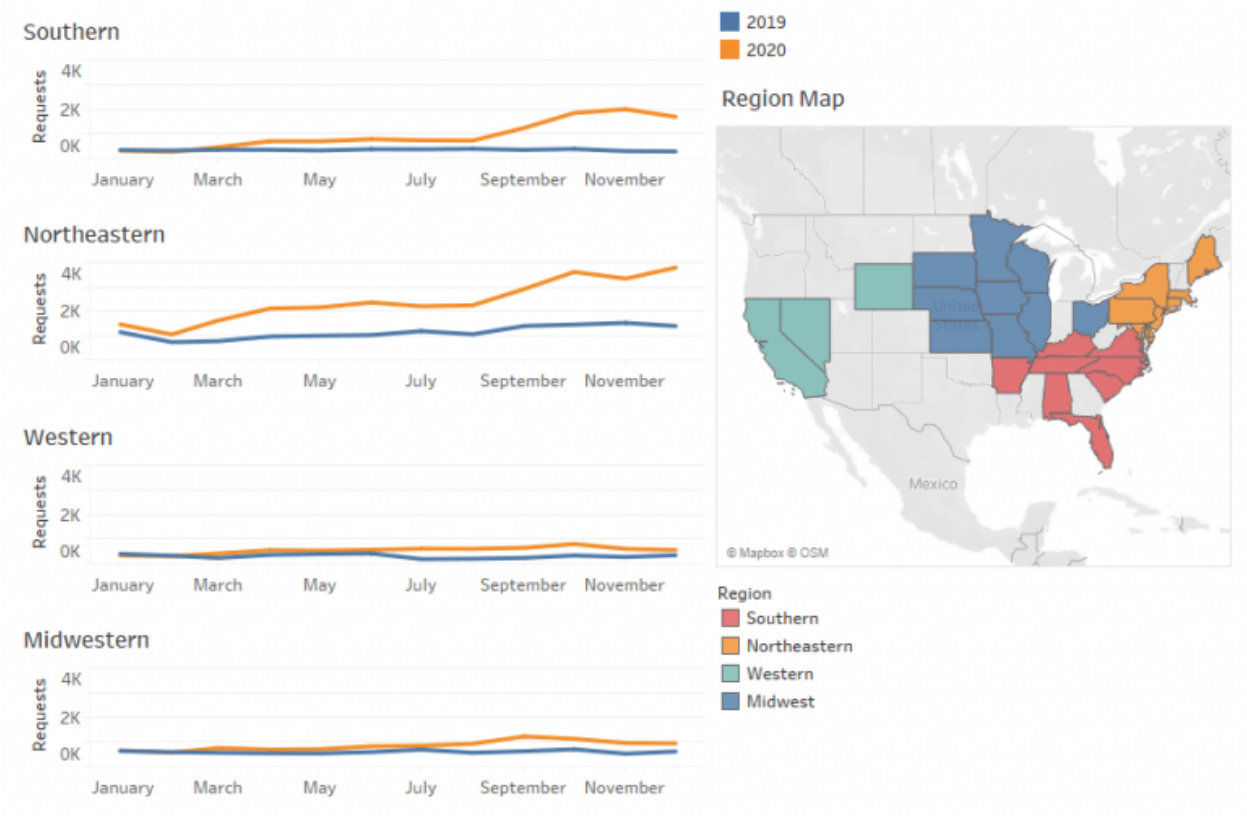
<u>COVID Impacts</u> – housing, children, prior mental health issues

COVID and the Impact on Housing

The following provides information across the United States. It is from Washington University in St. Louis, health Communications research laboratory, January 14, 2021, *By Sarah Thomas, Rachel Garg, Balaji Golla and Matthew Kreuter,* entitled "Year in Review: Landlord-tenant Issues Greatest in South, Northeast." The review provided information on the significant impact on housing during COVID 19 based on 211 call information. Further, this impact was particularly higher in the eastern and south regions. The following is an excerpt from this review:

> *"We examined 85,894 requests for help with landlord-tenant issues to 211s in 28 states during 2019 and 2020…..Requests for help with landlord-tenant issues were also higher among northeastern states in 2020 (2nd chart from top), up 113% over 2019, with increases evident almost as soon as the pandemic began, and increasing every month thereafter."*

The more specific Maryland impact is further reviewed in the Special Analysis section - Health and Behavioral Health Disparities Response.



Source -- https://hcrl.wustl.edu/year-in-review-landlord-tenant-issues-greatest-in-south-northeast/

<u>COVID 19 Impact</u> - Previously Diagnosed Anxiety and Depression

During June 24–30, 2020, a total of 5,470 (54.7%) of 9,896 eligible invited adults completed web-based surveys administered by Qualtrics. Symptoms of anxiety disorder and depressive disorder were assessed, along with reporting of COVID-19–related symptoms of a trauma and stressor-related disorder (TSRD). Respondents also reported whether they had started or increased substance use to cope with stress or emotions related to COVID-19 or seriously considered suicide in the 30 days preceding the survey.

This was a nationwide study. The yellow highlighted areas (see chart below) details specific indications that bear interest. The chart highlights persons with previously diagnosed conditions verses people who were not previously diagnosed, using three disorders – anxiety, depression, and PTSD. Since COVID-19, the percentage of adverse mental health outcomes is more than doubled in nearly every category of conditions for persons treated previously then with persons who were not treated for a previously diagnosed condition. The last three columns to the right are significant, as they show a sharp increase in substance use and suicidal ideation, or adverse mental or behavioral health symptoms due to the stress related to COVID-19.

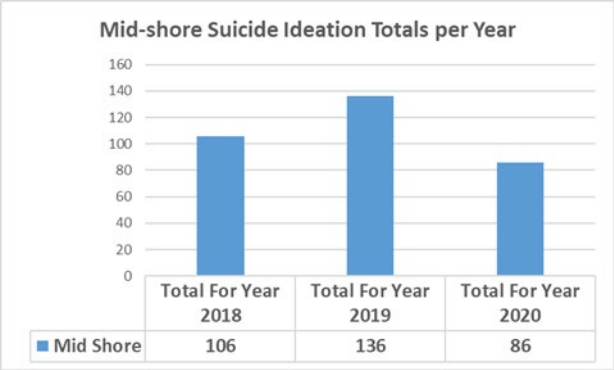
Respondent characteristics and prevalence of adverse mental health outcomes, increased substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation — United States, June 24–30, 2020

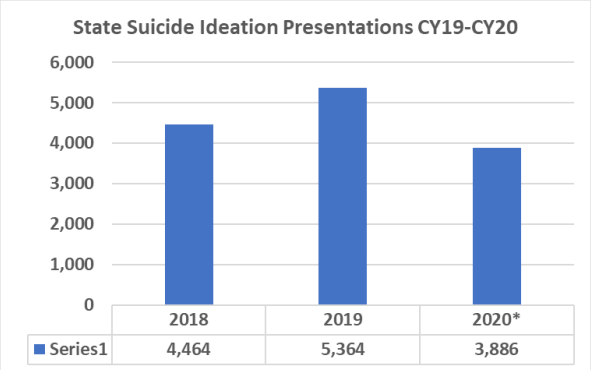
		Weighted 96%						
		CONDITIONS						
	All respondents who completed surveys during June 24–30, 2020	Anxiety disorder	Depressive disorder	Anxiety or depressive disorder	COVID-19–related TSRD	Started or increased substance use to cope with pandemic-related stress or emotions	Seriously considered suicide in past 30 days	≥1 adverse mental or behavioral health symptom
Characteristics								
All Respondants	**5,470 (100)**	25.5	24.3	30.9	26.3	13.3	10.7	10.9
Receiving Treatment for Previously Diagnosed Conditions								
Anxiety								
Yes	536 (9.8)	59.6	52.0	66.0	51.9	26.6	23.6	72.7
No	4,934 (90.2)	21.8	21.3	27.1	23.5	11.8	9.3	37.5
Depression								
Yes	540 (9.9)	52.5	50.6	60.8	45.5	25.2	22.1	68.8
No	4,930 (90.1)	22.6	21.5	27.7	24.2	12.0	9.4	37.9
PTSD								
Yes	251 (4.6)	72.3	69.1	78.7	69.4	43.8	4.8	88.0
No	5,219 (95.4)	23.3	22.2	28.6	24.2	11.8	9.0	38.7

Table extract and information Source -- MMWR Morbidity Mortality Weekly Rep. 2020 Aug 14; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7440121

<u>COVID 19 Impact</u> – Suicide Ideation and Opioid Presentation

The following information shows an increase from 2018 to 2019, however, then it drops significantly in 2020 – this is seen in both the mid-shore and state data.

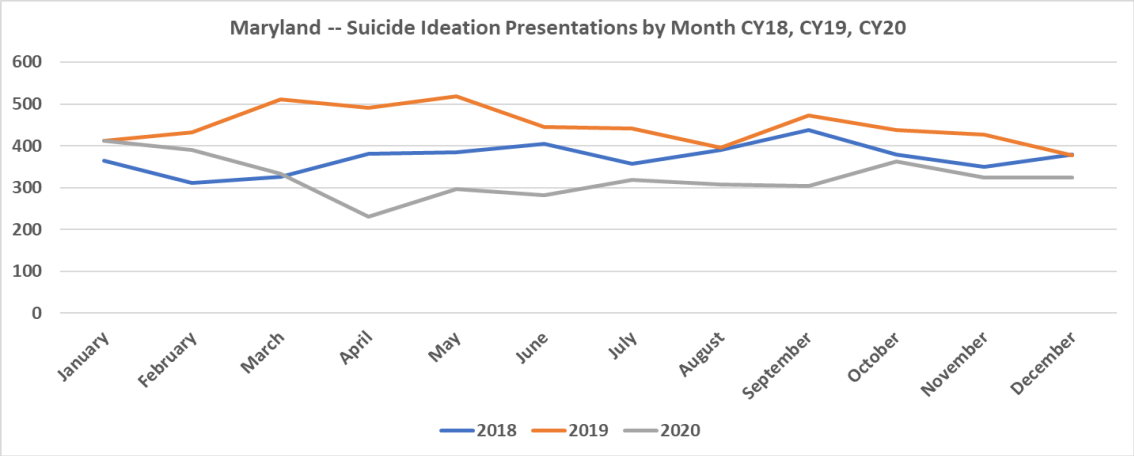


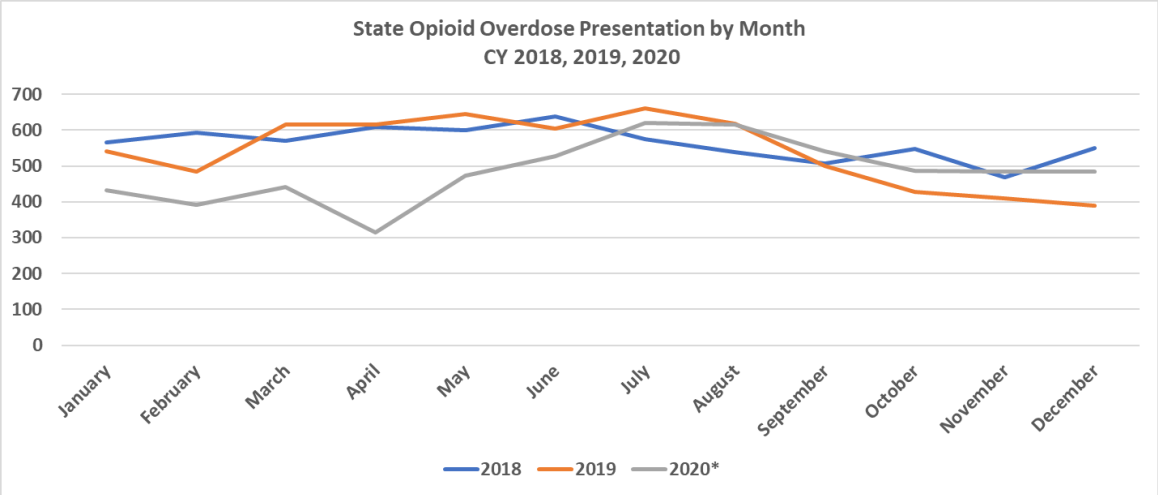


Source - ESSENCE

This appears to have been impacted by COVID based on the following: A review of the monthly suicide ideation and opioid overdose presentation by month for three years shows some correlation among years, however, the most notable variance is in the year 2020 in the month of April, the month the state of Maryland fully implemented pandemic mitigation efforts. Both the suicide and opioid charts show a significant decrease in April 2020.

NOTE – Source ESSENCE -- Year 2020 represents 10 months of actual and 2 months of extrapolated data for comparison purposes.





<u>COVID 19 Impact</u> - Children and Adolescents

Although there is no data to reference, it is important to provide some information on the impact on children and adolescents. Over the past year, families have reached out on a very limited basis for support for their children and adolescents' behaviors in the home. Traditionally, the school has been a referral source for children and adolescents but with students being in school virtually, very few school referrals to crisis services have been made. Children and adolescents are stressed, anxious and unengaged and we have seen an increase in out of home placement requests due to children not engaging online with therapists, PRP services or online school and additional stressors in the home, such

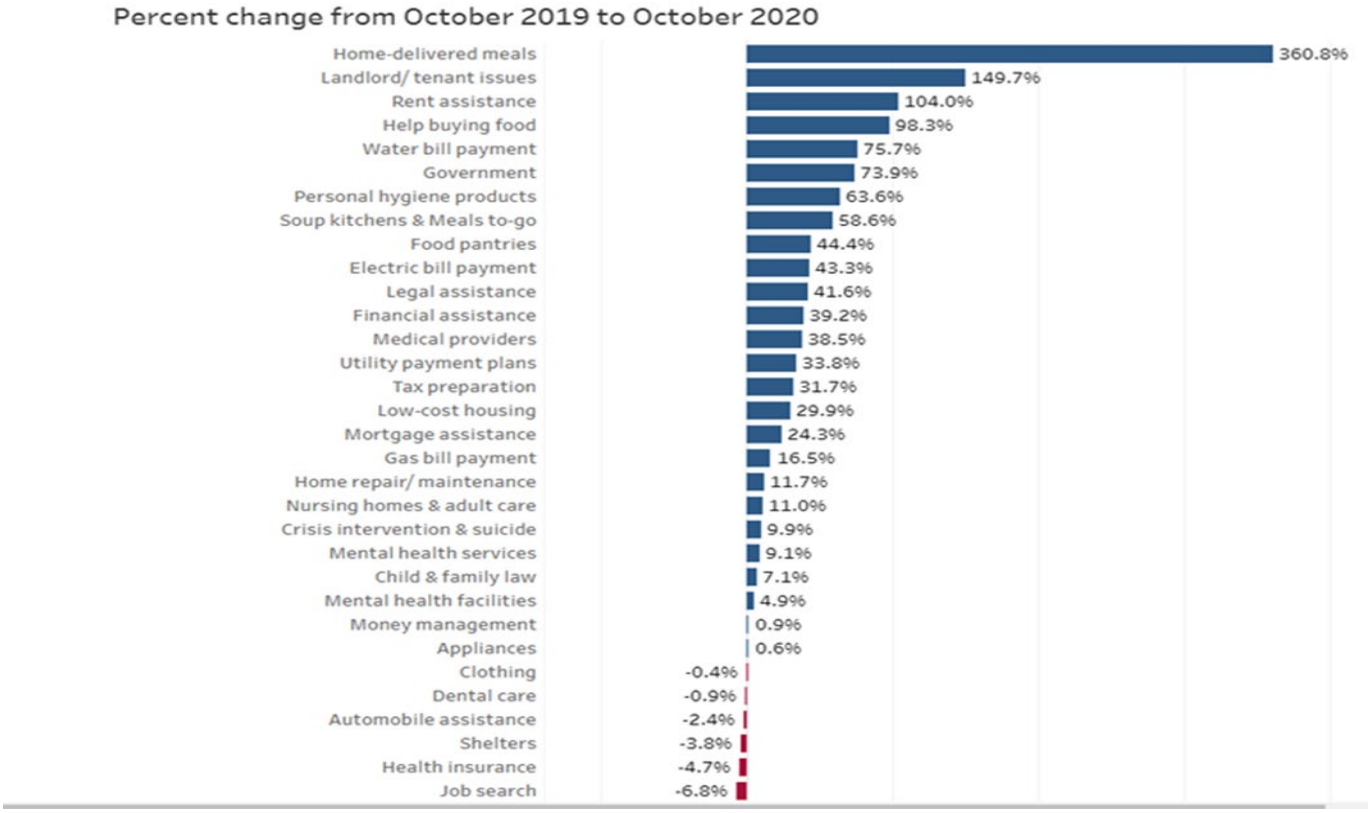
as COVID, loss of jobs, food and housing insecurity. The next few months to a year when children are re-engaging in school after a year of social isolation and minimal educational engagement it is critical to have behavioral health services and supports available such as HB1092. More than ever, when our children and adolescents return to school, we will need more therapeutic, behavioral and support services available for school, home and community.

Special Analysis

I. Health and Behavioral Health Disparities Response

Challenges to Meeting Basic Individual Needs

Food, housing, and utility needs reported to 2-1-1s in October 2020 were sharply higher than totals from October 2019. The following chart included information from 30 states:



Source -- https://hcrl.wustl.edu/year-over-year-changes-october-2019-to-2020/

Food, housing, and utility needs reported to 2-1-1s in October 2020 were sharply higher than totals from October 2019. Requests to 2-1-1 for help with landlord/tenant issues (+150%), rent assistance (+104%), helping buying food (+98%) and paying water bills (+76%) rounded out the top 5. Multi-state 211 data show a high increase in calls requesting landlord/tenant issues, rental assistance, and food needs.

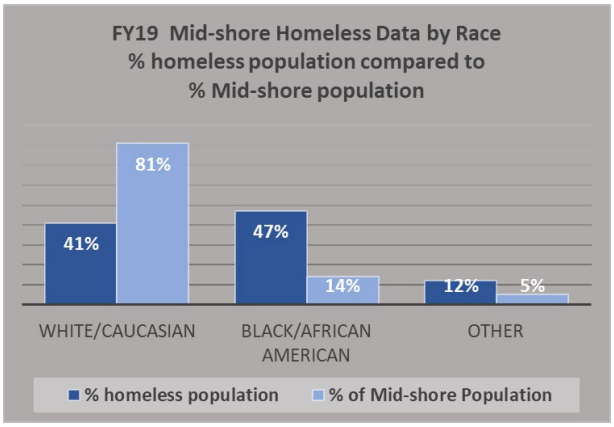
Mid-shore homeless service providers have seen similar increases in requests for the same issues. Mid Shore Behavioral Health, Inc. has been able to address some of these needs through additional COVID-

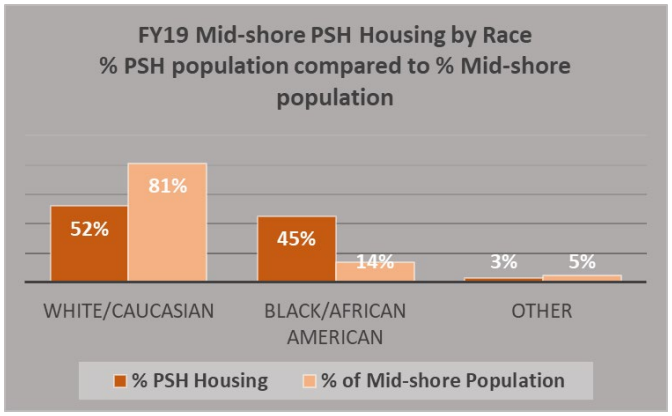
relief funding provided by the Maryland Department of Housing and Community Development. To supplement the FY2020 Homelessness Solutions Program funding, our Continuum of Care received an additional $635,000 for COVID-relief funding. The Continuum of Care expects to receive additional COVID-relief funding to supplement the FY2021 Homelessness Solutions Program funding in the near future.

MSBH Continuum of Care Homelessness Data – Analysis of homelessness demographics

Analysis of Racial Disparity – The following is based on Mid Shore Roundtable Continuum of Care data for people experiencing homelessness for the period FY 19. It includes both state and mid-shore demographics.

Analysis of Racial Disparity in the Mid Shore Roundtable CoC for people experiencing homelessness for the period 7/1/2018 - 6/30/2019									
MD/Counties	Total Population	White	White %	AA/Black	AA/Black %	Multiple races	Multi-race %	Hispanic	Hispanic %
Maryland	6,062,917	3,395,233	56%	1,758,246	29.00%	181,888	3%	545,662	9.00%
Caroline	33,108	26,338	80%	4,376	13%	1,046	3%	1,047	3%
Dorchester	32,145	21,345	66%	8,901	28%	1,234	4%	864	3%
Kent	19,437	16,175	83%	2,914	15%	291	1%	470	2%
Queen Anne's	49,667	43,799	88%	3,439	7%	1,019	2%	901	2%
Talbot	37,020	31,137	84%	4,342	12%	1,007	3%	1,444	4%
Average	171,377	138,794	81%	23,972	14%	4597	3%	4,726	3%
FY 2019	Total Homeless	White	White %	AA/Black	AA/Black %	Multiple races	Multi-race %	Hispanic	Hispanic %
	1280	531	41%	605	47%	77	6%	66	5%
FY 2019	PSH Housing								
	105	55	52%	47	45%	3	3%	0	0%





Source -- FY2019 Continuum of Care Notice of Funding Availability (NOFA) Internal Data

The data shows that Whites and Blacks were nearly experiencing the same rate of homelessness, although Blacks make up a significantly less percentage of the population. Black Americans, multiracial Americans, and Hispanics/Latinxs are far more likely to be homeless than the national average shows for White Americans. The analysis of the mid-shore demographics, the Black population is experiencing homelessness at a significantly higher rate than the White population despite only representing 14% of the overall mid-shore population.

Statewide Maryland Continuum of Care Data

MSBH participates in an annual Point in Time count of the homeless populations. The purpose of this is to gather data to show the number of people experiencing homelessness, both in emergency shelter and places not meant for human habitation, throughout the state. This is an annual nationwide survey conducted by local Continuums of Care during the last ten days of January, in efforts to gain an accurate count of individuals and families experiencing homelessness.

The geographical size and overall rural nature of the mid-shore region poses a challenge in locating people who are experiencing homelessness. Despite this, MSBH still found homeless numbers increasing over a four-year period during our annual count. Relative to more populated areas such as Baltimore City and Montgomery County, the mid-shore region works with less resources.

Unemployment and Workforce

A review of the unemployment data per BHA information was provided in the overview section.
In addition, the following chart from Maryland Department of Labor was reviewed.

Local Area Unemployment Statistics (LAUS)

Upper Shore Workforce Development Area	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020
Unemployment Rate	7.3	6.7	5.8	6	6	5.3
Unemployment	6,365	5,975	5,094	4,938	5,135	4,498
Employment	81,149	83,741	82,636	77,714	80,055	79,680
Labor Force	87,514	89,716	87,730	82,652	85,190	84,178

Upper Shore Counties include (Kent, QA, Dorchester, Caroline, Talbot)
Source -- https://www.dllr.state.md.us/lmi/areas/upperwia.shtml

According to the unemployment data reviewed earlier and this information from MD Department of Labor, unemployment rates have decreased across the state and in our mid-shore counties from June 2020 to November 2020.

This data may be reflective of:

- On June 12th, many of the small businesses and other industries that were most affected at the start of the pandemic were able to open at lowered capacities during phase 2.
- The benefits provided to the unemployed from the Federal COVID-Relief unemployment supplement under the Federal CARES Act (which was an additional $600 a week) combined with state unemployment benefits ended on July 31, 2020. With the end of the added benefits it is possible this had some individuals seeking employment again.
- Risk of contracting COVID 19 also had individuals drop out of the workforce, thus reducing overall labor pool from which the unemployment statistic is determined.

Transportation needs increased during COVID-19.

The rural nature of the mid-shore region brings significant challenges to meeting the transportation needs of our community, and specifically our medically assisted MH and SUD consumers. COVID 19 has made this even more of a challenge.

Information from 2-1-1 for the period July 2020 to January 2021 – specific to mid-shore counties

QA County - Requests are for Medical and Dr. appointments. Females made 100% of requests. Public transportation is also a great need and 100% of requests were made by females.

- Medical transportation
  50.0%
  0%
- Public transportation
  50.0%
  0%

Kent County – The major request in Kent County is for public transportation: discounted fares/passes for those with special needs and/or no personal means of transportation. 100% of requests made by females.

- Medical transportation
  0%
  0%
- Public transportation
  100.0%
  0%

Dorchester County – Requests for medical transportation is 71.4% (rides to and from doctor appointments) and 28.6% requests for public transportation.

- Medical transportation
  71.4%
  0%
- Public transportation
  28.6%
  0%

Caroline County – Requests for medical transportation is 81.8%, which is the highest out of each mid-shore county.

- Medical transportation
  81.8%
  22%
- Public transportation
  9.1%
  0%
- Automobile assistance
  9.1%
  0%

Source -- https://211counts.org/home

Talbot County has no transportation needs or requests for transportation through MD 211.

The data shows requests for transportation to 211 from July 2020 to January 2021. The data supports the need for medical and public transportation in the mid-shore counties. It is important to emphasize that 100% of the calls to 211 in the mid-shore were from the female population. Resources in the mid-shore region are greatly impacted by distance and travel time as resources are centered around larger towns. The need to collaborate with others to address these barriers is essential to closing the gap and creating greater access to services.

Forensic Mental Health Review – Concern over Racial Disparities

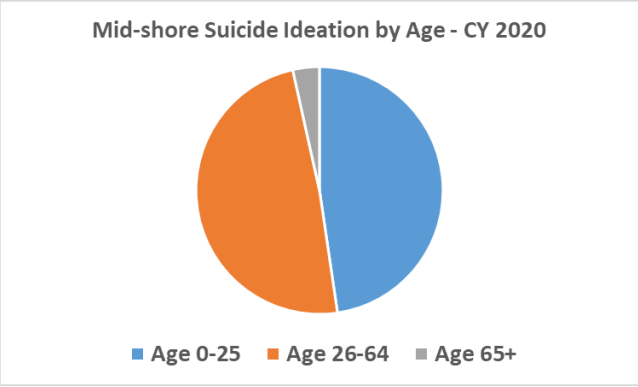
MSPC staff reviewed MSBH collected data to assist in addressing concerns in this area and to provide needed analysis. It was determined that MSBH data was limited in being able to provide a comprehensive contextually based analysis from which to draw substantive conclusion. With appropriate data MSPC believes that the racial inequity will become apparent and will demonstrate the need for a greater portion of our population to be receiving needed services.

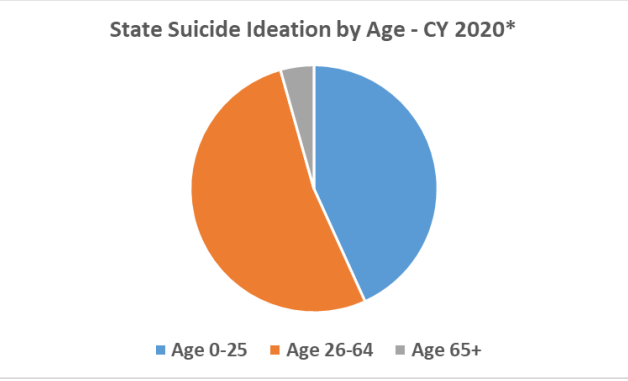
Based on our working knowledge, MSPC has identified the need to provide greater outreach to providers and families on the benefits offered through the FMH operations. There is a specific need to focus outreach efforts and provide education to the criminal justice workers, especially the Forensic Workgroup. Additionally, a follow up with clients after evaluations or advocating for them to see if all their resources are still accessible to them. Partnering with Community providers may be needed and/or educating the family on the positives of behavioral health services. Educational information can be provided to the community virtually or in person. Provide literature at events conducted in our five (5) counties, and in various languages to assure individuals are aware of available services.

MSBH will be modifying and revamping its FMH data collections to include those areas from which more data is needed and/or the context from which to view the data that it currently collects.

Suicide Ideation Analysis as it relates to health disparities – age, gender, race

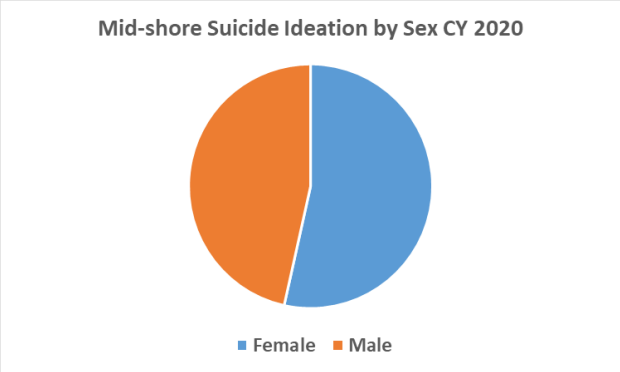
When we review the suicide ideation for the state and the mid-shore relative to age and gender, we see comparable demographic information. The one item of note is suicide for age 0-25 is notably greater in the mid-shore area than the state.

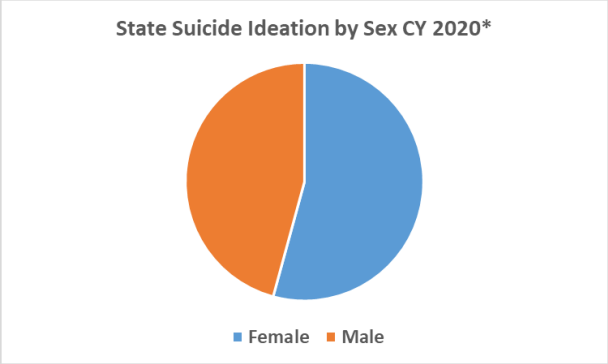




Source - ESSENCE

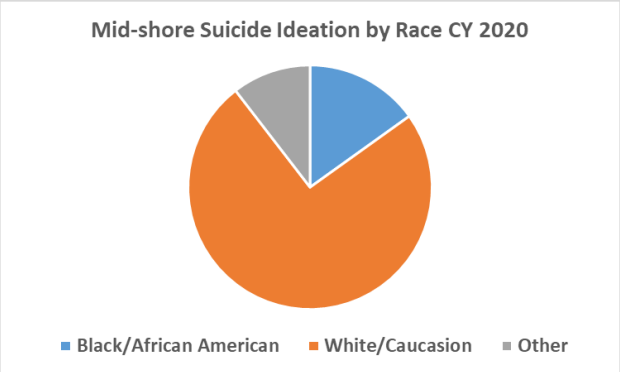
Suicide Ideation by Sex -- The state and mid-shore compare similarly in suicide by sex.

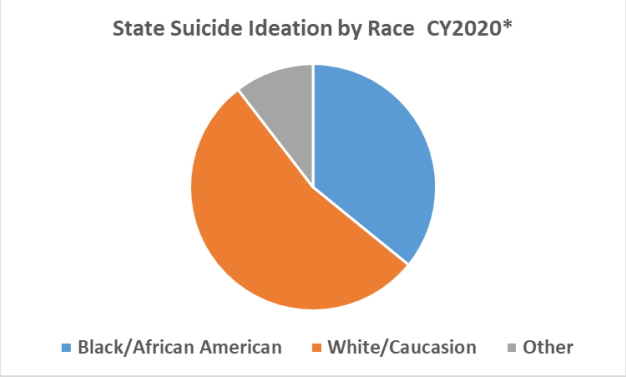


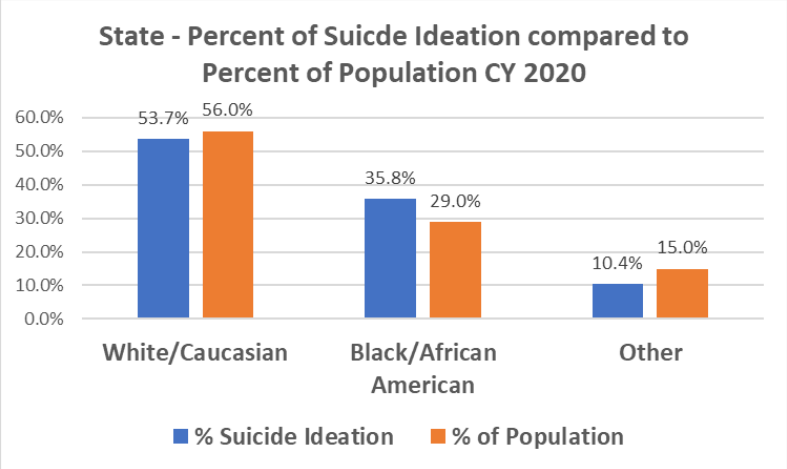


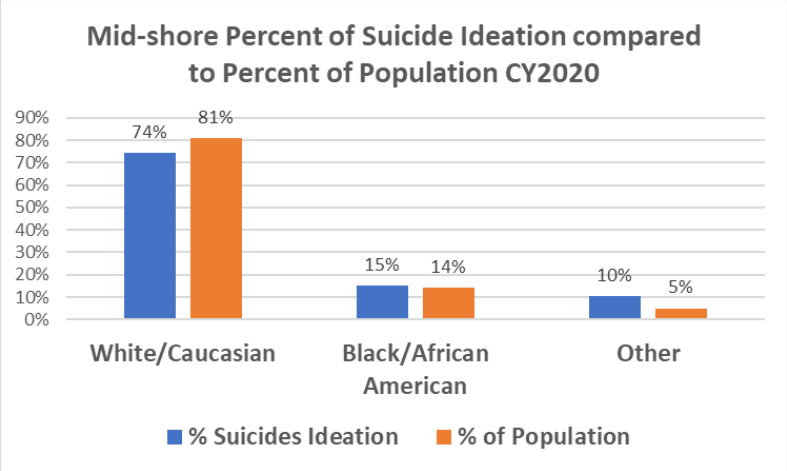
Source - ESSENCE

Suicide Ideation by Race – The following four charts a marked difference for the mid-shore region as compared to the state region. These charts show that there is a higher percentage of Black/African Americans relative to this populations as compared to White/Caucasian. The disparity is greater at the state level than the mid-shore level.









Source – ESSENCE and MSBH 2019 NOFA internal data

These charts reflect a disparity in the Black/African American population as compared to the White/Caucasian population. Please refer to the overdose events area and crisis response for further analysis that does show more marked health disparities.

MSPC Goals to address 'Health and Behavioral Health Disparities Response'

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

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

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

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

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

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

II. Crisis Response and Prevention

This year the MSPC is proud to have the opportunity to highlight the robust crisis response system located here in the mid-shore region. MSBH has collected data on our crisis response operations for years. The analysis presented is a review of the last three years of data collected. This review focuses on just three aspects of the crisis operations system:

- Eastern Shore Operations Center (ESOC)
- Urgent Care Clinics (UCC)
- Mobile Crisis Teams (MCT)

Important clarification on data being reviewed – Although some of these crisis operations cover all nine Eastern Shore counties, the data presented in this plan only represents the five counties represented within the MSPC.

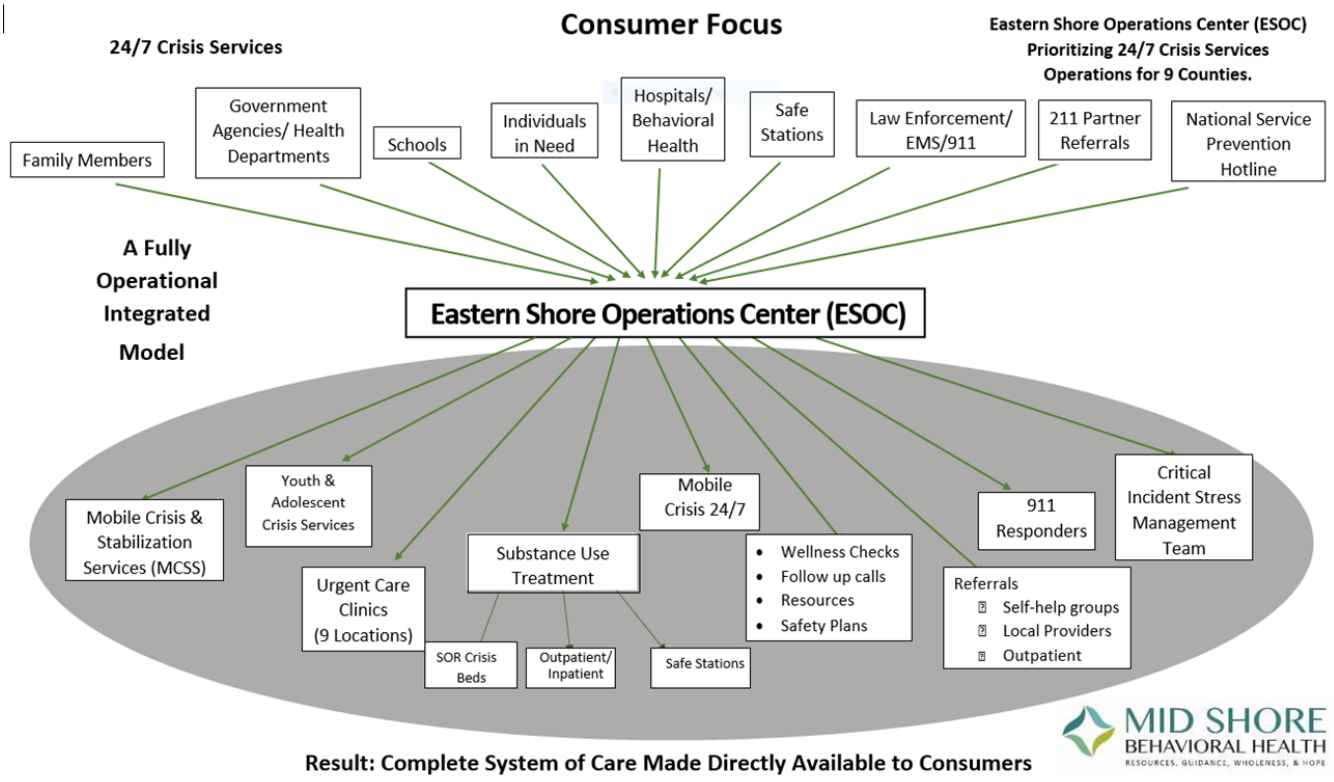
Eastern Shore Operations Center

The review will start with ESOC, the hub of the crisis response system serving the behavioral health emergent, urgent needs of the Eastern Shore.

ESOC is available 24 hours a day, 7 days a week, 365 days a year to assess and respond to calls from MH and SUD consumers, family members, community members, businesses, human services agencies, and law enforcement agencies. The ESOC staff is trained to triage each call and provide linkages to community resources through referral to all appropriate and existing behavioral health and human services – Urgent Care Clinics, Mobile Crisis Services, State Opioid Response (SOR) operations (crisis beds, safe stations, recovery houses), Mobile Crisis Stabilization Services (MCSS) and other resources.

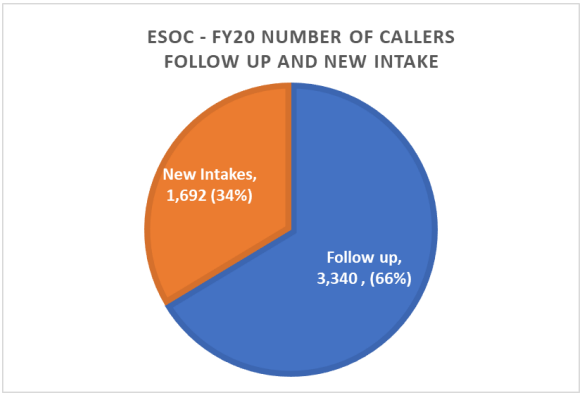
ESOC services for consumers include:

* Crisis Intervention, Assessments & Referrals
* Emergency Petitions
* Anyone in Crisis, i.e., Situational Crises
* Individuals with Suicidal Thoughts and/or Plan
* Individuals with Psychosis and/or Delusions
* Family and Marital Conflicts
* Child/Teen/Elder Issues
* Domestic Violence
* Substance Abuse
* Developmental Disabilities
* Links to Mental Health and Substance Abuse Services
* Family Education



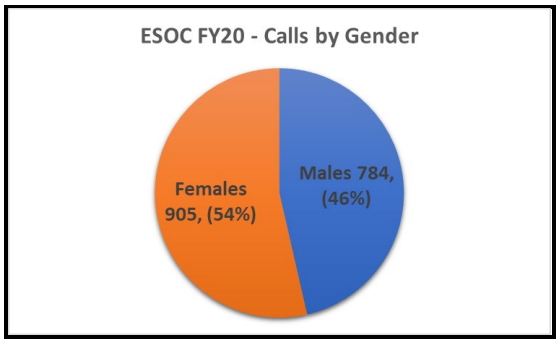
One group that places calls into ESOC is law enforcement. One important program to mention is the Crisis Intervention Training (CIT) program in the mid-shore. This program works to educate our law enforcement personnel and helps to train officers in diverting individuals who need MH or SUD treatment away from the criminal justice system and into appropriate health services.

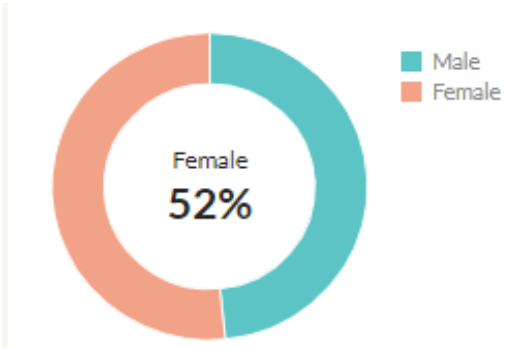
ESOC – FY 20 Data -- Number of calls, gender, age, main issue.

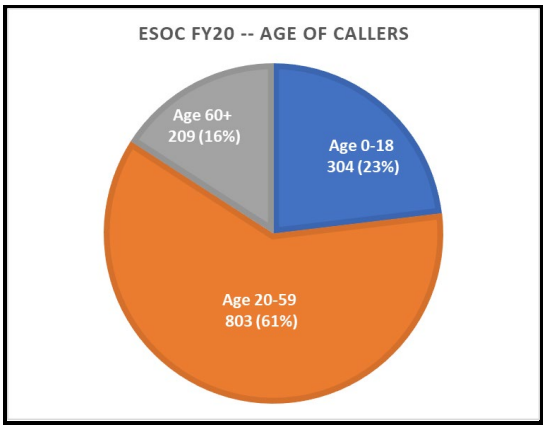


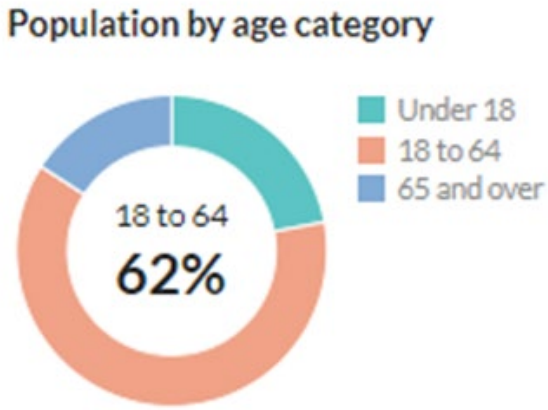
Total calls for FY20 were down from both FY18 and FY19, while prior to FY20 the calls were increasing. From FY19 to FY20 there was a 22% reduction in calls with a decline of 1,438 calls. This significant change is believed to be an impact of COVID -19 which correlates to the reduction in service utilization reviewed in the overview section.

Following Charts – ESOC data is provided by MSBH. The chart showing demographic data for both gender and age are based on state demographic data from censusreporter.org February 2021 Maryland data.



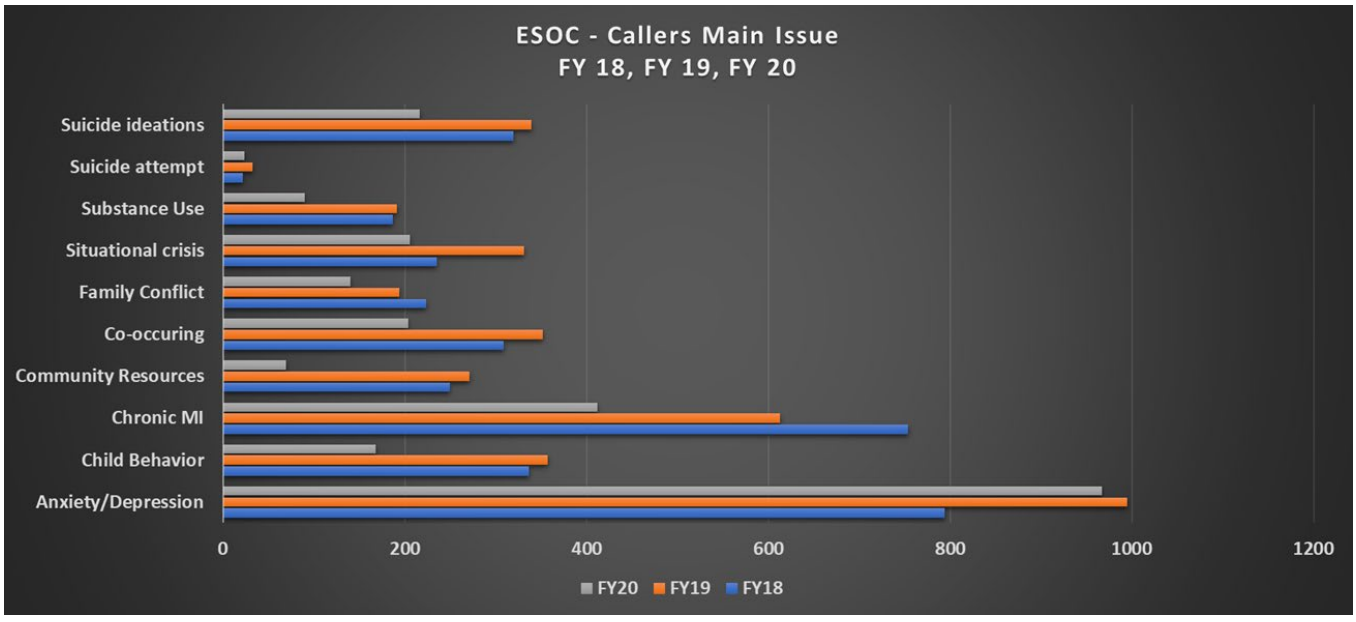






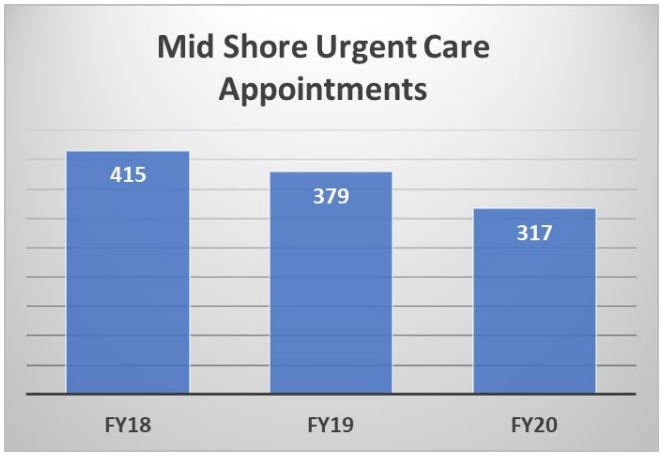
The ESOC calls for the mid-shore region are in-line with the demographics for gender and age.

Callers Main Issue – Correlates with the Mobile Crisis Team Dispatches (MCT)



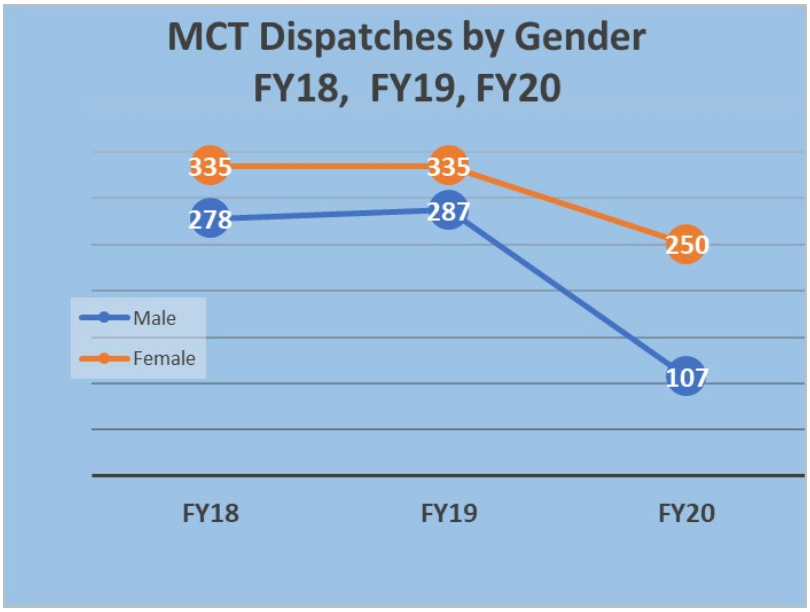
One of the most frequent caller issues each year is anxiety and depression. In FY20, although calls were down 22% from the prior year, anxiety, and depression still nearly equaled that of the FY19 data. This appears to be attributed to COVID 19 with its impact on individuals' levels of anxiety and depression.

Urgent Care Clinic -- Appointments



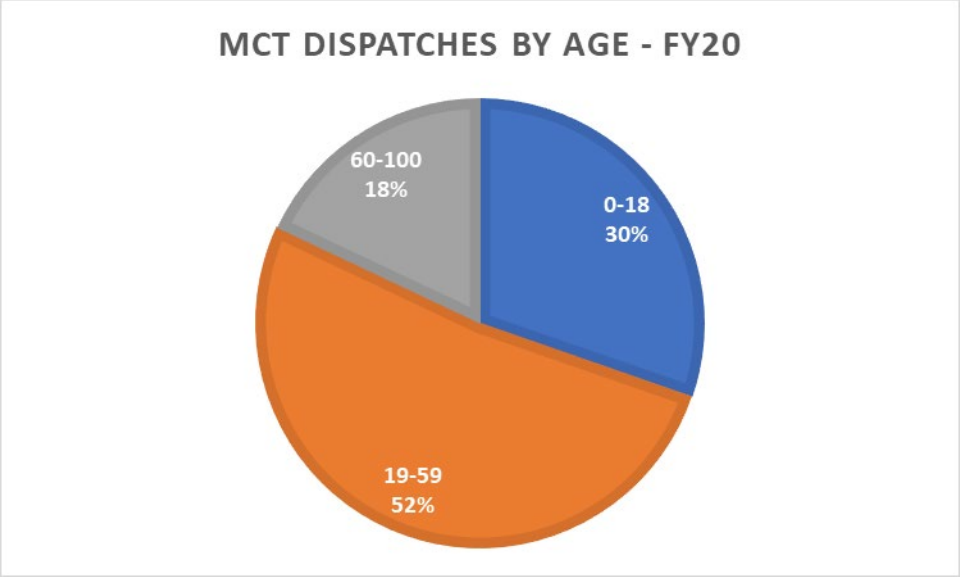
In our analysis, we see that ESOC triaged calls to mid-shore urgent care appointments. These appointments have been dropping over these three years with a greater reduction from FY19 to FY20. The FY20 drop may be reflective of COVID-19.

Mobile Crisis Teams (MCT)
MCT Dispatches by Gender



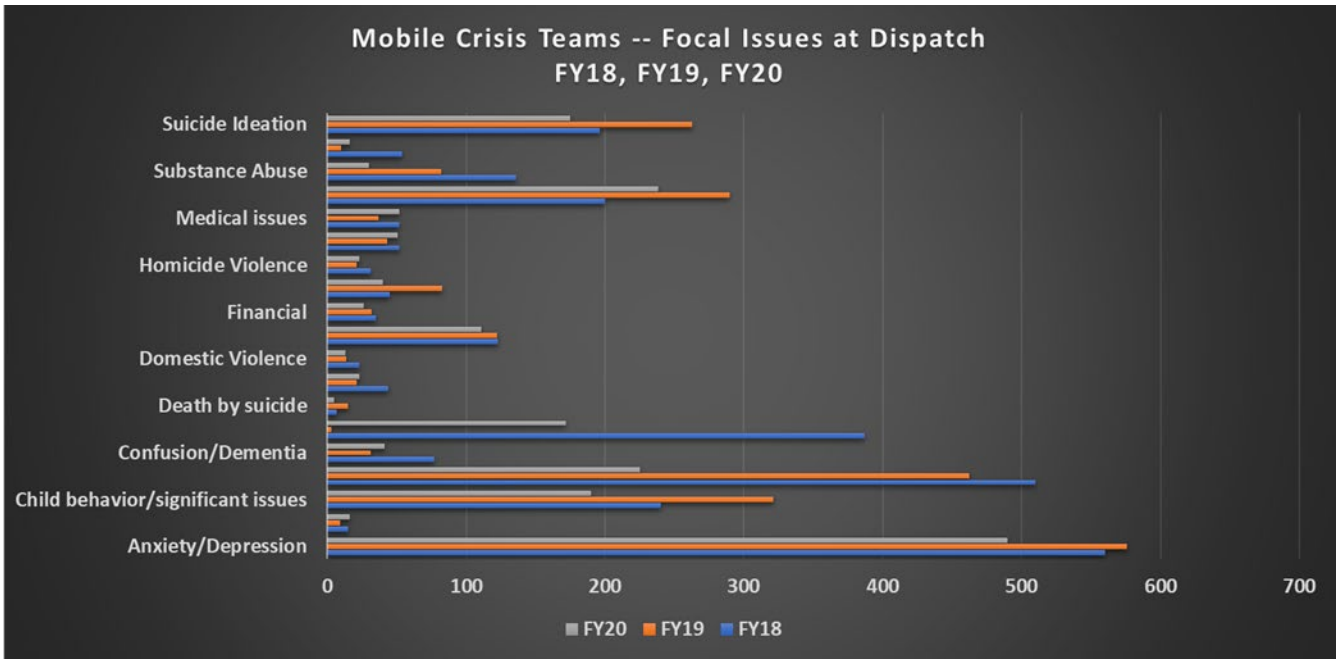
The ESOC calls approximate a closer 50/50 ratio of male/female, however, we see in the actual dispatch of MCT services and significant difference in the male/female data, with female dispatches in FY 20 more than twice male dispatches.

MCT – Dispatches by age



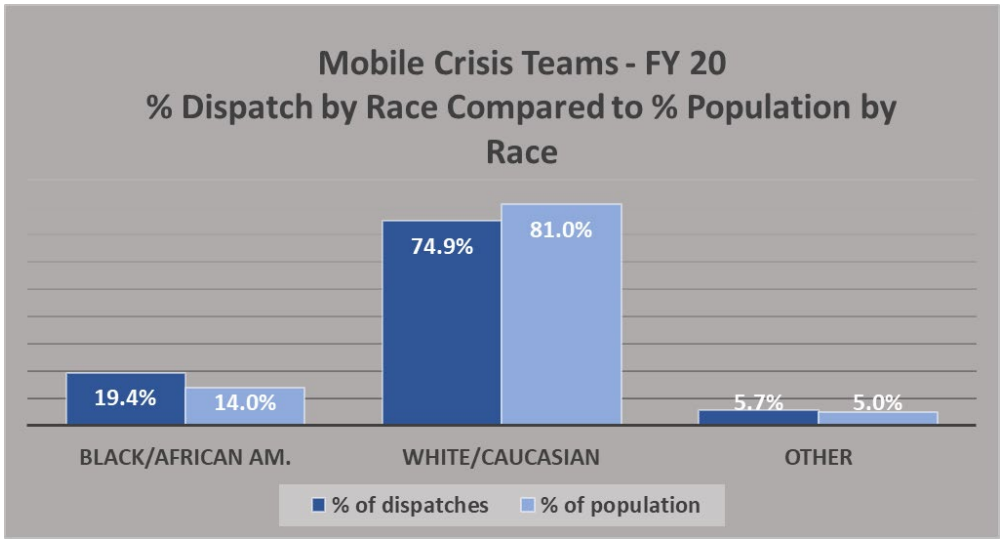
When we compare the ESOC call data with MCT dispatches we see an increase in dispatches for 0-18 age group relative to the calls per this age group.

MCT – Dispatch Issues



ESOC caller issues compare to MCT dispatch issues with anxiety/depression leading as the main health issue.

MCT Dispatches by Race



ESOC does not have caller data by race. In review of the MCT data and comparing that to mid-shore demographics there is a clear health disparity. For White/Caucasian there is 6% less dispatches in comparison to the mid-shore White population whereas there was a need for 19.4% dispatches for Black/African Americans when the mid-shore population is only 14%.

MSPC Goals to address Crisis Response and Prevention:

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

Objective 2: Collaborate with key stakeholders to expand knowledge of behavioral health among professionals and the community, promoting integrated care and working towards health literacy.
Strategy 2B. MSBH will continue to manage the Behavioral Health Services Network (BHSN) and its representation of an integrated system of care.

Objective 4: Actively involve members of the mid-shore community in behavioral health systems management.
Strategy 4C. MSBH participation in national, state, and local conferences in an effort to support, promote and spread the most relevant behavioral health information.

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

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

Strategy 2L. MSBH will ensure the provision of crisis intervention services in the region.

Goal 4: Implement an integrated systems management structure.

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

Strategy 4C. MSPC will manage and utilize behavioral health data which is representative of the mid-shore region.

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

Objective 2: Enhance and sustain our current community workforce.

Strategy 2A. Contract with local provider to offer Crisis Intervention Team (CIT) training and certification opportunities to the mid-shore region.

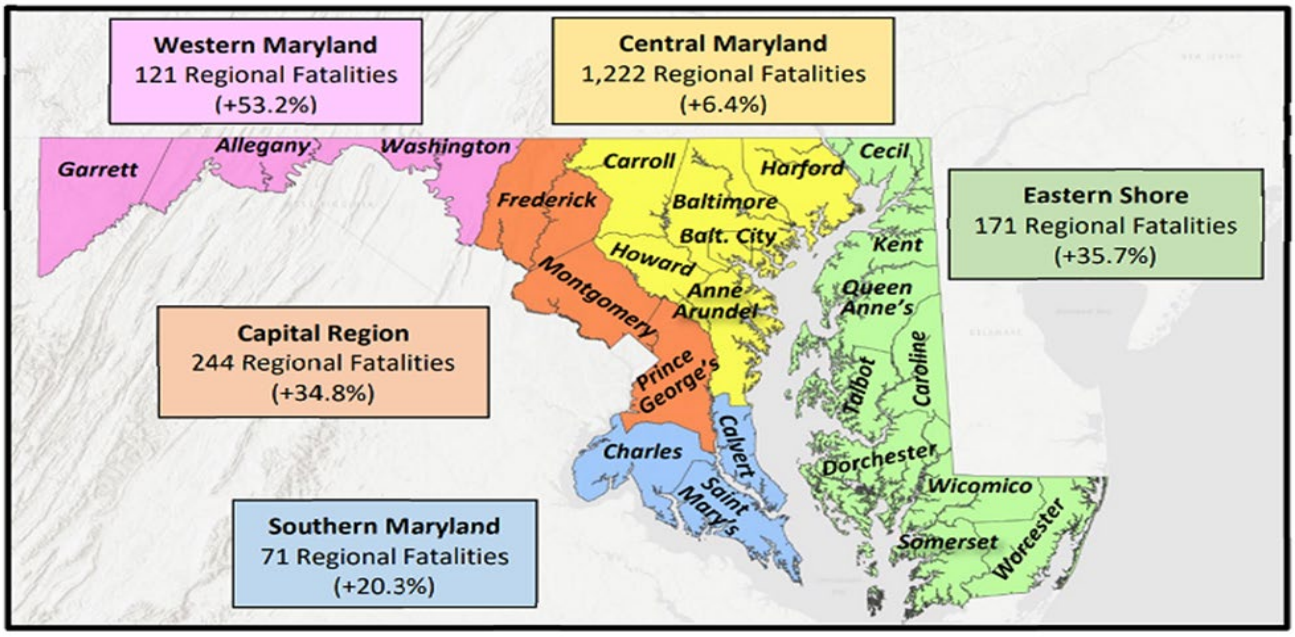
III. Overdose Events

The following data analysis is from BHA provided information from ESSENCE, various BHA recommended websites, and LAA operations data. The data, as discussed is different from previous years, in that it was not ASO-focused solely. The mid-shore region was able to look at local data, mid-shore performance measures, what were met, how programming and services changed due to COVID-19, as well as COVID's suspected impact on services as well as overdoses, both fatal and non-fatal.

Opioid related deaths

Overdose fatalities are rising across the state with mid-shore showing a 36% increase in opioid fatalities. If we then add in the deaths from other substances and the affects on individuals and families from the many non-fatal events, we start to understand the breadth of the affect.

Figure 5. Percent Change in Opioid-Related Intoxication Deaths by Region
*January through September, 2020**

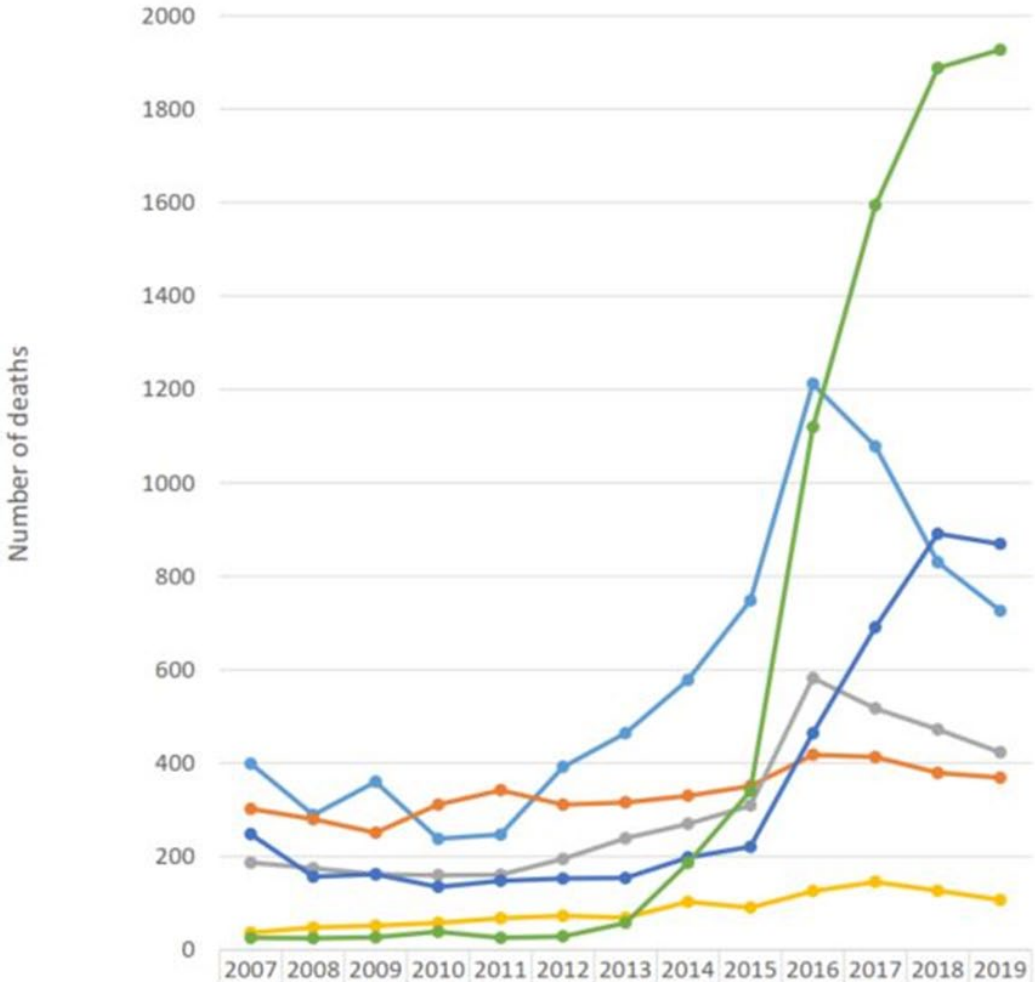


Source – Opioid Operations Command Center (OOCC) Jan – Sept 2020

Overdose deaths by Substance

In review of overdose death by substance, the following chart shows that starting in 2013 fentanyl has been on an upward trajectory as the primary causal substance while other substances are showing a clear decline. Fentanyl is being used in place of opiates or methamphetamines intentionally (as requested by user) or unintentionally (used by the dealer for higher profit).

Number of Unintentional Drug- and Alcohol-Related Intoxication Deaths by Selected Substances*, Maryland, 2007-2019.



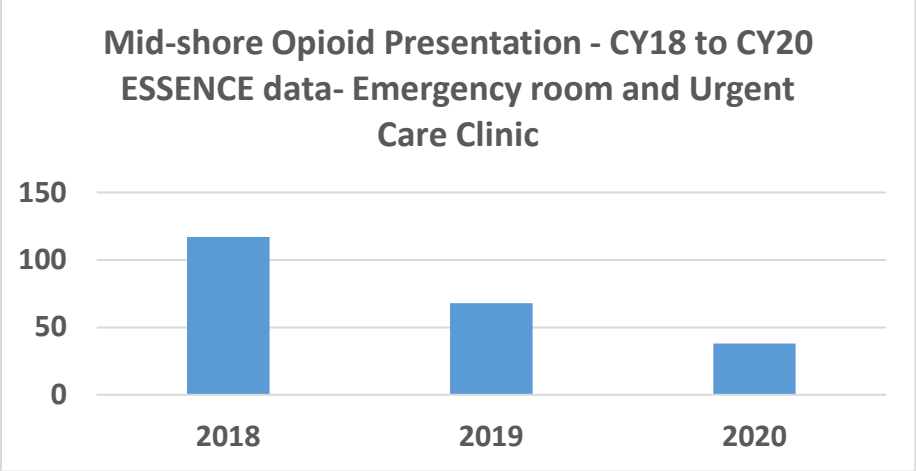
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Heroin	399	289	360	238	247	392	464	578	748	1212	1078	830	726
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413	379	369
Alcohol	187	175	162	160	161	195	239	270	309	582	517	472	423
Benzodiazepines**	37	48	52	58	68	73	69	103	91	126	146	127	107
Cocaine	248	157	162	135	148	153	154	198	221	464	691	891	869
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594	1888	1927

*Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.
**Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

Source -- MD Dept of Health website – Jan 14, 2021

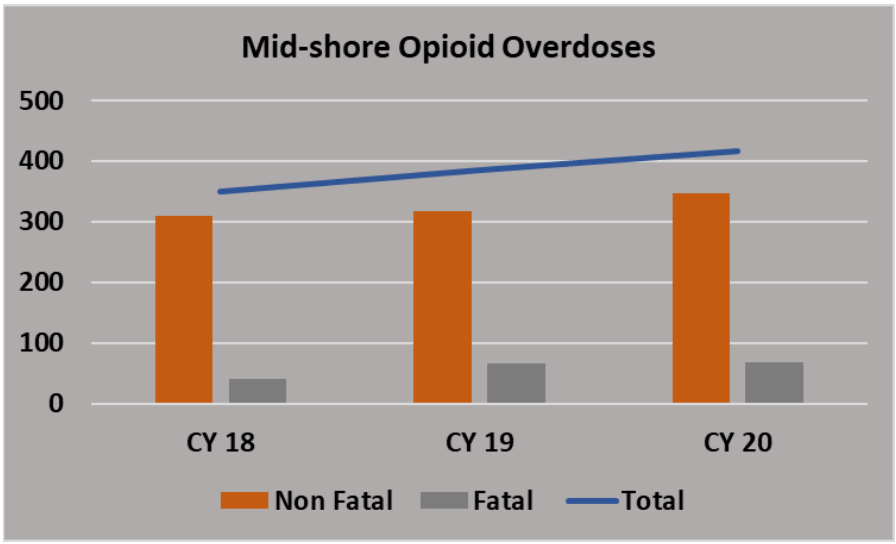
Mid-shore Emergency room and Urgent Care Clinic (UCC) overdose data reviewed in conjunction with LAA operational data

The following chart is data sourced from ESSENCE which is emergency room and urgent care clinic (UCC) data.



It would appear that opioid presentation is trending downward, however, based on review of mid-shore LAA operations data it is actually trending upward as the following chart points out.

Mid-shore Local Addictions Authorities Opioid Overdose Events Data

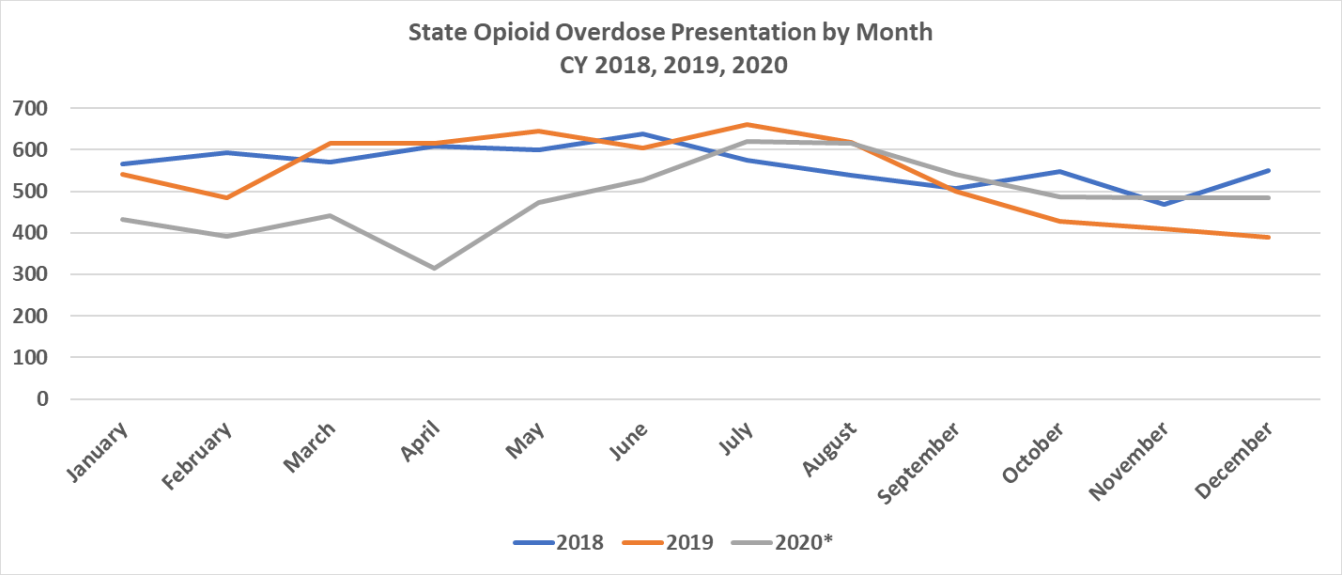


The mid-shore LAA data shows a substantial number of fatal and non-fatal opioid overdoses over those recorded by the ESSENCE data base. For CY18 the LAA data shows 3 times the opioid overdoses and in CY20 the LAA data shows ten times the opioid overdoses. It is important to understand the significant events that go unrecorded by hospitals and clinics. Opioid presentation at emergency room and UCCs is going down may be due to shelter-in-place mandates, fear of the virus (in 2020 data), and a saturation of jurisdictions with Naloxone.

Fatal overdoses are holding relatively steady while the increase in non-fatal overdoses is believed to have been mitigated through various operations: crisis services, anti-stigma campaigns, increased peer support, increased mobile treatment, and all jurisdictions taking advantage of all community relationships to saturate neighborhoods with Naloxone, and affiliated trainings.

Noted COVID 19 Impact

In reference to the state ESSENCE data, we do see what appears to be a direct COVID impact. This was referred to earlier and we are again showing the chart on state opioid overdoses by month where there is a clear dop in April of 2020. This may be due to the effects of COVID on persons travelling outside of their homes, another may be due to users switching to alternate substances during this time to mitigate the withdrawal effects from opiates. This drop was also reflected in Queen Anne's County data, showing a 75% reduction in overdoses for the first quarter of 2020.



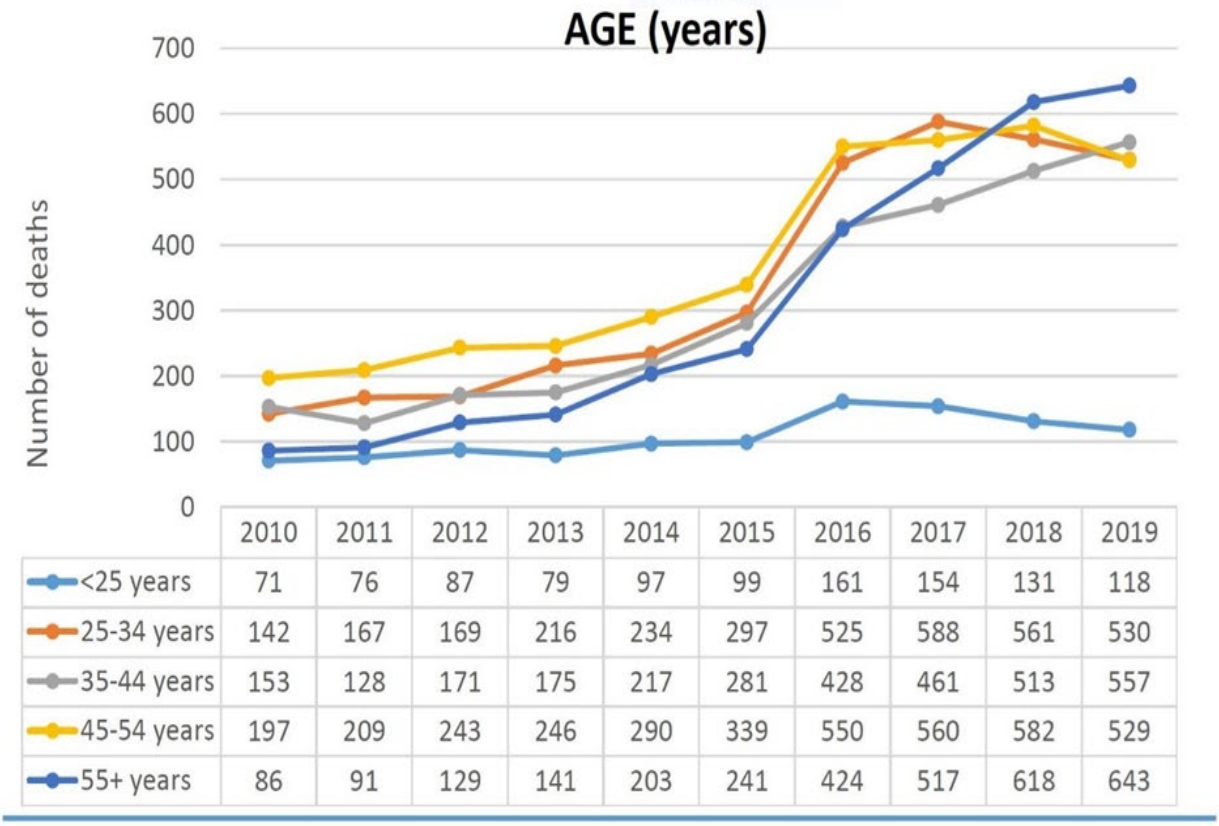
Source – ESSENCE - *Year 2020 represents 10 months of actual and 2 months of extrapolated data for comparison purposes.*

Overdose events – Age, gender, race

As each path may look different, supporting individuals on their path to recovery provides multiple challenges. Cultural, linguistic, age and gender differences all impact the perception of behavioral health, specifically substance use and abuse. The following data charts highlight specific demographics of state and mid-shore residents and the challenges that they are facing.

Overdose deaths by Age

Figure 3. Total Number of Drug- and Alcohol-Related Intoxication Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2010-2019.

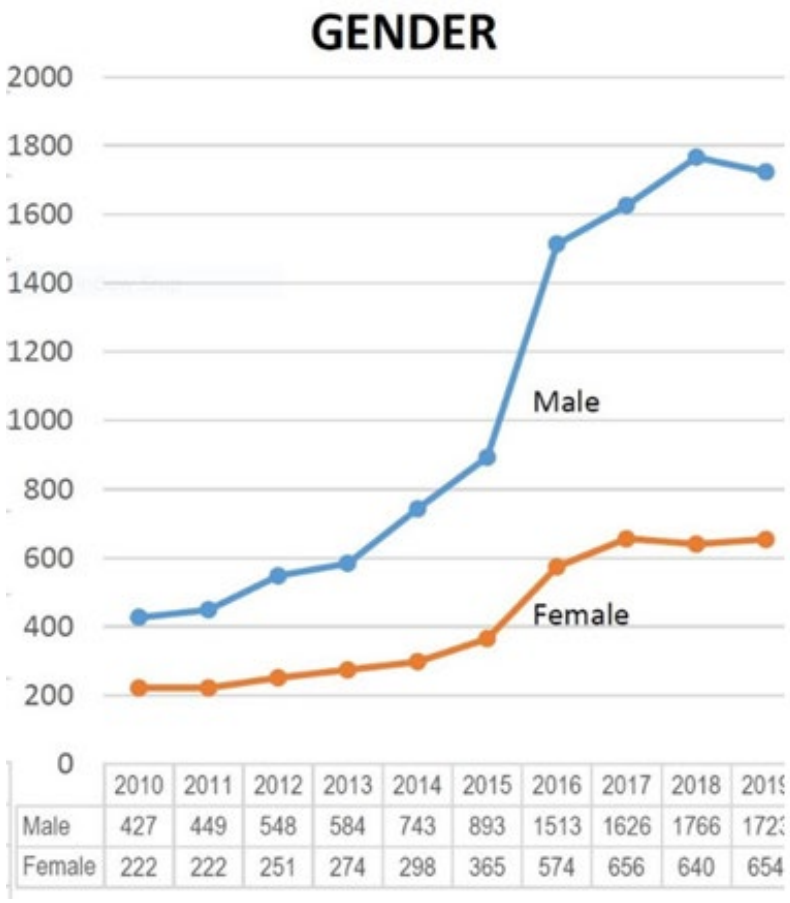


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<25 years	71	76	87	79	97	99	161	154	131	118
25-34 years	142	167	169	216	234	297	525	588	561	530
35-44 years	153	128	171	175	217	281	428	461	513	557
45-54 years	197	209	243	246	290	339	550	560	582	529
55+ years	86	91	129	141	203	241	424	517	618	643

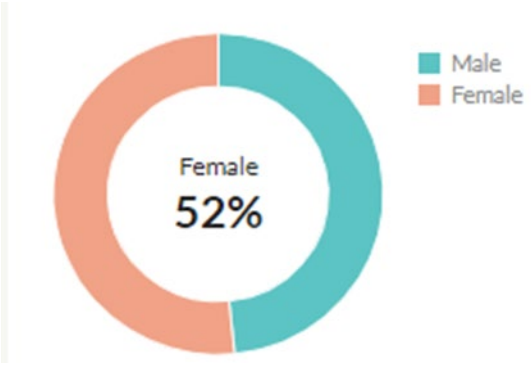
Source – MD Dept of Health – June 2020 Overdose Report

This chart shows a trajectory upward for the 55+ age group. Also, of concern is the 35 to 44 age group. While the proto-typical person with substance use is between 18-30, that is not an accurate reflection of what is being seen at this time. While in 2015, all age groups experienced a sharp increase in overdoses, the current data for all age groups is showing a decline EXCEPT for 35-44 and 55 and older.

Overdose deaths in Maryland by gender



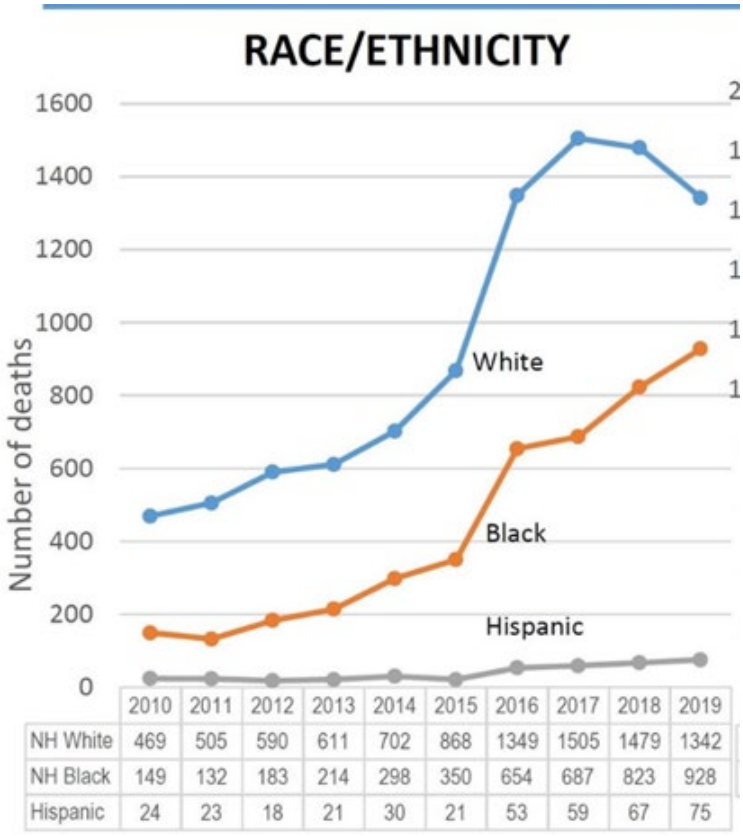
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Male	427	449	548	584	743	893	1513	1626	1766	1723
Female	222	222	251	274	298	365	574	656	640	654



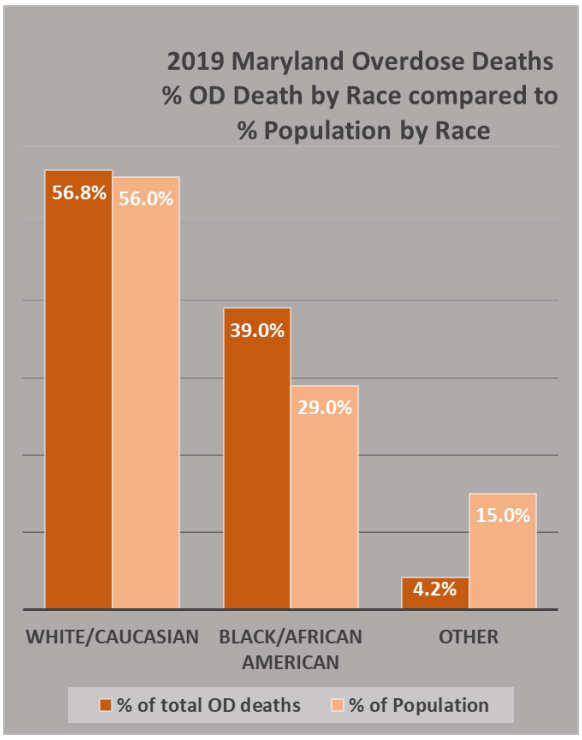
Source – first chart 'MD Dept of Health June 2020 Overdose Report', second chart 'cencusreporter.org February 2021, Maryland data'

The male overdose deaths are significantly higher than females. When reviewed relative to gender demographics, this is a very significant differential. In the earlier review of health disparities and crisis response, the data showed females as reaching out for more assistance such as in 2-1-1 data and the mobile crisis dispatch data.

State overdose deaths by race/ethnicity



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
NH White	469	505	590	611	702	868	1349	1505	1479	1342
NH Black	149	132	183	214	298	350	654	687	823	928
Hispanic	24	23	18	21	30	21	53	59	67	75



Source – first chart 'MD Dept of Health, June 2020 overdose report', second chart 'ESSENCE data and demographics from MSBH NOFA filing data'

The above chart that shows overdose deaths by race from 2010 to 2019 reflects three important trends:

- Positive downward trending of White overdoses that started in 2017
- Negative upward trajectory of Black overdoses. Both White and Black started on steeper trends upward in 2015 with Whites starting to trend downward in 2017 while the Black overdoses continued a steep climb.
- Hispanic population shows a gradual increase since 2016.

The above bar chart takes the overdose data for 2019 and compares to race demographics. White overdoses are comparative to the White population, however, the Black overdoses are significantly higher than the Black population. The realm of behavioral health services is not exempt from concerns over racial disparities as pointed out in this chart. This variance may be due to cultural differences and stigma experienced by each group, perspectives on behavioral health, substance use, obtaining services through the public (or private) behavioral health system, as well as lack of adequate outreach and communication on behalf of providers.

Per information from SAMHSA -- the opioid-related overdose death rates among non-Hispanic Blacks were the same or worse when compared to rates by total (all race/ethnicities combined) state population (Table 2).

Source -- https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

Table 2. Opioid Overdose Death Rates (age-adjusted per 100,000), Top 5 States and District of Columbia, by Total and non-Hispanic Black Populations, 2018

Total			non-Hispanic Black		
1.	WV	42.4	1.	WV	58.2
2.	DE	39.3	2.	DC	47.7
3.	MD	33.7	3.	MO	40.5
4.	NH	33.1	4.	MD	34.3
5.	NJ	29.7	5.	IL	31.3

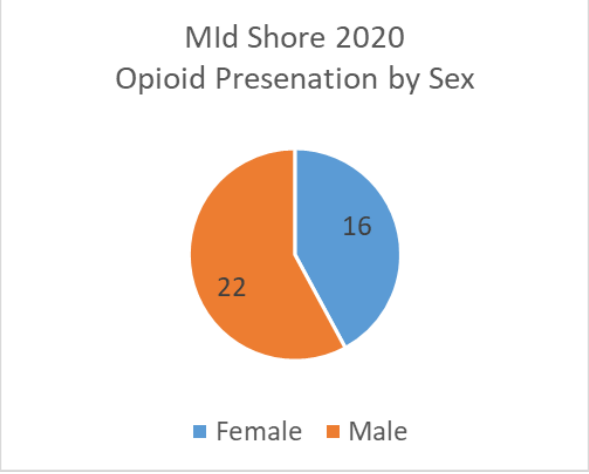
Table 3. Number of Opioid Overdose Deaths, Top 5 States, by Total and non-Hispanic Black Populations, 2018

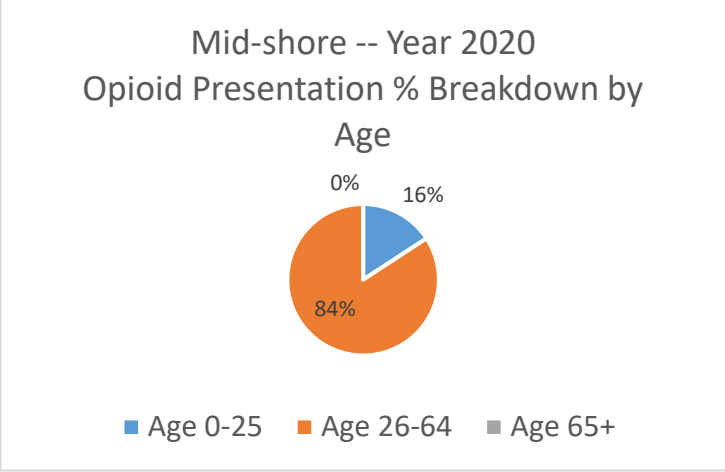
Total			non-Hispanic Black		
1.	OH	3237	1.	MD	709
2.	FL	3189	2.	IL	598
3.	NY	2991	3.	NJ	459
4.	PA	2866	4.	MI	426
5.	NJ	2583	5.	OH	402

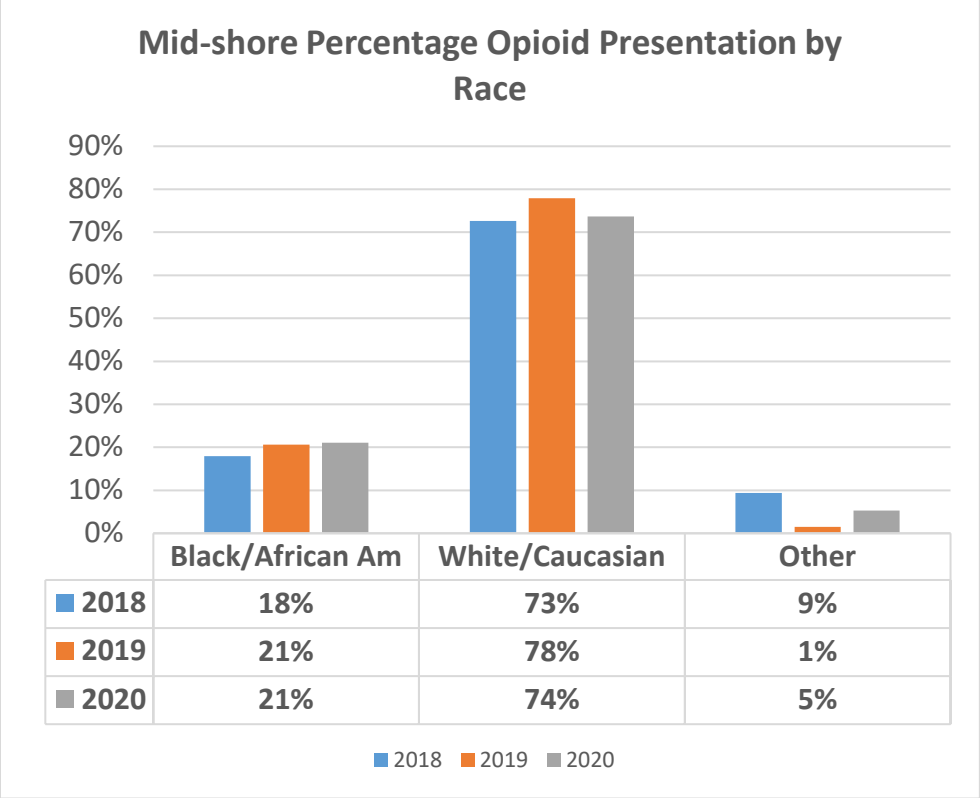
Mid-shore overdose presentation

The following data for the mid-shore area is from ESSENCE and as such is limited to emergency room and urgent care clinics. There are significantly more overdose events occurring from which the breakdown is not available. Further, this section is limited in presenting county data since numbers may be below the 11 threshold for protecting individual's identity.

Mid-shore data on gender and age







	Black/African Am	White/Caucasian	Other
2018	18%	73%	9%
2019	21%	78%	1%
2020	21%	74%	5%

The trending of opioid presentation for the mid-shore region reflected an increase in Black/African American opioid presentation and plateauing in CY20 and in the White opioid presentation we see the increase then a reduction in CY20. The mid-shore has a White population of 81% and Black population of 14%. This shows a racial disparity in opioid presentation.

MSPC Goals and Objectives

Each of MSPC's five overarching goals detail multiple objectives and strategies that will support the prevention and reduction of both fatal and non-fatal overdoses: Enhance the health and wellness of our mid-shore community, strategically address the impact of social determinants across the lifespan, build and support a regional behavioral health system of care, implement an integrated systems management structure, and collaborate to expand and sustain a dynamic rural workforce.

The goals were created through the compilation and assessment of multiple factors such as education, access to treatment, stigma, as well as specific needs of identified demographics outlined in these charts that can create an environment where substance use negatively impacts communities. Being mindful of social determinants of health, ACES, cultural competence, crisis intervention services, mobile treatment, peer support, community outreach, peer support, faith-based partnerships, and collaboration with partner agencies and committees such as DSS, local management boards, local care teams, and local departments of aging, as well as implementation of SBIRT in community settings, we believe the FY22 Goals support our data analysis and planning.

The following is a reference to the guiding priorities and goals that MSPC referenced in the development of our FY2022 Community Behavioral Health Plan Goals and Objective. The development of the MSBH FY2022 Goals was a process that involved the leadership and team members from each mid-shore local authority and was endorsed by the Health Officers for each of the mid-shore counties. The FY2022 Objectives and Strategies are driven from experiences with our provider community, consumers, and stakeholders. MSPC team members utilized a virtual platform with breakout rooms to revise and to update the Strategies, Performance Measures and Targets, as we agreed to use the same overarching Goals and Objectives. We acknowledge that our Goals and Objectives are best written for a three to five year time span.

Local Systems Management Integration planning and the assessment of our mid-shore region of care are key elements of the planning. We are mindful of the Goals and Priorities of BHA and SAMHSA.

Behavioral Health Administration Goals:

Increasing access to care by expanding:

- Capacity of 24/7 crisis services
- The workforce
- The use of telehealth and other information technology applications

Improving quality of care by:

- Improved data collection and analysis capabilities
- Moving to measurement-based care
- Expanding cultural and linguistic competency trainings
- Increasing support of evidence-based practices and promising practices
- Increasing integration of care

Improving coordination of care by:

- Developing and utilizing an integrated system

Behavioral Health Administration Systems Management Integration Domains:

1. Leadership and Governance *(vision, community engagement, management, policy advocacy, innovation).*
2. Budgeting and Operations *(financing and billing, technology infrastructure, resource and expense sharing).*
3. Planning and Data-driven Decision Making *(data analysis, community needs assessment, network adequacy, program outcomes).*
4. Quality *(provider training, client experience, complaints, performance improvement, licensing and credentialing).*
5. Public Outreach, Individual and Family Education *(messaging, communication, feedback).*

6. Stakeholder Collaboration *(with providers of BH, somatic care, community services, and other partners).*
7. Workforce *(recruitment, training and development, retention).*

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

Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services
Goal: Reduce opioid misuse, use disorder, overdose, and related health consequences, through the implementation of high quality, evidence-based prevention, treatment, and recovery support services.
Priority 2: Addressing Serious Mental Illness and Serious Emotional Disturbances
Goal: Reduce the impact of serious mental illness (SMI) and serious emotional disturbance (SED) and improve treatment and recovery support services through implementation of the comprehensive set of recommendations put forward by the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).
Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use
Goal: Reduce the use of tobacco (encompassing the full range of tobacco products and reduce the misuse of alcohol, the use of illicit drugs, and the misuse of over-the-counter and prescription medications and their effects on the health and well-being of Americans.
Priority 4: Improving Data Collection, Analysis, Dissemination, and Program and Policy Evaluation
Goal: Expand and improve the data collection, analysis, evaluation, and dissemination of information related to mental and substance use disorders and receipt of services for these conditions to inform policy and programmatic efforts, to assess the effectiveness and quality of services, and to determine the impacts of policies, programs, and practices.
Priority 5: Strengthening Health Practitioner Training and Education
Goal: Improve the supply of trained and culturally competent professionals and paraprofessionals to address the nation's mental and substance use disorder healthcare needs across the lifespan.

H. FY22 GOALS, OBJECTIVES, and STRATEGIES

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

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

Strategy 1A. MSPC will support an integrated media presence and increase public knowledge throughout the mid-shore.
Performance Measure: Media presence will include a regional resource guide, user-friendly website, strategic social media, printed collateral, and a weekly e-newsletter. Track social media posts, likes, retweets, and shares.
Performance Target: 600 Resource Guide distribution annually; Minimum of 40 weekly e-newsletters distribution annually; Increase social media engagement by 25% annually. Increase Facebook fans and followers by 25% annually.

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

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

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

Strategy 1E. MSPC will promote and support Mental Health First Aid (MHFA) trainings.
Performance Measure: Seek out opportunities to bring MHFA Training to the region. Support any other agencies that offer MHFA Training and help identify organizations in need of MHFA Training.
Performance Target: Support all MHFA trainings in the mid-shore region.

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

Strategy 2A. MSPC will increase public awareness of behavioral health priorities and trends by way of data sharing.
Performance Measure: MSPC will promote public behavioral health awareness and improved communication through the sharing of relevant data and trends. Maintain and expand electronic distribution list to serve as an avenue for distribution of data.
Performance Target: At a minimum, extend annual PBHS data out to the distribution contacts and partner agencies, and present trends to community stakeholders and advisory councils. Increase attendance by seven new community partners in FY2022.

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

Strategy 2C. Representatives from MSPC will present at and/or support conference activities. and conference sponsorships, in an effort to support, promote and spread the most relevant behavioral health information.
Performance Measure: MSPC conference presentations at the following annual conferences: Sequential Intercept Model Annual Meeting, Across the Life Span Annual Conference, and any other conference presentation opportunities as identified.
Performance Target: One presentation at each of the conferences listed above and those identified during FY2022.

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

Objective 3: Identify and address the culture and stigma associated with behavioral health in the mid-shore.
Strategy 3A. MSPC will support provider and community education to defeat behavioral health stigma.
Performance Measure: Host, sponsor, and/or volunteer at public virtual events to promote behavioral health, wellness, and awareness.
Performance Target: MSPC will participate, organize, or sponsor a minimum of six public virtual events in FY2022.

Strategy 3B. MSPC will gather data points to gain a baseline for areas most needed to address stigma reduction.
Performance Measure: MSPC will gather data points for a survey on stigma reduction.
Performance Target: MSPC will be prepared to conduct the survey in FY2022.

Strategy 3C. To incorporate anti stigma messaging, MSPC will promote and participate in mid-shore substance use awareness initiatives with a concentration on the "Going Purple" and/or "Going Purple Together" campaign.
Performance Measure: Engage and market regional community events. Participate on county level planning committees for community events, school-based initiatives, and provider targeted activities.
Performance Target: Representation on all five mid-shore planning committees and participate in each county's "Going Purple" campaign. Invite all 5 counties to participate in a Going Purple Together event.

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

Highlight suicide prevention articles and information at least 30 times in the weekly newsletter and social median FY2022.

Strategy 3E. MSPC will promote the Art of Wellness with Kevin Hines Suicide Prevention and Wellness Series in the mid-shore and State of Maryland.
Performance Measure: MSPC will promote the presentation and utilization of the Art of Wellness Kevin Hines series initially launched in FY21 with target groups, multiple service settings, and community groups. The series has seven specialized focus groups that have a diversity and inclusion perspective that can be used for education, suicide prevention, and wellness initiatives. The focus groups are: First Responders and Clinicians, Youth and Adolescents, Impacted Families of Suicide and Mental Illness, Individuals Working from Home, Men, and the Male Perspective, Aging, and the General Community.
Performance Target: Over the course of the four-year available license for the film series, MSPC will promote the series and target multiple groups in the mid-shore region for wellness initiatives. In FY22, MSPC will work to identify four-six new audience groups to present the series and provide community outreach and education with the wellness series tool.

Objective 4: Actively involve members of the mid-shore community in behavioral health systems management.
Strategy 4A. MSPC will promote, garner membership in and support growth with peer organizations.
Performance Measure: Contribute resource expertise and systems involvement with peer organizations.
Performance Target: Support local peer involvement through two regional community events during FY2022.

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

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

Strategy 4D. MSBH will lead the Eastern Shore Behavioral Health Coalition.
Performance Measure: Participate in local and state-level Behavioral Health Coalitions to aid with providing accurate and impactful data and facts for decision making and advocacy.
Performance Target: Host a minimum of four meetings of the Eastern Shore Behavioral Health Coalition. Plan and facilitate annual Eastern Shore Delegation Legislative forum to prepare for legislative priorities in FY2022. Monitor legislative changes and developments to be reviewed at Behavioral Health Coalition meetings and identify priority areas as a group.

Strategy 4E. MSPC will diversify advising and governing bodies by involving consumers, youth, family members, and advocacy organizations' participation.
Performance Measure: MSPC will involve representation from consumers, family members and persons with lived experience on the Board of Directors, LDAACs, RBHAC, the Mid Shore Roundtable on Homelessness and The People's Roundtable. Encourage consumer, youth, family, and advocacy organization representation on the MSBH BHSN and workgroups.
Performance Target: Persons with lived experience will be members of all formalized groups to include representation from the target members.

Strategy 4F. Identify behavioral health needs and community resources for individuals aging within the mid-shore region through the Adult Services Workgroup.
Performance Measure: Host bimonthly meetings; create and/or update annual goals; collaborate with BHA to promote, advocacy by offering education to service providers, health care workers, older adults, caregivers and the public. Attend local Commission on Aging meetings and MAP interagency meetings to share resources and promote integrated systems of care for the aging population. Identify and seek additional resources through grant funding opportunities.
Performance Target: Host a minimum of six meetings in FY2022 and share goals in FY2022. Promote the Assisted Living Facility Behavioral Health program throughout the mid-shore region.

Strategy 4G. MSBH will address behavioral health needs, trends, and gaps in services through the BHSN Child and Adolescent Workgroup.
Performance Measure: Collaborate with state and local stakeholders to promote existing resources and encourage resource development specific to child and adolescent population. Offer education to service providers, community partners, and the public, informing them of the behavioral health needs of the child and adolescent population. Identify and seek additional resources through grant funding opportunities.
Performance Target: Host a minimum ten meetings in FY2022 and share goals in FY2022.

Strategy 4H. MSBH will continue to identify behavioral health needs for individuals who are involved with the criminal justice system through the BHSN Forensic Workgroup.
Performance Measure: Invite community stakeholders to participate in the workgroup and give input on topics that affect the forensic population. Continue to strengthen partnerships with community agencies in supporting the forensic population.
Performance Target: Host a minimum ten meetings in FY2022 and share goals in FY2022.

Strategy 4I. MSPC will support the continuation of the Mid Shore Recovery House Workgroup.
Performance Measure: Help the leadership of the local Recovery Houses in continuing their workgroup.
Performance Target: MSPC will attend workgroups biannually.

Strategy 4J. MSPC will support the formation of a Mid Shore Peer Recovery Workgroup.
Performance Measure: Collaborate with mid-shore organizations that provide peer support for behavioral health services.
Performance Target: Host a minimum of two meetings to establish partnerships, purpose, mission of the workgroup.

Strategy 4K. MSBH will continue to coordinate updates to the Sequential Intercept Model (SIM) for the mid-shore region through the BHSN Forensic Workgroup.
Performance Measure: MSBH prioritizes keeping the relevancy of the SIM to reflect the evolving forensic system of the region. By way of the SIM Annual Meeting, identify priority areas for the FY2022 Forensic Mental Health Program (FMHP).
Performance Target: Organize and facilitate the annual SIM meeting annually.

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

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

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

Strategy 4O. MSPC in collaboration with the nine counties of the Eastern Shore, will administer and facilitate the Behavioral Health Services on the Eastern Shore Provider and Stakeholder Meeting.
Performance Measure: MSPC will maintain the Provider and Stakeholder meetings on behalf of the mid-shore local authorities and the local authorities in Cecil, Somerset, Wicomico, and Worcester Counties. MSPC will maintain and organize representation requests and presentations from BHA, ASO, local governance, and special presentations regarding behavioral health systems developments. Providers from all service lines supporting behavioral health, crisis services, case management, and homeless services will be represented and report out on any program developments and new resources.
Performance Target: MSPC will be responsible for at a minimum, twenty-six (bi-weekly) Provider and Stakeholder calls in FY2022.

Goal 2: Strategically address the impact of social determinants across the lifespan.
Objective 1: Recognize the role of systemic social injustice and racial inequity and how it inhibits wellness in the mid-shore community.

Strategy 1A. Improve access to and community awareness of, for both consumers and providers, culturally sensitive behavioral health services for populations with unique needs, including but not limited to: persons of color, deaf and hard of hearing, traumatic brain injury (TBI), persons living with chronic illnesses/chronic pain, older adults, veterans, LGBTQ+ and developmental disabilities.
Performance Measure: Expand the newly formed Cultural and Linguistic Competency (CLC) workgroup to identify service needs for the underserved populations. Recruit workgroup members and develop the purpose, mission, and vision for the workgroup. Representatives of the CLC workgroup will report out to all MSPC workgroups, and jurisdictional provider meetings.
Performance Target: Host at a minimum, quarterly CLC workgroup meeting. CLC representatives will report out at a minimum, quarterly, to each MSPC workgroup jurisdictional provider meetings.

Strategy 1B. Address trauma-related needs for the Latino Population.
Performance Measure: MSBH will continue to contract annually for the provision of coordinated therapeutic counseling with the bi-lingual advocate to the Latino/Hispanic population identified as victims of domestic or sexual violence as well as those identified as experiencing trauma.
Performance Target: Review contract and communicate with provider agency throughout FY2022 about the need for increased services for this population.

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

Strategy 1D. Improve cultural and linguistic competency of MSPC staff, on the continuum to cultural humility and promote awareness to other community agencies of the need for culturally competent services throughout the region.
Performance Measure: Provide training that aims to improve cultural awareness to MSPC staff, board, and committees.
Performance Target: Facilitate and/or host at least one cultural humility training in FY2022.

Strategy 1E. Queen Anne's County will expand new peer-led groups that will be tailored to address the unique needs of diverse populations.
Performance Measure: Increase awareness and participation within support groups for populations who experience social injustice; the group will promote whole health.
Performance Target: Continue to grow support groups for unique populations (ex. LGBTQ+, MAT recovery, faith-based, and women) in FY2022.

Strategy 1F. Support the establishment of the Rural Mental Health Initiative, which proposes to address stigma, to oversee culturally sensitive and appropriate mental health services, and to enhance the provider network in the region.
Performance Measure: Establish a network of partners, providers, and invested community stakeholders to form the Rural Mental Health Initiative (RMHI). MSPC in partnership with Georgetown University's School of Psychiatry, Choptank Community Health, Inc., Eastern Shore Area Health Education Center, and University of Maryland Shore Regional Health will garner the interest and investment of our provider community to develop a network that supports a community and academic partnership of mental health providers, thought leaders, community organizers, youth, and caregivers. The objective is to develop a culturally, linguistically, and geographically appropriate plan to address behavioral health and wellness needs in our communities.
Performance Target: In FY22, the RMHI will work on partnership building, conduct a community assessment, and review a plan for service provision by way of telehealth, recruitment, training and forming a culturally sensitive and appropriate clinical care model. The RMHI will seek to apply for funding to support the initiation and foundation of a rural behavioral healthcare model.

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

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

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

Strategy 2C. Conduct the Mid Shore on Homelessness annual Point in Time Homeless Count during the last week of January.
Performance Measure: Facilitate a comprehensive annual count during the last week of January, partnering with emergency shelters, transitional housing programs and homeless service providers to get as accurate a count as possible of those who are homeless in the mid-shore region.
Performance Target: Plan and execute the Point in Time Count on the Last Wednesday of January 2022 and provide results to the community.

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

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

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

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

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

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

Strategy 3A. Continue to monitor the Maryland Community Criminal Justice Treatment Program (MCCJTP) which includes mental health screening and mental health management in the local detention centers.
Performance Measure: Contract annually for the provision of MCCJTP services in all mid-shore detention centers; Analyze the effectiveness and efficiency of the program through contract data deliverables. Attend quarterly MCCJTP meeting at BHA.
Performance Target: FY2022 data deliverables for the MCCJTP contract will show 100% compliance with contract deliverables.

Strategy 3B. Partner with agencies who serve the forensic population, through the FMHP, to evaluate and make recommendations for those individuals and connect them with behavioral health resources.
Performance Measure: Accept referrals, provide evaluations and clinical reports with recommendations such as appropriate placement, treatment interventions, and clinical factors for consideration.
Performance Target: Manage referrals and complete a minimum of 60 of the evaluations requested annually.

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

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

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

Strategy 4A. Promote Trauma Informed Care integration throughout the local Public Behavioral Health System.
Performance Measure: Identify and promote certifications and training opportunities to our network. Track number of and attendance at trainings.
Performance Target: Facilitate and/or host at least one virtual Trauma Informed Care training in FY2022.

Strategy 4B. Continue to monitor the Trauma Addictions Mental Health and Recovery (TAMAR) program in mid-shore detention centers.
Performance Measure: Provide TAMAR services in the Caroline and Dorchester County detention centers and explore options on expanding the program to the entire region.
Performance Target: TAMAR will serve a minimum of 80 individuals during FY2022.

Strategy 4C. Provide education to community partners regarding Adverse Childhood Experiences (ACEs) and their impact on development.
Performance Measure: Work with community stakeholders to promote, support and/or provide training on ACEs.
Performance Target: Promote, support and/or provide at least three trainings on ACEs, whether in person or virtual, in the mid-shore region during FY2022.

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

Strategy 5A. Involvement in local efforts to reduce transportation barriers to accessing behavioral health services when telehealth services are not an option.
Performance Measure: Advocate for the transportation needs of the behavioral health community. Support the development and implementation of programs that address transportation needs through local partnerships. Explore grant opportunities to expand transportation services.
Performance Target: Support new transportation programs and peer transportation programs. Discuss with community transportation services the need of increased drop-off/pick-up sites.

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

Strategy 5C: MSBH will monitor and manage the Maryland Recovery Network (MDRN) non-recovery house funds that can be used for transportation needs associated with a consumer's behavioral health treatment goals.
Performance Measure: Utilization of Maryland Recovery Network (MDRN) non-recovery house funds, in compliance with the Conditions of Award and MSBH internal protocols to provide transportation services for consumers in the public behavioral health system.
Performance Target: Process and approve 50 consumer support requests annually.

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

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

Strategy 6B. Promote BHA's supported employment program to increase awareness for consumers, transitional-age youth, and families.
Performance Measure: In collaboration with supported employment provider, promote the role the program plays in facilitating consumer recovery and economic self-sufficiency.
Performance Target: Provide a minimum of one training to the provider network from Supported Employment Providers at the Quarterly BHSN meeting.

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

Strategy 7A. Collaborate with the local Public Education Systems' School-Based Behavioral Health Services or School-Based Wellness Centers to promote behavioral health integration.
Performance Measure: Promote strong somatic and behavioral health integrated services within each local county school system; participate in the Eastern Shore School-Based Mental Health Coalition; Participate on the Advisory Boards of School-Based Wellness Centers as invited.
Performance Target: Attend monthly Eastern Shore School Mental Health Committee meetings. Invite the 5 mid-shore county school mental health coordinators to attend the monthly Child and Adolescent workgroup in FY2022.

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

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

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

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

Strategy 1C. MPSC will support existing and expand recovery housing in the mid-shore region.
Performance Measure: Provide referrals to existing recovery housing and assist with Administrative Service Organization (ASO) relations and payment. Address NIMBY and stigma in the communities of the mid-shore.
Performance Target: Support with oversight of recovery support staff for houses and funding opportunities. MSPC will formally check-in with the recovery house workgroup to receive and share current progress and concerns. Provide bi-annual updates to behavioral health community via BHSN on provider statuses.

Strategy 1D. MSPC will support and promote Safe Stations.
Performance Measure: Partner with community stakeholders to promote existing Safe Station locations. Support opportunities for the development of new Safe Station locations in other mid-shore counties.
Performance Target: Strengthen existing Safe Stations through quarterly Safe Station Coalition meetings. Strategic outreach to target counties without current Safe Stations to plan for expansion opportunities. Support and promote a minimum of two safe station marketing campaigns supporting community awareness in the surrounding jurisdictions of new Safe Station sites.

Strategy 1E. MSPC will promote tobacco cessation, vaping curriculum, and nicotine replacement therapies to the behavioral health community.
Performance Measures: Promote efforts to behavioral health treatment providers to support tobacco cessation, vaping curriculum, and nicotine replacement therapies services in their programs. Track and disseminate regional tobacco cessation, vaping curriculum, and nicotine replacement therapies related data.
Performance Target: Promote and/or sponsor tobacco cessation, vaping curriculum and nicotine replacement therapies a minimum of five times annually. Incorporate tobacco cessation, vaping curriculum, and nicotine replacement therapies information into a minimum of six trainings and/or events. Share information and links to tobacco cessation, vaping curriculum, and nicotine replacement therapies on social media, through newsletters and webpages once a month.

Strategy 1F. MSPC will work with primary care physicians and behavioral health providers to strengthen the "Warm Hand-off" process.
Performance Measure: MSPC will educate and encourage providers to use the provider waitlist dashboard and distribute the developed "Warm Hand-off" Tool Kit.
Performance Target: Update the Warm Hand-off Tool Kit annually. Promote Warm Hand-Off Tool Kit at quarterly BHSN provider meetings. Launch Waitlist dashboard in FY22.

Strategy 1G. Promote the Data Waiver 2000 training for private physicians and Nurse Practitioners to prescribe Buprenorphine.
Performance Measure: Promote and advocate within the mid-shore community for Data Waiver 2000 training that is available online.
Performance Target: Track on SAMHSA's website Practitioner and Program Data Tracker the number of trained physicians. Bring to Opioid Taskforce, Health Officers, LDAACs and Shore Regional workgroup to promote training and need for additional prescribers.

Strategy 1H. Expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) practices in expanded community settings.
Performance Measure: Promote provider awareness of SUD screening tools in support of integrated healthcare delivery. Educate and encourage the utilization of SBIRT through the Warm Hand-Off and other initiatives.
Performance Target: Collaborate with mid-shore counties school mental health coordinators, outpatient providers and other treatment and crisis providers to promote SBIRT use in their treatment settings.

Strategy 1I. Dorchester County will continue to collaborate with the Dorchester County Detention Center (DCDC) to plan a method to provide MAT to include buprenorphine and methadone into the treatment protocol at the DART Program (SUD Program) behind the walls of the detention center. DCBHS will attend regular planning meeting, purchase buprenorphine, and provide necessary resources such as staff and supplies as needed.
Performance Measure: DART and DCDC will provide MAT for 90% of individuals in DART that MAT is found to be medically necessary. Conduct SBIRT screening on all individuals detained at DCDC. Staff program with physician and SUD counselor.
Performance Target: 90% of individuals in DART medically requiring MAT (buprenorphine/Vivitrol) are on medication. MAT data collected quarterly. Implementation of services by August 2022.

Strategy 1J. Dorchester County will collaborate with the Dorchester County HIV Department, Johns Hopkins Hospital, DCBH, and Dorchester County Detention Center to plan and implement HIV and HCV testing and treatment to individuals having SUD in the community and detention center. DCBHS will attend regular planning meeting, purchase HCV test kits, and provide necessary resources such as staff and supplies as needed.
Performance Measure: Partners will provide HIV and HCV test for 95% of detainees in the DART Program. DCBH will incorporate HIV and HCV testing into their intake process to test all

admissions by July 30, 2022. Upon release from DCDC detainees will seamlessly move to Outpatient Treatment for SUD and or HIV/HCV. Program resources provided by DCBH to include HCV 100 test kits.
Performance Target: Quarterly data collected by DCDC on HIV and HCV. Quarterly data collected by DCBH on HIV and HCV. SUD and or HIV/HCV treatment provided to 95% of detainees from DART requiring treatment. Implementation of services by July 30, 2022.

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

Maternal Health, Post-Partum, Newborn, Early Childhood

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

Strategy 2B. MSPC will support and monitor the provision of integrated behavioral health services for children, adolescents, and transitional-aged youth.
Performance Measure: Collaborate with B-HIPP program to increase awareness of and participation in BHIPP consultation program in the mid-shore.
Performance Target: Partner with B-HIPP to provide a minimum of one presentation to a primary care provider outlining the benefits of participating in the B-HIPP program.

Strategy 2C. MSPC will identify the need for early intervention and treatment services and advocate for capacity and expansion of services for child and adolescent behavioral health needs on the mid-shore.
Performance Measure: Provide oversight of revised 1915i implementation, Targeted Case Management (TCM) plus, Care Coordination Organization, Residential Treatment Services, Residential Substance Use, Respite, and Crisis Services. Explore opportunities to create Child and Adolescent Crisis Bed services in the region. Participate in Child, Adolescent and Young Adult MABHA Subcommittee.
Performance Target: MSBH will attend the Maryland Association of Behavioral Health Authorities (MABHA) Child, Adolescent and Young Adult Coordinators group and Care Coordination Organization provider meetings. Complete annual audit of care coordination organization. Promote 1915i providers and services at mid-shore county LCT meetings.

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

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

Strategy 2E. MSPC will conduct outreach in the school systems and school-based wellness centers that will target school-aged students on the negative impacts of initial use and/or misuse of substances.
Performance Measure: Mid-shore county mental health coordinators participate in Child & Adolescent Workgroup monthly.
Performance Target: MSBH Youth Outreach Coordinator will develop a relationship with mid-shore counties mental health coordinators as evidenced by increased contact and initiation of referrals.

Strategy 2F. MSPC will support expansion of adolescent substance use services on the mid-shore through the addition of two Adolescent Clubhouses.
Performance Measure: MSBH will provide grant oversight and assistance in implementing two mid-shore Adolescent Clubhouses.
Performance Target: MSBH will assist the Adolescent Clubhouses by providing partner linkage and a minimum of two BHSN presentations a year.

Strategy 2G. MSPC will provide oversight for Fed Block Grant/School-Based Mental Health in Caroline County.
Performance Measure: MSBH will support the expansion of school based mental health services in Caroline County schools with the addition of one additional school-based therapist.
Performance Target: MSBH will assist Caroline County Behavioral Health in reaching an additional 28 unduplicated children in Denton Elementary School.

Transitional-aged Youth (TAY)

Strategy 2H. MSBH will contract and support the Healthy Transitions grant.
Performance Measure: Support contract vendor in implementing program model. Support provider compliance with unduplicated TAY participants by marketing the availability of this service to generate referrals. MSBH will work in collaboration with BHA and local provider to address program needs and meeting the conditions of award.
Performance Target: MSBH will review outcomes of program to determine if TAY are actively engaged in services.

Strategy 2I. MSPC will develop, enhance, and promote behavioral health support services for TAY.
Performance Measure: Provide oversight of existing TAY services through regular meetings with contracted provider and annual audit. Advocate for expansion of TAY services and promote TAY services throughout mid-shore region.
Performance Target: Monitor program for compliance related to conditions of award. MSBH will meet monthly with TAY contractor to assist in developing the Healthy Transitions Program.

Adult Population

Strategy 2J. MSPC, in collaboration with the Eastern Shore Behavioral Health Coalition will organize a subcommittee of regional, county, and local stakeholders to address increased capacity and sustainability of the A.F. Whitsitt Center.
Performance Measure: Cultivating interested Eastern Shore stakeholders in the development of the subcommittee. Work in partnership with leadership from the Kent County Health Department in analyzing facility infrastructure and capacity building opportunities.
Performance Target: Subcommittee will be developed and hope to meet at a minimum twice during FY22 to develop the A.F. Whitsitt Center sustainability plan.

Strategy 2K. MSBH will address complex consumer needs through treatment team collaboration.
Performance Measure: Track weekly programs team meeting minutes including individuals identified as high service utilizers to effectively reduce costs and improve treatment. Support the facilitation of treatment team meetings for individuals identified as high service utilizers by local partners, BHA or the ASO. Inclusion of ESHC social work and psychiatry staff during programs team meeting to support community transition planning for individuals preparing for discharge.
Performance Target: During FY2022 MSBH team will meet weekly to track high service utilizers and monitor their needs and report outcomes. Track number of supported individuals leaving state hospital.

Strategy 2L. MSBH will ensure the provision of crisis intervention services in the region. Performance Measure: Contract annually for the provision of Urgent Care Clinics, Eastern Shore Operations Center, Maryland Crisis Hotline (MCH) and Mobile Crisis Teams. Monitor utilization of adult services through contract data deliverables. Advocate to increase capacity of the regional crisis response system. Inclusion of mid-shore systems managers to address quality service delivery.
Performance Target: Through FY2022 MSBH will monitor contracts quarterly, identifying growth of services, utilize data to define systems gaps, and an annual review of services to ensure appropriate funding allocation.

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

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

Strategy 2O. Caroline County will work collaboratively with the Caroline County Detention Center and University of Maryland in the planning and development of their MAT program by participating on the committee, attending scheduled meetings, and providing staffing and other programming support, as necessary.
Performance Measure: Support the implementation of the MAT program in the detention center by way of attending meetings and providing staffing support if needed.
Performance Target: In FY2022 current detention SUD staff will identify 10 inmates in need of MAT while incarcerated.

Strategy 2P. MSPC will coordinate a Peer Response Overdose (PRO) workgroup with the goal of developing a streamlined response across the mid-shore.
Performance Measure: Engagement of LAA leadership in the mid-shore, emergency managers,

peers and UMSRH leadership to meet and develop a mid-shore peer overdose response protocol.
Performance Target: In FY2022, develop and strive to implement the protocol.

Strategy 2Q. Caroline County will continue to improve the process for Peer Response after an overdose.
Performance Measure: Continue to provide consistent OD response according to the peer overdose response protocol, in conjunction with EMS and the Heroin Coordinators in other jurisdictions.
Performance Target: In FY2022, continue to follow OD protocol and support real-time linkages to treatment and provide face-to-face outreach to 80% of the ones that refuse transport.

Strategy 2R. MSBH, Caroline County Health Department, and other partners will implement the Farming Stress Management Project.
Performance Measure: Collaboration with key stakeholders, county leadership, and farming community to increase outreach, awareness, and education in the community.
Performance Target: Successful implementation of Farming Stress Project by the end of 2022. Participate in one outreach education event per month to disseminate educational materials to the community.

Strategy 2S. Caroline County Mobile Treatment Unit (MTU) will continue to support the expansion of treatment services in the Mid-Shore.
Performance Measure: Expand locations identified within the nearby Mid-Shore jurisdictions to meet additional consumer needs.
Performance Target: One additional location will be identified in FY2022 and that location will see a minimum of five clients per week in the first three months on the MTU by the counselor and MTU team.

Aging Population

Strategy 2T. MSBH will continue to track institutionalized adults with behavioral health needs and support facility administration in the use of the Pre-admission Screening and Residential Review (PASRR) process, provision of care for their residents and training for staff.
Performance Measure: Behavioral Health Coordinator for Aging Adults/Eastern PASRR Specialist will determine through Long Term Support Services database, the long-term care facility of residence of individuals who have screened positive through a Level II PASRR and report to Administrative Service Organization (ASO). Support BHA's development of a protocol for follow up of these individuals to confirm provision of appropriate services. Through collaboration with LTC Ombudsmen, AERS, MCT's, and related stakeholders begin to identify facilities that admit individuals with behavioral health needs to identify training opportunities.
Performance Target: Track the number of individuals visiting to regional long-term care facilities, the number of trainings provided, number of consultations requested by facility staff as indicators of developing partnerships and report quarterly to BHA.

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

Strategy 2V. MSBH will assist with placement of individuals with behavioral health needs who may remain in a restrictive level of care and present as candidates to transition to a lower level of care.
Performance Measure: Collaborate as requested with discharge planners of the Eastern Shore Hospital Center and community hospital behavioral health unit discharge planners to characterize the individual's behavioral health needs, identify possible area nursing home providers, and assist with development of a care plan with built-in transition supports. Begin to identify characteristics of successful transfers.
Performance Target: Track number of requests for assistance, number of successful transfers and receiving facilities, and report to BHA quarterly.

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

Strategy 2V. MSBH will implement the new Behavioral Health Assisted Living Project by partnering with assisted living facilities on the Eastern Shore, placing and supporting older adults with behavioral health needs.
Performance Measure: PASRR Specialist assisted with placement referral processes, will train assisted living staff, and provide case management to the placed individuals residing at the assisted living.
Performance Target: The Behavioral Health Assisted Living Project will place and serve four to six older adults beginning in FY21, through FY22.

Goal 4: Implement an integrated systems management structure.

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

Strategy 1A. Mid-Shore Counties Local Systems Integration Workgroup will develop a regional behavioral health systems integration plan.
Performance Measure: The Mid-Shore Counties Local Systems Integration Workgroup, which includes the mid-shore Local Addictions Authorities (LAA), their leadership and invested stakeholders, will meet in support of expanding our provider community, promote access to services, and collaborate on local systems development. Workgroup priorities will concentrate on systems integration on a local and state level and change management. The workgroup will assist with the continued growth of the goal of regional planning and needs assessment, in addition to strengthening the local authority role and presence in our community. The workgroup will review, plan, and disseminate information regarding national, state, regional, and local initiatives. The workgroup will develop a regional integration plan for a regional Local Behavioral Health Authority.
Performance Target: MSPC will organize and facilitate Local System Integration Workgroup meetings. MSPC will develop a formalized timeline for mid-shore counties LBHA development. MSPC will delineate essential elements necessary for regional integration and present these to BHA, MDH, and local governing bodies. In FY2022, the workgroup will work to execute the established timeline developed in FY2021.

Strategy 1B. MSPC will prepare for an integrated behavioral health regional needs assessment.
Performance Measure: Collaborate with systems management partners to strategize and plan for a regional behavioral health needs assessment. Research best practices for an integrated needs assessment that would support a rural model of systems management and behavioral health services delivery. Review and analyze all available mid-shore needs assessments and strategic plans to establish priorities and develop goals, objectives, and strategies to address disparities in the PBHS. Attention to impacts of COVID-19 with increased need for behavioral health services.
Performance Target: Organize and strategize for the implementation of regional needs assessment and gap analysis to be initiated by the conclusion of FY2023.

Strategy 1C. MSPC will develop a Mission and Vision Statement that is representative of the integrated collaboration as behavioral health systems managers serving the mid-shore.
Performance Measure: MSPC will prioritize working to develop a Mission and Vision statement during the remainder of FY21 and throughout as MSPC works to refine the integrated structure and plan for enhanced collaboration. MSPC will embrace the plans and needs of the region as well as the collective impact that MSP intends to have on the wellness and health of the mid-shore community.

Performance Target: MSPC will have a Mission and Vision statement by the end of FY22 that is representative of our integrated collaborative model in the mid-shore.

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

Strategy 2A. Maintain a Regional Behavioral Health Advisory Committee (RBHAC) and engage the committee in strategic planning to formalize an integrated structure.
Performance Measure: MSPC will engage committee by way of providing pertinent information regarding local systems management, state, and local integration initiatives, and soliciting committee feedback and guidance.
Performance Target: RBHAC members will participate on Integration Workgroup and encourage participation on all advisory groups (ex. county LDAAC's), during FY2022.

Strategy 2B. MSPC will serve and lead the mid-shore region's Local Drug and Alcohol Abuse Councils, Substance Use Committees, and related community initiatives.
Performance Measure: MSPC will be represented on each mid-shore Local Drug and Alcohol Abuse Councils (LDAAC), mid-shore counties Opioid Intervention Teams (OIT), Overdose Fatality Review Boards and Regional Opioid Task Force with Shore Regional Hospital. MSBH will maintain responsibility of administrative and leadership duties for Drug Free Caroline (the Caroline County LDAAC).
Performance Target: MSPC will be represented at 100% of the LDAAC meetings in each mid-shore county over the course of FY2022. MSBH will be responsible for the 100% of the Drug Free Caroline meetings in terms of organization, planning, and leadership.

Strategy 2C. MSPC will participate/facilitate Maryland's Local Advisory Council Subcommittee on the assessment of the local advisory councils.
Performance Measure: MSPC will support the coordination of state-wide stakeholders to collaborate to address the legislative, Statute, and local governing expectations of local advisory council responsibilities, membership, and impact. Stakeholders will be represented from local authorities, BHA, Maryland's General Assembly, OOCC leadership, Behavioral Health Advisory Council, and MDH.
Performance Target: To assess and develop guiding principles in preparation for recommendation for integrated advisory council language in calendar year 2022 legislative session related to integration of local advisory committees and councils.

Strategy 2D. MSBH will maintain an integrated, diverse, and regional regionally represented Board of Directors.
Performance Measure: MSBH Board members will include leadership from all counties representing integrated services, law enforcement, healthcare, local hospital, fiscal, school

based, quality, legal, peer leadership and providers represented. MSBH prioritizes that the Board of Directors be representative of the community and representative of diverse groups.
Performance Target: 100% compliance with our board composition as defined in the MSBH Bylaws and full Board membership.

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

Strategy 3A. Develop foundation model of integrated funding in support of systems management integration planning.
Performance Measure: MSPC will evaluate the current funding pattern and structure of each local authority, to assess preparedness for an integrated model. MSBH will identify priority funding that requires additional support from our state leaders to guide an integrated funding model development. MSPC will work collaboratively with our local systems management leaders to render support and data to support the fiscal plan to endorse local integration.
Performance Target: MSPC will work over the course of FY2022 to inform agency program and fiscal leadership of budgetary responsibilities currently managed in a non-integrate structure. MSPC will evaluate procurement procedures in preparation for blended funding. MSPC will evaluate capacity to integrate funding. MSPC will work with system management partners to draft a budget management model that will support enhanced fiscal management of integrated funding streams.

Strategy 3B. MSPC will implement a Regional Behavioral Health Annual Plan.
Performance Measure: MSPC will continue to collaborate across agencies to implement the integrated systems annual plan. MSPC will inform local stakeholder groups to include mid-shore LDAACs, RBHAC, and The Peoples Roundtable to foster representation of all stakeholders of the plan implementation process.
Performance Target: FY2022 Behavioral Health Annual Plan, collaborate with MSPC partners to monitor annual plan strategy implementation, and track progress. Promote accountability to stakeholder and governing groups with plan implementation progress reporting.

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

Strategy 4A. MSPC will plan for the integration of program planning, contract management, and reporting.
Performance Measure: MSPC will work to manualize current practices for contract management and reporting to support agency structure and preparation for an integrated model of systems management. MSPC will evaluate current contract oversight procedures and determine what agency needs would be a priority for expanded systems management and contract management.

Performance Target: MSPC will solicit the support and technical assistance of our local and state leadership with the development of a formalized procedure for the operational oversight of integrated funds, programming, and contracts. MSPC will engage leadership to partner in planning for an integrated contracted management process and reporting requirements.

Strategy 4B. MSPC will work to formalize contract monitoring practices to support an integrated model of quality oversight.
Performance Measure: MSPC will work to streamline and support the expansion of contract management as we work towards an integrated model of systems management. MSPC will create a contract management manual following the annual timeline of practices that include pre-contracting, revision of scopes of services, provider/sub vendor education and collaboration, quarterly reporting locally and state level, data collection and analysis, site visits, and reporting.
Performance Target: By the conclusion of FY2022, MSPC will pilot using uniformed process and documentation.

Strategy 4C. MSPC will manage and utilize behavioral health data which is representative of the mid-shore region.
Performance Measure: Monitor and evaluate the performance of local PBHS and MSBH Programs data. Utilize data-driven decision making to improve quality, efficiency, and outcomes of behavioral health services within the PBHS.
Performance Target: In FY2022, MSPC will continue to evaluate integrated data that reflects the mid-shore region with local system management partners to support enhanced planning, program development, and funding needs for the region.

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

Strategy 4E. MSPC will support quality assurance practices with accreditation, licensure, and compliance expectations on a state and local level, and will support integrated systems collaboration.
Performance Measure: MSPC will monitor quality practices with our behavioral health provider groups; observe and adhere to the expectations of accreditation maintenance; comply with licensure expectations and regulation; communicate expectations from the state and accrediting bodies. MSPC will partner with BHA to support compliance with quality regulations and Agreement to Cooperate expectations.
Performance Target: MSPC will support mid-shore behavioral health providers with quality practices, correspondence with state and accrediting bodies, assistance, and assurance of compliance with accrediting bodies, and collaborate with LAA partners with any provider that is co-occurring capable and providing services.

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

Strategy 4G. MSPC will develop an integrated Mid-Shore Counties Behavioral Health Emergency Response Plan that comprises a regional approach.
Performance Measure: MSPC Integration Workgroup will develop a mid-shore region BH Emergency Response plan.
Performance Target: MSPC will develop a regional behavioral health emergency plan representative of cross-county and regional infrastructure response. Require that all sub vendors provide copies of their Emergency Preparedness documents/policies as a part of contracting for FY2022. MSPC will collaborate with all mid-shore Emergency Operations Mangers to validate the behavioral health response plan needs in each county. MSPC will strive to provide Emergency Preparedness training to provider network in FY2022 to present the Behavioral Health Emergency Response Plan (ex. Provider closure).

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

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

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

Performance Measure: Continue and build new partnerships to engage residents to explore behavioral health career opportunities. Work with local higher education institutions to engage students in internship opportunities throughout the region.

Performance Target: Promote at least three career expansion opportunities and identify five local providers to participate in internship opportunities.

Strategy 1B. MSPC will work closely with our legislative partners to promote initiatives that support Behavioral Health workforce expansion.

Performance Measure: Promote federal, state, and local opportunities for higher education loan repayment and other incentives to work in mid-shore region. Participate in the regional Behavioral Health Coalition's legislative efforts with regards to professional licensure and paneling.

Performance Target: Participate in legislative events that highlight the workforce expansion.

Strategy 1C. In partnership with the Eastern Shore Behavioral Health Coalition, MSPC will continue to advocate for a streamlined credentialing process for licensed clinicians.

Performance Measure: Partner with local outpatient mental health clinics to identify specific challenges that providers face with professional credentialing. Support legislation that addresses barriers to credentialing.

Performance Target: Facilitate ongoing discussions with local providers and legislator to discuss barriers to provider credentialing and cultivate potential solutions.

Strategy 1D. Support and advocate for the utilization and access needs to expand telehealth, tele-psychiatry, and virtual behavioral health delivery of services infrastructure in the mid-shore region.

Performance Measure: Advocate for continued expansion and permanency of the current tele health regulations and established infrastructure in the mid-shore region, with a focus on delivery of services to by way of telehealth to underserved populations and addressing disparities and stigma in behavioral health.

Performance Target: Monitor and survey the utilization of telehealth as a delivery of service for our mid-shore provider network. Support legislative and regulatory permissions for the expansion of telehealth services. Routinely solicit provider and consumer need for telehealth equipment.

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

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

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

Objective 2: Enhance and sustain our current community workforce.

Strategy 2A. Contract with local provider to offer Crisis Intervention Team (CIT) training and certification opportunities to the mid-shore region.
Performance Measure: Support the collaboration and partnership between law enforcement, emergency first responders, correctional facilities, Mobile Crisis Teams, local Emergency Departments, and acute inpatient psychiatric units to effectively respond to behavioral health crisis in the community. Through these partnerships, offer behavioral health and other community supports to enhance diversion wherever possible. Advocate for the availability of supports and resources that address the behavioral health needs of law enforcement and emergency first responders. Participation in quarterly Crisis Advisory Subcommittee and Maryland Mental Health and Criminal Justice Partnership Crisis Intervention Teams Subcommittee.
Performance Target: The provider will host a minimum of four CIT trainings in FY2022. Increase stakeholder engagement by three new partner contacts that could support additional training and collaboration on a state-level.

Strategy 2B. Support the current behavioral health workforce through continuing education and relevant training opportunities.
Performance Measure: Serve as an approved sponsor of the Maryland Board of Social Work Examiners for continuing education credits for licensed social workers. Pursue and provide training opportunities to address workforce training needs.
Performance Target: Provide a minimum of 25 CEUs and 3 sponsored community training opportunities to the mid-shore workforce during FY2022.

Strategy 2C. Support the American Society of Addiction Medicine (ASAM) and DSM-5 training on the mid-shore for clinical staff.
Performance Measure: 20 clinicians receive ASAM and DSM-5 training from the mid-shore providers.
Performance Target: Promote at a minimum two trainings on ASAM and DSM-5 to providers in the mid-shore region in FY2022.

Strategy 2D. Support required Peer Recovery Support Specialist training in the mid-shore for recovering individuals seeking to become Certified Peer Support Specialists.
Performance Measure: 20 individuals receiving Peer Recovery Support Specialist training from the mid-shore.
Performance Target: Promote two required trainings for Peer Recovery Support certification.

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

COVER PAGE

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

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

****Known as Mid Shore Planning Collaborative (MSPC).**

(a) **Address:** see above

(b) **Region:** Caroline, Dorchester, Kent, Queen Anne's and Talbot counties

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

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

(e) **and (f) Agency/organization mission and vision statement:**
As a group of six distinct agencies, we are dedicated to local systems management integration; referencing the FY2022 Integration Goal 4, we plan to develop both a mission and vision statement for the Mid Shore Planning Collaborative.

PART 1: CLAS SELF-ASSESSMENT:

See FY2022 Community Behavioral Health Plan Appendices.

PART 2: OVERARCHING GOALS AND SELECTED STANDARDS FOR PRIORITY FOCUS

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES
Standard 15 *- We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.*
Strategies to build competency: Continue to facilitate and host the regional Diversity and Inclusion Workgroup. Being intentional to share CLC strategies and tools with community stakeholders, constituents, and the general public.
Performance Measures: Quarterly CLC Leadership group meetings, sign in sheets, agenda items, track through CLC related newsletter articles and website/social media post engagement.
Intended impact: To improve the level of Cultural and Linguistic Competency services provided to consumers throughout the region. Encourage participation of consumers in the CLC Workgroup.
GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS BEHAVIORAL HEALTH SERVICES
Standard 6 *- We inform all individuals of the availability of verbal, signing and written professional language assistance services in their preferred language or form of communication.*
Strategies to build competency: Signage/posters at each facility, that reference availability of language assistance for clients and community. Review language assistance policy and resources with all staff at each agency (LAA/CSA). Review use of the Language Link and other Translation/Interpreting services. Be intentional in acknowledging the efforts and improvements by providers, throughout the year.
Performance Measures: Data and relevant information from Providers, during quarterly BHSN meeting, LDAAC, county provider and respective LAA meetings.
Intended impact: To reduce stigma of accessing mental health and substance use treatment across all populations. Increase access of CLC services to behavioral health consumers and for the community at large. To prevent communication barriers to individuals accessing services, who have limited English proficiency.

GOAL 3: CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES
Standard 12 *- We conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of the community we serve.*
Strategies to build competency: Continue to work with identified community health assets, through the CLC Strategic Plan. Conduct the Diversity and Inclusion Workgroup meetings, using the Blueprint Worksheets (see Performance Measure).
Performance Measures: Referencing A Blueprint for Using Data to Reduce Disparities/Disproportionalities in Human Services and Behavioral Health Care (Dr. Karen Francis et al). Use data analysis of Blueprint Worksheets received by community Providers/Workgroup participants.
Intended impact: Strengthened partnerships within the Diversity and Inclusion Workgroup, engagement of workgroup members from various cultures. Increase awareness of the disproportionalities within disadvantaged populations in the mid-shore.

GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS IN MARYLAND'S PUBLIC BEHAVIORAL HEALTH SYSTEM
Standard 13 *- We partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.*
Strategies to build competency: Meetings with partners outside of the behavioral health field. Observance of monthly awareness themes (ex. Recovery/Purple, Domestic Violence, Minority Health Awareness, Hispanic Heritage). Attend and contribute to the BHA CLC Committee meetings and trainings, sharing information with Diversity and Inclusion Workgroup participants. Connect with local school system and community college diversity committees.
Performance Measures: Review the event attendance and populations within the community who were involved (ex. Hispanic, deaf, LGBT+). MSPC will survey the targeted population for acceptance and promotion of the awareness events.
Intended impact: Stakeholders outside of the behavioral health realm are knowledgeable of CLC appropriate services and seek to implement CLAS Standards in their respective agencies.

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

Caroline County: All Hazards Plan

CCC will utilize our Emergency Preparedness Plan for our local Jurisdiction. We will coordinate with other nearby jurisdictions when an emergency arises to fill any gap services necessary. The need for substance-related disorders has exploded with the opioid epidemic. As a whole, the mid-shore regional Public Behavioral Health System needs to improve access to both mental health and substance-related disorders treatment across the spectrum. The integrated Eastern Shore Crisis Response System is growing exponentially, particularly with the continuous training of CIT officers. Both the helpline call center and the mobile crisis teams urgently need increased capacity to meet current needs. During a disaster, these services would need to expanded quickly and efficiently.

Outpatient services access needs to improve for MH and SUD. In Caroline County where the health department is the largest single provider, and there has been limited provider expansion, there is no program to enter into with a MOU as due to lack of staffing and space capability currently at these alternative program locations. A list of key staff contacts to be reached in case of emergency is included in the document (see appendix I). CCBH also supports the Emergency Preparedness plan for the Mid-shore and will work collaboratively with MSBH. See collaborative All Hazards Plan beginning on the following pages.

Unfortunately, we have added a new risk to our all Hazards Plan regarding the nuclear threat from North Korea. If there were to be a nuclear missile air burst the nuclear fallout area is a one-thousand-mile radius, excluding wind drift factors. If there were to be a nuclear missile land strike the nuclear fallout area is a one-hundred-mile radius, excluding wind drift factors. Either of these disasters would include our jurisdiction should an attack on our Nation's Capital ever become a reality. The All Hazards Plan can be viewed in the following pages.

MID SHORE BEHAVIORAL HEALTH, INC.
MENTAL HEALTH and SUBSTANCE USE DISASTER PLAN

I. PURPOSE:

Mid Shore Behavioral Health, Inc. (MSBH), the local behavioral health authority for Caroline, Dorchester, Kent, Queen Anne's and Talbot counties, is responsible for planning, monitoring, evaluating, and funding all public behavioral health services in the Mid Shore region. It is the lead agency for mobilization, coordination, and delivery of disaster behavioral health services during an emergency.

The purpose of this plan is to establish a comprehensive, integrated and coordinated behavioral health plan to respond to environmental and man-made disasters in the Mid Shore region. It aims to minimize the adverse effects of stressful situations and/ or traumatic events affecting citizens in the workplace and community. The plan enables MSBH to maximize the use of personnel, facilities, and other resources in providing behavioral health assistance to disaster victims, emergency response personnel, and the community at large.

The disaster plan includes provisions for the services MSBH will deliver, coordinate and/or procure, as well as when, how, and by whom these services will be provided. Backup MSBH staff

and community resources are also a part of the plan, in the event the first behavioral health responders are not available or are immobilized by the disaster.

This plan was developed by MSBH in cooperation with the Support Agencies that would assist should the plan need to be implemented.

II. SITUATION

The Mid Shore region of the Eastern Shore of Maryland is comprised of five counties, three of which share a border with the state of Delaware. The area is primarily rural in character. Tourism, farming, and small businesses drive much of the economic climate. Major business centers are the towns of Chestertown, Centreville, Easton, Denton, and Cambridge.

There are four hospitals/emergency rooms in the area, with two counties having no hospital facilities. Choptank Community Health Systems, Inc., a federally funded agency providing services for underserved areas, has eight federally qualified health centers in three of the five counties.

Based on the 2015 County census estimates, the population covered by Mid Shore Behavioral Health is 171,176. The area has a higher than Maryland average of citizens over the age of 65, in three of the five counties near or above 20%. The area also has a higher rate of those living below poverty level – near or above 13% in three counties.

As in most rural areas, the primary hazards in the Mid-Shore area are major fires, flooding, hazardous material incidents, severe winter weather, power failures, essential resource shortages, and transportation accidents. Located midway on the Delmarva Peninsula between the Chesapeake Bay and the Atlantic Ocean, hurricanes are also of great concern to this area. Routes 404, 50, and 301 are major highways traveling through the area, all part of hurricane evacuation routes.

Toxic Release Inventory facilities are located in Caroline County in Federalsburg and Denton. Most of the area is also included within the 50-mile plume area of the Calvert Cliffs Nuclear Plant, with parts of Dorchester County being part of the initial response. In today's environment, there is also a real threat of the terrorist use of biological agents in addition to the "usual" disasters of weather, transportation incidents, radiological, and hazardous materials.

The area is, of course, subject to the kinds of wide-spread or localized Public Health emergencies that can occur anywhere, such as epidemics or other outbreaks. Large area gatherings include the Waterfowl Festival, Chesapeake Balloon Festival, and the Chestertown Tea Party.

III. ASSUMPTIONS

- The Mid Shore area is subject to a naturally occurring infectious disease emergency or a covert terrorist attack (BT event), as well as natural disasters, which may cause injuries to a considerable number of people, produce physical and/or biological health hazards throughout the affected area, and create a widespread need for behavioral health care. Special behavioral health

needs can emerge that include the “worried well”. It has been estimated that in a terrorist attack, the "worried well" may outnumber the injured by as much as 20 to 1.

- Mid Shore Behavioral Health (MSBH) will assume primary oversight responsibility for disaster behavioral health services in the five-county area for which it is responsible and will assist local health departments in coordinating a regional response to meet the behavioral health needs.

- Disaster behavioral health response will be coordinated through each county’s Emergency Operations Centers (EOC).

- There may not be an adequate number of behavioral health personnel available to support the response.

- All partnering agencies are responsible for the development of agency-specific standard operating procedures that dictate their roles and responsibilities in responding to the behavioral health needs of the community, including their own staff, during an emergency.

- Response to a health emergency may be exclusively dependent upon local/regional resources for the first 24 to 72 hours.

IV. LEGAL AUTHORITIES

MSBH is a local Core Service Agency (CSA), under contract with the Behavioral Health Administration (BHA), Department of Health and Mental Hygiene Administration (DHMH).

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707, requires that states plan for the provision of disaster behavioral health services. It authorizes financial assistance for state/local agencies or private organizations to provide crisis counseling, outreach, education, referrals, and other short-term interventions to survivors of major disasters. Section 416 of this act specifically addresses the behavioral health function.

Legal authority of Maryland Department of Health and Mental Hygiene concerning disasters derives from Maryland Health General Articles 18-901 to 18-908. Disaster Mental Health is particularly referenced in Maryland Policy 1043(SYS) 08-1, Disaster and Terrorism Preparedness. The Maryland Department of Health and Mental Hygiene (DHMH), state hospitals and training centers, and mental/behavioral health authorities are expected to do the following: respond and coordinate with other state agencies to provide crisis-counseling programs and other mental health response initiatives, prepare grants to secure federal emergency response funding, and ensure the provision of accurate, timely, and instructive information to the public during a disaster. These responsibilities will be fulfilled in accordance with § 416 of the Stafford Act.

The extent and limits of emergency authority of the Governor and the Secretary of Health and Mental Hygiene are defined in Senate Bill 234, Catastrophic Health Emergencies. Where necessary, support agencies listed in this plan will sign a Memorandum of Understanding with MSBH to define the coordination of mental health services within the five-county area in the event

of a health emergency. Each support agency will be responsible for the tracking and reporting of resources and other financial records related to the health emergency.

V. PARTNERS

Supporting Agencies and Organizations

MD Responds: Maryland Medical and Public Health Volunteer Corps (MVC)
Working under the Office of Preparedness and Response (OP&R) in the Maryland Department of Health and Mental Hygiene (DHMH), the Maryland Volunteer Corps consists of health care and community professionals ready to assist with disaster and emergency recovery during an emergency situation. The MVC is a Medical Reserve Corps (MRC) administered by the Department of Health and Mental Hygiene. The MRC program coordinates the skills of practicing and retired physicians, nurses, other health professionals, and citizens who are eager to address their community's ongoing public health needs and to help during large-scale emergency situations. A MVC registrant is provided with liability protection and has the option of choosing where he or she wishes to work geographically.

Only the Health Officer in the county where MVC registrants reside has direct access to those names, and request for volunteers through the MVC must be conducted through the local Health Department. Furthermore, MVC registrants can only be activated as MVC members (and thus covered by state-provided liability protection) by the DHMH Office of Preparedness and Response. They can, of course, have individual or employer-based liability coverage.

Mid Shore Behavioral Health recruit volunteers who are urged to register with the MVC. Those working specifically with County Health Departments serve as a local all-hazards resource, augmenting and supporting the existing local public health system. Many of these volunteers are being trained in Psychological First Aid and/or Mental Health First Aid to support the community's behavioral health needs, as well as self-care training to help them maintain their own psychological well-being.

Maryland Department of Health and Mental Hygiene
The Maryland Department of Health and Mental Hygiene (DHMH) includes the state system for public behavioral health (including mental health and substance use) and intellectual disabilities. During an emergency, DHMH will address the associated public health ramifications, including the continuity of public health functions and the delivery of public health services, and act as the overall lead agency for Emergency Support Function 8 Health and Medical Services. In this capacity, DHMH will coordinate the provision of emergency response (e.g., pre-hospital, hospital, and other) at the state level. DHMH may engage in the roles and responsibilities associated with the Four Phases of Emergency Management (mitigation, preparedness, response and recovery).

All public health related requests are generated at the local level first. If the local health department cannot fill the request, it is then forwarded to the Local Emergency Management Agency Emergency Support Function 8 (Health). In the event the local EMA cannot locate or does not have access to the resources needed, then the request is forwarded to the state EOC or the state

Department of Health and Mental Hygiene EOC or the DHMH Office of Preparedness and Response, depending on the level of state-wide activation

American Red Cross, Delmarva

The American Red Cross (ARC) helps people prevent, prepare for, and respond to emergencies. All Red Cross DMH personnel are licensed mental health professionals. Acceptable licensures include: 1) School Counselor; 2) School Psychologist; 3) National Certified School Psychologist; 4) Licensed School Psychologist; 5) Licensed Clinical Psychologist; 6) Licensed Professional Counselor; 7) Marriage and Family Therapist; 8) Licensed Substance Abuse Treatment Practitioner (not Substance Abuse Counselor); 9) Licensed Clinical Social Worker (not Licensed Social Worker); 10) Registered Nurse, Clinical Nurse Specialist or Nurse Practitioner with psychiatric nursing experience and training beyond the normal RN rotation; 11) Doctor of Medicine or Doctor of Osteopathic Medicine specializing in psychiatry. In addition to licensure, Red Cross DMH volunteers must pass a background screening process and complete two training courses: Foundations of Disaster Mental Health and Disaster Services: An Overview. DMH volunteers are encouraged to take additional Red Cross disaster training. The Delmarva Regional Office, as a part of the National disaster system of the American Red Cross, facilitates resource sharing throughout the region to increase disaster response capabilities.

Other Resources

Mobile Crisis Teams (MCT)

Four regional Mobile Crisis Teams (MCT) cover eight (8) counties of the Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot and Wicomico. Mobile Crisis Team members intervene with callers referred from the Eastern Shore Operations Center who are experiencing a behavioral health emergency. Mobile Crisis Teams assist law enforcement and emergency responders, providing behavioral health crisis consultation and intervention to stabilize the consumer in the least restrictive environment through a range of services including assessment, crisis intervention, supportive counseling, information and referrals, linkage with appropriate community based behavioral health services for ongoing treatment, and follow up.

Critical Incident Stress Management (CISM) Teams

Local CISM Teams are coordinated through local Emergency Services and Fire Departments. Caroline, Dorchester, and Talbot County EMS have a Tri-County CISM team. Kent and Queen Anne's County Rescue Squad through the fire departments also have a CISM team. CISM teams are dispatched through the EOC.

U.S. Public Health Service Commissioned Corps Behavioral Health Team

The Behavioral Health Team (BHT) consists of mental health and substance use experts who assess behavioral health risks within the affected population, manage responder stress, and provide therapy, counseling, and crisis intervention. The BHT may be requested through the State EOC and can deploy within 36 hours of notification.

DHMH Office of Preparedness and Response (OP&R) website

The OP&R website (http://preparedness.dhmh.state.md.us) lists information and web hyperlinks for resources to help address the needs of those family or community members experiencing crisis due to an emergency event. In the event of an actual public health and/or medical emergency or

other traumatic event, information regarding behavioral health teams and how to contact such personnel will be made available both on the DHMH OP&R web site and via media outlets.

Faith Based Organizations
Members of a number of faith-based organizations in the Region have received specialized training in self-care and "psychological first aid" for others. They are best utilized as a resource when faith-based support is sought.

Citizens Emergency Response Team (CERT)
A part of the Talbot County Citizen Corps under the auspices Talbot County Emergency Management, these volunteers have had at least 20 hours of specialized emergency-related training, and some have been organized into town-based teams. Their particular emphasis is on community outreach and preparation and mitigation.

Local Behavioral Health Provider Network
MSBH maintains an accurate and up-to-date resource guide of behavioral health providers and partners with the regions. Providers are licensed and regulated by the Office of Health Care Quality ensuring professional licensure and required training standards are met.

County Schools Critical Incident Response Teams
Some County School Systems have a Critical Incident Response Team (CIRTs) activated when incidents occur in the school system. These teams are a potential behavioral health resource, especially within the school system, during disasters.

Behavioral Health Response Team at University of Maryland Shore Regional Health
The Behavioral Health Response Team is a group of licensed mental health professionals at UM Shore Medical Centers at Chestertown, Dorchester and Easton with educational backgrounds in nursing, psychology, and social work. Their job is to perform mental health and substance abuse evaluations and referrals to consumers in our hospitals, 24 hours a day, seven days a week. This includes emergency room assessments, medical floor consultations, debriefing medical staff, crisis counseling, and bereavement counseling. In addition, the team answers calls from individuals in the community about emergency services and outpatient and inpatient resources.

Hotlines

Eastern Shore Operations Center (ESOC), 1-888-407-8018
Serves as the behavioral health emergent, urgent, and information and referral call center for all nine counties of the Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties. The ESOC is available 24 hours a day, 7 days a week to assess and respond to calls from consumers, family members, community members, businesses, and human services agencies. ESOC staff provides linkage to community resources through referral to all appropriate and existing behavioral health and human services.

Maryland Crisis Hotline, 1-800-422-0009

Provides counseling for victims of domestic violence or sexual assault, suicide prevention, support groups, emergency shelter, shelter referral, medical care, and assistance with the process of prosecution. The Life Crisis Center answers 2-1-1 calls made from all nine counties on the Eastern Shore.

Maryland Life Crisis Center - 211
Administered by Life Crisis Center and sponsored by the Maryland Department of Social Services, this statewide hotline network provides residents with suicide prevention, crisis intervention, emotional support, and information and referrals for health and human services on Maryland's Eastern Shore. The network is available 24/7 and can be accessed from within or outside Maryland. The Maryland Crisis Hotline and Life Crisis Center will merge in FY19 and the 211 number will be provided although the

Mid-Shore Council on Family Violence, 1-800-927-4673
Providers direct services for victims of family violence including a 24 hour hotline, crisis intervention, counseling, support groups, emergency shelter, client advocacy, children's program, court accompaniment, information, and referral.

VI. OPERATIONS

Federal, state and local governments recognize there is a role for local behavioral health authorities in disaster planning and response. Each county within MSBH's jurisdiction will have their own specific Emergency Operation Plans (EOP). MSBH will work with each county's Health Department to assure they have a departmental EOP that includes behavioral health planning and response, and will maintain a copy of that plan.

These plans will:

- Ensure that appropriate behavioral health services are available for disaster victims, survivors, bystanders, responders and their families, and other community caregivers during response and recovery. Services may include crisis counseling, critical incident stress debriefings, information and referral to other resources, and education about normal, predictable reactions to a disaster experience and how to cope with them. There should be a capacity to provide specialized assistance for those affected by a traumatic event or who become traumatized by cumulative stress related to the disaster experience.
- Provide outreach to identify and serve those in need of behavioral health support.
- Provide needs assessments/information gathering annually to update plan.
- Ensures quality training for the behavioral health community.

The MSBH shall assist the Health Officer in each of the five counties to maintain clear communications with the State Behavioral Health Administration and serve as coordinator to the State Mental Health Emergency and Disaster Preparedness and Response Plan.

Specifically, the MSBH Director will:

- Coordinate the State and County Plans;

- Develop and coordinate with the State and County Critical Incident Stress Management (CISM) team organizations;
- Assure that all levels of behavioral health personnel are trained and ready; and
- Plan for continuing education and practice drills.

In general, MSBH will base its operations on the federal Emergency Support Function (ESF) model. Under such a model, the local Health Department will serve as lead agency for ESF-8 (Public Health and Medical), of which behavioral health is a part. If the local Health Department does not staff the behavioral health function itself, MSBH will function under ESF and will staff the behavioral health function in three possible ways depending on the nature of the situation in the counties it serves. (1) If required, they will provide staff to the local EOC. (2) If Public Health as ESF 8 is not in the EOC, MSBH will co-locate with ESF 8 if required. (3) MSBH will designate a staff liaison for each county. This latter option will also make it easier for the liaison to coordinate with persons serving as liaisons to other jurisdictions. Depending on the type of incident, MSBH may provide support to one or more emergency support functions, including, ESF-5 (Emergency Management), and ESF-6 (Mass Care), among others.

If serving as the behavioral health lead in a county:

- The MSBH Director (or designee) will oversee all requests for behavioral health resources and will be the main point of contact for coordination and delivery of behavioral health services.
- MSBH will be responsible for mobilizing qualified behavioral health personnel and directing a response to the behavioral health needs of residents and response personnel.

For all counties:
- MSBH will coordinate with DHMH and other partnering agencies to ensure that the appropriate level of behavioral health services is available.
- In coordination with local, state, and federal agencies, MSBH will plan for follow-up services to ensure long-term recovery, such as additional community interventions, individual or family counseling, or community education.

Pre-Emergency Period (two phases)

Normal Preparation Phase
Emergency Support Function assigns to Health Departments the responsibility for the provision of behavioral health services. MSBH will develop policies and procedures as necessary to define the behavioral health and special needs services.

Current internal personnel notification rosters, external communication routes with other CSAs, notification rosters of behavioral health agencies, disaster trained behavioral health professionals, and crisis technicians, and standard operating procedures will be maintained. There are also special preparations needed to be addressed for terrorist activities.

Readiness at the community level means having in place not only a preparedness plan that meets pre-determined criteria, but also a workforce that can demonstrate an understanding of preparedness and the behavioral health clinician's role in that plan. MSBH will assure that quality

training is provided for individuals who may work in the disaster behavioral health function. It will be responsible for an annual training needs assessment to identify areas of interest by behavioral health professionals and will work with Local Health Departments to identify natural helpers/community responders. Behavioral health trainings will be annually offered. Both the identification of qualified individuals and the provision of training may be coordinated by the Maryland Professional Volunteer Corps/MD Responds.

MSBH will encourage participation of behavioral health providers in Disaster Behavioral Health education through such topics as the American Red Cross Disaster Health Class, Critical Incident Stress Management training, NOVA training, Mental Health First Aid training, Psychological First Aid training, Bioterrorism Symposia, Incident Command Instruction, Emergency Management drills and classes, and the treatment of trauma. This will be in addition to the training presented by UMBC for the Maryland Disaster Volunteer Corps.

Mid Shore Behavioral Health staff will receive assignments regarding their roles during a disaster and will have the opportunity to attend educational seminars. All staff will receive training in Incident Management, CPR, First Aid, and Mental Health First Aid.

Those agencies receiving funding from MSBH will be responsible for the development of their individual disaster plan, including procedures for evacuation and sheltering in place for residential facilities. MSBH will provide guidance.

Increased Readiness Phase

This phase will begin upon the receipt of a credible prediction of an event that may require the activation of Emergency Operations Centers. Standard Operating Procedures and checklists detailing the disposition of public and private mental health resources will be reviewed, resource listings will be updated and communication will be made with the five health department contacts. Business continuity plans and redundancy communication plans will be addressed.

Emergency Period

The primary goal during the response phase is to ensure that there is an appropriate behavioral health response to the immediate and ongoing needs of affected people in the Mid Shore Counties and response personnel. During this phase, Mental Health First Aid, Psychological First Aid (PFA), and crisis counseling services will be provided as necessary. If it appears that the behavioral health needs precipitated by the incident require a response greater than the capability of local resources, additional resources will be sought first from neighboring jurisdictions and then from the state and/or federal levels.

During this period, it is the responsibility of MSBH to coordinate behavioral health resources not already dedicated to a health department's initial response. This includes mobilization of MSBH staff to man the 1-800 emergency phone number lines, acquiring volunteers from the Maryland Volunteer Corps, and recruiting and assigning behavioral health professionals from the local provider network. Assistance with the special needs populations served by MSBH programs will also be coordinated.

Upon notification of a public health emergency, the Director will initiate the staff call down list and the first shift workers will report to the Mid Shore office. Appropriate information for the disaster will be pulled from the plan and received from the five counties. It will then be copied for those manning the 1-800 regional behavioral health help number. Calls will then be made to the trained behavioral health professionals and crisis technicians and assignments will be made as requested from the five counties through the State DHMH EOP and/or the Maryland Volunteer Corps/MD Responds. Staff will be briefed at the beginning of each shift and changes in planning will be made at that time.

Mid Shore Behavioral Health will either directly do the following or ensure these activities are conducted:

- Serve as the lead for Disaster Mental Health working within ESF-8.
- Assess the behavioral health needs of emergency workers and victims following an emergency, considering both the immediate and cumulative stress resulting from the emergency.
- Coordinate behavioral health activities among response agencies.
- Provide outreach to serve identified behavioral health needs.
- Coordinate behavioral health support for workers and families, as appropriate.
- Provide advice to the community for dealing with the event.
- Coordinate the dissemination of public education on critical incident stress and stress management techniques through the County PIO or a Joint Information Center.
- Arrange for state-licensed medical and behavioral health support personnel, as requested.
- Arrange for counseling and crisis intervention to emergency victims in mass care settings.
- Coordinate increased staffing of telephone hotlines, as necessary, to field incoming calls.
- Assess and communicate the needs of the Department's residential populations.

Immediate and Intermediate Actions

Upon notification of a potential or evolving incident, each Health Department will activate according to its Emergency Operations Plan (EOP). If the incident requires a behavioral health response, the Health Department will notify MSBH who will then activate under guidance from the ESF 8 lead. The MSBH Director (or designee) will oversee all requests to the EOC for behavioral health resources and will be the main point of contact for coordination of behavioral health services during the response.

Health Departments will coordinate with MSBH to identify the nature, scope, and severity of the incident, as well as to conduct a disaster behavioral health needs assessment. Information gathered should include:

- Extent of physical damage and/or other types of impact on individuals and the community
- Location of different types of impact
- Number of individuals likely to have immediate disaster behavioral health needs
- Diverse populations, special needs, priority groups for intervention
- Response sites being set up and services planned by other agencies/organizations
- Assistance expected or requested by other agencies/organizations
- Availability of behavioral health staff and volunteer responders in the impacted areas

- Availability of staff and resources in non-impacted areas

In coordination with the EOC, MSBH will be responsible for determining the settings where behavioral health needs should be addressed. Locations may include:

- Site where the incident occurred
- Locations where impacted individuals are gathering
- Shelters and feeding sites
- Family assistance centers
- Medical settings including points of dispensing (PODs)
- First responder respite sites
- Locations of routine assembly (such as churches and schools)

Community Behavioral Health

Once the appropriate service settings have been identified, MSBH will mobilize and deploy qualified behavioral health personnel to respond to the behavioral health needs of the community. The range of behavioral health services to be provided includes outreach, Mental Health First Aid, Psychological First Aid, triage, assessment, crisis counseling, and referrals. Services will be carried out in accordance with MSBH emergency response plans.

The primary objective of behavioral health interventions immediately following an incident will be to facilitate emotional stabilization. Once an individual has achieved some degree of emotional stability and has the ability to verbalize and process limited information, interventions will aim to alleviate distress and help with problem-solving and recovery.

As required and depending on the scope of the emergency, the Emergency Support Function 8 will activate MMPH volunteers through the state EOC, the DHMH EOC, or directly through the DHMH OP&R to support behavioral health response in the community. These volunteers might be directed to, for example:

- Greet individuals who arrive at PODs, shelters, health care sites, hospitals, feeding sites, first responder respite sites, or other locations, as necessary
- "Float" in these locations to offer assistance, answer questions, and observe individuals for stress or other problems
- Provide MHFA & PFA as necessary and appropriate
- Refer individuals who exhibit extreme signs of distress to the Behavioral Health Supervisor in charge
- Distribute behavioral health information throughout the community (e.g., flyers or brochures)
- Staff a telephone hotline

As requested by the EOC, the Red Cross will mobilize their Disaster Mental Health (DMH) volunteers to support the response. DMH personnel are able to provide interventions such as crisis counseling, MHFA, FA, psychological triage and referral, condolence visits, and psycho-education to responders and the community in accordance with established guidance (see ARC Disaster Mental Health Handbook). Assistance can be provided on scene, by telephone, or through

follow-up interviews. If a shelter is opened, the Red Cross will ensure that a licensed behavioral health professional is on site at all times. If the number of Red Cross DMH personnel is insufficient to support the response, regional resources may be utilized.

In conjunction with their role in Emergency Support Function 8, MSBH will communicate and coordinate with (but have no direct operation authority with) the Talbot County Schools Critical Incident Response Team (CIRT), local professional volunteer organizations, charitable groups, and faith-based teams to provide short and long-term interventions for specific populations as needed.

Communication

Each county has a designated Public Information Officer (PIO) through which information should be relayed to the media. In addition to MSBH, other sources may release information but it is imperative, in order to reduce panic and confusion within the community, that releases be coordinated among the agencies, preferably at the Incident Command Center. MSBH will provide examples of public health information messages regarding behavioral health matters when requested by the PIOs. MSBH will coordinate with the county PIO to disseminate behavioral health information and guidance to affected residents, response personnel, and the general public, including:

- Stress symptom identification
- How to cope with emotional reactions to the incident
- Where and how to access behavioral health services
- Issues related to children, their families, and teachers
- Issues related to special needs
- Dispelling rumors

Radio and television stations, websites, computer aided dispatch, Emergency Alert System cable interrupt, etc., will be utilized by the Local Health Department to disseminate information to the public.

In addition to English, the main languages spoken in the Mid Shore area are Spanish, Creole, Mandarin, and Russian. Notices will be sent to the local Spanish television. A list of staff and persons within the community who speak foreign languages as well as those who know sign language are listed in this section with their contract numbers.

Media briefing will be conducted as necessary at the Incident Command Center with alternate sites at the service provision locations.

If needed, the county has the ability to set up a hotline to answer questions and provide information on local behavioral health services. The county may also rely on hotlines (identified earlier) to provide residents with additional information and referrals for behavioral health services in the area.

The Executive Director is the Public Information Officer for MSBH, with the Deputy Director the secondary PIO.

Death Notification

Health Department and MSBH staff/volunteers typically do not deliver information regarding deaths, but they may participate on teams that accompany the person responsible for this notification. Behavioral health responders may provide support to the family receiving the news and, at times, to those persons conducting the notifications. In some cases, MSBH staff/volunteers may be able to provide information on specific cultural or ethnic customs regarding the expression of grief and rituals surrounding death and burial.

Responder Behavioral Health

Personal stress management is a key mechanism in preserving responders' abilities to perform and function effectively. During an incident, response personnel will be encouraged to self-monitor for symptoms of stress and fatigue using a self-monitoring checklist and to take actions to maintain their psychological well-being. Supervisors should be attentive to stress responses among their staff.

As described above, Critical Incident Stress Management (CISM) teams and/or the Mobile Crisis Teams (MCT) may be activated to provide support to responders, including post-incident stress defusing, demobilization, and debriefing, to first responder units (e.g., Fire, EMS, Police). Health Department personnel who are involved in response or who are affected by the incident may also receive behavioral health support from these teams. The Maryland Department of Health and Mental Hygiene will activate CISM members, if needed, in response to notification from Fire/Police dispatch or at the request of the EOC.

MSBH and MPVC volunteers who need behavioral health support will be encouraged to access the behavioral health services and resources available to the wider community. Formal psychological debriefing (or the use of techniques that include trauma remembrance) will not be part of the standard behavioral health response.

Red Cross DMH personnel will provide behavioral health exit interviews to Red Cross relief workers during their out-processing.

On-Site Incidents

A number of possible incidents (e.g., natural disaster, fire, explosion, workplace violence, threats, and medical emergencies) may occur at Health Department or other agency locations and many of these incidents have the potential to raise levels of stress and anxiety among staff, volunteers, and clients. MSBH may provide behavioral health guidance for on-site incidents.

Special Needs Populations

The following are potentially vulnerable populations that may require additional support:

- Age groups (children and seniors)
- Cultural and ethnic groups (recent immigrants, non-English speakers, undocumented residents, etc.)
- Low-visibility groups (homeless, unemployed, cognitively impaired, etc.)
- Individuals with persistent mental illness or substance abuse disorders

- Group residential facilities (hospitals, nursing homes, and correctional facilities)
- Human service, healthcare, and disaster relief workers

Hospitals, nursing homes, group homes, ambulatory care centers, schools, religious centers, and other facilities that provide behavioral health care to special needs populations may be damaged or destroyed, or may be overwhelmed in dealing with the response to the incident. These facilities are expected to maintain plans to ensure continuity of behavioral health services for the populations they serve.

Continuity of Operations

In addition to meeting behavioral health and broader public health needs that may emerge in the community following a disaster, Mid Shore Behavioral Health must ensure that its essential other services are maintained. MSBH has a Continuity of Operations Plan (COOP) that addresses these issues, whether a disaster or emergency impacts their agency directly or impacts the services it can provide. The COOP prioritizes services provided by the agency and describes processes for maintaining their critical functions during an incident, including prioritizing the services it supports with other agencies.

Post-Emergency Period (Recovery)

Priorities during this period will be focused on continuing to provide essential behavioral health care and aid in the restoration of the area's behavioral health care delivery capacity. Disaster behavioral health services may need to continue beyond the immediate and intermediate phases of the response for weeks, months, and even years, depending on the nature of the incident. MSBH will continue to act in a coordinating role with behavioral health, private sector, and other government and partnering agencies when addressing the long-term needs of the community.

The methods utilized will depend on the incident; however, recovery actions should include:

- Ensuring that normal functions are restored as quickly as possible to provide needed services to the community.
- Providing extensive and continued public education regarding the behavioral health impact/risks of the event and the community resources available to help individuals cope.
- Continuing to support the staffing of family assistance centers (if established) so that behavioral health professionals may provide ongoing counseling to residents and response personnel.
- Supporting ongoing hotline staffing to provide support and appropriate referrals.
- Renewing outreach and resilience efforts that were in place prior to the incident.
- Assisting, if needed, in community memorial and commemoration activities.
- Evaluating the disaster response and developing recommendations to improve planning, response, and recovery.

If it is a nationally declared emergency, MSBH will assist with the application process for federal assistance and will be involved locally with the administration of the FEMA funded disaster crisis counseling and training grants and/or monitoring the grant programs and financial expenditures as well as preparing the mandated reports for the federal government will be implemented.

Reporting
In addition to reports that may be required by DHMH, MSBH will coordinate to provide regular behavioral health situation reports to the EOC during the incident.

Operational Records
The operational records generated during a behavioral health response will be collected and filed in an orderly manner by ESF-8. A record of events is kept in order to determine the possible recovery of emergency operation expenses, to document response costs, to assess the effectiveness of operations, and to update emergency plans and procedures. Administrative records will be kept in accordance with established practices.

Clinical Records
Clinical records will not be created or maintained for individuals receiving mental health first aid, psychological first aid, crisis counseling, etc. during the response. Instead, MSBH will track individual and group encounters using SAMHSA-developed data collection tools. The full manual and toolkit is available at http://www.samhsa.gov/dtac.

Documentation of Costs
Response costs and expenditures will be documented in accordance with established practices and forwarded to the appropriate ESF Group Supervisor during the incident. Expenses incurred in carrying out behavioral health services for certain hazards may be recoverable through FEMA or a third party. Hence, all agencies should maintain records and/or substantiating documentation of personnel time expended, equipment used, and supplies consumed during the response.

Grant Funding
In the event of a presidentially declared disaster, federal funding may be available for crisis counseling and education through the FEMA Crisis Counseling Assistance and Training Program (CCP). SAMHSA Emergency Response Grant (SERG) funds may also be available and do not require a presidential disaster declaration. MSBH, in concert with the Office of Emergency Management, will be responsible for coordinating any documentation required by the State to receive grant funds.

Caroline County Behavioral Health will refer patients to alternative programs for medication stabilization in the event of a disaster or emergency. We are fortunate to have alternative programs in the mid-shore region who are licensed as MAT providers. We have also discussed alternative pharmacy strategies with big-box chain store pharmacies in our area. The Wal-Mart Pharmacy especially has had multiple experiences meeting the needs of consumers after disaster riddled communities were devastated by forces of nature or mankind. Caroline County Behavioral Health will enter into memorandums of understanding (MOU) with neighboring providers to ensure continuum of care for our consumers and community members. We will also assist neighboring communities with any services in the event of an emergency or disaster in neighboring jurisdictions.

Caroline County ORG STRUCTURE FY22 Program Plan

Caroline County experienced a significant health officer transition this past year during the COVID-19 pandemic. Starting in December 2020, Laura Patrick was named the new Health Officer for Caroline County. Since she has been in her new position, Caroline has been largely focused on COVID testing and vaccinations for Caroline County residents during the pandemic. For Caroline Behavioral Health, staffing has largely remained stable and has even grown with the introduction of expanded services. This past year we have added an additional therapist to our School-based Mental Health program to serve Denton Elementary students. We currently have full-time Mental Health clinicians in 4 of our jurisdiction's schools and caseloads continue to grow. We will continue to add additional clinicians as necessary to support the needs of the children in Caroline County. We have added a full time SUD Counselor to the team of the Mobile Treatment Unit to provide SUD counseling to the clients of the MTU when they come for their Physician visits, which now makes it a one-stop shop in providing evidenced based mobile treatment for opioid use disorders. In FY22 we will be hiring a clinician who can provide treatment to dually diagnosed clients, thereby increasing our staffing in this area to 2 clinicians—one in the school-based program and one in our adult clinic. Caroline County Behavioral Health continues to evaluate and respond to the needs of the community when it comes to Behavioral Health treatment and we look at creative, evidence-based, approaches to providing for these needs. We hope to continue to further expand services offered as the needs in the community increase.

Terri Ross

2/1/2021

CONTINUITY OF OPERATIONS PLAN
(COOP)
Attachment to Emergency Operations Plans
Working Copy

REGIONAL COUNTY PLAN
Caroline County Health Department
Queen Anne's County Health Department
Kent County Health Department
Talbot County Health Department

FOR COVID-19 RESPONSE
DRIVE-THRU TESTING

DRAFT
03/18/2020

NOTICE: This document contains information pertaining to the deployment, mobilization, and tactical operations of the Caroline, Queen Anne's, Kent and Talbot County Health Department's response to the COVID-19 Emergency situation.

Changes made by	Date	Section (s) changed	Notes:
Laura Patrick	**03/18/20**	**Added TCHD throughout**	

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The mission of the Caroline, Queen Anne, Kent and Talbot County Health Departments is as follows:
Working together to improve the health and safety of all residents through disease prevention access to care, improving the environment, quality management and community engagement.

Section 1. INTRODUCTION

1.1 Purpose

The purpose of the COOP plan attachment is to establish guidance to ensure that essential functions for the Health Departments of Caroline, Queen Anne, Kent and Talbot, along with their partners are continued due to the event of the COVID-19 Pandemic. The COOP plan attachment will enable the above Health Departments mentioned to operate with a reduced work force and with a limited number of resources due to the demand for supplies related to the COVID-19 spread. This document will ensure that Health Departments are prepared to do the following:

- Respond to the COVID-19 pandemic, to recover from the event and to lessen the impact to the residents in the four County region
- To provide crucial services in a time where we are threatened by the COVID-19 virus and are ability to continue work as we now it has changed
- To provide timely direction, control and coordination to the Health Department staff and assist our partners during and after the threat of the COVID-19 virus pandemic
- Assist the four County region and its staff and partners to return to normal functioning as soon as the threat of the virus is gone

This COVID-19 attachment to the COOP plan was developed with assistance from CDC and Maryland Department of Health (MDH) guidance along with format and template guidance from the City of Danbury and the Kansas City Department of Health.

1.2 Applicability and Scope

This is a working document for the four county region and its partners to include by not limited to: County Commissioners, Emergency Management Services, Department of Social Services, County Sheriff's Offices, State and Local Police Offices. MDH and the CDC once again also provide further guidance to the Health Departments.

This document is for use by the County Health Departments and its partners during the COVID-19 pandemic situation for its use for a drive thru testing of the virus. The County Health Officers will determine when this plan will be activated and will oversee the responsibilities related to the activation of a drive thru testing site for the COVID-19 virus in the tri-county region.

During this pandemic from the COVID-19 virus the overall goals of the Health Departments and its partners is to assure that the sick get the treatment that they need, to try and prevent the spread of the virus to more of our residents, and to see that impacts to the economic and social welfare of our residents are as few as possible. In addition, we hope that our plan will help to ensure that those who are sick do not infect others and those that are well do not become infected with the virus.

The Health Departments will review and update this attachment to our COOP plan frequently during the course of the pandemic and will share a copy with their partners. A copy of this document will be printed out and

kept in the Emergency Preparedness Office at the local Health Departments and will be backed up on the Health Department Servers.

1.3 Supersession

The County Health Departments have created there first COOP attachment for a drive thru testing site for the COVID-19 pandemic. This plan will be incorporated into our overall COOP plan developed by our Emergency Preparedness Office at the Health Departments.

1.4 Authorities

The following authorities were consulted in the development of this attachment to our COOP plan attachment as it is written due to the pandemic of the COVID-19 virus

Health Officers for the tri-County Region:
Caroline**- Scott T. LeRoy MPH/**
Medical Director: Dr. Leland Spencer
Queen Anne**- Dr. Joseph Ciotola, Jr. M.D.**
Talbot- **Dr. Fredia Wadley**
Kent**- William Webb MPH**
Medical Director: Dr. Leland Spencer

1.5 References

- Center for Disease Control (CDC)
- Maryland Department of Health and Mental Hygiene (MDH)

1.6 Policy

The four County Health Departments recognize that the health of our residents in our County is our primary responsibility. We are writing our COOP plan attachment in regards to a regional drive-thru testing site for the COVID-19 virus to ensure residents who are symptomatic receive testing. In addition, our plan also will cover the continuation of other services at our health departments that

are vital to our residents. Our Health Officers and other leadership staff are responsible for developing and maintaining a viable COOP plan for the COVID-19 virus that follows insurance, regulator and ethical practices.

Section 2: Operations

2.1 Objectives

This regional COOP plan attachment for a drive thru testing site for COVID-19 virus was developed to help ensure the health of our residents in the tri-county region. In addition, we want to make sure the following items is achieved:

- Health Departments essential functions are still met during this pandemic
- All facilities, equipment, and records are protected during this emergency
- To try and continue operations at local Health Departments for other vital services
- Determine support staff who will participate in regional drive-thru testing for COVID-19
- Allow for continued update and additions to the COOP attachment plan
- Have orderly recovery from the pandemic and testing and resume full services to all local Health Departments

2.2 Planning and Considerations

- The COVID-19 pandemic may affect the local Health Departments abilities to provide some essential department services and may be limited to the amount of staff they can provide for the drive thru testing
- Staff and other resources from the local health departments will be made available to continue needed services. This may be a challenge

for local Health Officers due to absenteeism and teleworking during the State of Emergency in Maryland as authorized by Governor Larry Hogan.

- The local Health Departments will together provide a coordinated effort in collaboration with emergency management, other health care providers and from guidance again from MDH officials and CDC.
- Threats and further emergencies will be prioritized based on their impact to the drive thru testing program.
- This plan will take maximum advantage of local, State, and Federal assistance.

2.3 COOP Attachment Plan for Drive thru Testing Execution for COVID-19

1. Place for Drive Thru Testing is Chosen. MOU is signed by both parties for permission for site use (See Appendix A)Plan will be made for a tent or awning to be present in case weather is a problem for staff and those participating in the drive-thru
2. All four Health Officers and Medical Director will be in contact with MDH in order to ensure that test kits are available and the number of tests kits/lab slips to begin testing
3. Coordination will be confirmed with the lab that will be receiving the specimens
4. Each Health Department will submit inventory numbers of # of N95/surgical masks/Gowns/Gloves available for staff participating in the drive-thru clinics
5. Each health department will submit at least 2 nurses per Health Department that will participate in the drive thru clinic(s) per clinic date

6. Each Health Department will designate their nurse who will be following up on clients in their County who have symptoms and are to be on home quarantine
7. Each Health Department will designate two environmental health staff to serve as runners during for the drive-thru testing site
8. Emergency Preparedness Staff (3) will discuss and get needed containment items needed for nasopharyngeal specimens obtained
9. The 1st drive thru date will be **Friday March 20, 2020 from 10 am to 2pm at Chesapeake College**
10. A designated staff member for each local health department will be appointed by the Health Officers to assist in the planning and execution of the drive thru clinics. (This may be the emergency preparedness coordinators
11. Contact with be made with the local Department of Transportation and police agencies to determine the flow of traffic for those coming to the drive-thru clinics
12. PIO's for each Health Department will learn of the drive-thru dates and will review critical information to be given out to the public via Facebook/radio/local TV/newspapers and on State and local Health Department websites. When doing press releases, if possible make sure to seek guidance from: pio:mema@maryland.gov
    They would just like to keep updating for what is going out from the Counties.
13. Local providers will be updated on the drive thru dates included but not limited to local hospital systems, FQHC's and other health providers within each County
14. Practice (dry-run) date/time will be given to all staff involved in participating in the drive thru

15. Emergency Preparedness Staff will make sure that preparations are made to have all waste from the collection of specimens to be disposed of properly.

2.3 Vulnerability

Local Health Officers and their leadership will assess in each of their Counties areas where staffing might be a problem for a drive thru clinic(s). Each Health Department will continue their daily operations as best as they can with the staff that are available back at their original sites.

2.3 COOP Plan Activation of Drive thru Clinic(s)

- Health Department staff that need to report to the drive thru clinic will receive notification by alert and notification from the Health Department Emergency Preparedness Coordinator for each local Health Department
- Staff will report to the site for the drive thru clinic and assume their responsibilities as assigned.
- Upon arrival to the drive thru site local assigned leadership will review the process for the drive thru clinic and the leadership will take notes and document the entire process to be discussed at the end of the clinic with what went well and what needs changing

2.4 Time-phased Implementation

The COVID-19 virus pandemic is considered a major disaster with its potential impact for the number of residents that can be effected. A major disaster is defined as any disaster that has the potential to exceed local capabilities and that will require outside support from

local, State or Federal authorities. The four-County Emergency managers will notify MEMA with potential needs of the drive-thru clinics.

Below are the Activation Phases for the COVID-19 drive thru clinics:

Phase I-0-12 hours
During this phase, notification will be made to all those who will participate in a clinic. This is when all those involved will be notified when to report to the site of the clinic.

Phase 2- 12 hours to termination of drive thru clinic
During this phase, the functions of operation of the drive-thru clinic will commence. Notes will be taken by authorized leadership on-site to make further clinics operate the same or certain changes will be made to make the clinic more efficient.

Phase 3- Reconstitution
Once the drive-thru clinic is over all personnel will be meet to discuss next steps

2.5 COOP Team
The members of the COOP team will be responsible for carrying out essential functions during activation of the drive-thru clinics. Part-time staff may be called in for full-time hours. Depending on the need, Health Officers may call in all essential staff as needed.

Members of the COOP Team for the Drive thru Clinics will include but are not limited to:

- **Health Officers in the Four County region**
- **Medical Director**

- **COOP Team leaders for drive thru clinics**
- **Leadership staff**
- **Emergency Preparedness Coordinators**
- **Safety Coordinators/Environmental Health Directors**

Prior to the COOP-Drive Thru Activation the team will review the checklist for Essential Functions (See Appendix B). Staff members should cross-train in order to ensure that the mission-essential functions are carried out. Local Health Officers may choose support team members to be present at the drive thru testing site in order to assist team members in making sure the testing runs as efficiently as possible.

2.6 Alternative Work Site

When choosing an alternative work site consider the following items below:

- Ensure the facility has sufficient space to support the drive-thru concept
- Ensure the facility has the capability of sustaining the drive-thru clinics for up to 30 days
- Ensure the facility has reliable logistic support i.e.: water, electrical power
- Ensure the facility has toilet facilities for staff members
- Ensure that security is in place
- Ensure that a MOU with the facility is put in place

2.7 Mission-Essential Functions

The local Health Departments in the four-county region of Caroline, Queen Anne, Kent and Talbot Counties have identified and prioritized the essential functions of opening a COVID-19 drive thru testing site. The Health Officers and their designated administrators will ensure that

the essential functions of the drive thru testing will run smoothly and will change if situations change.

MISSION ESSENTIAL FUNCTIONS

1. Once needed test kits COVID-19 tests are made available the four County Health Departments will begin testing of residents who are symptomatic having a fever above 100.4, have a cough, have been around someone with COVID-19 and/or have chronic conditions that might make their symptoms worse. **All those that come to the testing site MUST have an ORDER from their Physician for COVID-19 testing and MUST be 18 years and older**
2. Make sure that those who are identified with symptoms and who are diagnosed with COVID-19 once test results are obtained are follow-up by the local Health Department nurses from the county that they reside and are reported to MDH per guidelines.
3. Drive thru testing will commence until local Health Officers/Medical Director and/or MDH determines that testing is no longer needed

2.8 Assignment of Essential Functions:

To ensure that all functions of the drive-thru testing are completed, it is very important that each Health Officer from the four County region assign a qualified staff member to oversee the testing site. For each function for each testing day, a primary point of contact should be assigned. **See Appendix C for a list of resources needed**

2.9 Warning Conditions

With warning- The COVID-19 drive thru testing will come with warning to health department staff in the four-county region. This will

allow for the full execution from local Health Officers to secure resources and to deploy personnel . Local staff will be notified through the emergency preparedness staff from each health department.

Off-Hours Assignments-Once a site and date is secured for a COVID-19 testing site the local Health Officer will contact their leadership staff in order to make staff who are to assist in the testing site aware.
Duty Hours: Drive thru testing may occur during normal work hours of the four county Health Departments. Local Health Officers will notify their leadership and their emergency preparedness staff will contact those staff that are needed.

2.10 Direction and Leadership during Activation of Drive-Thru Clinics

The local Health Officers will be responsible for maintaining a list of their leadership team. Each Health Officer will choose a administrator to oversee the functioning of the drive-thru testing. These administrator's will keep their Health Officer informed of how the testing site is performing. One administrator will be on-site for each Health Department.

Functions of Drive-Thru Testing Staff:

1. **Administrator-**Reports directly to their Health Officer and oversee the overall functioning of the drive-thru COVID-19 testing
2. **Emergency Preparedness Coordinator-**contacts needed staff for the testing site as instructed by the Health Officer or administrator. Along with assistance from IT, staff see that advertising is done to promote site utilization. Make sure the PIO is briefed on what message(s) is needed to get out to the

community. Gives needed supplies to the administrator for use at the testing site.

3. **Nurses-** will provide nasopharyngeal testing for those clients who meet testing criteria. Nurses will make sure to have on appropriate PE attire to protect them from the COVID-19 virus. All nurses who are to work at the drive thru testing site collecting specimens will receive training before the event. The training consists of a video which describes how to obtain a nasopharyngeal test. Nurses will ensure that specimens are properly put into the appropriate container in order for specimens to be sent to the lab on contract to run the necessary tests.
4. **Environmental Health Staff-** 2 staff from each of the four Health Department's Environmental staff are to report to the drive thru clinic to assist as runners. This is to assist with the flow of traffic and to ensure that the testing runs as smoothly as possible.

Incident Command System with COOP Attachment for COVID-19 Drive thru Testing

The local Health Departments use the Incident Command System (ICS) that follows the National Incident Management System (NIMS). Local staff will be instructed by the administrator or designated staff in how to perform their duties at the drive-thru testing sites.

2.11 Operational Hours

- Local Health Officers and/or their designated administrator's will determine the hours of operation
- Those at the drive-thru testing for COVID-19 will remain at the testing site until told to leave as determined by the local Health Officer or administrator

- All Health Department staff should expect to potentially be called to report to the testing site if necessary

2.12 Alert and Notification

- Staff will be alerted as soon as possible that they will need to report to the test site prior to the testing to start. All partners assisting in the testing will be alerted as well with as much notice as possible.

- The Health Department's call-down list will be used to keep all Health Department staff to be aware of upcoming testing and their role. A minimum of two attempts will be made to contact those needed. For those that are not able to be contacted, a message will be left on their voicemail asking the employee to call back as soon as possible.
- Health Department staff in the four county region should remain at their home or office until specific guidance is given
- Once initial planning is completed and a site it chosen as well as a day and time, Health Department staff and partner should prepare to deploy when needed
- Once again, the local Health Officers or their appointed administrators will activate the COOP plan and its attachment as it relates to COVID-19 drive thru testing.

Section 3: Procedures

- **Personnel Coordination**

Each County Health Officer in the four county region will collaborate with their personnel officer in order to make all employees aware of the change in their daily operations, information on payroll, time and attendance, assignments, and reimbursement if needed. The above

information will be distributed via the Maryland.gov email address. All employees will be given educational information on social distancing, and any information related to the COVID-19 virus that might assist the employee and their families to try and remain virus free.

- In addition, employees should be given information on where they can call if counseling services are needed related to apprehension and concern related to the pandemic.

- **Vital Records and Databases**
  During the pandemic related to the COVID-19 virus administrators should ensure that all data collected can be kept on file at the local health departments both in paper and in electronic forms. (See Appendix E for a copy of client information needed for the drive thru testing)

  Records should be kept in paper and electronic forms for the following related to the following:
  - COOP attachment plan for drive-thru for COVID-19
  - Delegation of Authority
  - Staff Roster
  - Staff Assignments
  - Records of any policies and procedures related to the COVID-19 work
  - Expense Reports
  - Record of how to ensure medical records from the testing site and back to the Health Dept.
  - Record of any equipment purchased/lost or damaged items during drive-thru testing

3.3 Pre-Positioned Resources

The four county Health Departments involved in the drive-thru testing should have an inventory list of items needed for the testing site. Items should be inventoried and if possible extra items ordered to ensure that these items will be available as the testing may continue for several months.
(See Appendix F for Inventory List)

3.4 Drive-Away Kit (prepared by Emergency Preparedness Staff)

The drive away kit for the COVID-19 drive thru should contain:

- Gloves
- Surgical Masks
- N95 Masks for those obtaining nasopharyngeal specimens
- Gowns
- Face Shields
- Hand Sanitizer
- Disinfectant wipes
- Waste disposal bags
- Signage
- Office supplies such a clip boards, pens, staplers, paper clips
- Organizational Chart
- Copy of the COOP plan and COOP attachment plan
- Radio phones
- ICS Forms
- Bottled Water

Make sure that all staff members bring with them their personal identification cards such as driver's licenses and State of Maryland work badges, insurance cards, personal medications that need to be taken.

3.5 Telecommunications

The four county health departments need to be able to communicate both internally and externally at the drive through testing site. Communication is crucial during testing for the COVID-19 pandemic.

Internal Communication examples:

- **Phones**
- **Satellite Phones**
- **Fax Machines**
- **Two-way Radios**

External Communication examples:

- **800 megahertz radios**
- **Satellite Phones**

****** Access to critical information systems are critical to accomplish mission essential functions of the COVID-19 drive-thru testing. The local health department emergency preparedness staff should make sure that all systems are backed up on a daily basis. In addition, staff should ensure that connectivity exists at the site for the drive-thru testing. Back up technical support from IT should also be pre-arranged. ******

3.6 Security and Access Controls

Local Health Officers and their designated administrator's should ensure that all types of security are addressed and in place at the testing site. The four types of security are listed below:

1. Operational
2. IT
3. Physical
4. Access Controls

Considerations should be addressed on using State, County or local law enforcement at the testing site as a resource to maintain order and calm.

3.7 Personal and Family Preparedness

If possible, local staff from the four-County Health Departments should be actively involved in the COOP attachment drive-thru testing planning. If time allows training should be completed and focus on preparing employees for the situation noted above where they will not be able to work from the health department facility. The training should also include personal go-kits and to prepare their families at home. Information about family and home preparedness is available at www.fema.gov.

3.8 Site Preparedness

The administrator and/or Emergency Preparedness Director at the local Health Department should ensure the readiness of the testing site and to see that is functions well throughout the number of testing dates. The transition from the local health departments to the testing site should be a smooth transition.

Section 4: Phase I-Activation

The following procedures are to be followed in the execution of the COOP attachment plan for the drive-thru COVID-19 testing.

4.1 Alert and Notification Procedures

The four County Health Departments notification process related to the drive thru testing for a smooth transition should allow essential functions to be completed.

1. Local Health Officers and /or their appointed administrators will alert staff that activation of the drive thru testing will commence
2. The announcement will allow essential staff to focus on mission-essential functions.
3. The announcement will provide instructions to all staff involved regarding set-up, and when to report to the testing site.

4.2 Initial Actions

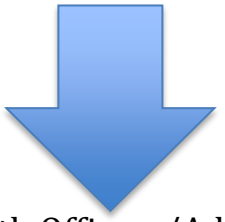
Once the COOP attachment plan for the testing site starts procedures will be put in place for duty hours and non-duty hours.

1. The call down procedures will start as directed by local health officers
2. Staff will be told where to report and the day and time they are to report
3. The local health officers or appointed administrators will notify the County Emergency Managers, their Emergency Operation Centers (EOC,s) and local supporting agencies of the drive thru testing plans
4. The Health Officers and/or administrators will estimate the following:
    - # of personnel needed
    - # of items on inventory list needed
    - # of testing kits needed
    - # of testing days/times
5. Initial staff that are needed for the first testing date are notified and are told to get their personal identification items ready.

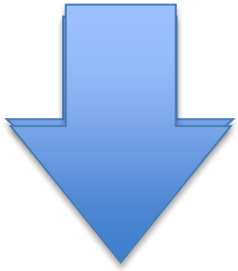
6. Emergency preparedness staff and other designated staff needed to assist prepare drive-away kits with all items needed for the drive thru's.

4.3 Activation Procedures: Duty Hours

Local Health Officers/Administrator's Notify COOP team members



The Local Health Officers/Administrator's activate the drive through testing plan and appropriate community partners are notified



Notification procedures are put in place

The COOP administrator and Emergency Preparedness offices at the county Health Departments direct members of their teams to begin to deploy to the sites on the chosen day/time

Support staff perso[illegible]local Health Departments will remain on stand-by to assist with future drive thru testing/ and/or will continue local daily activities at the Health departments.

4.4 Deployment and Departure Procedures for Relocation Operations

The Local Health Officers will determine the designated site for drive thru testing for the four county region. The Health Officers will determine the mission-essential functions. Specific instructions will be provided to testing staff and to other partners involved with the mission. Those initial staff who will report to the 1st drive thru testing will being to get their personal identification items ready and Drive-Away Kits will be prepared and loaded for transport to the testing site. Specific instructions will be provided to all staff on site location and when to report.

Section 5: Phase II-Alternate Operations

5.1 Mission-Essential Functions

Upon activation of the COOP attachment plan for drive thru testing the Local Health Officers and their administrator's will:

- Ensure that the essential functions of the drive thru testing are completed
- Monitor and assess the need for further testing dates
- Monitor the status of personnel needed and further resources needed
- Continue to maintain contact with MDH, County Officials, their EOC's and other supporting agencies on the success of testing and or changes being made to make testing more efficient
- Planning and preparing for the restoration on normal operations to return to local health departments

5.2 Establishment of Communications

- PIO staff for the four county Health Departments will ensure that all necessary and preplanned communications are established, are adequate and function properly in order to educate, calm, and inform all residents regarding the COVID-19 process from testing to maintaining self-quarantines if necessary.
- PIO staff will communicate clearly and frequently updates to the public at large on how community testing is proceeding and any new information for them that is given by the CDC or MDH officials.

5.3 Support Team Responsibilities

Support Team members are those who will be back up or ones who will relieve current staff at testing sites. They will continue to remain at the local health departments continuing to provide needed services to our residents or they will remain home on non-work days and prepare to be

deployed if needed to testing sites. In addition, support staff may be asked to assume different roles at the Health Department in the absence of staff who are assigned to the testing sites.

5.4 Site Testing Team Responsibilities

The following functions will begin for personnel who are identified to deploy to the testing site:

- Administrators will disseminate logistical information to the testing team upon activation of the testing site. This information should cover operation and procedures for the next 30 days.
- Administrators will continually brief the site team and support personnel on updates regarding testing and any updates from MDH and or County officials
- The teams will perform the mission essential functions of from the Caroline, Queen Anne, Kent and Talbot Health Departments for testing as many residents they can due to the COVID-19 virus

5.5 Augmentation of Staff

- Local Health Officers and/or Administrator's need to continually access if staff and or resources are not adequate for the demand for testing.
- Local Health Officers and/or Administrators will update State and County Officials of the need for more staff/resources if needed
- Local Health Officers and/or Administrators will ensure that staff have the skills to perform the testing
- Local Health Officers and/or Administrators will consider implementing MOU's/mutual aid agreements with other agencies if needed to continue the testing of residents in the four county regions of Caroline, Queen Anne, Kent and Talbot Counties.
- Requests for outside agency support will be submitted to the County Emergency Managers and MDH and County officials.

5.6 Guidance to Testing Team Personnel

- Local Health Officers and/or appointed administrators will develop a communication pattern for dissemination to all employee and agency staff involved on pertinent information related to testing. Information will include anticipated times/dates for future testing, duration of testing, Local, State and National numbers on testing, number of those with the virus and number of deaths.

5.7 Transferring of Duties

Local Health Officer's in the four county region with orders from MDH officials may decide that the functions for testing of transfer residents to an outside agency. This could occur if local Health Officers find that staff is incapable of continuing drive thru testing due to shortage of staff or resources. If transferring of duties is deemed necessary then health department officials will make sure that trained staff from another agency resume the vital roles for testing. Staff from another agency are made aware of the communication that has been given to local residents. Other agencies taking over testing functions are made aware of documents that need to be completed and the need for the local health department to have documents of those tested for follow-up and notification of results.

5.8 Development of Plans and Schedules for Reconstitution and Termination

Local Health Officers/Administrators and Health Department Emergency Preparedness Coordinator's will ensure that plans and schedules resume to normal functioning once testing is complete. A termination memo will be made and sent to all Health Department staff. The plans will allow for an orderly transition back to normal business

operations. Local Health Officers may choose to form a reconstitution team made up of staff from all four health departments in the four county plan. Members of outside agencies that assisted at the testing site would also be included in the reconstitution team.

Section 6: Phase III-Reconstitution and Termination

6.1 Overview

The reconstitution phase will commence when the local Health Officers determine that the drive thru testing for the COVID-19 virus is complete. At this time, staff who were involved in testing will return to their normal job duties. Staff will begin to resume normal functions based on priority ranking with supervisors. Transition staff who were temporarily reassigned go back to their usual duties after updating returning staff on all they accomplished.

6.2 Procedures

Upon a decision by local Health Officers to stop testing at the drive thru Site, the administrator/and or Emergency Preparedness Coordinator will create a debriefing document describing in detail the entire process of drive thru testing for the COVID-19 virus from start to finish. The document will be shared with all staff and other agencies involved in the testing.

6.3 After Action Review and Remedial Action Plan

The local Health Officer will initiate a debriefing meeting. All staff who were involved in the drive thru testing will attend the meeting. The meeting often referred to as a “hot-wash” will review all the strengths and weaknesses of the COVID-19 virus testing. The meeting should provide for actions to improve areas that were determined a weakness. The evaluation process for changes should follow the SMART objectives.

Once the meeting is complete, the administrator and/or Emergency Preparedness Coordinator will write a corrective plan of action and submit to the local Health Officer for review. The local Health Officer will likely present the finding to MDH and County Officials.

6.4 Future Testing, Trainings and Exercises

- The drive thru plan will be review annually and approved by the local Health Officer
- The Emergency Preparedness Coordinator will ensure that all employees and new employees be trained on the drive by testing exercise
- The exercise for drive by testing will be practiced annually as a drill by Health Department staff
- The Emergency Preparedness Coordinator will teach lessons learned and actions taken based on the drive by testing done for the COVID-19 virus

APPENDIX A
MOU with Site Designated for Testing
Will be obtained and copy put with Plan

Drive Thru Testing
Chesapeake College
Friday March 20, 2020
10 AM- 2PM

Maryland
DEPARTMENT OF HEALTH

APPENDIX B

CHECKLIST FOR OUTPATIENT TESTING FOR COVID-19

1. **Physical Infrastructure Considerations**

- ❒ **Setting**: A closed room (minimize opportunities for spread to adjoining rooms or occupied spaces) **OR** a well-ventilated open-air venue (away from areas of pedestrian traffic). If considering a "drive-by" venue (tent, other facility), evaluate both pedestrian and vehicular traffic in selecting a location. If specimens are collected in a residential or congregate housing setting (e.g., group home), keep the door closed and other residents at a distance outside the collection room.
- ❒ **Communications:** Communicate clearly to patients regarding procedures for check-in and testing, recommendations regarding patient preparation (including masking of ill patients on arrival and social distancing). Consider patient and vehicle flow and other logistics. Include instructions regarding patients who may be too ill to collect specimens in an outpatient setting.

2. Personal Protective Equipment

- ❒ Use gloves and gowns consistent with Standard and Droplet precautions.
- ❒ Use either a surgical mask or a fit-tested N-95 respirator or powered air-purifying respirator. Either a face shield or goggles to protect the eyes is essential.

3. Specimen Collection, Shipping, and Result Reporting

- ❒ Verify collection, packing, and shipping procedures for the commercial or
- ❒ Ensure that you have a process for reporting positive results to the health department. Please distribute to your staff.

APPENDIX C

PROTOCOL for 1st Regional Drive Thru Testing March 20, 2020

We will meet at Chesapeake College, near the Security Office which is on the back side of the campus. We are set up on the left just prior to the Security Office, you will see a tent (10 x 20) in the parking lot and lots of traffic cones. Please plan to arrive about 9:15 am for JIT training and the drive thru runs from 10am - 2pm. I have PPE, face shields, tyvek gowns, masks and gloves plus vests. I have attached a video for the nurses related to obtaining the specimens as this is not something we do everyday.

March 20th - Friday

Paramedic- Alec
Rita Kullley, RN (Kent)
Leigh Marquess, RN (Caroline)
Melissa - Traffic/Crowd (Caroline)
Josh Parker - Traffic/Crowd (Kent)

March 23rd - Monday
Paramedic-
Amy Crooks, RN (QA)
Julia Kemp, RN (CC)
Josh Parker- Traffic/Crowd (Kent)
Mary Lou Christian - Traffic/Crowd (QA)

March 25th - Wednesday
Paramedic-
Amanda Moseley, RN (TA)
Christina Zimmerman, RN (CC)
Josh Parker- Traffic/Crowd (Kent)
Erica Hercher - Traffic/Crowd (Kent)

March 27th- Friday
Paramedic-
Sarah Curlett, RN (QA)
Leigh Marquess, RN (CC)
Steve Johnson - Traffic/Crowd (Caroline)
Josh Parker- Traffic/Crowd (Kent)

https://www.youtube.com/watch?v=hXohAo1d6tk

-

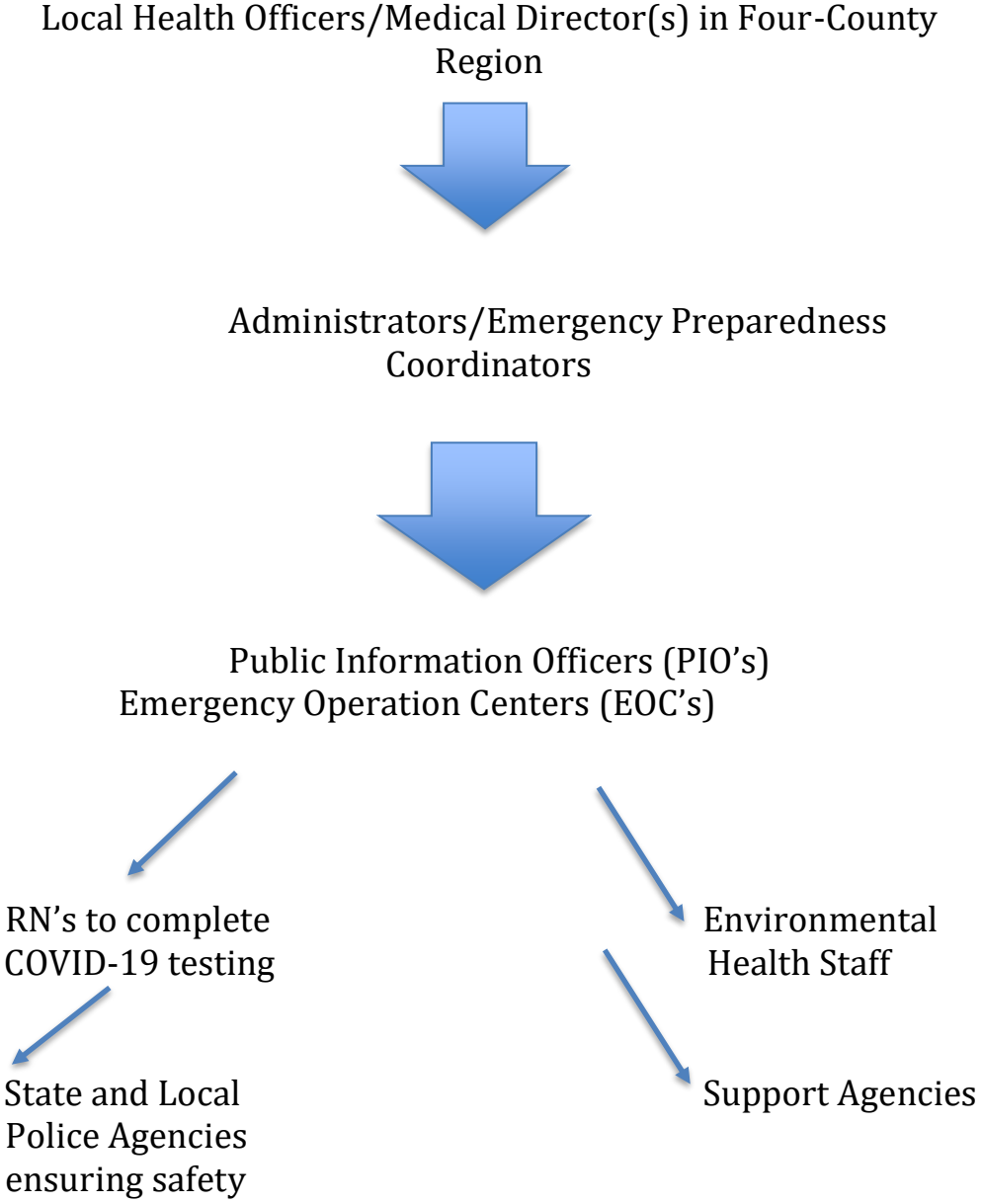
Preview YouTube video Nasopharyngeal Swab

APPENDIX D

RESOURCES NEEDED FOR DRIVE THRU TESTING
COVID-19 VIRUS

1. **PPE Equipment**
    - **Gowns**
    - **Gloves**
    - **Surgical Masks**
    - **N95 Masks**
    - **Facial Shields**
2. **Testing kits for COVID-19 virus**
3. **Lab testing sheets for COVI-19 virus testing**
4. **Tables 3-4 for staff to prepare documentation for client demographics by county for clients follow-up**
5. **Office Supplies**
    - **Pens, clipboards, staples, tape for signage**
    - **Portable copier(s)**
6. **Tent for staff to continue to function if inclement weather**
7. **Safety cones to allow for traffic flow**
8. **Large signage posted to show clients where testing will occur, (Involve State Highway for larger signage)**
9. **Educational information packets on COVID-19 to give the public present for testing**

APPENDIX E
ORGANIZATIONAL CHART
COVID-19 DRIVE THRU TESTING



Appendix F
STAFF ASSIGNMENTS
DRIVE THRU STAFF COVID-19 TESTING
FROM EACH LOCAL HEALTH DEPARTMENT FOUR COUNTY REGION

HEALTH OFFICER	
ADMINISTRATOR	
PIO	
EMERGENCY PREPAREDNESS COORDINATOR	
NURSE 1	
NURSE 2	
ENV STAFF 1	
ENV STAFF 2	
SUPPORT STAFF	
SAFETY	
IT SUPPORT	

APPENDIX G

This is for a copy of the lab slip to be used by

LABCORP

Will insert when necessary

as a sample to go by

APPENDIX H
INVENTORY LIST

Date of Drive Thru Testing

_____

Item Used at Drive thru Clinic	Amount Used
Gloves	
Gowns	
Masks	
N95 Masks	
Test kits	
Information Packets	

APPENDIX I
Information for Clients

Coronavirus disease 2019 (COVID-19) an

t is coronavirus disease 2019?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can I get COVID-19?

Yes. COVID-19 is spreading from person to person in parts of the world. Risk of infection from the virus that causes COVID-19 is higher for people who are close contacts of someone known to have COVID-19, for example healthcare workers, or household members. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.
Learn more about places with ongoing spread at https:// www.cdc.gov/coronavirus/2019-ncov/about/transmission. html#geographic.

The current list of global locations with cases of COVID-19 is available on CDC's web page at https://www.cdc.gov/ coronavirus/2019-ncov/locations-confirmed-cases.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but is now spreading from person to person. The virus is thought to spread mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or

sneezes. It also may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.Learn what is known about the spread of newly emerged coronaviruses at https:// www.cdc.gov/ coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of:

- fever
- cough
- shortness of breath

What are severe complications from this virus?

Some patients have pneumonia in both lungs, multi-organ failure and in some cases death.

THE PRESIDENT'S **CORONAVIRUS GUIDELINES** FOR AMERICA

15 DAYS TO SLOW THE SPREAD

Listen to and follow the directions of your **STATE AND LOCAL AUTHORITIES.**

IF YOU FEEL SICK, stay home. Do not go to work. Contact your medical provider.

IF YOUR CHILDREN ARE SICK, keep them at home. Do not send them to school. Contact your medical provider.

IF SOMEONE IN YOUR HOUSEHOLD HAS TESTED POSITIVE for the coronavirus, keep the entire household at home. Do not go to work. Do not go to school. Contact your medical provider.

IF YOU ARE AN OLDER PERSON, stay home and away from other people.

IF YOU ARE A PERSON WITH A SERIOUS UNDERLYING HEALTH CONDITION that can put you at increased risk (for example, a condition that impairs your lung or heart function or weakens your immune system), stay home and away from other people.

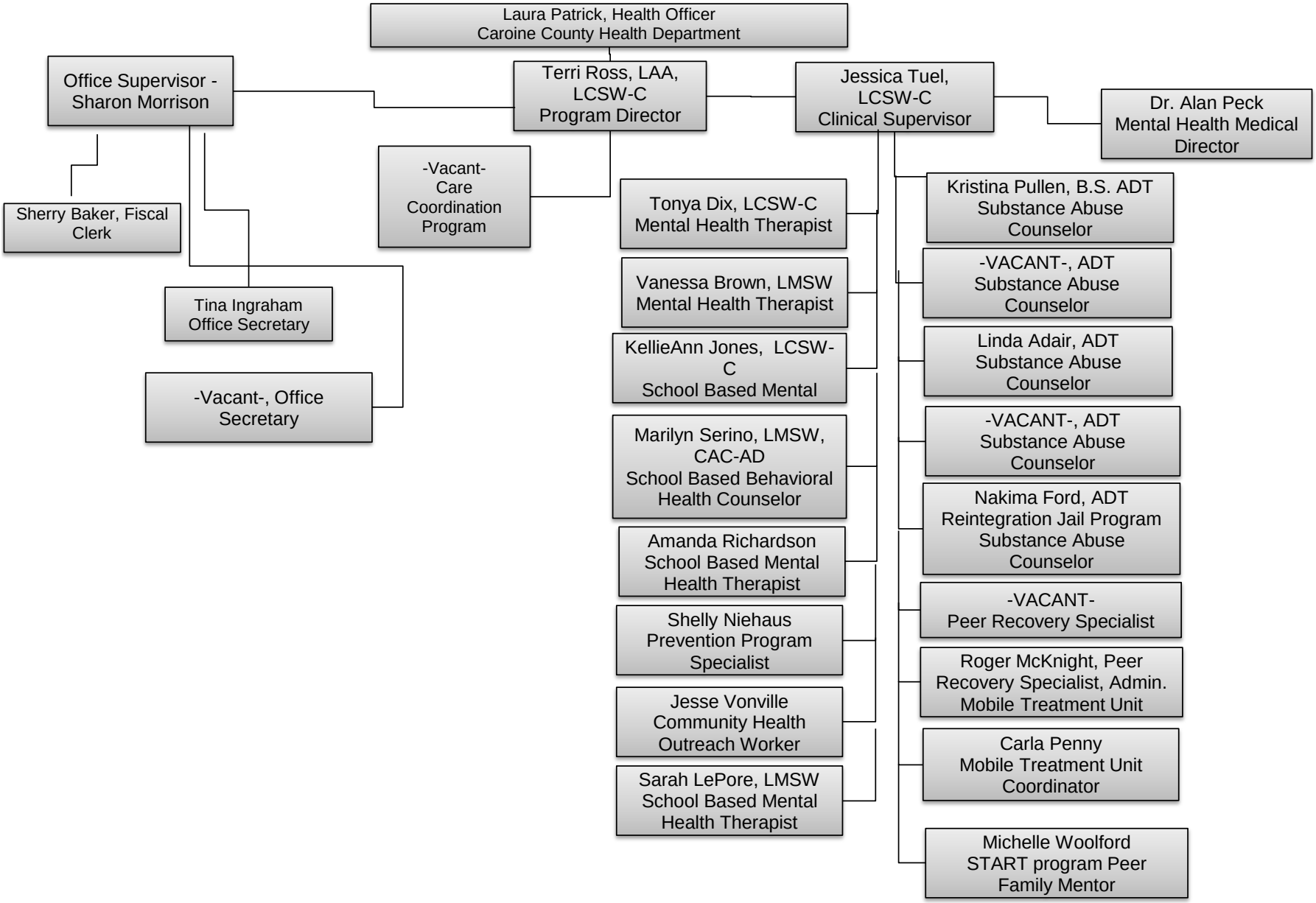
THE WHITE HOUSE

CD

For more information, please v

CORONAVIRUS.G

Caroline County Behavioral Health



Continuity of Operations Plan

Dorchester County Health Department

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ACRONYMS

ACC	Administrative Care Coordination	GYN	Gynecology
ADAA	Alcohol & Drug Abuse Administration	ICS	Incident Command System
ADC	Annapolis Data Center	LAW	Leave of Absence without Pay
AED	Automatic External Defibrillator	MA	Medical Assistance
AERS And CPAS	Adult Evaluation Review Service And Community Personal Assistance Program	M-B-P Files	Map-Block-Parcel Files
AST	Alcohol Severity Index	MCHP	Maryland Children's Health Program
BCCP	Breast & Cervical Cancer Program	MCO	Managed Care Organization
CARES	Client Automated Resource Eligibility System	MMIS	Maryland Management Information System
CDC	Centers for Disease Control & Prevention	NEDSS	National Electronic Disease Surveillance System
CFC	Community First Choice	NIMS	National Incident Management System
COMAR	Code of Maryland Regulations	NM	Nurse Monitoring
COOP	Continuity of Operations Plan	NRT	Nicotine Replacement Therapy
CRF	Cigarette Restitution Funds	OP & R	Office of Preparedness & Response
CVR	Client Visit Record	OSAS	Open Systems Accounting Software
DCHD	Dorchester County Health Department	PASRR	Preadmission Screening Residence Review
DDA	Developmental Disability Administration	POD	Point of Distribution
MDH	Department of Health & Mental Hygiene	POSIT	Problem Oriented Screening Instrument for Teenagers
ECP	Emergency Contraception Pills	PPD	Purified Protein Derivative
EOC	Emergency Operation Center	STD	Sexually Transmitted Disease
EVS	Electronic Verification System	STEPS	Statewide Evaluation Planning Service
FMIS	Financial Management Information System	TB	Tuberculosis
FPC	Federal Preparedness Circular	USPS	United States Postal Service
GES	Geriatric Evaluation Service	WBCCHP	Women's Breast & Cervical Cancer Health Plan

DEFINITIONS

Critical Function: A function or service, which if disrupted, must be restored within 12 hours or less.

Delegation of Authority: Identifies the programs and administrative authorities needed for effective operations at all organizational levels having emergency responsibilities. Also identifies circumstances where these authorities would be exercised. Documents necessary authorities at all points where emergency actions may be required, delineating limits of authority and accountability.

Priority Function: A function or service, which if disrupted, must be restored within 24 hours.

Ongoing Function: A function or service that is normally provided by the program and which, if disrupted, should be restored as soon as possible, consistent with the emphasis provided to restoration or critical and priority services.

RECORD of CHANGES

The Dorchester County Health Department COOP Point of Contact, Brice Strang, has primary responsibility for the maintenance, revision and distribution of this plan. Delegation of responsibilities are listed in Annex 3.

Changes and revisions will be made in the event of:

- Failure during emergency, drills or exercises
- Problems identified for correction in after-action reports
- Significant personnel or responsibility shifts
- Agency Organizational or government infrastructure adjustments
- State law or regulations changes
- Any other condition that affects this plan

See Annex 8 for a list of individuals and organizations in possession of a controlled copy of this plan. Controlled copyholders will be provided updates and revisions—plan holders are responsible for posting and recording these changes.

Please refer to the "Record of Changes" form on the following page.

RECORD of CHANGES FORM

Nature of Change	Date of Change	Page(s) Affected	Changes Made by: (Please PRINT)	Changes Made by: (Signature)
Initial plan development	**04/2008**	**all**	**Cheryl MacLaughlin**	
Revisions per request of MEMA	**09/2008**	**all**	**Cheryl MacLaughlin**	
Update following site consolidation	**05/2009**	**all**	**Cheryl MacLaughlin**	
Review for Pandemic Plan and staff changes	**08/2009**	**all**	**Cheryl MacLaughlin**	
Update from all programs	**08/2011**	**Multiple**	**Cheryl MacLaughlin**	
Update from all programs	**04/2014**	**Multiple**	**Cheryl MacLaughlin**	
Update of personnel changes	**08/2014**	**Multiple**	**Brice Strang**	
Update of personnel changes and program changes	**02/2015**	**Multiple**	**Brice Strang**	
Update of personnel changes	**05/2015**	**Multiple**	**Brice Strang**	
Update of personnel changes; Addition of HAN as notification system; Staff changes; Update of drive away kits; Program changes; Alternate site additions.	**02/2016**	**Multiple**	**Brice Strang**	
Program updates	**02/2017**	**Multiple**	**Brice Strang/Program Managers**	
Program updates, contact updates, formatting updates	**03/2018**	**Multiple**	**Brice Strang**	
Program updates, Outline of DCHD Telework Capabilities, Added Information Technology Disaster Plan	**12/2019**	**Multiple**	**Hannah Mayhew, Brice Strang, Program Managers**	

AGENCY MISSION

The mission of the Dorchester County Health Department is: *From disease prevention to crisis intervention, from birth to death, we are working in partnership with the community to make a safer place for healthier people.*

PURPOSE

This document, the ***Continuity of Operations Plan (COOP)***, has been developed for the purpose of providing guidance for actions to be taken in the event that significant numbers of staff members are unable to report for work or there has been an event that precludes normal business operations due to physical disruptions to the facility. Emergencies that are natural or man-made events can cause widespread illness, injuries or deaths to clients and employees. This plan has been established and is intended to guide the Dorchester County Health Department (DCHD) in the continuity of essential operations during an emergency.

APPLICABILITY AND SCOPE

Support from other state agencies and local governments as described herein will be coordinated with the responsible office as applicable.

This document applies to situations determined by the Health Officer that require relocation/re-establishment of essential functions of the health department. The scope does not apply to temporary disruptions of day-to-day health department activities during short-term building evacuations or other situations where services are anticipated to be restored in the primary facility within a short term. The Health Officer will determine situations that require implementation of the COOP, for example equipment failure, personnel safety, inhabitability of the building, etc.

A partial or full implementation of the COOP is dependent on the extent of personnel deficit or damage incurred to the structure of the Department of Health. Phase I – Activation and Relocation occurs during the 0 – 12 hour initial timeframe. Phase II – Alternate Facility Operations involves the transfer of essential business operations to an off-site facility or may involve mass treatment/ distribution operations off-site; this phase has an indeterminate timeframe. Phase III – Reconstitution or Return to Normal Operations also has an indeterminate time-frame with respect to building restrictions that may be applicable and/or waves of disease which may occur.

SITUATION AND ASSUMPTIONS

Situations that can occur causing this plan to be implemented include any sudden or evolving event that disrupts the normal function and capacity of the Dorchester County Health Department daily operations. Examples include natural disasters such as hurricanes and floods, man-made disasters involving chemical or biological introductions to the environment and disease contagions that affect widespread sectors of the population (such as Pandemic influenza). Severe effects on business functions from a contagious disease are expected from loss of staff affected by illness, sequestered with an ill family member or from fear of exposure. Destruction of property from a natural disaster will impede normal business and necessitate plans to function only at an "essential" level, protect vital information and operate from a remote location. In Dorchester County, vulnerabilities include severe weather, hazardous materials spills, acts of terrorism and the potential for a pandemic illness. The following assumptions would exist to implement the Continuity of Operations Plan on a partial or complete level:

- Widespread absenteeism of employees due to illness
- Widespread, contagious disease in the general population
- Structural damage to the facility and loss of access
- Disruption of main infrastructure and loss of access
- The events may indirectly impact all of the facilities and staff, or may impact only a portion of those facilities and staff.
- The mission and responsibilities of the Health Department persist when there is disruption to the normal state of affairs in the community and the Health Department.

OBJECTIVES

The objective of this COOP is to ensure that a viable capability exists to continue essential health department functions across a wide range of potential emergencies, specifically when the primary facility is either threatened or inaccessible. The objectives of this document are also referenced in Federal Preparedness Circular 65 (FPC) which includes:

- Ensure the continuous performance of health department's essential functions/operations during an emergency;
- Protect essential facilities, equipment, records, and other assets;
- Reduce or mitigate disruptions to operations;
- Executing as required, successful succession of office with accompanying authorities in the event a disruption renders agency leadership unable, unavailable, or incapable of assuming and performing their authorities and responsibilities of office;
- Reduce loss of life, minimize damage and losses;
- Identify and designate principals and support staff to be relocated;
- Facilitate decision-making for execution of the Plan and the subsequent conduct of operations;
- Achieve a timely and orderly recovery from the emergency and resumption of full service to all customers;
- Ensuring and validating COOP readiness through a dynamic, integrated test, training, and exercise program to support the implementation of COOP plans; and
- Ensuring the health department has alternate facilities from which to continue to perform their essential functions during a COOP event.

I. COOP RESPONSIBILITY

Upon request of a program supervisor, the County Manager, County Council or Emergency Management Director, the Health Officer will activate the Dorchester County Health Department COOP.

Point of Contact:

Name	Title	Work	Home	Cell	Alternate
Brice Strang	Public Health Emergency Planner	410-901-8156		410-200-5551	443-205-2275

COOP Team/Reconstitution Team:

Name	Title	Work	Home	Cell	Pager
Roger Harrell	Health Officer	410-901-8142	410-643-4598	443-521-0851	N/A
Casey Scott	Deputy Health Officer/Med. Director				
Lanise Mohn	Assistant, Emergency Preparedness	410-901-8108		410-463-1801	N/A
William Forlifer	Director, Environmental Health	410-901-8148	410-763-8989	443-521-4997	N/A
Angela Grove	Director, Health Education	410-901-8126		410-463-4309	N/A
Carla Neugroschel	Administrator	410- 901-8140	410-221-8569	201-874-2332	N/A
Beth Spencer	Director, Healthy Families	410-901-8177	410-901-1494	410-463-1033	N/A
Donald Hall	Director, Addictions	410-228-7714x106		443-631-5895	N/A
Jeffrey Parmer	Information Technology	410-901-8138		410-310-7084	N/A

Key Management Personnel:

Name	Title	Work	Home	Cell	Pager
Carolyn Hallowell	Supervisor, School Health	410-901-6952	410-943-4578	443-521-3985	N/A
Belinda Kowitski	Supervisor, ACC/MCHP	410-901-8167		443-521-3870	N/A
Brice Strang	Supervisor, DDA	410-901-8118	443-521-2245	443-521-7455	N/A
Pamela Quillen	Supervisor, Infectious Diseases	410-901-8106		443-235-9489	N/A
Carla Bromwell	Supervisor, Family Planning	410-901-8175		410-463-2924	N/A

If the COOP cannot be implemented for any reason, such as too great a loss of personnel due to illness or death (pandemic, natural or man-made disaster) the DCHD operations and responsibilities will revert to the MDH. The MDH will then:

- Determine which health department or other organization will perform this public health mission for the county or
- Assume the responsibility for ensuring the continuous performance of the DCHD mission essential functions..

II. ESSENTIAL FUNCTIONS and KEY PERSONNEL

It is important to establish priorities before an emergency to ensure that the relocated staff can complete the essential functions. All staff shall ensure that essential functions can continue or resume as rapidly and efficiently as possible during an emergency relocation. Any task not deemed mission essential must be deferred until additional personnel and resources become available. In the event that there is a loss of personnel, the Health Officer will determine the final priority of functions.

1. Essential Functions by Location

1. CRITICAL FUNCTIONS

a. 3 Cedar Street

CRITICAL FUNCTIONS or Services, which if Disrupted, Must be Restored within 12 Hours

Program	Essential Function	Description of Function	Priority within Program
Administration	Secretarial/Clerical Support—Emergency Preparedness	Coordinate clerical coverage during emergency & distribute correspondence as directed by Emergency Preparedness Coordinator	1
Administration	Public Information Announcements	Inform public on relevant health issues	1
Administration	Main Switchboard/Reception	Receive incoming calls/front desk reception	1
Administration	Purchasing/Receiving Freight	Process supply requests, check in freight & distribute to staff	1
Administration	Screening Medical Assistance Transportation Calls	Screen calls	1
Administrative Care Coordination Unit	Coordination of Care Single Point of Entry	Coordinate patient care including locating providers, billing issues, MCO education and navigation, other available programs resource and prevent barriers to care	1
Building Maintenance	Doors/Alarms	Unlock public entrance doors and deactivate the security alarms system	1
Building Maintenance	Building Functions	Confirm that building functions are operating properly	1

3 Cedar Street
CRITICAL FUNCTIONS or Services, which if Disrupted, Must be Restored within 12 Hours

Building Maintenance	Investigate Complaints	Investigate malfunction complaints	1
AIDS/HIV	Crisis Intervention—Urgent Referrals	Directing clients to needed care or services	1
Emergency Preparedness	EOC Liaison	Represent DCHD during times when EOC is activated	1
Emergency Preparedness	DCHD Contact to MDH OP & R	Gather and report requested information during times of emergency	1
Emergency Preparedness	Assist with Health Care in Shelters	Provide nursing coverage at shelters opened by Emergency Management Agency	1
Environmental Health--Food	Food-borne Illness Investigation	Investigation prompted by two or more cases of food borne illness, per COMAR 10.15.03	1
Environmental Health--Food	Local Emergency Response	Response to public safety emergencies created by nature or humans	1
Environmental Health--Food	Response to Food Facility Emergencies	Food facilities experiences disruption in service requiring immediate enforcement action	1
Information Technology	Run Backup of Server at Main Building	Insert appropriate tape in tape drive after removing previous day's backup and storing that tape in a fire-proof safe as well as transmitting offsite network backup to Cecil Co Health Dept	1a Handled in order listed
Information Technology	Maintain Main Server at Main Building	Diagnose server related hardware and software problems and make repairs and adjustments or obtain service from hardware, software, or maintenance vendors as required	1b
Information Technology	Maintain Server at Addictions	Diagnose server related hardware and software problems and make repairs and adjustments or obtain service from hardware, software, or maintenance vendors as required	1c
Information Technology	Network Set-up for New Users	Assign new users user-id's, passwords, and network privileges	1d

3 Cedar Street
CRITICAL FUNCTIONS or Services, which if Disrupted, Must be Restored within 12 Hours

Program	Essential Function	Description of Function	Priority within Program
Information Technology	Setup Workstations	Install and maintain PC's and associated software assigned to individual users	1e
Information Technology	Maintain Network Security	Monitor network activity, look for intrusion activity and take action necessary to eliminate it	1f
Information Technology	Maintain Network Performance	Monitor the performance of network software and hardware and recommend and implement upgrades as necessary	1g
Maryland Children's Health Program	MCHP Eligibility Determinations	Medicaid eligibility and re-determinations	1

b. 524 Race Street

CRITICAL FUNCTIONS or Services, which if Disrupted, Must be Restored within 12 Hours

Program	Essential Function	Description of Function	Priority within Program
Addictions	Assessments	Determine eligibility & level of client placement in person or via phone/phone conferencing	1
Addictions	Counseling	Group/Individual/Family Counseling in person or via phone/phone conferencing	1
Addictions	Client Transportation	Provide transportation services to facilitate clients access to counseling services	1
Addictions	Telephone	Provide telephone service for making client appointments and provide communications for all staff and clients	1
Addictions	Client Recordkeeping	Maintaining client's charts	1
DriDock	Communication	Provide information to staff/members	1
DriDock	Recordkeeping	Access to records (client/billing/contact)	1

c. Public Schools

CRITICAL FUNCTIONS or Services, which if Disrupted, Must be Restored within 12 Hours

Program	Essential Function	Description of Function	Priority within Program
School Health	Promote and Protect the Optimal Health of Students	-sick and injured care -administer medications and treatments	2
Wellness Center	Acute Health Care	Provide acute care to students/staff enrolled in wellness center. Emergency care as needed	1
Wellness Center	Maintain Contact with Parents	Call or letter to parent/guardian	1
Wellness Center	Maintain Written Health Records	Written notes of health office visit	1

2. PRIORITY FUNCTIONS

a. 3 Cedar Street

PRIORITY FUNCTIONS or Services, which if Disrupted, Must be Restored within 24 Hours

Program	Essential Function	Description of Function	Priority within Program
Administration	Vehicle Distribution	Assign cars to drivers	2
Administration	Vehicle Maintenance	Service vehicles for routine maintenance; repair or make arrangements for repair	2
Administration	Maintain Physical Vital Records	Insure confidentiality & safety of birth & death records	2
Administration	Mail	Process all incoming & outgoing mail, transport to Post Office	2
Administration	Collections/Bank Deposits	Sign receipt books, distribute check copies from checks received via USPS; prepare bank deposit, verify & take deposit to bank	2
Administration	Arranging/Investigating transportation requests	Arranging/investigating transportation requests	1
Building Maintenance	Maintenance	Maintain building infrastructure	2
AERS/CFC/CPAS	AERS & NM Billing	Submit Assessments and NM bills/invoices.	1
AERS/CFC/CPAS	Community Inquires	Take referrals, provide information & consultation, identify/address crisis needs	2
AIDS/HIV	Crisis Intervention—Medication Monitoring	Assisting clients with obtaining pre-filled pill boxes and monitoring medication prescriptions/adherence	2
AIDS/HIV	Crisis Intervention—Medical Transports	Transporting clients to urgent/important medical appointments	2
BCCP	Application Process for Diagnosis and Treatment Program	Provides and assist with application to the Diagnosis and Treatment Program	1

3 Cedar Street

PRIORITY FUNCTIONS or Services, which if Disrupted, Must be Restored within 24 Hours

Program	Essential Function	Description of Function	Priority within Program

Communicable Disease	Refer for Chest X-ray	Requisition written and given to patient who will go to local hospital for chest x-ray to rule out active disease	1
Communicable Disease	Directly Observed Therapy for Active Tuberculosis Cases	Observe Tuberculosis patient while taking each pill of TB medication regimen	1
Communicable Disease	Contact Investigation	Contacts of reportable diseases (including STD's)-interviewed, examined if necessary and treatment given if warranted	1
Communicable Disease	Refer for Chest X-ray	Requisition written and given to patient who will go to local hospital for chest x-ray to rule out active disease	1
DDA	Assess Service System	Initiate programs to fill gaps in identified area of need/crisis prevention and intervention	1
Emergency Preparedness	Organize and Supervise Operation of POD's	Distribute medication, vaccines, etc. during times of emergencies	1
Emergency Preparedness	Supervise Disaster Mental Health Teams	Coordinate response of mental health teams to staff and county residents during time of need	1
Environmental Health--Food	Food Facility Inspections—Critical Violations	Critical violations of COMAR 10.15.03 are immediate hazards to public health	1
Environmental Health—Water	Water Quality/Potability Sampling—Catastrophic Event	Large scale, area wide sampling to reestablish potable drinking water	1
Environmental Health--Rabies	Rabies Control	Investigate all reported animal bites and respond to situation according to protocol	1
Health Education	Community Health Education—Inform	Inform, educate and empower people about critical health issues affecting the county in emergency situations.	1

b. 524 Race Street

PRIORITY FUNCTIONS or Services, which if Disrupted, Must be Restored within 24 Hours

Program	Essential Function	Description of Function	Priority within Program
DriDock	Client Transportation	Provide transportation to/from treatment, appointments, etc.	1

c. *Public Schools*

PRIORITY FUNCTIONS or Services, which if Disrupted, Must be Restored within 24 Hours

Program	Essential Function	Description of Function	Priority within Program
Wellness Center	Maintain Contact with Primary Care Providers	Fax or mail health visit information	1

Note: After one week of emergency operations either normal operation must be reinstated or emergency operations must ensure the functions listed below are performed.

3. ON-GOING FUNCTIONS

a. 3 Cedar Street

ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
Administration	Payroll Verification	Check accuracy of employee paychecks	2
Administration	Timekeeping	Assure timely and accurate processing of employee timesheets and leave documentation	2
Administration	Payroll Exception Reporting	Notification of errors in payroll that cannot be corrected by adjusting the employee's timesheet	2
Administration	Invoice Processing	Verify accuracy & code invoices; post to FMIS & OSAS; send to Comptroller's office	2
Administration	Invoice Authorization	Authorize direct vouchers in FMIS	2
Administrative Care Coordination	Complaint Resolution Referrals	Follow up on complaint referrals received and resolve based on individual issues such as MCO education and navigation, locating specialty providers, dental, vision etc.	1
Administrative Care Coordination	Local Health Service Request/Maryland Prenatal Risk Assessments/Infant ID/Self referrals	Follow up on referrals received from MCO's, providers and local health departments regarding non-compliance with immunizations, keeping appointments, substance abuse, etc. Care coordination for Pregnant Women/Children/Adults	1
AERS/CFC/ CPAS	Conduct Evaluations and perform NM activities,(NM Activities in the absence of the contracted NM RN/Agency).	Perform GES, STEPS, PASRR,CFC,CPAS, RSA Checklists & Waiver evaluations. Submit interRAI subset and NM activity notes in the absence of the contracted Nurse Monitor/Agency	1
AERS/CPAS	Short Term Case Management	Take referrals & monitor service linkages	1
AERS/CPAS	Clerical Support	Data entry, statistical reports, typing, LTSS tracking system & PatTrac entry/oversight	2
AERS/CPAS	Documentation	Format evaluations & recommendations	2
AIDS/HIV	HIV Prevention/Counseling & Testing	HIV antibody test pre- and post-test counseling	3

3 Cedar Street
ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
BCCP	Screening Services for Breast and Cervix	Provides a clinical breast exam, mammogram and pelvic/PAP to program eligible women (symptomatic women have higher priority)	1-symptoms 2- no symptoms
BCCP	Insurance Navigator	Refer and direct to enroll, if eligible, with Maryland Health Benefit and/or Medical Assistance	2
Child Health	Lead Case Management	Provide education to children with elevated blood lead levels of 10 – 14 with follow-up blood lead levels and case management and education to children with elevated blood lead levels >15	1
Child Health	Baby Matters	Provide face-to-face or telephonic contact to medical assistance recipients who are pregnant or under age 2 years with risk factors that could result in poor health outcomes	1
Child Health	Immunization Clinic	Provides immunizations according to State of Maryland guidelines to children ages birth to 18 years in the clinic setting	2
CRF-colorectal	Client Enrollment—Colorectal	Enrollment into Colorectal Cancer Screening Program—intake & referrals	1
CRF-colorectal	Client Recalls-Colorectal	Monthly recalls for clients due for repeat colonoscopies	2
CRF-tobacco	Individual Session with RN-Tobacco	Counseled on cessation and provided with NRT	2
CRF	Billing	Processing invoices received for colorectal & tobacco programs	2
Communicable Disease	Rabies Treatment Surveillance	On-going monitoring of client receiving post-exposure rabies vaccine for completion of treatment	1
Communicable Disease	Preventative Medication Administration for TB Contacts with Positive PPD	In collaboration with patient's health care provider, patient will be started on preventative TB medication	1

3 Cedar Street

ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
Communicable Disease	Communicable Disease Billing	Third party and self-pay billing and monitoring accounts receivable	1
Communicable Disease	Sexually Transmitted Disease Clinic	Examinations and testing performed to diagnose STD's. Treatment ordered or given if necessary.	2
Communicable Disease	Ordering Medications/Supplies/Vaccines	Order specific medications/vaccines/supplies on requisition and have signed for approval	2
Communicable Disease	PPD Skin Test Screening for Active Tuberculosis Case Contacts	Initial PPD skin test to determine baseline exposure to TB. Repeat PPD skin test in 10 – 12 weeks	2
Emergency Preparedness	Educate DCHD in ICS and NIMS	Assure all employees of DCHD are compliant with NIMS requirements	3
Environmental Health--Food	Nuisance Complaint Investigations	Conduct investigation of complaint received from public regarding violations at food facilities	3
Environmental Health—Food	Temporary Food Event Permits	Assess safety of procedures used in food preparation and service at temporary, occasional events	3
Environmental Health—Sewage	Septic System Installation Inspections	Inspect all septic system installations prior to covering	2
Environmental Health—Sewage	Septic Permit Issuance—Repair	Provide minimum specifications for a replacement septic system	2
Environmental Health—Sewage	Land Evaluations for Septic Repairs	Return property to a non-hazardous condition	2
Environmental Health—Water	Well Construction Permits—Emergency	Issuance of well permits when customer is out of water	1

3 Cedar Street
ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
Environmental Health--Water	Water Quality/Potability Sampling—Doctor's Request	Water quality sampling due to illness	1
Family Planning	Family Planning Clinic	Provide GYN care and birth control services to women of reproductive age according to MDH Family Planning clinical guidelines	1
Family Planning	Birth Control Visits—Current Clients	Birth control pickup or evaluation	1
Family Planning	Lab Follow-Up	Address lab results as they come back and make sure appropriate action is taken	1
Family Planning	Emergency Contraception Protection	Provide emergency contraception to unprotected sexually active patient	1
Family Planning	Billing/Accounts Receivable	Submit billing claims/receive payment	1
Family Planning	Mailing	Contact patient via mail re: appointment, test results, certified letter	2
Family Planning	Data Entry	Data transferred from lab/chart to Ahlers data software/PatTrac	3
Family Planning	Ordering Supplies including Medications	Ordering proper amount of birth control, antibiotics, etc. as needed	3
Family Planning	Family Planning Meeting	Obtain updates on Family Planning	3
Health Education	Community Health Education—Assess	Assess and monitor the county's health status to identify immediate community health problems in emergency situations	3
Health Education	Community Health Education—Mobilize	Mobilize community partnerships to identify and solve immediate and critical health problems during an emergency in the county	3
Healthy Families	Crisis Intervention	Assist families with unexpected crises that may arise between scheduled home visits	2

3 Cedar Street

ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
Healthy Families	Voluntary Home Visiting	Home visits to enrolled families focused on positive parenting, child development & enhanced family functioning	3
Maryland Children's Health Program	Processing of Medicaid for Continued Eligibility	Process MCHP redetermination applications and determine eligibility based on information received	2
Maryland Children's Health Program	Determine MCHP Eligibility for New Applicants	Determine eligibility based on information received	1

b. 524 Race Street

ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
Addictions	Client Scheduling	Scheduling client appointments for assessments	1
Addictions	Drug Screens	Gather client samples (breath/urine/saliva, etc.) to determine if substances are present in client's system (will be suspended during a social distancing order)	2
Addictions	Timesheets	Reviewing timesheets for timekeeping & payroll	2
Addictions	Billing	Posting payments, processing authorizations, self-pay/insurance billing, follow-ups	2
Addictions	Data Reporting	Recording and reporting clients admissions/discharges and other misc. statistics to ADAA for State reporting	2
Addictions	Correspondence	Tracking and maintaining written correspondence as it relates to the business of addictions treatment	2
Addictions	Admissions/Discharges	Admitting/Discharging clients in/out of the program	2
DriDock	Client Scheduling	Meeting with members and prospective clients	1
DriDock	Data reporting	All required reporting to state level	2
DriDock	Timesheets	Reviewing timesheets for timekeeping & payroll	2
DriDock	Billing	Documentation of encounters/service delivery for ATR program	2

c. Public Schools

ON-GOING FUNCTIONS that are not Considered Critical or Priority but Must be Continued for Program to Function

Program	Essential Function	Description of Function	Priority within Program
Wellness Center	Mental Health Assessment and Treatment—Continuation of Treatment	Ability to communicate with clients and provide treatment services as needed	1
Wellness Center	Billing	Billing insurance companies	2

Note: After one month of emergency operations all functions must be resumed at some level by priorities determined by the Health Officer.

2. Key Personnel

1. 3 Cedar Street

Administration

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Secretarial/Clerical Support—Emergency Preparedness	Gregory Coleman	Linda Bradford	Carla Neugroschel	Donna Reed	Cheryl Bailey
Public Information Announcements	Roger Harrell	Casey Scott	Angela Grove	Lanise Mohn	Individual Program Managers
Main Switchboard/Reception	Alyssa Holliday	Cinthya Herrnandez	Tina Daniel	Linda Bradford	Jennifer Willey
Purchasing/Receiving Freight	Sandra Bland	Jennifer Willey	Cheryl Bailey	Carla Neugroschel	
Screening Medical Assistance Transportation Calls	Donna Reed	Theresa Hines	Maria Hernandez	Estrella Ramirez	Carla Neugroschel
Vehicle Distribution	Alyssa Holliday	Cinthya Hernandez	Tina Daniel	Linda Bradford	Jennifer Willey
Vehicle Maintenance	Gothlee Johnson	Linda Bradford	Alyssa Holliday	Jennifer Willey	Cinthya Hernandez
Maintain Physical Vital Records	Linda Bradford	Jennifer Willey	Sandra Bland		
Mail	Alyssa Holliday	Cinthya Hernandez	Jennifer Willey	Linda Bradford	Cheryl Bailey
Collections/Bank Deposits	Jennifer Willey	Sandy Bland	Carla Neugroschel	Cheryl Bailey	Gregory Coleman
Arranging/Investigating transportation requests	Donna Reed	Theresa Hines	Maria Hernandez	Estrella Ramirez	Carla Neugroschel
Payroll Verification	Carla Neugroschel	Greg Coleman	Cheryl Bailey	Sandy Bland	Jennifer Willey
Timekeeping	Gregory Coleman	Carla Neugroschel	Cinthya Hernandez	Jennifer Willey	
Payroll Exception Reporting	Gregory Coleman	Carla Neugroschel	Cinthya Hernandez	Jennifer Willey	

Administration (cont.)

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Invoice Processing	Jennifer Willey	Sandra Bland	Cheryl Bailey	Carla Neugroschel	
Invoice Authorization	Sandra Bland	Cheryl Bailey	Roger Harrell	Carla Neugroschel	

Building Maintenance

Essential Function	Key Position	Successor 1	Successor 2	Successor 3
Doors/Alarms	David Thompson	Robert Tyler	Other county maintenance staff	Keith Adkins
Building Functions	David Thompson	Robert Tyler	Other county maintenance staff	Keith Adkins
Investigate Complaints	David Thompson	Robert Tyler	Other county maintenance staff	Keith Adkins
Maintenance	David Thompson	Robert Tyler	Other county maintenance staff	Keith Adkins

Administrative Care Coordination

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Coordination of Care Single Point of Entry	Belinda Galanek	Fay Wilson	Millie Morales		
Complaint Resolution Referrals	Fay Wilson	Belinda Galanek			
Local Health Service Request/MPRA/Infant ID's/Self referrals	Millie Morales	Belinda Galanek			

AERS/PC

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
CFC/`CPAS Evaluations	Donielle Shores	Glenda Vaughan	Beth Barcus		
Community Inquires	RN or SW Assigned	Glenda Vaughan	Beth Barcus	Donielle Shores	
Conduct Evaluations	RN or SW Assigned	Beth Barcus	Donielle Shores	Glenda Vaughan	
Short Term Case Management	RN or SW Assigned	Beth Barcus	Glenda Vaughan	Donielle Shores	Short Term Case Management
Clerical Support	Tina Daniel	Jen Willey	Sandra Bland	Christine English	Clerical Support
Documentation	RN or SW Assigned	Beth Ireland	Donielle Shores	Glenda Vaughan	

AIDS/HIV

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Crisis Intervention—Urgent Referrals	Lori Conklin	Katherine Harrison	Tavonya Chester	Susan Russ	Suzanne Frost
Crisis Intervention—Medication Monitoring	Lori Conklin	Susan Russ	Suzanne Frost	Katherine	Lanise Mohn
Crisis Intervention—Medical Transports	Lois Elliot	Tavonya Chester	Katherine Harrison	Suzanne Frost	Susan Russ
HIV Prevention/Counseling & Testing	Katherine Harrison	Tavonya Chester	Lori Conklin	Susan Russ	Suzanne Frost

Child Health

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Lead Case Management	Valerie Laureska	Kate Price	Carla Bromwell	Pam Quillen	
Child Health	Valerie Laureska	Pam Quillen	Carla Bromwell		
Immunization Clinic	Valerie Laureska	Pam Quillen	Carla Bromwell		
Lead/Asthma	Kate Price	Carla Bromwell	Annette Matias Rodriguez		

Cigarette Restitution Fund—Colon/Tobacco

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Case Manage Clients--Colon	Kathy Riggins	Pam Quillen			
Client Enrollment—Colorectal	Kathy Riggins	Pam Quillen			
Client Recalls-Colorectal	Kathy Riggins	Pam Quillen			
Individual Session with RN-Tobacco	Miranda LeCompte				
Billing	Pam Quillen	Kathy Riggins	Cheryl Bailey		

Communicable Disease

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Disease Surveillance	Pam Quillen	Kathy Riggins	Carla Bromwell		
Refer for Chest X-ray	Pam Quillen	Kathy Riggins	Carla Bromwell		
Directly Observed Therapy for Active Tuberculosis Cases	Pamela Quillen	Valerie Laureska	Carla Bromwell		
Contact Investigation-non-STD's	Pam Quillen	Kathy Riggins	Carla Bromwell		
Contact Investigation- STD's	Kara Eckels	Kathy Riggins	Pam Quillen	Carla Bromwell	
Rabies Treatment Surveillance	Pamela Quillen	Kathy Riggins	Carla Bromwell		
Preventative Medication Administration for TB Contacts with Positive PPD	Casey Scott, MD	Pam Quillen	Kristie Gauck, CRNP		
Communicable Disease Billing	Christine English	Cindi Link	Mary Clay	Sarah Robinson	Tempia Cooper
Accounts Receivable	Michelle Moulds	Kathy King	Mary Clay	Cindi Link	Christine English
Sexually Transmitted Disease Clinic	Casey Scott, MD	Kristie Gauck, CRNP			
Ordering Medications/ Vaccines	Pamela Quillen	Valerie Laureska	Carla Bromwell		
Ordering Supplies	Pat Gardner	Kara Eckels	Carla Bromwell		
PPD Skin Test Screening for Active Tuberculosis Case Contacts	Pamela Quillen	Valerie Laureska	Carla Bromwell		

Developmental Disabilities Administration Resource Coordination

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Assess Service System	Brice Strang	Daneya Borradaile	Ebone Dorman	Stephanie Humphries	

Emergency Preparedness

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
EOC Liaison	Brice Strang	Brice Strang	Roger Harrell	Lanise Mohn	Pam Quillen
DCHD Contact to MDH OP & R	Brice Strang	Brice Strang	Roger Harrell	Lanise Mohn	Pam Quillen
Assist with Health Care at EMA Shelters	Pam Quillen	Carolyn Hallowell	Carla Bromwell	Lanise Mohn	
Organize and Supervise Operation of POD	Pam Quillen	Carla Bromwell	Kara Eckels		
Supervise Disaster Mental Health Team	Christa Chelsey	Beth Spencer			
Educate DCHD in ICS and NIMS	Brice Strang	Lanise Mohn	Pam Quillen		

Environmental Health

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Food-borne Illness Investigation	Gayle Schneider	Paul Galanek			
Local Emergency Response	William Forlifer	Paul Galanek	Kim Keene		
Response to Food Facility Emergencies	Gayle Schneider	Paul Galanek			
Food Facility Inspections—Critical Violations	Gayle Schneider	Paul Galanek			
Water Quality/Potability Sampling—Catastrophic Event	William Forlifer	Paul Galanek	Kim Keene		
Rabies Control	Kim Keene	William Forlifer	Paul Galanek		
Nuisance Complaint Investigations	Gayle Schneider	Paul Galanek	Kim Keene		
Temporary Food Event Permits	Gayle Schneider	Paul Galanek			

Septic System Installation Inspections	Paul Galanek	Kim Keene	William Forlifer		
Septic Permit Issuance—Repair	William Forlifer	Paul Galanek	Kim Keene		
Land Evaluations for Septic Repairs	Paul Galanek	William Forlifer	Kim Keene		
Well Construction Permits—Emergency	Paul Galanek	Kim Keene	William Forlifer		
Water Quality/Potability Sampling—Doctor's Request	Kim Keene	Paul Galanek	William Forlifer		

Family Planning

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Family Planning Clinic	Casey Scott, MD	Kristie Gauck, CRNP			
Birth Control Visits—Current Clients	Carla Bromwell	Valerie Laureska	Pam Quillen		
Lab Follow-Up	Carla Bromwell	Valerie Laureska	Pam Quillen		
Emergency Contraception Protection	Carla Bromwell	Valerie Laureska	Pam Quillen		
Billing	Christine English	Cindi Link	Mary Clay	Sarah Robinson	Tempia Cooper
Accounts Receivable	Michelle Moulds	Kathy King	Mary Clay	Cindi Link	Christine English
Data Entry-Ahlers	Carla Bromwell	Pat Gardner	Valerie Laureska		
Ordering Supplies	Pat Gardner	Kara Eckels	Carla Bromwell	Pam Quillen	
Ordering Medications	Carla Bromwell	Pam Quillen			
Mailing	Pat Gardner	Carla Bromwell	Valerie Laureska		
Family Planning Meeting	Carla Bromwell	Valerie Laureska	Casey Scott, MD	Pat Gardner	

Health Education

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Community Health Education—Inform	Angela Grove	Julie Jones	Charlene Jones	Erin Hill	Miranda LeCompte
Community Health Education—Assess	Angela Grove	Julie Jones	Charlene Jones	Erin Hill	Miranda LeCompte
Community Health Education—Mobilize	Angela Grove	Julie Jones	Charlene Jones	Erin Hill	Miranda LeCompte

Healthy Families

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Crisis Intervention	Assigned Home Visitor	Home Visitor #2	Home Visitor #3	Home Visitor #4	Supervisor
Voluntary Home Visiting	Assigned Home Visitor	Home Visitor #5	Home Visitor #6	Home Visitor #	Supervisor

Names of Home Visitors:
Robin Alexander
Mary-Angela Martin
Jessica Johnson
Beryl Long
Kaitlyn Jolley
Kim Turner (sup)
Valerie Davis (sup)

Information Technology

Essential Function	Key Position	Successor 1	Successor 2	Successor 3
Maintain Main Server at Main Building	Jeff Parmer	Alan McIntee	**Steven Brechbiel** IT Department Network Administrator Mobile (443) 553-2691 Office (443) 245-3755 Fax (410) 996-5179 steven.brechbiel@maryland.gov	Carol Crouch Queen Anne Co HD IT 410-758-0820
Maintain Network Security	Jeff Parmer	Alan McIntee	James Karns Eastern Shore Hospital Center 410-221-2470	Carol Crouch Queen Anne Co HD IT 410-758-0820
Maintain Server at Addictions	Jeff Parmer	Alan McIntee	James Karns Eastern Shore Hospital Center 410-221-2470	Carol Crouch Queen Anne Co HD IT 410-758-0820
Maintain Network Performance	Jeff Parmer	Alan McIntee	James Karns Eastern Shore Hospital Center 410-221-2470	Carol Crouch Queen Anne Co HD IT 410-758-0820
Network Set-up for New Users	Jeff Parmer	Alan McIntee	James Karns Eastern Shore Hospital Center 410-221-2470	Carol Crouch Queen Anne Co HD IT 410-758-0820
Run Backup of Server at Main Building	Jeff Parmer	Alan McIntee	James Karns Eastern Shore Hospital Center 410-221-2470	Carol Crouch Queen Anne Co HD IT 410-758-0820
Setup Workstations	Alan McIntee	Jeff Parmer	James Karns Eastern Shore Hospital Center 410-221-2470	Carol Crouch Queen Anne Co HD IT

Maryland Children's Health Program

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Assist applicants with online application	Carrie Slacum	Dawn Bradshaw	Richie White	Joyce Thomas	Fay Wilson
Determine MCHP Eligibility for New Applicants	Carrie Slacum	Dawn Bradshaw	Richie White	Joyce Thomas	Fay Wilson

3 Cedar Street

Maryland Children's Health Program

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Processing of MCHP for Continued Eligibility	Carrie Slacum	Dawn Bradshaw	Richie White	Joyce Thomas	Fay Wilson

2. 524 Race Street

Addictions

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Assessments	Lesley Williams	Andrea Mancini	Owen Smith	Ashley Hall	Sabrina Whalen
Counseling	Owen Smith	Andrea Mancini	Lesley Williams	Ashley Hall	Sabrina Whalen
Client Transportation	Hansel Greene	Delbert Benson	Delano Frazer		
Client Recordkeeping	Lesley Williams	Owen Smith	Andrea Mancini	Ashley Hall	Sabrina Whalen
Telephone	Delbert Benson	TBD	Delano Frazer		
Client Scheduling	Delbert Benson	TBD	Delano Frazer		
Drug Screens	Owen Smith	Lesley Williams	Sabrina Whalen	Ashley Hall	Andrea Mancini
Timesheets	Donal Hall	Cheryl Metzbower	Delano Frazer		
Billing	Cindi Link	Mary Clay	Christine English		
Data Reporting	Donald Hall	Cheryl Metzbower	Delano Frazer		
Correspondence	Donald Hall	Cheryl Metzbower	Delano Frazer		

DriDock

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Communication					
Recordkeeping					
Client transportation					
Scheduling					
Timesheets					
Data Reporting					

3. Public Schools

School Health

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Promote and Protect the Optimal Health of Students	RN, LPN assigned to the school	Carolyn Hallowell	Any RN, LPN, @ DCHD		

Wellness Centers

Essential Function	Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Acute Health Care CSDHS/MLMS or NDHS/NDMS	Kristie Gauck	Casey Scott			
Maintain Contact with Parents CSDHS/MLMS or NDHS/NDMS	Kristie Gauck	Casey Scott	Tempia Cooper	Celeste Korby	Sarah Robinson
Maintain Written Health Records CSDHS/MLMS or NDHS/NDMS	Kristie Gauck	Casey Scott			
Maintain Contact with Primary Care Providers CSDHS/MLMS or NDHS/NDMS	Tempia Cooper	Celeste Korby	Sarah Robinson	Kristie Gauck	Casey Scott
Mental Health Assessment and Treatment—Continuation of Treatment	Mona Carey	Mindy Black-Kelly	Sue Radcliffe	Christa Chesley	Summer Trader
Billing	Christine English	Cindi Link	Mary Clay	Sarah Robinson	Tempia Cooper

III. Delegation of Authority

In any public health emergency or disaster, the Health Officer of the DCHD has primary authority and responsibility for the agency's response to the incident or event including COOP activation. If the Health Officer is unavailable or unreachable for an extended period of time, responsibility shall pass to the next position in the line of succession. The designated individual retains all assigned obligations, duties, and responsibilities of the Health Officer until officially relieved by an individual higher on the list of succession or until the Health Officer re-assigns administrative responsibility.

(Unavailable is defined as: The designated person is incapable of carrying out the assigned duties by reason of death, disability, or distance from or response time to the incident.)

Per COMAR 17.04.01.04 (5) the Health Officer has delegated the following individuals as authorized successors:

1. Director, Nursing, Clinical/Case Management, EP- Lanise Mohn
2. Director, Environmental Health—William Forlifer
3. Director, Addictions—Donald Hall
4. Director, Healthy Families—Beth Spencer
5. Deputy Health Officer- Dr. Casey Scott

Delegation shall be determined/ approved by the Health Officer for all essential functions and will be effective immediately upon designation. Delegation will last for an indefinite period of time. The Health Officer will determine when delegations are no longer required.

All duties and responsibilities associated with the key position will go to the successor in the event the titleholder is unable to fulfill their responsibility. All successors meet the minimum legal requirements for the position (licensure or certification) and have been trained in the essential function.

Order of Succession

Succession of duties will occur if the Key Position is unavailable. The successors will perform essential duties for time limits set forth by MDH regulations regarding acting capacity.

IV. VITAL RECORDS, SYSTEMS AND EQUIPMENT PROTECTION

A. First 12 Hours—Critical Functions

Program	Essential Function	Vital Records	Equipment and Systems
Addictions	Assessments	State of Maryland Automated Record Tracking (SMART) data	SMART, ASI and POSIT software; Computer; Printer
Addictions	Counseling	SMART data	SMART; computer; Printer
Addictions	Client Transportation	Transportation tracking—vehicle log book	State vehicle
Addictions	Client Recordkeeping	SMART data	SMART; computer
Administration	Secretarial/Clerical Support—Emergency Preparedness	Call down lists	Telephones
Administration	Public Information Announcements	Literature or educational materials pertaining to issue	Network; Public radio; Television; Newspaper; Telephone; Fax; Copier
Administration	Main Switchboard/Reception	Phone extension list; Phone books; Miscellaneous Resource Directories	Switchboard; Fax
Administration	Purchasing/Receiving Freight	Supply requisitions; Purchase orders; Packing slips; Corporate purchasing cards, tax exempt certificate, CPC log sheets	Telephone; Copier; Fax; USPS; Computer; Internet connectivity; Miscellaneous delivery services
Administration	Screening Medical Assistance Transportation Calls	MA Transportation screening form	Telephone; PC; Printer; PatTrac program; Network
Building Maintenance	Doors/Alarms	All records/plans/contact information maintained by county	Keys; Security alarm system
Building Maintenance	Building Functions	All records/plans/contact information maintained by county	N/A
Building Maintenance	Investigate Complaints	N/A	N/A
ACC	Coordination of Care Single Point of Entry	Community Resource Directory; Primary care and specialty provider listing	Phone; Computer

First 12 Hours—Critical Functions

Program	Essential Function	Vital Records	Equipment and Systems
Information Technology	Run Backup of Server at Main Building and transmit offsite backup to Cecil Co Hlth Dept	Instruction sheets/checklists	Server; Back-up tapes; Fireproof safe, Network MD, duplicators at DCHD & Cecil Co Hlth Dept
Information Technology	Setup Workstations	Instruction sheets/checklists	PC or lap tops
MCHP	MCHP Case Record Transfers	Electronic client record	Phone; Computer
School Health	Promote and Protect the Optimal Health of Students	Medication/treatment orders; Individual health/emergency care plans; "Guide for Emergency Care" binder	First aid supplies; Infection control supplies; School nurse "Go Bag"; AED; Individual and emergency stock medications and delivery systems; Diabetic, tube feeding & nebulizer treatment supplies and equipment
Wellness Centers	Acute Health Care	Health visit record	Medical equipment and supplies; Over the counter medications
Wellness Centers	Maintain Contact with Parents	Form letter to parent or guardian if unavailable to reach by telephone	Phone; Mailing supplies
Wellness Centers	Maintain Written Health Records	Health visit record	No system or equipment—writing supplies only

B. First 24 hours—Priority Functions

Program	Essential Function	Vital Records	Equipment and Systems
Addictions	Telephone	Appointment book; Telephone book	Telephone
Administration	Vehicle Distribution	Vehicle log	Vehicles, keys
Administration	Vehicle Maintenance	Warranty records	Automotive tools
Administration	Maintain Physical Vital Records	Death records	N/A
Administration	Mail	N/A	Postage machine/scale; Postage download system; Telephone line
Administration	Collections/Bank Deposits	Receipt books; Stat Sheet; Checks & money orders; Bank deposit slips; Deposit sheets; bank bag; petty cash	Copier; Safe
Administration	Arranging/Investigating transportation requests	Trip request data forms Booking data file	Fax; PC; Printer; EVS; Telephone; PatTrac; network
Building Maintenance	Maintenance	Maintained by County off-site	Maintained by County
AERS/CPAS	Community Inquires	AERS/CPAS patient records/forms; data base lists	Computer; Phone; Fax; lap top
AERS/CPAS	AERS & NM Billing	AERS client record; Financial records and access to LTSS NM Activity Reports	Computer;Internet; PatTrac Program software; Printer; Phone; Fax
AIDS/HIV	Crisis Intervention—Ryan White Emergency Funding	Client chart	Phone; Fax; Computer; Laptop; Internet; Careware & PatTrac Program software; calendar
AIDS/HIV	Crisis Intervention—Medication Monitoring	Client chart	Phone; Fax; Computer; Laptop; Internet; Careware Program software; calendar; Pill boxes

First 24 hours—Priority Functions

Program	Essential Function	Vital Records	Equipment and Systems
AIDS/HIV	Crisis Intervention—Medical Transports	Appointment book; Calendar; Client chart	Phone; Fax; Computer; Laptop; Internet; Careware Program software; Vehicle; Cell phone
BCCP	Application Process for Diagnosis and Treatment Program	Application form for Diagnosis and Treatment Program	1 Telephone; Fax; Computer; Copier; CAST software
CRF-Colorectal	Case Manage Clients--Colon	CPEST data forms	Phone; Fax; Computer
Communicable Disease	Disease Surveillance—required by COMAR to be reported within 24 hours	Patient chart; NEDSS data; Lab reports; Morbidity reports	Telephone; Computer; NEDSS software
Communicable Disease	Refer for Chest X-ray	Requisition	Telephone
Communicable Disease	Directly Observed Therapy for Active Tuberculosis Cases	Patient chart	Telephone; Vehicle; TB meds
Communicable Disease	Contact Investigation	Patient chart; Lab results; Medication orders	Telephone; USPS; Medication/vaccine
DDA	Assess Service System	Individual's chart	Computer; internet access to PCIS2 & Access; cell phone
DriDock	Transportation	Vehicle log book	State vehicle
Emergency Preparedness	Organize and Supervise Operation of POD's	COMAR & CDC directives	Computer; Cell phone; 800 MHz radio; supply tubs
Emergency Preparedness	Supervise Disaster Mental Health Teams	DCHD Disaster Mental Health plan	Computer; Cell phone; 800 MHz radio
Environmental Health--Food	Food Facility Inspections—Critical Violations	Food facility inspection records	Inspection equipment; Computer
Environmental Health—Water	Water Quality/Potability Sampling—Catastrophic Event	N/A	Vehicle; Lab forms (supplies); Sample containers; Ice
Environmental Health--Rabies	Rabies Control	Rabies vaccination data; Report records	Vehicle; Lab forms (supplies); Specimen bags; Coolers; Ice

First 24 hours—Priority Functions

Program	Essential Function	Vital Records	Equipment and Systems
Health Education	Community Health Education—Inform	Press Releases from local, state & Federal agencies; Educational brochures, flyers specific to critical health issues related to the emergency; Information to develop brochures, flyers, and PSAs specific to critical health issues related to the emergency	Computers; Internet; Supplies; Copier; Flash drives; Telephone; Vehicle
Wellness Center	Maintain Contact with Primary Care Providers	Health visit record	Fax; Mailing supplies; Copier

C. On-Going Functions

Program	Essential Function	Vital Records	Equipment and Systems
Addictions	Client Scheduling	Appointment book; Protomed electronic recordkeeping data; Celerity	Protomed system; Computer; Internet; Celerity; Telephone; Printer
Addictions	Drug Screens	Drug screening logbook	Breathalyzer; Courier service—DHL
Addictions	Timesheets	Timesheets	Computer
Addictions	Billing	Protomed data	Computer; Internet; Celerity Telephone; Fax; Printer; Protomed System
Addictions	Data Reporting	SMART data	SMART; Protomed; Telephone; Computer; Printer; Fax
Addictions	Correspondence	Letters/documents to various agencies, clients, etc.	Computer; Printer; Fax; USPS
Addictions	Admissions/Discharges	SMART data	SMART; Protomed; Computer; Printer
Administration	Payroll Verification	Exception reports; Check registers; Payroll summary reports; Workday timekeeping records	Network; Network printer; Annapolis Data Center (ADC); PC; Rhumba software; Internet; Workday
Administration	Timekeeping	Timekeeping records; leave cards; leave documentation; Workday timekeeping records	Network; Network printer; Annapolis Data Center (ADC); PC; Rhumba software; Internet; Workday

On-Going Functions

Program	Essential Function	Vital Records	Equipment and Systems
Administration	Payroll Exception Reporting	Check registers; payroll summary report; Workday timekeeping records; Exception report	PC; printer; Fax; gmail; internet / ADC connectivity
Administration	Invoice Processing	Invoices; Purchase orders; Packing slips; mail code listing, cd's, envelopes	PC; scanner; ADC; USPS; Rhumba software; Network; Network printer; Open Systems (OSAS) software
Administration	Invoice Authorization	Invoices	PC; Network; ADC; Rhumba
ACC	Complaint Resolution Referrals	Client complaint referral/Community resource list	Phone; Computer
ACC	Local Health Service Request/MPRA/Infant ID's/Self Referrals	Client referrals/Community resource list	Phone; Computer
AERS/CPAS	Conduct Evaluations	Evaluation forms; Regulation guidelines	Vehicle; Phone; Computer; Printer' lap top; MiFi
AERS/CPAS	Short Term Case Management	CPAS& AERS patient records	Phone; Fax; Computer; Printer; lap top
AERS/CPAS	Clerical Support	CPAS& AERS client & administrative information	Phone; Computer; fax; Printer;Internet; PatTrac Program software
AERS/CPAS	Documentation	AERS/CPAS evaluations	Computer; lap top; Printer; MiFi; PatTrac Program software
AIDS/HIV	HIV Prevention /Counseling & Testing	Client record; Testing results	Phone; Fax; Testing forms (supplies); Refrigerator
BCCP	Screening Services for Breast and Cervix	Patient chart; CAST data	Telephone; Fax; Copier; Computer; CAST software
Child Health	Lead Case Management	Patient record	Phone; Vehicle; Fax
Child Health	Healthy Start	Patient record	Vehicle; Phone

On-Going Functions

Program	Essential Function	Vital Records	Equipment and Systems
Child Health	Immunization Clinic	Patient record	Needles; Syringes; Cotton balls; Alcohol preps; Gloves; Fax; Phone
CRF-colorectal	Client Enrollment—Colorectal	Client Chart	Phone; Fax; Computer
CRF-colorectal	Client Recalls-Colorectal	Data from CPEST	Phone; Computer
CRF-tobacco	Individual Session with RN-Tobacco	Client chart	Phone; Blood pressure cuff
CRF	Billing	Invoices; Client Chart	Computer
Communicable Disease	Rabies Treatment Surveillance	Patient chart; Emergency Room record	Telephone; Fax; Computer
Communicable Disease	Preventative Medication Administration for TB Contacts with Positive PPD	Patient Chart	Telephone; Medication
Communicable Disease	Billing	Patient chart; medical records	PatTrac program
Communicable Disease	Accounts Receivable	Patient charges; bills; receipts	Computer
Communicable Disease	Sexually Transmitted Disease Clinic	Patient chart; Lab results	Microscope; Courier service; Medications
Communicable Disease	Ordering Medications/Supplies/ Vaccines	Requisition forms	Telephone; Fax
Communicable Disease	PPD Skin Test Screening for Active Tuberculosis Case Contacts	PPD cards; Active TB case chart	Telephone; PPD solution; Syringes; Sharps container
DriDock	Data reporting	Excel spreadsheet	Computer with Microsoft excel
DriDock	Billing	SMART records	Computer with internet access
Emergency Preparedness	Educate DCHD in ICS and NIMS	Notebook; PowerPoint presentation for IS-100 & IS-700	Computer; PowerPoint projector
Environmental Health--Food	Nuisance Complaint Investigations	Nuisance complaint form; Food facility inspection records	Inspection equipment; Computer

On-Going Functions

Program	Essential Function	Vital Records	Equipment and Systems
Environmental Health—Food	Temporary Food Event Permits	Food facility inspection forms Temporary food service event permit	Inspection equipment; Computer
Environmental Health—Sewage	Septic System Installation Inspections	Septic permit	Vehicle
Environmental Health—Sewage	Septic Permit Issuance—Repair	M-B-P Files	Computer; printer
Environmental Health—Sewage	Land Evaluations for Septic Repairs	M-B-P Files	All necessary field equipment
Environmental Health—Water	Well Construction Permits—Emergency	M-B-P Files	Computer; Printer
Environmental Health--Water	Water Quality/Potability Sampling—Doctor's Request	N/A	Vehicle; Lab forms (supplies); Sample containers; Ice
Family Planning	Family Planning Clinic	Patient chart; Ahlers/PatTrac data; Patient roster; Appointment book; CVR record	Speculum; Exam table; Culture medium; BP cuff; Stethoscope; Microscope; Scale; Computer; Ahlers/PatTrac software
Family Planning	Birth Control Visits—Current Clients	Patient chart; Ahlers/PatTrac data; CVR record	Birth control; BP cuff; Stethoscope; Scale; Computer; Ahlers/PatTrac software
Family Planning	Lab Follow-Up	Patient chart; Ahlers data	Telephone; USPS; Computer; Ahlers/PatTrac software
Family Planning	Emergency Contraception Protection	Patient chart; ECP record; Ahlers/PatTrac data; CVR record	ECP; BP cuff; Stethoscope; Pregnancy test; Computer; Ahlers/PatTrac software
Family Planning	Data Entry	Patient chart; Lab slip; Ahlers/PatTrac data	Computer; Ahlers/PatTrac software
Family Planning	Ordering Supplies including Medications	Supply requisition; Ahlers/PatTrac data	Computer; Ahlers/PatTrac software

On-Going Functions

Program	Essential Function	Vital Records	Equipment and Systems
Family Planning	Mailing	Patient chart; Letter to patient; Certified receipt; Appointment card; Ahlers data	Computer; Ahlers software; Office supplies
Family Planning	Family Planning Meeting	Written updates/minutes from: MDH-Family Planning Policy & Procedure; Reproductive Health Update; Annapolis Clinical meeting	Computer/lap top; internet connection
Health Education	Community Health Education—Assess	Assessment/data forms	Computers; Internet; Supplies; Copier; Flash drives; Telephone; Vehicle
Health Education	Community Health Education—Mobilize	Contact lists	Computers; Internet; Supplies; Copier; Flash drives; Telephone; Vehicle
Healthy Families	Crisis Intervention	Community Resource Binder; Participant record	Phones
Healthy Families	Voluntary Home Visiting	Participant record; Parenting/home visiting curricula	Toys/supplies
MCHP	Determine eligibility for New Applicants	Client information/forms	Computer; Internet
MCHP	Processing of MCHP for Continued Eligibility	Client information/forms	Computer; Internet
Wellness Centers	Mental Health Assessment and Treatment—Continuation of Treatment	Client medical record	Telephone; writing supplies
Wellness Centers	Billing	HCFA 1500; Pat Trac data	Computer; Billing software—Pat Trac

D. Back-up & Protection

Electronic records are backed up to server on a daily basis. The server is backed up daily and the tapes are stored in a fire proof safe onsite and the offsite tape at the Addictions location on Race Street. Server is also backed up daily to Cecil Co Health Department via duplicator in both locations.

E. Restoration and Recovery

Administration

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
MDH – Payroll / Timekeeping	Cathie Thompson	201 W. Preston Street Baltimore, MD (410) 767- 6425 M-F, 8-5, closed holidays	Supervision of Payroll and Timekeeping services; mainframe maintenance and document re-creation for timekeeping and payroll
MDH – General Accounting	Irma Bevans	201 W. Preston Street Baltimore, MD (410) 767- 5821 M-F, 8-5, closed holidays	Chief of Fiscal Services; accounting records maintenance
State of Maryland – General Accounting	Misc. auditors	80 Calvert St. – Room 203, P.O. Box 746, Annapolis, MD (410) 260 - 7330 M-F, 8-5, closed holidays	Maintenance of original vendor invoices
Delmarva Community Services, Inc.	Jerome Stanley	2450 Cambridge Beltway, Cambridge, MD (410) 221-1910 M-F, 8-5 closed holidays	Transportation vendor for ambulatory and wheelchair-van transports; maintenance of trip/booking data
Best Care Ambulance	Shirley K. Gardner	29468 Laurwayn Dr., Unit #11, Trappe, MD (410) 476-5905	Ambulance Transportation vendor; maintenance of ambulance trip data
Local funeral homes, hospital, physicians	Misc. Individuals	Misc.	Re-creation of death certificates

PatTrac	Lauren Malone	Lauren.malone@michaelgibson.com	Technical Assistance for database/software issues

Addictions/DriDock

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
BHS/SMART (web-based)	Sharon Olhavier	55 Wade Ave.; Catonsville MD 410-402-8602 M-F, 8-5, closed holidays	Behavioral Health Administration assist with restoration of data

AIDS/HIV; Family Planning

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
PatTrac	Lauren Malone	Lauren.malone@michaelgibson.com	Technical Assistance for database/software issues

BCCP

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
MDH	Jerry Gaylord Data Manager	201 W. Preston Street; Baltimore, MD 410-767-5861 M-F, 8-5, closed holidays	Restoration of data submitted to MDH on CAST program

Cigarette Restitution Fund

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
MDH	Lorraine Underwood Jia Soeliner	201 W. Preston Street; Baltimore, MD 410-767-0791 410-767-0815 M-F, 8-5, closed holidays	Restoration of data submitted to MDH on CPEST program

Communicable Disease

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
MDH	Joyce Mason	201 W. Preston Street; Baltimore, MD 410-767-6709 M-F, 8-5, closed holidays	Restoration of data submitted to MDH on NEDSS program
PatTrac	Lauren Malone	Lauren.malone@michaelgibson.com	Technical Assistance for database/software issues

DDA

Company Name	Contact Name	Address / Phone/Hours	Services
Eastern Shore Regional Office for DDA	Rachel White Dave Benjamin Kim Gscheidle	926 Snow Hill Road, Building 100 Salisbury, MD 21801 410-572-5920 M-F 8– 4:30 closed holidays On call Pager number on message	Regional office for DDA services. Will have many documents that can be reproduced to help re-build any lost at the local office level; review & approve emergency requests
"PCIS2" Maryland State Database for DDA	N/A	24/7 available with secure password at http://www.ddamaryland.org	Maintains demographic information, contact notes and individualized plans for all people assigned to resource coordination with DCHD. Maintains records regarding individuals funding through DDA
Delmarva Community Services	Santo Grande	2450 Cambridge Beltway Cambridge, MD 21613 410-221-1900 M-F 8– 4:30	Local provider agency records include the official plan for each individual actively served. Much of our record would be in the binders at the agency.
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance

Emergency Preparedness; Environmental Health; Health Education; ACCU; MCHP; Child Health; Healthy Families

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance

School Health/Wellness Centers

Company Name	Contact Name	Address / Phone/Hours	Services
DCHD – I.T. Department	Jeff Parmer	3 Cedar Street ; Cambridge, MD Phone: 410-901-8138 Cell: 443-477-1325	PC, program and server backups; server maintenance
Dorchester County Public Schools—IT Department	Rob Carpenter	700 Glasgow Street, Cambridge, MD 410-228-4747 M – F 8 - 5	PC program & server back-ups; server maintenance
PatTrac	Lauren Malone	Lauren.malone@michaelgibson.com	Technical Assistance for database/software issues

Please see Annex 1 for information on the establishment and recovery of Information and Technology Systems.

V. ALTERNATE WORK SITE ASSESSMENT and RELOCATION

The COOP will be implemented to address relocation in three phases, Activation, Alternate Facility Operations, and Reconstitution.

A. Activation and Relocation

1. Decision Process

The purpose of a time-phased implementation is to maximize the preservation of life and property in the event of any natural or man-made disaster or threat thereof. The extent to which this will be possible will depend on the emergency, the amount of warning received, whether personnel are on duty or off-duty at home or elsewhere, and possibly, the extent of damage to the primary health department facility and its occupants. The Disaster Magnitude Classification definitions may be used to determine the execution level of the COOP. These levels of disaster are defined as:

Minor Disaster: Any disaster that is likely to be within the response capabilities of local government and results in only minimal need for state or federal assistance.

Major Disaster: A disaster that will likely exceed local capabilities and require a broad range of state and federal assistance.

Catastrophic Disaster: Any disaster that will require massive state and federal assistance, including immediate military involvement. Federal assistance will involve response as well as recovery needs.

2. Warning Conditions

With Warning: It is expected that, in most cases, the DCHD will receive a warning of at least a few hours prior to an event. This will normally enable the full execution of the COOP with a complete and orderly alert, notification, and deployment of the COOP Team and Key Personnel (see I-p. 11)

Without Warning: The ability to execute the COOP following an event that occurs with little or no warning will depend of the severity of the emergency and the number of personnel that survive. If the deployment of the essential staff is not feasible because of the loss of personnel, temporary leadership of the DCHD will be passed to MDH.

3. Alert, Notification, Implementation Process

The DCHD notification process as related to COOP activation should, if necessary, allow for a smooth transition of the essential staff to an alternate facility to continue the execution of essential functions across a wide range of potential emergencies. Notification may be in the form of:

- A COOP alert sent to the following:
  - COOP Team
  - Key Personnel Group
  - Essential staff
  - Non-essential staff
- See Checklists 1 through 5 for roles and responsibilities of initial response personnel.
- An announcement of COOP activation will direct initial response personnel to report to an assembly site or a designated alternate facility, and provide instructions regarding movement, reporting, and transportation details.

Upon receipt of a COOP alert from the Health Officer, or a designated successor, an Administrative Call Down will be initiated to notify essential and non-essential employees. Notification will be via Health Alert Network (HAN), personal contact, telephone, cell phone, pagers, radio and TV broadcasts, or a combination thereof. Staff contact lists are located with the COOP POC (Brice Strang), Assistant Coordinator—PHEP (Lanise Mohn), the Distribution Team Leader (Pamela Quillen) and the Dorchester County Emergency Management Agency. Employee contact information is located in Annex 7.

The Health Officer notifies the Office of Emergency Management, MDH Office of the Secretary, and the County Administrator that an emergency relocation of the DCHD is anticipated or is in progress and may request activation of the Emergency Operations Center if needed.

The decision to implement the COOP should be based upon the nature and severity of the event. A short duration event such as a building evacuation will not likely require implementation of the COOP. The COOP should be implemented in those situations requiring a systematic continuation of essential functions within the DCHD.

4. Initial Actions

Based on the situation and circumstance of the event, the Health Officer will evaluate the capability and capacity levels required to support the current essential function of the health department facility and select an appropriate alternate facility.

The Health Officer notifies the Initial Response Team of the emergency requiring activation of the COOP and directs them to begin movement to the assembly site or to the designated alternate facility immediately.

The COOP Point of Contact notifies the designated alternate facility to expect the relocation of the DCHD.

The Initial Response Team coordinates the immediate deployment to the designated alternate facility.

The Director, Environmental Health prepares the alternate facility for the DCHD operations and provides instructions and guidance on operations and the location of the alternate facility.

The Initial Response Team establishes itself at the assembly site or designated alternate facility to assume essential functions.

The COOP Point of Contact provides regular updates to the Health Officer regarding alternate facility activation.

All staff initiates their respective call down procedures. After the call down is complete, the results, including individuals not contacted, are reported to the Emergency Planner.

The essential staff members report to an assembly site or deploy to the designated alternate facility to assume the essential functions.

Designated staff, who have established drive-away kits, will ensure that they are complete, with current documents and equipment, to begin preparation for the movement of resources.

All staff assembles remaining documents and other assets as required for the performance of essential functions to begin preparations for the movement of these resources.

All personnel of the affected DCHD facility should implement normal security procedures for areas being vacated.

The Director, Environmental Health should take appropriate measures to ensure security of the affected health department facility and equipment or records remaining in the building and ensure local law enforcement authorities are notified.

Other employees may be directed to remain at home pending further guidance.

5. Deployment and Departure Procedures – Time-Phase Operations

Allowances for partial pre-deployment of any essential functions which are critical to operations will be determined by the Health Officer at the time the COOP is activated. This determination will be based on the event or the level of threat. The following actions establish general administrative procedures to allow for travel and transportation to the alternate facility. Specific instructions will be provided at the time a deployment is ordered.

The Health Officer directs the Initial Response Team to begin deployment of select staff members to the alternate facility.

The Initial Response Team is directed by the Health Officer to either relocate to a designated assembly site or an alternate facility. Team members should ensure that they have their official drive-away kits and any other supplies necessary to begin operations of critical functions of the Health Department. Privately owned vehicles will most likely be used for transportation to the designated facility. Specific instructions will be provided at the time of activation.

Essential staff personnel will immediately begin relocation, taking with them drive-away kits, if applicable. They will most likely use privately owned vehicles for transportation to the designated facility. Specific instructions will be provided at the time of activation.

Non-essential personnel present at the affected health department facility at the time of an emergency notification will be directed to proceed to their homes to await further instructions. At the time of notification, any available information regarding routes that should be used to depart the health department facility or other appropriate safety precautions will be disseminated. During non-duty hours, non-essential personnel will remain at their homes pending further guidance.

6. Transition to Alternate Operations

Following the activation of the COOP and establishment of communications links at the alternate facility the Health Officer or designee orders the cessation of operations at the affected health department facility.

The Health Officer or designee notifies the County Emergency Operations Center that an emergency relocation of the health department is complete and provides contact numbers.

As appropriate, press, news media, outside customers, vendors and other service providers, are notified by the County Public Information Officer that the health department has been temporarily relocated.

7. Site-Support Responsibilities

Following notification that a relocation of the health department has been ordered or is in progress, the appropriate alternate facility management staff will implement site-support procedures and prepare to receive the Initial Response Team within six (6) hours and the essential staff within twelve (12) hours.

8. Leadership

Orders of Succession/Delegations of Authority:

***See section III. Delegation of Authority

Delegation shall be determined/ approved by the Health Officer for all essential functions and will be effective immediately upon designation. Delegation will last for an indefinite period of time. The Health Officer will determine when delegations are no longer required. (See IIB—page 24 - 33 for list of successors for essential functions)

The Director, Health Education may be requested by the Health Officer to disseminate COOP guidance and direction during the activation and relocation phases. Pending the activation of the COOP, the team will monitor the situation and assist in the notification process as necessary.

When executed, the appropriate County Emergency Operations Center (EOC) should be notified and requested to provide any previously agreed upon assistance to the DCHD

9. Devolution

If the COOP cannot be implemented for any reason, the DCHD operations and responsibilities will revert to the MDH. The MDH will then:

- Determine which health department or other organization will perform this public health mission for the county or
- Assume the responsibility for ensuring the continuous performance of the DCHD mission essential functions.

B. Alternate Facility Operation:

1. Mission Critical Systems Drive-Away Kits

The Emergency Preparedness Coordinator is responsible for providing guidance to staff on the requirement for and the contents of Drive-Away Kits, which may contain such items as medications, PPE, publications, laptop computers, etc. Each functional area will develop and maintain Drive-Away Kits and provide checklists to help ensure the inclusion of all necessary contents. The kits will contain a one-week supply of mission essential resources. See checklist 6 through 9 for Drive-away kits checklist.

2. Execution of Mission Essential Functions

Upon activation, the Associate Coordinator—Public Health Emergency Program (Lanise Mohn) will begin providing support for the following functions:

- Monitor and assess the situation that required the relocation;
- Monitor status of personnel and resources;
- Ensure that communication mechanisms are established and maintained with the County Emergency Operations Center and the State or other designated persons.
- Plan and prepare for the restoration of operations at the health department facility or alternate facility.

3. Initial Response Team Responsibilities

As soon as possible following their arrival at the designated alternate facility, the essential staff will begin providing support for the following functions:

- The designated health department manager will disseminate administrative and logistic information to the essential staff upon arrival. This information should generally cover the operational procedures for the next 30 days.
- The essential staff will receive continual briefings and updates.
- The essential staff will perform the essential functions of the affected health department facility as necessary.

4. Augmentation of Staff

If it becomes evident that the essential staff cannot ensure the continuous performance of mission essential functions, the Health Officer or designee will assign additional staff members as necessary who have the requisite skills to perform the tasks or with a request to MDH for assignment of staff from other county Health Departments.

5. Amplification of Guidance to Essential and Non-Essential Personnel

The designated health department manager will develop an informative Memorandum for dissemination to all health department employees regarding the duration of alternate operations, pertinent information on payroll, time and attendance, duty assignments, and travel authorizations and reimbursements.

The Health Officer will approve this Memorandum and the designated manager will then distribute the document to the relocated personnel and the non-essential staff through appropriate media and other available sources as deemed necessary at the time of emergency.

Issues relating to compensation, time, and scheduling will be coordinated through the State of Maryland Department of Budget and Management. The FPC 65 – Annex H (4-5) will be used for planning considerations.

Agency Guidelines for Communicating to Employees

- Work with the State of Maryland Department of Budget and Management to review and revise as needed, employee work policies, extended leave, working from home, etc.
- Establish and disseminate written procedures for dismissal or closure to employees at least annually;
- Identify employees who must report for work under various emergency situations and projected scenarios to continue Health Department operations and notify these employees in writing that they are so designated;
- Identify when work may or must be performed at the regular worksite or alternative worksite(s);
- Establish a procedure for notifying "non-emergency employees" or "non-special categories of employees" to report for or remain at work when Health Department operations are disrupted;
- Notify employees that if they are required to report for work and are not otherwise granted excused absence, they will be charged absence without leave (AWOL) for the period not worked and may potentially be disciplined for the AWOL at the agency's discretion.

Methods of Employee Communications

Employees should be encouraged to familiarize themselves with the procedures that have been put into place, as well as the means of notification that will be used to inform and instruct employees. Activities to support communications with employees may include any of the following:

- Convening meetings;
- Soliciting employee comments and suggestions;
- Communicating plans and changes, including recurring distribution of emergency guides;
- Maintaining current contact information for all staff;
- Advising employees of support services available through agency Employee Assistance Programs (EAPs), if applicable.

6. Development of Plans and Schedules for Reconstitution and Termination

The designated health department manager will develop Reconstitution and Termination Plans and Schedules to ensure an orderly transition of all health department functions, personnel, equipment, and records for the temporary alternate location to a new or restored health department facility.

The Health Officer will approve the plans and schedules prior to the cessation of operations at the alternate facility.

The designated health department manager will oversee the Reconstitution and Termination process.

3. Reconstitution

1. Overview

Within twenty-four (24) hours of an emergency relocation, the Health Officer will initiate operations to salvage, restore, and recover the affected health department facility after the approval of the local law enforcement and emergency services involved. Reconstitution procedures will commence when the Health Officer ascertains that the emergency situation has ended and is unlikely to recur. Once this determination has been made, one or a combination of the following options may be implemented, depending on the situation.

- Continue to perform essential functions at the alternate facility for up to thirty (30) days.
- Begin an orderly return to the affected health department facility and reconstitute full operations.
- Begin to establish a reconstituted health department facility in some other facility.

2. Procedures

Upon a decision by the Health Officer, the health department facility can be reoccupied, or that a different facility will be established as a new county health department facility:

- The designated health department manager (Administration-Carla Neugroschel) will oversee the orderly transition of all health department functions, personnel, equipment, and records from the alternate facility to a new or restored county health department facility. The designated health department manager (Health Education—Angela Grove) will institute a call down to inform staff of orders to return to work at a new health department facility or at the restored health department facility. Information will also be distributed on hours of operations, work assignments and other pertinent information regarding reconstitution.
- Prior to relocating back to the primary health department facility or another building, the designated health department manager (Environmental Health—William Forlifer), in conjunction with MOSHA, County Officials, and County and Health Department Information Technology Departments staff, will conduct appropriate security, safety, and health assessments for suitability of both the building and surrounding areas for resumption of operations.
- The Information Technology Program Manager will restore new or restored facility and reconstitute normal operations and ensure that back-ups are properly installed. Additionally, information technology staff will note problems encountered and develop procedures that will prevent them from reoccurring.
- When necessary equipment and documents are in place at the new or restored health department facility, the staff remaining at the alternate facility will transfer essential functions and resume normal operations.

3. After-Action Review and Remedial Action Plan

An After-Action Review information collection process will be initiated prior to the cessation of operations at the alternate facility. The information to be collected will, at a minimum, include information from any employee working during COOP

activation and a review of the strengths and weaknesses at the conclusion of the operations. The information should be incorporated into a COOP Remedial Action Plan. Recommendations for changes to the COOP and any accompanying documents will be developed and incorporated into the COOP Annual Review Process.

4. Logistics

1. Alternate Facilities

The determination of the alternate facilities will be made at the time of activation by the Health Officer in consultation with DCHD Executive Staff, the County Administrator, and the County's Emergency Management Director and will be based on the incident, threat, risk assessments, and execution timeframe.
To ensure the adequacy of assigned space and other resources, all alternate facilities will be reviewed annually. The Health Officer will be advised of the results of this review and any updates to the alternate facility information.

Alternate facilities should provide:

- Sufficient space and equipment
- Private examination rooms with running water after the first week
- Capability to perform essential functions within 12 hours, up to 30 days.
- Reliable logistical support, services, and infrastructure systems
- Consideration for health, safety, and emotional well-being of personnel
- Interoperable communications
- Computer equipment and software

Both a primary alternate facility and a secondary alternate facility will be predicated upon the nature of the emergency incident and the geographic area in which the incident occurred. If only one location is affected, operations will move to another Health Department site. If a public school is affected, relocation site for Health Department employees will be determined by the Board of Education. If all four sites are affected, we will work in cooperation with county government to find a suitable alternate location. (The Developmental Disabilities Administration program has a satellite office in Salisbury, which will be used to relocate that program, if necessary) Health Department programs have client/patient contact as part of their essential function. An alternate facility must be located in the county in order for patients/clients to have access to them. No employees are dependent on public transportation.

Current Facility	Primary Alternate Facility	Secondary Alternate Facility
3 Cedar Street 524 Race Street	524 Race St.-- (clinical programs) 3 Cedar Street -- (office-based programs)	If all sites were unavailable (a catastrophic event since they are located apart) the alternate site would be determined by the county and MDH
Public Schools in Dorchester County	TBD by Board of Education	TBD by Board of Education

There is an MOU in place with local law enforcement to provide security to any designated emergency site.

Current Facility Statistics:

- Number of Employees: 133
    - 3 Cedar Street—85 employees
    - 524 Race Street—19 employees
    - Public Schools—29 employees

Alternate Facility Minimum Requirements (for incidents greater than 1 day and less than 1 week):

- 2000 Square Feet
- AC Electrical Components (Ample 20amp 110V Outlets)
- Refrigeration Units
- Running Water Supply
- Internet Service Provider
- Telephone
- Fax
- Copier
- Parking for Clients
- Barrier Free Access to Building

Note: Approximately 35 essential staff will operate from the alternate facility which includes:

- Administration Essential Staff
- Building Maintenance Essential Staff
- AIDS/HIV Essential Staff
- Emergency Preparedness Staff
- Environmental Health Essential Staff
- Information Technology Staff
- Administrative Care Coordination Unit Essential Staff
- Maryland Children's Health Program Essential Staff
- Addictions Program Essential Staff
- AERS/PC Essential Staff
- BCCP Essential Staff
- Cigarette Restitution Essential Staff
- Communicable Disease Essential Staff
- Health Education Essential Staff

Staggered shifts would be instituted if the alternate site could not hold all of the essential staff at one time.
Alternate Facility Minimum Requirements (for incidents greater than 1 week and less than 1 month):

- Increase to 10,000 - 15,000 Square Feet of Operating Space

Note: Approximately 75 - 99 essential staff will operate from the alternate facility depending on the priorities determined by the Health Officer. If the Health Officer determines that only critical and priority functions will be maintained the number will be reduced to 35.

2. Interoperable Communications

Interoperable communication tools available to maintain redundant critical communication in the event of COOP activation must be flexible and depend on the facilities capability and resources available. This will be used to establish communications to maintain essential functions, communicate with personnel and other agencies, as well as accessing databases and IT support. The following current communications, preventative controls and alternative communication methods are listed by current site.

Communications Systems Supporting Essential Functions:

a. *3 Cedar Street*

Communication Mode	Current Provider	Services Provided	Special Services Available
Voice Lines	MCI / Verizon	Local / long distance	Conference calling
Fax Lines	MCI / Verizon	Local / long distance	N/A
Cellular Phones	Verizon Wireless	Voice / text	Mobile web, VZ Navigator, Location Management, Mobile IM, Wireless Sync email
Pagers	USA Mobility	Beepers / paging services	N/A
E-mail	MDH – Gmail	Email service delivery	N/A
Internet Access/Data Lines	MDH T-1 Line (Verizon)	Internet access / mainframe connectivity	N/A
Instant Messenger Services	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A
Radio Communication Systems	Calbaugh	800 MHz radios	N/A
Other - Dedicated video conferencing line	Verizon	Video conferencing	N/A
Other – VOIP, CISCO IP Phone	MEIMSS	Voice satellite communication	N/A
Other - Satellite Phone	MSAT	Satellite communication	Push to talk, 500 & 800 numbers

Communication Systems Supporting Essential Functions

b. *524 Race Street*

Communication Mode	Current Provider	Services Provided	Special Services Available
Voice Lines	Verizon	Local / long distance	Conference calling
Fax Lines	Verizon	Local / long distance	N/A
Data Lines	N/A	N/A	N/A
Cellular Phones	Verizon	Voice / text	Mobile web, VZ Navigator, Location Management, Mobile IM, Wireless Sync email
Pagers	N/A	N/A	N/A
E-mail	MDH-Gmail	Email service delivery	N/A
Internet Access	Comcast	Internet access / mainframe connectivity	N/A
Instant Messenger Services	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A
Radio Communication Systems	N/A	N/A	N/A
Other	N/A	N/A	N/A
DriDock			
Voice Lines	Comcast	Local / long distance	N/A
Fax Lines	Comcast	Local / long distance	N/A
Data Lines	N/A	N/A	N/A
Cellular Phones	Verizon	Voice / text/ data	Mobile web, VZ Navigator, Location Management, Mobile IM, Wireless Sync email, face time, mobile hotspot, camera scanning to PDF
Pagers	N/A	N/A	N/A
E-mail	MDH-Gmail	Email service delivery	N/A

Internet Access	Comcast	Internet access / mainframe connectivity	N/A
Instant Messenger Services	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A
Radio Communication Systems	N/A	N/A	N/A
Other	N/A	N/A	N/A

Communication Systems Supporting Essential Functions

c. Public Schools

Communication Mode	Current Provider	Services Provided	Special Services Available
Voice Lines	Verizon	Local / long distance	Conference calling
Fax Lines	Verizon	Local / long distance	N/A
Data Lines	N/A	N/A	N/A
Cellular Phones	N/A	N/A	N/A
Pagers	N/A	N/A	N/A
E-mail	Dorchester County Board of Education	Email service delivery	N/A
Internet Access	Dorchester County Board of Education	Internet access / mainframe connectivity	N/A
Instant Messenger Services	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A
Radio Communication Systems	N/A	N/A	N/A
Other			

3. Preventative Controls for Communication Systems

a. 3 Cedar Street

Communication System	Optimal Preventative Controls	Preventative Controls Currently In Place
Voice Lines	Electric generator, Secondary Provider account established and ready to use if needed, satellite voice line capability (MSAT)	Cell phones, satellite phones, direct lines; Password needed to call long distance, surge protection
Fax Lines	Electric generator, 2nd fax line provider, satellite fax line capability	Email, USPS; Password needed to call long distance, surge protection
Cellular Phones	Cell phones via satellite instead of towers	Landlines, satellite phones; Password prompt access
Pagers	Secondary Provider account established and ready to use if needed, Pagers via satellite	Satellite phones, cell phones
E-mail	Electric generator, Secondary Provider account established and ready to use if needed	Blackberry/DROID; text messages, fax; Firewall, virus and spyware protection, email via cell phones
Internet Access/Data lines	Secondary Provider account established and ready to use if needed, satellite internet	Mobile web; Firewall, virus and spyware protection
Instant Messenger Services	N/A	N/A
Blackberry and other Personal Digital Assistants (PDA)	N/A	N/A
Radio Communication Systems	Secondary Provider account established and ready to use if needed	None
Other – Dedicated video conference line	Secondary Provider account established and ready to use if needed	Video conferencing, cell phone conference calling
Other – VOIP, CISCO IP phone		None
Other - Satellite Phones	Secondary Provider account established and ready to use if needed	None

Preventative Controls for Communication Systems

b. 524 Race Street

Communication System	Optimal Preventative Controls	Preventative Controls Currently In Place
Voice Lines	Electric generator, Secondary Provider account established and ready to use if needed, satellite voice line capability	Cell phones, surge protection
Fax Lines	Electric generator, 2nd fax line provider, satellite fax line capability	Email, USPS, surge protection
Data Lines	N/A	N/A
Cellular Phones	Cell phones via satellite instead of towers	Landlines
Pagers	N/A	N/A
E-mail	Electric generator, Secondary Provider account established and ready to use if needed, email via cell phones	Text messages, fax; Firewall, virus and spyware protection
Internet Access	Secondary Provider account established and ready to use if needed, satellite internet	Mobile web; Firewall, virus and spyware protection
Instant Messenger Services	N/A	N/A
Blackberry and other Personal Digital Assistants (PDA)	N/A	N/A
Radio Communication Systems	N/A	N/A
Other	N/A	N/A
DriDock		
Voice Lines	Electric generator, Secondary Provider account established and ready to use if needed, satellite voice line capability	Cell phones
Fax Lines	Electric generator, 2nd fax line provider, satellite fax line capability	Email, USPS
Data Lines	N/A	N/A
Cellular Phones (iPhones)	Cell phones via satellite instead of towers	Landlines
Pagers	N/A	N/A

E-mail	Electric generator, Secondary Provider account established and ready to use if needed, email via iPhone	Mobile web; Firewall, virus and spyware protection
Internet Access	Secondary Provider account established and ready to use if needed, satellite internet	Mobile web; firewall, virus and spyware protection
Instant Messenger Services	N/A	N/A
Blackberry and other Personal Digital Assistants (PDA)	N/A	N/A
Radio Communication Systems	N/A	N/A
Other	N/A	N/A

Preventative Controls for Communication Systems

c. Public Schools

Communication System	Optimal Preventative Controls	Preventative Controls Currently In Place
Voice Lines	Electric generator, Secondary Provider account established and ready to use if needed, satellite voice line capability	Cell phones, direct lines, surge protection
Fax Lines	Electric generator, 2nd fax line provider, satellite fax line capability	Email, USPS, surge protection
Data Lines	N/A	N/A
Cellular phones	N/A	N/A
Pagers	N/A	N/A
E-mail	Electric generator, Secondary Provider account established and ready to use if needed, email via cell phones	Text messages, fax; Firewall, virus and spyware protection
Internet Access	Secondary Provider account established and ready to use if needed, satellite internet	Mobile web; Firewall, virus and spyware protection
Instant Messenger Services	N/A	N/A
Blackberry and other	N/A	N/A

Personal Digital Assistants (PDA)		
Radio Communication Systems	N/A	N/A
Other	N/A	N/A

4. Alternative Modes of Communication

a. 3 Cedar Street

Communication System	Current Provider	Alternative Provider	Alternative Mode #1	Alternative Mode #2
Voice Lines	Verizon/MCI	Comcast	Cell phones; Direct Line in Health Officer's Office	Satellite phones Fax w/ direct line
Fax Lines	Verizon/MCI	Comcast	Email	USPS
Data Lines	N/A	N/A	N/A	N/A
Cellular Phones	Verizon Wireless	Cingular	Landline	MSAT-Satellite phone
Pagers	USA Mobility	Salisbury Communications	Cell phones	MSAT-Satellite phone
E-mail	MDH – Gmail	Comcast	Cell phone	Text messages; Fax w/ direct line

Internet Access/Data Lines	MDH T-1 Line (Verizon); Projected switch to Fiber Backbone April 2017	Comcast	Mobile web	
Instant Messenger Services	N/A	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A	N/A
Radio Communication Systems	Calbaugh		Cell phone	
Other - Dedicated video conferencing line	Verizon	Comcast	Cellular conferencing	Skype
Other – VOIP, CISCO IP Phone	MEIMMS			
Other - Satellite Phone MSAT	St. of Maryland		Cell Phone	Internet

Alternative Modes of Communication

b. 524 Race Street

Communication System	Current Provider	Alternative Provider	Alternative Mode #1	Alternative Mode #2
Voice Lines	Verizon	Comcast	Cell phones	Satellite phones, Fax w/ direct line
Fax Lines	Verizon	Comcast	Email	USPS
Data Lines	N/A	N/A	N/A	N/A
Cellular Phones	Verizon	Cingular	Landline	Satellite phones
Pagers	N/A	N/A	N/A	N/A
E-mail	MDH-Gmail	Comcast	TREO	Text messages; Fax w/ direct line
Internet Access	Comcast; Projected switch to Verizon EVPL March 2017	Comcast	Mobile web	N/A

Instant Messenger Services	N/A	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A	N/A
Radio Communication Systems	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A
DriDock				
Voice Lines	Comcast	Verizon	Cell phones	Satellite phones
Fax Lines	Comcast	Verizon	Email	USPS
Data Lines	N/A	N/A	N/A	N/A
Cellular Phones (iPhone)	Verizon	AT 7 T	Landline	Satellite phones
Pagers	N/A	N/A	N/A	N/A
E-mail	MDH-Gmail	Comcast	Text messaging	USPS Fax w/ direct line
Internet Access	Comcast	Verizon	Mobile web	N/A
Instant Messenger Services	N/A	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A	N/A
Radio Communication Systems	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A

c. Public Schools

Communication System	Current Provider	Alternative Provider	Alternative Mode #1	Alternative Mode #2
Voice Lines	Verizon	Comcast	Cell phones	Fax w/ direct line
Fax Lines	Verizon	Comcast	Email	USPS
Data Lines	N/A	N/A	N/A	N/A
Cellular Phones	N/A	N/A	N/A	N/A
Pagers	N/A	N/A	N/A	N/A
E-mail	Dorchester County Board of Education	Comcast	TREO	Text messages; Fax w/ direct line
Internet Access	Dorchester County Board of Education	Comcast	Mobile web	
Instant Messenger Services	N/A	N/A	N/A	N/A
Blackberry and other Personal Digital Assistants (PDAs)	N/A	N/A	N/A	N/A
Radio Communication Systems	N/A	N/A	N/A	N/A

VI. TRAINING, TESTING and COOP EXECUTION

COOP exercises are anticipated, at a minimum, annually and possibly more frequently depending on staff changes or perceived need. Annex 2 provides the exercise schedule, Annex 3 provides plan maintenance, Annex 4 provides the training program plan and Annex 5 provides the testing schedule.

VII. FAMILY SUPPORT PLANNING

Guidance

Internet Resources

- Maryland Emergency Management Agency: http://www.familyfirst.md
- Department of Homeland Security: http://ready.gov and http://www.citizencorp.gov
- Office of Personnel Management: http://www.opm.gov/emergency
- The Red Cross: http://www.redcross.org

Dorchester County Health Department: http://www.dorchesterhealth.org

Emergency Supplies

DCHD is utilizing the Plan to Be Safe (Plan 9) material developed by the Montgomery County, MD Advanced Practice Center. Disaster preparation is presented in three steps:

1—Start a conversation

- What to prepare for
- Whom to contact
- Where to meet
- Where to stay
- What to do

2—Make a plan

- Personal information
- Local contact
- Out-of-state contact
- Nearest relative
- Pets cared for by
- Meeting place

3—Make a list (Nine essential items)

- Water—one gallon of water per person per day for three days
- Food—non-perishable food such as canned or packaged food
- Clothes—one change of clothes and footwear per person
- Medications—three days' worth of prescription medications (if needed)
- Flashlight—flashlight and extra batteries
- Can opener—manual can opener
- Radio—battery-powered, solar-powered or hand-crank radio
- Hygiene items—hygiene items like soap, toilet paper and a toothbrush
- First aid—first aid basics like antiseptic, bandages and non-prescription medicine

This program is a basic, easy plan that all employees can utilize.

Other supplies that are recommended to be added are:

- Whistle

- Dust mask, plastic sheeting for shelter and duct tape
- Moist towelettes, garbage bags for personal sanitation
- Blankets
- Wrench or pliers to turn off utilities
- Aspirin or non-aspirin pain reliever
- Anti-diarrhea medicine, antacid, laxatives
- Cell phone with extra batteries
- Scissors
- Tweezers
- Petroleum jelly

Assistance

Counseling services will be provided by the DCHD Disaster Mental Health Team led by Christa Chelsey. All employees involved in the Emergency Response will be offered Psychological First Aid and/or short term trauma counseling. Referrals to Mental Health professionals (Mid Shore Mental Health) in the area will be made if long term counseling is required.

VIII. Annexes

A. Annex I: Checklists

CHECKLIST 1

HEALTH OFFICER COOP EXECUTION

☑	Action Step	Notes
	Make decision to implement COOP	
	Determine which functions are affected and require relocation	
	Determine which mission essential functions require reestablishment at alternate facilities	
	Determine which alternate facility will be used	
	Identify essential Staff • Management team members • Clinical Personnel • Clinic Direct Support Staff • IT staff • Facilities Staff Key Supervisors of any displaced mission essential function	
	Direct Public Health Emergency Management Team to coordinate essential staff and to assemble at alternate site	
	If mission essential functions cannot be reestablished, request assistance from state and neighboring CHDs	
	Initiate phone tree call down procedure to all staff	
	Notify: County Official(s) Office of Emergency Management	
	Determine staffing requirements and work hours for essential staff	
	Determine when to implement reconstitution and termination of the COOP	

CHECKLIST 2

COOP POINT of CONTACT (Brice Strang) EXECUTION CHECKLIST

☑	Action Step	Notes
	Upon notification of activation of the COOP:	
	Confirm status of closed facilities, alternate facilities, mission essential functions and essential staff	
	Ensure initiation of phone tree call down	
	Notify Alternate Facility of HD relocation	
	Ensure notification of essential staff	
	Direct essential staff in assembling at alternate location	
	Provide guidance concerning the use/location of drive-away kits	
	Assist in establishing essential functions	
	Assist with personnel communications	
	Oversee reconstitution and termination of the COOP	

CHECKLIST 3

DIRECTOR, HEALTH EDUCATION (Angela Grove) EXECUTION CHECKLIST

☑	Action Step	Notes
	Monitor and assess the situation requiring relocation	
	Monitor and assess the status of personnel and resources	
	Upon notification, initiate the phone tree call down and ensure completion and directives given to essential staff	
	Upon notification, assemble at alternate site	
	Recommend increased essential functions to be established at alternate site.	
	Determine the positions necessary to ensure the continuous performance of mission essential functions and staff with individuals who have the requisite skills to perform the tasks.	
	Determine status and guidance for nonessential staff	
	Prepare for restoration of operations at the relocated facility	

CHECKLIST 4

DIRECTOR, ENVIRONMENTAL HEALTH (William Forlifer) EXECUTION CHECKLIST

☑	Action Step	Notes
	Assist Health Officer to determine which facilities are affected	
	Ensure vacated facilities are secure	
	Activate security and access controls at alternate site	
	Initiate operations to salvage, restore and recover affected facilities	
	Ensure security, safety and health sustainability is available before reconstituting affected building	
	Assist reconstitution of essential functions in primary facility	

CHECKLIST 5

INFORMATION TECHNOLOGY (Jeffrey Parmer) EXECUTION CHECKLIST

☑	Action Step	Notes
	Assess Primary IT sites with County Information Systems Support to determine IT Functions affected	
	Notify Health Officer which IT functions are affected	
	Determine technical readiness/requirements for sites where applicable	
	Secure necessary resources to promote basic IT functions at site location(s) where applicable	
	Implement restoration of IT function based on identification of scenario using INFORMATION SYSTEMS SUPPORT (Prioritize Mission Essential Functions identified in COOP)	
	Ensure Drive-Away Kits are transferred to the Alternate Facility.	
	Facilitate the physical set-up at the alternate facility	
	Alert HO when IT functions are available at the alternate facility.	
	Provide direction and guidance to incoming staff to the alternate facility.	
	Assist reconstitution of essential functions in primary facilities.	

B. Annex II: Drive Away Kits

CHECKLIST 6

DRIVE-AWAY KITS –3 CEDAR STREET

Administration:

☑	Item	Notes
	Corporate purchasing cards	
	Rolodex (accounting/purchasing data/contacts)	
	Tax exempt certificate	
	Credit card log sheets	
	Blank supply requisition forms	
	Blank deposit tickets/distribution sheets	
	Petty cash and bank bags	
	Mail code list	
	Blank CD's & envelopes	
	Blank checks, check register	
	Backup for network files	
	Blank leave cards	
	Security paper-death certificates	
	Stamps for death certificates	
	Originals of death certificates	
	Keys to all state vehicles	
	Call down lists	
	Safe/fireproof lockboxes	

☑	Item	Notes
	Notary seals	
	M. A. transportation screening forms	
	Administration receipt book	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Administrative Care Coordination Unit:

☑	Item	Notes
	Telephone	
	Computer for internet access	
	Directories for resource information	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

AERS/CPAS:

☑	Item	Notes
	Evaluation/program forms for duplication	
	Data base/evaluation schedules/logs	
	Directories for Agency contacts and resource information	
	Lap Top & MiFi	
	Office supplies e.g. Paper, Pens etc.	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

AIDS/HIV:

☑	Item	Notes
	Lap top	
	VPN card	
	Smart phone	
	Testing kits/packets	
	Charts	
	Chart forms	For new referrals
	Rolodex	
	State vehicle	For client transport to medical appts
	Transport schedule book	
	Appt calendars	
	Printer/copier/paper/ink	
	Fax machine	
	Locking file bags	
	Education packets	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

BCCP:

☑	Item	Notes
	Screening registration binder	
	File box of all active clients	
	File box of abnormal results (due 6 months)	
	File box of schedule clients (recall) for upcoming months	
	Diagnosis & Treatment binder	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Child Health:

☑	Item	Notes
	Healthy Start:	
	Clients charts	
	Assessment bag	
	Education packets	
	Phone number index	
	Lead:	
	Client charts	
	Education packets	
	Phone number index	
	Immunizations:	
	Scheduled folder of appointments	
	Card file	
	Phone index file	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

CRF—Colorectal/Tobacco:

☑	Item	Notes
	Data forms for CPEST	
	Charts	
	Meds for bowel prep	
	Pens, pencils highlighters, magic marker, etc.	
	Hole punch	
	Computer	
	Printer	
	Copier	
	Tobacco forms	
	Stamp with name	
	BP cuff	
	Medications	
	Folders with all current clients	
	Stapler	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Communicable Disease:

☑	Item	Notes
	Computer with reporting software	
	Printer	
	Surveillance charts	
	Surveillance forms	
	Telephone/fax	
	STI medications	
	STI clinic supplies	
	Refrigerator	
	PPD cards & forms	
	TB medications	
	Water cups	
	Clinic supplies—syringes sharps container, etc.	
	Pens, etc.	
	Microscope	
	Credit card swiper	
	Receipt book	
	Vaccine coolers and Vaccine	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

DDA:

☑	Item	Notes
	Laptops with internet capability	All resource coordinators have a laptop & briefcase Office maintains 1 Mi-Fi device
	Virtual Protocol Network (VPN)	This will be maintained by program administrator to be used with home internet access to DCHD server
	Smart phone	iPhone 5s with internet w/hotspot for data transfer

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Emergency Preparedness:

☑	Item	Notes
	Laptops with internet capability	
	Flash drives with operational plans	
	Emergency contact notebook	
	Supply tubs for PODS	
	Supply tubs for shelters	
	1st Aid bags for shelters	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Environmental Health--Food:

☑	Item	Notes
	Cell phone with blue tooth	
	Thermometers	
	Alcohol wipes	
	Sanitizer test strips	
	Forms	
	Clipboard and pens	
	Laptop	
	Flash drive	
	Water sampling kit (includes forms, containers, permanent markers, bleach)	
	Pool testing kit (includes test reagents for chlorine)	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Environmental Health—Water/Sewer/Rabies:

☑	Item	Notes
	Cell phone	
	Water sampling:	
	Sample bottles	
	Coolers	
	Forms	
	Rabies:	
	Bags	
	Coolers	
	Forms	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Family Planning:

☑	Item	Notes
	Blood pressure cuff/stethoscope	
	Plan B	
	Condoms	
	Patient roster	
	Paper/pens, etc.	
	Appointment book	
	Pregnancy test kits/cups	
	Gloves	
	Flash drive—Ahlers (patient records)/PatTrac	
	Alcohol preps/band aids/cotton balls, etc.	
	Birth control methods	
	Sharps container/biohazard bags	
	Medications	
	Speculum	
	Hand sanitizer	
	Lap top	
	Printer	
	Credit card swipe	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Health Education:

☑	Item	Notes
	Lap tops—wireless capable	
	Flash drives	
	Cell phones	
	Printer	
	Access to Annapolis Data Center	

CHECKLIST 6
DRIVE-AWAY KITS –3 Cedar Street

Healthy Families:

☑	Item	Notes
	Community Resource Binder	
	Participant Binders	
	Copy of PIMS Database	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Information Technology:

☑	Item	Notes
	Laptops	
	Copy of Active Directory	
	Documentation-passwords	
	Backup tapes	
	Server-DCHD-Server, 2 & 3 & 4	
	Duplicator	
	Fireproof safe	

CHECKLIST 6
DRIVE-AWAY KITS –3 CEDAR STREET

Maryland Children's Health Program:

☑	Item	Notes
	Telephone	
	Laptops	
	Internet Access	
	Printer	
	Office Supplies (i.e. calculator)	
	Forms	
	Education Packets	

CHECKLIST 7
DRIVE-AWAY KITS –524 Race Street

Addictions:

☑	Item	Notes
	Back-up flash drives	
	Appointment book	
	Drug screen logbook	
	SAMIS logbook	
	iPad	
	Laptop computers x 1	
	Cell phones x 3	

CHECKLIST 8
DRIVE-AWAY KITS –524 Race Street

DriDock:

☑	Item	Notes
	Lap top computers (at least one, up to 3 if accessible	
	Back up flash drives	
	Cellular phones x4	
	iPhone x1	

CHECKLIST 9
DRIVE-AWAY KITS –PUBLIC SCHOOL

School Health:

☑	Item	Notes
	May vary by school depending on individual student needs	
	Individual students medications and treatment supplies (routine & emergency)	
	Individual health/emergency care plans	
	“Guide for Emergency Care” binder	
	School Nurse “Go Bag” (includes first aid supplies, vital signs monitoring equipment, etc.)	
	Emergency stock medications (Epi Auto Injectors)	

CHECKLIST 9
DRIVE-AWAY KITS –PUBLIC SCHOOL

Wellness Centers:

☑	Item	Notes
	Encounter Forms (blank)	
	Client records/charts	
	Copy of database—Pat Trac	

C. ANNEX III: INFORMATION AND TECHNOLOGY

The Dorchester County Health Department Information Technology staff will ensure all necessary and preplanned communications systems are established, adequate, and functioning properly, and will service and correct any faulty or inadequate communications systems or make arrangements for an outside vendor to do so.

The following procedures should be followed for the restoration of communications and information systems.

1. Loss of Internet

- **SCENARIO A**:
  No critical public health emergency exists and outage is expected to be short term.
  ACTION TO BE TAKEN:
  None. Wait for restoration of normal service.

- **SCENARIO B**: No critical public health emergency exists and outage or existing service is expected to be long or permanent.
  ACTION TO BE TAKEN:

There are numerous local services that offer Internet service. Contact local services and have new service installed.

- **SCENARIO C:** A public health emergency exists that requires immediate Internet access.
  ACTION TO BE TAKEN:
  The Dorchester County local public safety departments and many businesses have Internet access available. A relay system will be set up where a limited number of employees would relocate to sites with active Internet connections and provide needed information to other staff via telephone/cell phone/Two-Way Radio. The IT Department would reallocate existing portable computers and wireless equipment as needed to provide short or long term connections.

2. Loss of e-mail services:
   - **SCENARIO A**: No critical public health emergency exists and outage is expected to be short term.
     ACTION TO BE TAKEN: None. Wait for restoration of normal service.

   - **SCENARIO B**: No critical public health emergency exists and outage of existing service is expected to be long term or permanent.
     ACTION TO BE TAKEN: There are numerous local services that offer Internet and e-mail service. Contact local services and have new service installed.

   - **SCENARIO C**: A public health emergency exists that requires immediate Internet access.
     ACTION TO BE TAKEN:
     The Dorchester County local public safety departments and many businesses have Internet access available. A relay system will be set up where a limited number of employees would relocate to sites with active Internet connections and provide needed information to other staff via telephone/cell phone/Two-Way Radio. The IT Department would reallocate existing portable computers and wireless equipment as needed to provide short or long term connections.

3. Network connectivity is down:
   General network connectivity is provided through a series of network switches and network cabling. The DCHD IT Department maintains a supply of spare switching equipment which can be installed as needed.

4. DCHD has lost its Server:
   The network servers used by the Health Department are covered under a maintenance contract with the vendor. Under normal conditions, the server will be restored to a functional state within an acceptable period of time.

   If needed, the functions of the Health Department servers can be redirected to other servers within the County network. Critical data can be restored from the network backups to replacement servers. Currently, DCHD has server backups located at Cecil County Health Department.

   If the failing server cannot be repaired or needs to be replaced, critical functions will be reallocated to other servers until replacement equipment can be ordered and installed. Funding for replacement equipment will be through the Health Department budget or liability insurance reimbursements.

5. DCHD has lost electrical at building site:

   All servers and systems are connected to an uninterruptible power supplies that provide an hour of electricity during a power failure. If the DCHD loses electrical power for longer than an hour, personnel must revert to a manual system or relocate to another location.

6. DCHD has lost connection to the state:

   The connection to the State of Maryland is the responsibility of the IT Department at MDH. The problem must be reported to them. They will work with the communications vendor, to resolve the problem. If the problem cannot be resolved in a timely manner, the State IT Department may initiate a migration of the services to another State controlled line. If such an action is taken, DCHD must be notified. DCHD IT personnel will modify the network routers to facilitate the new path to the State.

Electronic Data

The DCHD client records require special consideration under this Plan. The IT staff will ensure procedures are in place to safeguard and back up electronic data.

As outlined in the Dorchester County Health Department Information Technology Disaster Recovery Plan (See Annex I, Section IX), the recovery strategy follows a 3-tier system: Activation and Notification, Recovery, and then Reconstitution.

The IT support staff is responsible for ensuring a means of recovery of damaged electronic records is available, if needed.

The IT support staff, with assistance from program managers, will identify all records, systems, and electronic data critical to essential functions. Examples include personnel records, payroll records, contracting and accounting records and so forth.

Wherever possible, provision for off-site storage of duplicate records and/or off-site backup of electronic record and databases should be implemented.

Annex IV: - DCHD Teleworking Capabilities

In the event of an emergency, teleworking may be used by Dorchester County Health Department employees to carry out the essential functions of their program. As outlined by the State of Maryland teleworking policy, "teleworking" can be defined as an employee working at any location other than their usual and customary worksite. Teleworking is a voluntary process and can be terminated at any time by both the employee and their supervisor. Only employees of whom have duties that can be completed via teleworking will be asked to do so.

Supervisor Responsibilities: The program supervisor should be aware of the daily tasks that are essential to the functioning of their program. The supervisor should only designate teleworking duties to those employees who have the capability of teleworking including the required equipment and job type. As set forth by the State of Maryland Office of Budget and Management, the program supervisor will review the following documents for each employee before allowing the employee to begin the teleworking process:

1.) The State of Maryland Department of Budget Management Teleworking Agreement

2.) The State of Maryland Department of Budget and Management Telework Schedule

3.) The State of Maryland Department of Budget and Management Teleworker Work Plan

These documents can be found and downloaded from https://dbm.maryland.gov/employees/Pages/telework/teleworkHome.aspx.

Employee Responsibilities: The employee shall be required to complete and return, to the supervisor, the agency teleworking agreement, the remote workplace self-certification checklist and the general teleworking requirements (schedule and work plan) before teleworking and annually when the teleworking arrangement continues beyond 12 months. Employees should be willing to perform all assigned duties even if they are outside your usual or customary duties. Be familiar with the agency's emergency plans (continuity plan, pandemic plan, and the manager's expectations). The Telework Work Plan defines the work expectations and the deliverables the employee is responsible for each time an employee is working a remote site. The Telework Schedule defines the hours worked by the employee and the location of the remote work site. Both employee and Supervisor should collaboratively review the teleworking capabilities of each program and program deliverables.

Equipment Provision:

- The Dorchester County Health Department may provide the designated teleworker with the following equipment: laptops, desktop computers, printers, modems, faxes, scanners, cables, and software. All equipment purchases must be related to the performance of the teleworker's specific teleworking job duties.

- The teleworker must have a telephone and a designated work space with appropriate equipment and supplies to do the assigned work at the remote workplace. Any computers assigned to teleworkers must be encrypted with Bit blocker, Symantec antivirus, and Malwarebytes.
- Access to the Maryland Department of Health Network requires a Virtual Private Network (VPN). To obtain a virtual private network with access to the MDH's network, a ticket must be sent to the Maryland Department of Health Office of Enterprise Technology through their MDH Service Desk portal.

D. ANNEX V: EXERCISE SCHEDULE

Function	Activity	Date of Activity	Point of Contact
Activate Call Down List	Functional	Quarterly	Brice Strang
Joint Agency COOP Ex.	Tabletop	Annually	Steve Garvin (DC EMA)
All Agency evacuation	Tabletop	Annually	

E. ANNEX VI: COOP PLAN MAINTENANCE

Activity	Tasks	Frequency	Activity Assigned to:
Maintain and update Orders of Succession	• Obtain names of current incumbents and designated successors • Update Delegation of authorities	Annually	Lanise Mohn
Checklists	• Update and revise checklists • Ensure annual update/validation	As needed Annually	Program Directors
Update rostering all positions	• Confirm/update information on rostered members of Emergency teams	Annually	Program Directors
Appoint new members of the COOP Team	• Qualifications determined by Health Officer and /or COOP Leaders • Issue appointment letter and schedule member for orientation	As needed	Roger Harrell
Maintain alternate work site readiness	• Check all systems • Verify access codes and systems • Cycle supplies and equipment as needed	Quarterly	Brice Strang
Review and update supporting Memoranda of Understanding/ Agreements	• Review for currency and new needs • Incorporate changes, if required • Obtain signature renewing agreement or confirming validity	Annually	Christine English
Monitor and maintain equipment at alternate sites	• Train users and provide technical assistance • Monitor volume/age of materials and assist users with cycling/ removing files	Ongoing	Brice Strang
Train new members	• Provide an orientation and training class • Schedule participation in all training and exercise events	Within 30 days of appointment	Brice Strang
Orient new policy officials and senior management	• Brief officials on COOP • Brief each official on his/her responsibilities under the COOP	Within 30 days of appointment	Roger Harrell
Plan and conduct exercises	• Conduct internal exercises • Conduct joint exercises with Regions • Support and participate in interagency exercises	Semi-annually Annually Annually or as needed	Brice Strang
Maintain security clearances	• Obtain, maintain and update appropriate security clearances	Ongoing	

F. ANNEX VII: COOP TRAINING PROGRAM PLAN

Program	Methods	Frequency	Audience
COOP awareness briefing (or other means of orientation) for the entire workforce	Classroom/Power Point/On-Line	Annual	All DCHD Personnel
Team training for COOP personnel	Small Group/Checklists	Annual	Program Leaders
Team training for agency personnel (and host or contractor personnel) assigned to activate, support, and sustain COOP operations at alternate operating facilities	Small Group/Checklists/Job-Action Sheets	Annual	Key Personnel and Successors
Annual exercise that incorporates the deliberate and pre-planned movement of the COOP personnel to an alternate operating facility; and,	Table Top	Annual	Key Personnel and Successors
A comprehensive debriefing conducted after each exercise for the participants to identify systemic weakness in plans and procedures and recommend COOP plans revisions.	Group Hot Wash/Written Comments	As Needed	Key Personnel and Successors

G. ANNEX VIII: TESTING SCHEDULE

Program	Methods	Frequency	Audience:
Testing of COOP alert, notification, and activation procedures	Call Down	Quarterly/Annual	Leadership—Quarterly All Staff--Annual
Testing of plans for the recovery of vital classified and unclassified records, critical information systems, services, and data	Functional	Semi-Annual	Program Leaders
Testing of COOP communications capabilities	Functional	Quarterly	Program Leaders
Testing of primary and backup infrastructure systems and services at alternate operating facilities (e.g., power, water, fuel).	Functional	Annual	COOP Team

H. ANNEX IX: INDIVIDUALS and ORGANIZATIONS in POSSESSION of a CONTROLLED COPY of this PLAN

Organization	Contact Person	Update Given	Update Given	Update Given	Update Given	Update Given	Update Given	Update Given
Dorchester County Health Department	Brice Strang							
Dorchester County Health Department	Lanise Mohn							
Dorchester County Health Department	Roger Harrell							
Dorchester County Health Department	Administrative Office							
Dorchester County Health Department	524 Race Street							
Emergency Management Agency	Steve Garvin							

X. ANNEX IX: DORCHESTER COUNTY INFORMATION TECHNOLOGY DISASTER RECOVERY PLAN

Introduction: The Dorchester County Health Department Disaster Recovery Plan focuses on the recovery and continued operation of system components that support mission-critical systems and mission-essential services.

System Assumptions: The following scenarios were used when developing the Disaster Recovery Plan:

Scenario 1

- Facility is accessible, but a server hosting SQL database has crashed.
- All required and affected personnel have been notified, and are available to active the Disaster Recovery Plan.
- A back-up copy of affected server can be recovered via Duplicator in Cecil County HD or Tape from Fire Proof Safe at Cedar Street, or off-site at Addictions location.
- All servers and systems are connected to uninterruptible power supplies that provide an hour of electricity during a power failure.
- Business would continue as usual within hours of crash.

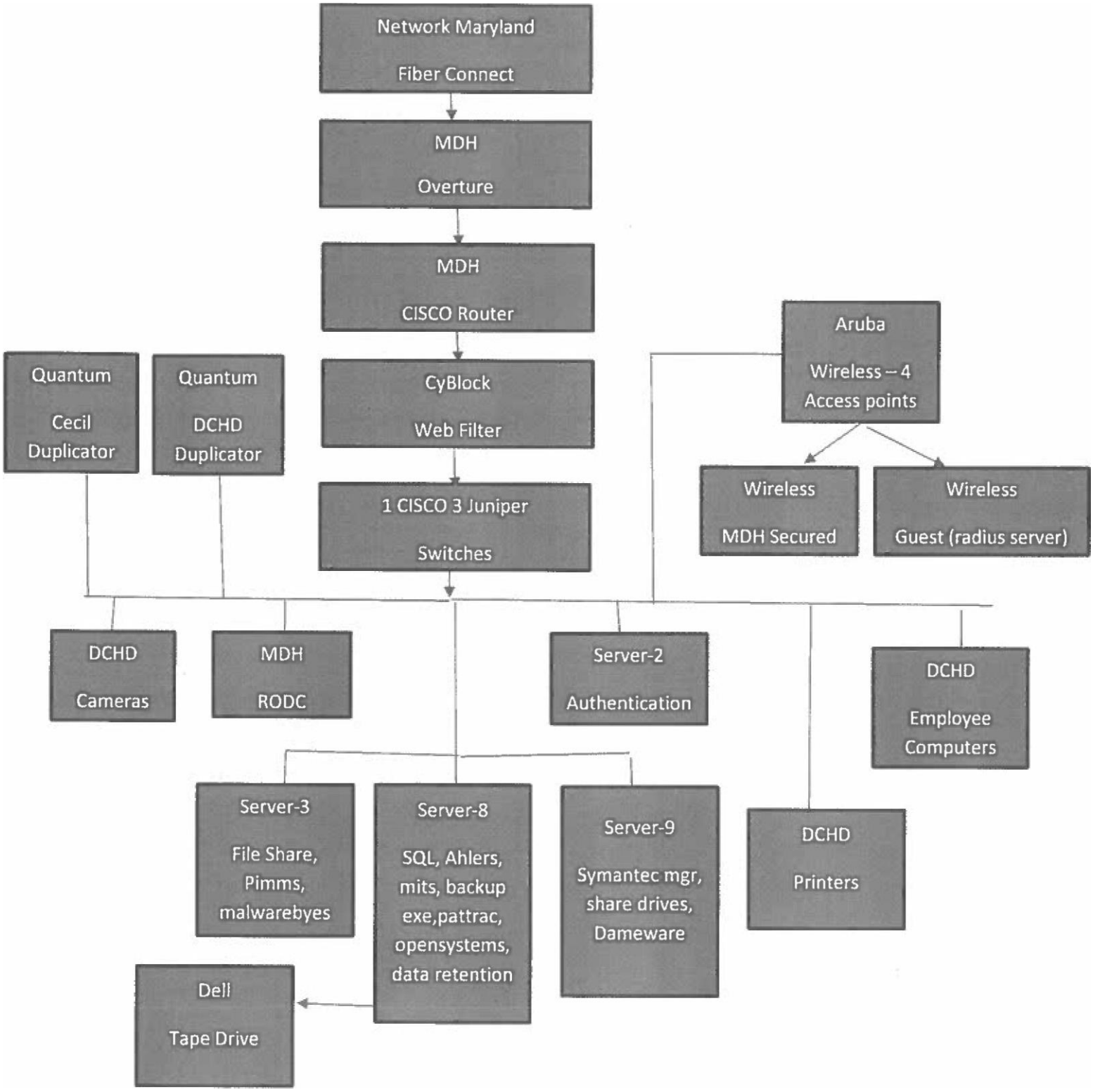
Scenario 2

- Facility is inaccessible, all servers are up and running.
- All required personnel have been notified, and are available to active the Disaster Recovery Plan.
- Copies of back-up are available by Duplicator remotely in Cecil County HD, or off-site tape at Addictions location.
- All servers and systems are connected to uninterruptible power supplies that provide an hour of electricity during a power failure.
- Back-up facilities at Addictions — 524 Race Street location and Maryland State Hospital Center — Woods Road Location. Both locations are on Network Maryland.
- Notifying the public of critical information for needed services.
- All essential personnel are identified within the COOP.
- -All essential personnel can access files and systems remotely from off sites.

System Description: The Dorchester County Health Department is part of a Wide Area Network (WAN), a 200-megabyte fiber connection, provided by Network Maryland, Managed by Maryland Department of Health. The Overture converts the fiber connection to an Ethernet connection. Maryland Department of Health manages the CISCO Router. CyBlock is a web filter that is used to manage, monitor and block web traffic. One 48 port cisco switch, and three 48 port juniper switches are configured to manage our LAN and our Wireless network. The wireless has two networks a secured network and a Guest. The secured network is tied to Active Directory. The Guest network is tied to a radius server in Baltimore City, which guests can access via WPA-2 Security. Cecil County Health Department store their Quantum Duplicator at our location. We

have a Quantum Duplicator store at our Cedar street location, which replicates daily to a second Duplicator at Cecil County Health Department. These Duplicators store back-ups from Veritas Back-Up Exec; Servers, Databases, systems, and files. Server-2 2008 being phased out only serves as an authentication server. Server-3 2008 being phased out host employee File Share, PIMMS Database, and Malwarebytes manager. Server-8 2019 is our SQL database server: hosting (Ahlers, MITS, Pattrac, Veritas Back-up Exec), OpenSystems, and our Data Retention files. Server-9 2019 is Symantec Endpoint protection manager, Department Share Drives, and a tape drive. Server-9 hosting Veritas Back-up Exec allows for backs-up from Veritas to be transferred and stored to a physical 10 TB tape. We store these tapes in two locations: in a fire proof safe at Cedar Street, and off-Site at the Addictions Location on Race Street. The employee computer environment consists of all Windows 10. Most printers on the network are Multi-Function Xerox Printers, and laser brother printers. Some employees are assigned Cell phones (iphone and android), Mifi's, and a few other peripheral devices (topaz signers, card readers, usb's). There are a multiple of other systems and databases stored elsewhere employee's access remotely or in the cloud: Annapolis Data Center, EVRS, EVS, MMIS, CARES, Careware, Pattrac 2.0, Worker Portal, Maxwell. The phone system is hosted by Verizon, services fax and voice.

System Architecture



Roles and Responsibilities: The Dorchester County Disaster Recovery Plan outlines the roles and Responsibilities for the Information Technology team to plan, assess, and recover the Information Systems in the case of a disaster.

Contact List — Recovery Team

#	Name	Office	Cell	Email
1	Jeff Parmer	410-901-8138	410-310-7084	Jeff.Parmer@maryland.gov
2	Alan Mcintee	410-901-8114	410-330-9180	Alan.McIntee@maryland.gov

IT Department Responsibilities:

- Support the establishment, staffing, training, and preparation of the Disaster Recovery Plan.
- Notification of necessary parties. Assess the extent and seriousness of a disaster.
- If alternate site is required, directing and managing of the relocation.
- Establish connection of all systems and applications to network.
- Perform system restoration from backup to needed systems, applications or files.
- Provide employees with resources/support needed to perform assigned functions as quickly and efficiently as possible.
- Maintain security procedures for sensitive data and systems.
- Keeping open communication between, the public, employees, staff, contractors, vendors, and others.

Recovery Strategy: The Recovery strategy follows a 3-tier system. Activation and Notification, Recovery, and then Reconstitution.

Activation Criteria and Procedure: The Dorchester County Health Department Disaster Recovery Plan may be activated if one or more of the following criteria are met:

1. The COOP is activated by the Health Officer or designated successor;
2. The type of outage that DCHD's Information Systems will be down for more than 48 hours.
3. The DCHD facility is damaged and inaccessible for more than 48 hours.

The following persons or roles may activate the DCHD disaster Recovery Plan:

	Name:	Title:	Phone:	Email:
1	Roger Harrell	Officer	410-901-8132	Roger.Harrell@maryland.gov
2	Casey Scott	Deputy Health Officer		Casey.Scott@maryland.gov
3	Carla Neugroschel	Administration Director	410-221-8569	Carla.Neugroschel@maryland.gov
4	Jeff Parmer	IT Director	410-901-8138	Jeff.parmer@maryland.gov

Notification: Upon activation of the Disaster Recovery Plan it is essential that all business contacts, system support personnel, employees, staff, MDH, the public, and all appropriate contacts should be notified of the situation.

In the case of a disaster situation, Emergency Preparedness staff can active the Maryland Health Alert Network. HAN notifies employees by a call down list and mass messaging via email, text message, and automated phone calls.

Recovery Phase:

Assess Outages: The Disaster Recovery Plan will ensure all essential employees understand and are prepared to evaluate the situation and estimate a time for resolution. To assess the severity of the incident there are several factors:

- Facility Damage — The degree of damage done to the facility. Evaluation of operational status of fire-retardant systems, environmental heating/cooling systems, and physical security of the building.
- Power Issues — the overall electoral systems of the building. Enough power to run all systems and applications.
- Applications issues — accessible of all systems and applications. Evaluation of all system programs should be tested.
- Networking connection — evaluate the condition of routers, switches, phones, and connectivity to Internet

Evaluate and determine the level and quality of security controls and safeguards to keep environment safe.

Use the below chart:

Name:	Assessment:	Estimated re air time:	Assessed by:	Notes:
Facility Damage				
Power issues				
Applications issues				
Networking Connection				
Security Evaluation				
Other:				

Recovery Approach: If a disaster were to occur Dorchester County Health Department has a number of Contingency plans:

1. Quantum Duplicator — DCHD has a duplicator stored at Cecil County Health Department. At DCHD we also have a duplicator that replicates data to the duplicator at CCHD. Back-up are sent from Veritas back-up exec to our duplicator and is then replicated. Full copies of systems and data bases are backed up.
2. On Site Tape-- Stored in a locked Fire Proof Safe at Cedar Street and a tape. This tape is a storage media device which can hold up to 10 TB of data. The same data the replicated to the duplicator are stored on this tape.
3. Off-Site Tape — Stored at the Addictions, locked in the secured IT server room, is stored a backup tape.

Multiple Off-Site Locations are available to the Dorchester County Health Department:

- Addiction program: Race Street, Cambridge MD. Has Network Maryland connection. Could hold 20-30 additional staff.
- Maryland State Hospital Center: Woods Road, Cambridge MD. Has Network Maryland Connection. Could hold all staff.

Reconstitution Phase

The goal of this final stage is to smooth transition back to normal operations; the objectives of this tier are:

- Assess existing site and determine if facility is restorable or new permanent location is required.
- Restore new or existing facility to fully recover and reconstitute normal operations and back-ups are properly reinstalled.
- Support the phase out and transition back to the permanent facility site.
- Ensure the transition has a minimum effect on availability of the user
- Implement standard operating procedures.
- Notify all personnel the recovery is complete.
- Deactivation of the Disaster Recovery Plan after formally Recovery and Reconstitution is completed.

Deactivation Plan: The Disaster Recovery Plan does not end with the full recovery and reconstitution of the IT operations. Formal closure needs to be included.

- Pinpoint weaknesses in the established IT policies, processes and procedures that may have caused or permitted the disaster to occur.
- Note problems encountered and develop procedures that will prevent them from reoccurring.
- Streamline and modify procedures to provide for a smoother execution in the future.
- Identify weakness in the execution that required better team training, preparation, and testing.
- Apply post-disaster knowledge and insight to normal day-to-day operations.
- Conduct a "Post-Disaster Lessons Learned" briefing.
- Establish and implement corrective actions.

Program Information:

1. Physical Security

Item	Oversight/Management	Description / Authority
Fire Alarm System	Bay Country	Certain employees are given unique codes to activate and deactivate the alarm.
Security Alarm System	Bay Country	5 code door locks are installed at locations where sensitive data is stored. Only individuals knowing the code are allowed access.
Keys	DCHD Administration, Key One	Keys are given out and recorded by administration for access to the building.

2. Hardware Installation

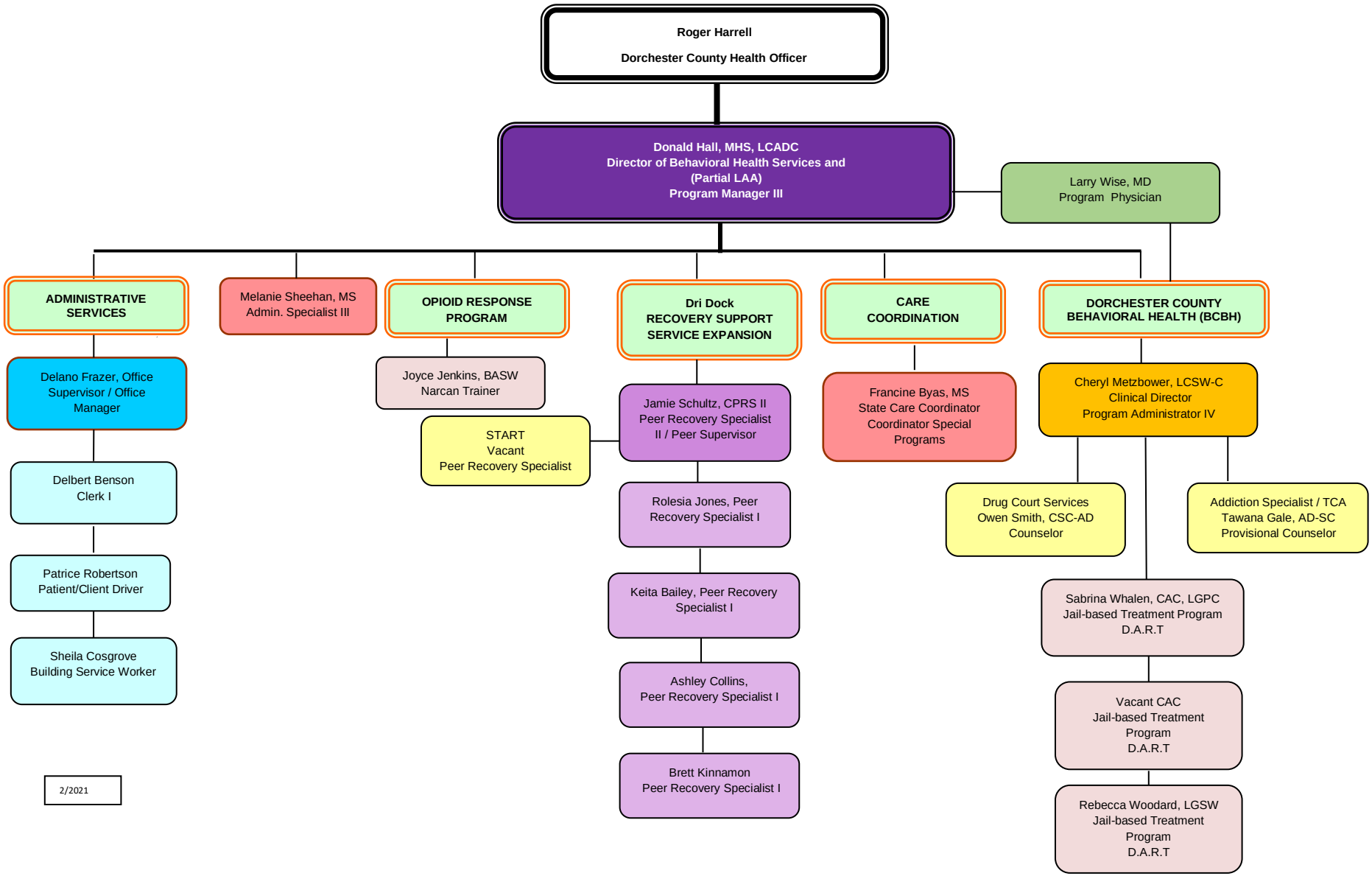
Item	IT Function
MDH Overture	Converts Network Maryland's Fiber lines to Ethernet
MDH Cisco Router	Managed by the MDH, Assigns the IPS of the LAN
CyBlock	Web filter hardware. All data coming and going is filtered and monitored.
Switches 1 Cisco 3 Juniper 48 Port Switches	Maintains DCHD in the network
Aruba Wireless	4 Access points placed around DCHD and grants access to 2 wireless networks. A secured Wi-Fi connected that is tethered to Active Directory, and a Guest Network that has its own IP Managed by a Radius served in Baltimore City, Maryland.
Quantum Duplicators	2 Duplicators are stored at DCHD, 1 is DCHD, Other is CCHD which stores their backup
DCHD Cameras	Installed by Talon, Managed by DCHD – 16 Port DVRs record motion inside and outside of the health department. There are 32 cameras and it stores about 3 weeks' worth of footage.
Read-Only Domain Controllers	Managed by MDH
2 sever 2008s	Hosts File Share, Pimms, Malwarebytes Manager, and our Authentication server are currently being decommissioned and will be phased out by 2020.
2 Server 2019s	New servers that will host all applications and systems. Dell Tape Drive An outboard tape drive that is connected to our backup exec server. Allows access to store backups on media tapes for quick access when data loss occurs.
DCHD computers	All computers are connected to Domain. Fully a windows 10 environment.
Printers	All printers are Xerox MFP networked printers or locally connected last Brother Printers. Xerox printers store encrypted data.

3. Systems, Applications, and Network Software

Item	IT Function
Cyblock	Software that works as a web filter. Monitors traffic and ability to block sites. Reports can be run on bandwidth, user activity, site activity.
Vertias Backup Exec	Grants ability to create and store back-ups from systems, applications and data in multiple formats.
Duplicator	Stores backups from backup executive and replicates from Duplicator 1 at the Dorchester County Health Department to Duplicator 2 at the Cecil County Health Department.
Symantec Manager	Manages Symantec End point Protection. Software is sent to networked computers and the antivirus is managed from server.
Malwarebytes Manager	Manages Anti-Exploit, anti-ransomware, malware protection systems
Patch Manager	Software that allows Microsoft, Dell, Windows, application updates/patches to be managed and pushed as soon as release
Vital Records	Birth and Death Certificate programs are accessible by networked connection to Network Maryland. Applications are accessed via double authentication by web address.
Open Systems	Accounting software stored on server. Access to server via mapped drive is required for user to access. Back-ups are available to recover to emergency Server.
Rumba	Rumba Software are installed on client computers, needed to access Annapolis data Center databases: MMIS, CARES, and more. Access to network computer on Network Maryland required. VPN available to grants access off network. Rumba install packages are kept by IT.
Ahlers	Clinical database. Program stored on server. Mapped drive to data files needed for access. Backups for files are recoverable via backup exec.
Pattrac	Clinical database program. Physically stored on server via SQL. Install files kept by IT. Backups of SQL and Documents are backed up. Restoration of SQL database and pattrac files needed for access. Network access to server needed. Pattrac 2.0 Cloud based Clinical database program. Is accessible via and internet connection.
Careware	HIV Department Database. Hosted by Baltimore, access via Secured Internet connection. Double Authentication is required to access remotely.
Pimms	Healthy Families Access Database. Stored on server. Backups are available. Software installation is available by IT.
Maxwell	Healthy Families Cloud based database. Employee store information. Access via Internet connection.
MITS	DCHD Inventory software. SQL database and software install on clients for the access to data. Backups are kept of SQL databases. Data is available via Network Maryland Connection.

Data Retention	Sensitive Files containing HIPAA and PHI are stored on the server. Access is strictly enforced. Backups are kept of data, and available for recovery
File Share	Employee Documents are stored on the Server. Windows Sync Center stores and Offline copy on the user's computer, and an online copy on the server. Backups are available to restore lost files. Accessible via networked connection.
Share Drives	Departmental share drives and employees store and share information. Files are backed up and backups are available for data loss occurs. Email and Workday are available via any internet connection.

FY- 2022 Dorchester County Behavioral Health Services Organizational Chart



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Criminal Justice Network/LDAAC Membership List 02/01/21

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Kent County Behavioral Health

Emergency Operations Plan

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PURPOSE

An emergency in the center or its community could suddenly and significantly affect the need for the centers' services or its ability to provide those services. A natural or manmade event that significantly disrupts the workplace (for example, damage to the center's buildings and grounds due to severe winds, storms) that significantly disrupts care, treatments, and services (for example, loss of utilities such as power, water, or telephones due to floods, civil disturbances, accidents, or emergencies within the center or in its community); or that results in sudden, significantly changed, or increased demands for the center's services, (for example, bioterrorist attack, building collapse, mass casualty event in the center's community, or pandemic.)

The purpose of this plan is to provide a guide for a comprehensive approach to emergencies in the center or our community, in case of a disaster or catastrophic incident, both internal and external to A. F. Whitsitt Center that would overwhelm staff immediately on duty.

Executive Order 01.01.2005.09 commits the State of Maryland to the implementation of the National Incident Management System (NIMS), a core set of values set forth in Homeland Security Presidential Directive -5 (HSPD-5). The A. F. Whitsitt Center's Emergency Operations Plan is designed as an operations plan to organize A. F. Whitsitt Center's staff and resources in the areas of emergency medical and nursing services for consumers, staff and others in the center, security, communications, food service, shelter, clothing, sanitation services, utilities, and transportation to deal with the emergency.

The goal of the plan is to safeguard, to the fullest extent possible, the lives and health of consumers, visitors, staff, and A. F. Whitsitt facilities.

SCOPE

The plan applies to the center's workplace: all buildings, departments, staff, visitors, volunteers and tenants utilizing buildings on Upper Shore Community Mental Health Center's property. The plan provides processes for cooperative planning with the Kent County Health Department (ESF-8) and other healthcare organizations as well as the surrounding neighbors and tenants regarding essential elements of their command structures, control centers and resources for emergency responses, as well as the Kent County Emergency Operations Plan. Each staff member at the facility has been

encouraged to develop a personal emergency plan with their family and friends and have been provided a list of resources to develop their personal EOP.

OBJECTIVES

1. To pre-plan a course of action necessary to safeguard the lives of consumers, staff and visitors of the center facilities in case of natural or manmade events that significantly disrupts the workplace, interrupting normal center operation, both internal and external to the center.

2. To maintain activities related to care, treatment, and services during emergency situations.

3. To identify potential emergencies that could affect the need for services or the ability to provide for those services by conducting a hazard vulnerability analysis

4. To provide processes for evacuation, both horizontally and when applicable, vertically when the environment cannot support adequate care, treatment, and services.

5. To provide processes for alternate care sites that have the capabilities to meet the needs of consumers when the environment cannot support adequate care, treatment and services.

6. To utilize exercises to prepare staff for actual emergencies relevant to the organization and to validate the effectiveness of the plan and identify opportunities to improve, both center wide and community wide, based on the hazard vulnerability analysis.

PLAN STATEMENT

The application of the Emergency Operations Plan will apply to both internal and external disasters and will vary with each situation. It was developed with the involvement of the center's leaders through the center and executive committee structures.

It cannot be emphasized strongly enough that a thorough knowledge of the contents of this plan may, at sometime, save lives.

The plan identifies specific procedures that describe: Mitigation, Preparedness, Response and Recovery strategies, actions and responsibilities for each priority emergency.

PHASES OF EMERGENCY MANAGEMENT

The 4 phases of the Emergency Operations Plan are addressed in this plan. They are:

- **Mitigation** – Activities that the center undertakes in attempting to lessen the severity and impact of a potential emergency.

- **Preparedness** – Activities the center undertakes to build capacity and identify resources that may be used if an emergency occurs.

- **Response** – Activities that occur during and immediately after a disaster.

- **Recovery** – Continues until all systems return to normal.

MITIGATION

A. F. Whitsitt Center works closely with the other departments in the center, meeting regularly to talk about emergency planning and to work jointly on exercises. The center also meets with KCHD Emergency Preparedness Planner to share information, as well as the Healthcare Emergency Response Coalition (HERC). Resources are secured through for training, protective equipment and supplies. Whitsitt Center partners with Shore Regional Hospital Center, Long Term Care facilities, Washington College and Office of Emergency Services to practice surge capacity in community wide exercises.

PREPAREDNESS
ORIENTATION/TRAINING

1. All new staff will be oriented to the Emergency Operations Plan within the first thirty (30) days of employment. This education will include:

   - Staff member's HICS/NIMS role and responsibilities during an emergency
   - Information about threats, hazards, and protective actions.
   - Processes for identifying and assigning staff to cover all essential staff functions under emergency conditions.
   - Notification, warning and communication procedures including back-up communications systems used during an emergency.
   - Means for locating family members in an emergency.
   - Processes for obtaining supplies and equipment during an emergency.
   - Emergency response procedures
   - Internal and external evacuation procedures and shelter and accountability procedures
   - Emergency shutdown procedures

2. All staff will be re-educated on the Emergency Operations Plan annually through Annual Mandatory Training Day; including revisions and updates. In-service training sessions shall be provided through New Employee Orientation, Annual Mandatory Training Day and department training along with exercises that shall be at least annually so that all individuals and groups will have a better understanding of the operation of this plan. Attendance is tracked through Staff Education and an

Acknowledgement of Instruction is signed by the employee with a copy in the Human Resources personnel file.

3. It is the responsibility of all supervisors to ensure that their staff have received training on the emergency plan and the supervisors will ensure training on related center and departmental policies and procedures set forth.

4. The responsibility for emergency preparedness rests with each individual. Therefore, all staff shall read and thoroughly acquaint themselves with the plan. It is the responsibility of each individual to be aware of the role they must assume when the plan is implemented. *See your Department Call Down List to determine if you are a 2 hour or 12 hour responder.*

EXERCISES

1. Periodic testing of the Emergency Operations Plan will be held, **at least annually for each activity** so that individuals and groups will become familiar with the Agency's procedures and can assess the plan's appropriateness, adequacy and the effectiveness of logistics , human resources, training, policies, procedures and protocols. The types of exercises are:
    a. Orientation and Education Sessions- These are regularly scheduled to allow discussion, provide information, answer questions, and identify needs and concerns.

    b. Tabletop Exercise – Members of the emergency management group meet in a conference room setting to discuss their responsibilities and how they would react to emergency scenarios. This is a cost-effective and efficient way to identify areas of overlap and confusion before conducting more demanding training activities.

    c. Walk Through Drill – The emergency management group and response teams actually perform their emergency response functions. This activity generally involves more people and is more thorough than a tabletop exercise.

    d. Functional Drills – These drills test specific functions such as medical response, emergency notifications, and warning and communication procedures and equipment, though not necessarily at the same time. Personnel are asked to evaluate the systems and identify problem areas.

    e. Evacuation Drills – Personnel walk the evacuation route to a designated area where the procedures for accounting for all personnel are tested. As they evacuate, participants are asked to make notes of things they notice that might become possible hazards during real emergency evacuation (such as stairways cluttered with debris or smoke in the hallways).

f. Scale Exercise – A real-life emergency situation is simulated as closely as possible. This exercise involves the organization's emergency response to personnel, KCHD, neighbors and tenants, and community response organizations.

2. Exercises should be planned to stress the limits of the organization's emergency management system. Tabletop drills may be conducted for planning and training, however, they are not to be substituted for testing of the organization's response to an actual emergency. Response to an actual event may substitute for an exercise when followed up by a thorough hotwash.

3. The goal of this testing is to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency or a plausible scenario that is realistic and relevant to the organization.

4. The exercise assesses the communication, coordination, and effectiveness of the center and the community's command structures, and as a potential disaster receiving station.

5. The exercise can be either planned or a response to an actual emergency. The center participates in communitywide practice exercises when announced by the KCHD, relevant to the priority emergencies identified in its hazard vulnerability analysis.

6. The center also participates in at least one exercise per year with campus tenants/neighbors, preferably related to their joint hazard and vulnerability assessments.

7. Events should validate the effectiveness of the plan and identify opportunities to improve. Planned exercise evaluates the effectiveness of improvements that were made in response to evaluations of the previous exercise.

8. During planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise documents opportunities for improvement. This individual may be a staff member of the center who is not participating in the exercise.

PERFORMANCE AREAS TO BE MONITORED DURING PLANNED EXERCISES

1. Event notification including processes related to activation of the emergency management all hazards command structure, notification of staff, and notification of external authorities.

2. Communication including the effectiveness of communication both within the center as well as with response entities outside of the center such as local governmental leadership, police, fire, public health and other health care organizations within the community.

3. Resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security.

4. Consumer management includes provision of both clinical and support care activities, processes related to triage activities, consumer identification and tracking, evacuation, shelter, shutdown and accountability processes.

   All exercises are evaluated (Hotwash) to identify deficiencies and opportunities for improvement. The evaluation includes an assessment of the communication, coordination and effectiveness of the center's and the community's command system.

5. Strengths and weaknesses of the performance revealed by the exercise are communicated to all levels of the organization, through the existing committee structure.

6. The Health and Safety committee will report the recommendations and findings to the Professional Staff Executive Committee (PSEC).

7. The Health and Safety Committee will report the findings to the PSEC Committee for further evaluation and will report additional findings and recommendations for improvement to the Health and Safety Committee.

8. When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements must be put in place until final resolution. A special PSEC meeting will be convened with the Health and Safety Committee to review the findings and develop an interim improvement action plan to present to PSEC.

9. Measures of success and evaluations will be maintained by the Health and Safety Committee. The committee will modify the Emergency Operations Plan in response to the evaluation of the exercises. Planned exercises evaluate the effectiveness of improvements that were made in response to evaluations of the previous exercise.

10. When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements will be put in place until final resolution. Progress of the improvements will be monitored through the PSEC Committee.

EMERGENCY AND CRITICAL SUPPLIES

1. Critical supplies and resources such as pharmaceuticals, medical supplies, PPE, food, linen, water and utilities will be managed according to HICS/NIMS structure by the **Agency Director**. Emergency medical supplies, PPE, blankets, flashlights, crowd management, etc. will be located at a designated area in the North and East Wing. The **Director of Nursing** will designate staff to take supplies to the disaster site, and for maintaining, updating and providing the supplies as needed.

2. **Emergency portable water** can be obtained in the North Unit Staff Lounge and also by contacting the KCHD. The bottles will be placed in the dining hall for cooking and distribution of drinking water as needed. The **Clinical Director** will assign staff to guard the food and water supplies.

3. **Finance / Procurement Section Chief** will facilitate purchasing of needed resources to respond to the disaster/emergency. They oversee the acquisition of supplies and services necessary to carry out the hospital's medical and psychiatric mission. They supervise the documentation of expenditures and staff time relevant to the emergency. The **Finance / Procurement Section Chief will** procure/replenishment needs identified in the action plan.

4. Medical equipment is inventoried as per Medical Equipment Plan and medical supply inventory is maintained by the **Agency Director and Director of Nursing/Facilities Unit Leader . The Director** with the help of the Inventory Specialist will maintain an ongoing inventory and issue medical supplies in bulk as needed. Medical supply may be accessed in an emergency by the **Nursing Director/Nursing Unit Leader** through the pre- established procedures. Items will be obtained directly from the storeroom or by coordinated deliveries with the **Security Department/Safety and Security Officer.**

DIETETICS SERVICES AND FOOD SUPPLIES

The food contractor has developed a plan that prepares the center for efficient smooth operation during emergency situations. The **Food Services Leader** will be responsible for issuing and setting up emergency food service.

The **Food Services Leader** will communicate with the **Clinical Director/Logistics Chief** to organize food and water stores for preparation and rationing, particularly during periods of anticipated or actual shortage. If there is a need for food and beverages for volunteers, this will be provided. Foods that are to be made available if the Central Kitchen is functional are listed in the Linton's Emergency Operations Plan.

The food contractor maintains an emergency plan for the hospital (Attached as an addendum to this plan). Community restaurants and grocery stores may also provide emergency cooked and uncooked food for a period of 48 hours or until we are able to receive food delivery.

EMERGENCY FOODS ON HAND – PREPAREDNESS

4 Breakfasts for 40 consumers and staff
4 Lunches for 40 consumers and staff
4 Dinners for 40 consumers and staff
4 Gallons of water for 40 consumers and staff

Additional bulk bottles of water, coffee, creamer, sugar, and staple foods are available in the employee kitchen.

PAPER GOODS HELD IN THE DINING AREA

4 cases 8-oz tall hot cups
10 cases spoons (1000/case for nourishment/supplements)
30 cases carryout trays (100/case)
10 cases knives, forks, and spoons for meal service
5 cases soup bowls
2 cases soup bowl lids
5 cases 5-oz juice cups
2 cases 5-oz juice cup lids
2 cases mug lids
Brown paper bags for bagged lunches

Each unit has a day's supply of peanut butter, jelly, bread, cheese and cereal.

RESPONSE PROCEDURES

DIETETICS SERVICES RESPONSE

Please see attached Emergency Readiness Plan developed by our contractor, Linton's Food Service

PHARMACEUTICAL SERVICES DISASTER POLICY AND PROCEDURES

1. A.F. Whitsitt Center does not have an onsite pharmacy – the center relies on a retail pharmacy approximately 100 miles from our site (Craigs Pharmacy).

2. Another temporary alternative would be to reconstruct the consumers' profiles from the consumer medication administration records on the units.

3. Providing Emergency Psychiatric Medications:
   The pharmacy keeps a list of emergency psychiatric medications in a designated location.

4. KCHD will provide vaccinations, antibiotics and other pharmaceutical services for mass treatment measures.

INTERNAL RESPONSE PROCEDURES

Initiation of Code response. These Codes are standardized emergency code nomenclature for HICS/NIMS:

1. When anyone on campus becomes aware of a situation that requires emergency response, that person will call the appropriate code.

2. The following codes are part of our emergency plan; however they would not result in a situation that would overwhelm the center's capacity to respond and therefore, implementation of HICS/NIMS NOT likely.

- **Code Behavioral Health needed in (area)** - Behavioral emergency
- **Code Security Needed in (area)** - Security (suspicious vehicle, person, break-ins, open or unlocked doors)
- **Code Medical Emergency Response needed in (area)** - Cardiac/Respiratory Arrest (heart, breathing, needs EMS response)
- **Code Medical Alert needed in (area)** - Medical/non-life threatening (injured, sick, does not need ambulance)
- **Code Bomb Threat** - Bomb Threat (threat or device found)
- **Code Hazmat Response needed in (area)** - Hazmat Spill/Release
- **Code Fire Response needed in (area)** - Fire
- **Code Disaster Response needed in (area)** - Natural or Man-Man Disaster (Weather, explosion, etc.)
- **Code Utility Outage in (area)** - Utility Outage: (Electrical, water, gas, etc.)
- **Code Active Assailant in (area)** - Armed person/hostage (need police/security intervention immediately)

The following code is part of our emergency plan; and the probability does exist that the situation would overwhelm the center's capacity to respond and therefore, implementation of HICS/NIMS is definite.

- **Code Weapons of Mass Destruction** - Weapons of Mass Destruction (Nuclear, biological, chemical, radiological)

INCIDENT COMMAND CENTER

The Incident Command Center for A.F. Whitsitt Center will be located in the Cecil Room 204. **NOTE:** If the Conference Room 204 is the disaster area, the alternate site for the Incident Command Center will be located in Conference Room 408.

AUTHORITY OF THE INCIDENT COMMANDER

1. The Incident Commander will be the Center's Director or other person pre- identified in the HICS/NIMS organization chart. The HICS/NIMS system identifies sections by color. The color designation is as follows:

Section	Color
Incident Commander/Administrative	Black
Operations	Red
Finance	Green
Planning	Blue
Logistics	Yellow

2. The Incident Commander will determine the extent of the emergency and decide whether or not to initiate the A.F. Whitsitt Center's Emergency Incident Command System/National Incident Management System. (HICS/NIMS) the initiation of the response and recovery phases of the plan, including how, when and by whom, will be the responsibility of the Incident Commander. In his/her absence, the chain-of-command shall proceeds as follows:

    - Director
    - Clinical Services Director
    - Director of Nurses
    - Risk Manager

3. Should any of the above be absent, the succeeding member will assume the responsibility of declaring a disaster and will direct emergency procedures until relieved by a preceding member. If no one in the chain of command listed above are available, **one of the Section Chiefs** should take the initiative to activate HICS/NIMS.

4. As soon as the decision to implement HICS/NIMS has been made, the following will be notified immediately by the **Communications/Information Technology Leader**:

    - Director
    - Clinical Services Director
    - R.N. Manager
    - Risk Management

    Other positions assigned by the Director

5. The **A.F. Whitsitt Incident Command Center (ICC)** will be established by the Incident Commander when needed to facilitate management of emergency response actions.

6. The **Incident Commander** will manage emergency response when notified by Kent County Health Department Emergency Operations Center and support activities from their site supported by key emergency managers.

7. All emergency responses and activities will be coordinated through the ICC. All information on the situation is channeled to the ICC and compiled. Key emergency managers will utilize the ICC or other sites as assigned by the **Incident Commander** and will coordinate all activities through the ICC. All contact with outside agencies will be made by the **Public Information Officer (PIO)** through the ICC and **Incident Commander**. The **Incident Commander** has a list of the people/ organizations that need to be contacted immediately and will begin to delegate this responsibility. The Incident Command Center will assume responsibility for managing facility space during a declared emergency situation.

8. A **Recording Secretary** shall be permanently assigned to the Incident Command Center to record proceedings of the operation. Support staff contact information is maintained in the confidential database.

INCIDENT COMMANDER – OVERVIEW OF DUTIES
(SEE TASK ACTION SHEET FOR DETAILS)

1. Dispatch an official liaison person to the scene to act as liaison between the Incident Command Center and any outside emergency forces on the scene. The person selected should be the one most familiar with the type of emergency occurring. For fires, the liaison should be maintenance staff for a bomb threat- Security; and for a utility problem Maintenance staff should coordinate the needs of the Command Center and the disaster site. The disaster site will have top priority in deployment of the staff available.

2. Determine need to occupy emergency shelters or previously determined shelter areas.

3. During the event, medication and food needs shall be assured through contact with Pharmacy and Dietetics; coordinated by the **Logistics Section Chief**.

4. Restrict radio communications to those related to the emergency.

5. Make preparations for evacuation, if necessary. *(See evacuation procedures)*

6. Assure that each unit faxes a written list of all consumers and staff accounted for and not accounted for to the Incident Command Center. The HICS/NIMS Patient Tracking Sheet A.F. Whitsitt Emergency Management Notebook – Section Forms list will be used for this purpose for initial consumer count and subsequent tracking.

7. Contact the **Logistics Section Chief** to have emergency supplies delivered to the Triage Areas and the Casualty Stabilization sites.

8. Notify the operator, when the disaster is over, to clear the Code (COLOR CODE). (Only the **Incident Commander** can determine that the disaster is over and so direct the operators)

9. Establish regular meeting times (on the half hour or hour) with the **Section Chiefs.**

OFFICERS IN THE COMMAND CENTER

Safety and Security Officer acts as a liaison between outside emergency forces and the Incident Command Center. They will communicate with the **Maintenance Director** to secure and post non-entry signs around unsafe areas. They will secure the Incident Command Center, the triage area, the food supply and Dietetics Services, the morgue area as outlined in the Maryland Mass Fatality Management Planning Framework in conjunction with the KCHD and other sensitive or strategic areas from unauthorized access.

Public Information Officer. A.F. Whitsitt Center Liaison/Public Information Officer (PIO) will establish contact with outside supporting agencies (notification tree located in the A.F. Whitsitt Emergency Management Notebook) and set up a public information center which will be located at the Kent County Health Department.

EQUIPPING OF OFFICERS, SECTION CHIEFS AND UNIT LEADERS

The Incident Command Center and Section Chiefs will be equipped with "To Go Bags"- containing: flashlights, vests, hats, maps, office materials, clocks, copies of the A.F. Whitsitt Center Emergency Management Notebook containing the Job Action Sheets, and other appropriate items. The "To Go Bags" are pre-positioned in the Section Chief Command Centers. The Officers and Section Chiefs don the vests and hats appropriate to their role and distribute hats and vests to the unit leaders for field identification.

COMMUNICATION DURING EMERGENCIES

NOTIFICATION OF HOSPITAL STAFF AND EXTERNAL AUTHORITIES

1. The **Communications/Information Technology Leader** will insure that the staff identified as the A.F. Whitsitt Center's HICS/NIMS responders are notified by telephone and pager once a disaster has been declared by the Incident Commander or his/her designee and that the HICS/NIMS procedures of the Emergency Operations Plan are in effect.

2. BHA (Behavioral Health Administration) and the Kent County Health Department will also be notified immediately by the **Liaison Officer/Public Information Officer (PIO)** that an emergency is in progress at A.F. Whitsitt Center. BHA will in turn contact Maryland Department of Health (MDH) and Kent County Health Department will contact the Kent County EOC (Emergency Operations Center).

3. The **Incident Commander** or designee will evaluate the situation and call off-duty staff under their charge to duty as the situation warrants and coordinate all activities through the Incident Command Center, utilizing the A.F. Whitsitt Center's HICS/NIMS, including notifications.

4. Center staff to be notified at the discretion of the Incident Commander:

   - Director of Nursing
   - Human Resources
   - Director of Maintenance
   - Director of Police Department
   - Director of Medical Services
   - Food Services Leader
   - Assistant Director of Risk Management and Safety

5. A current listing of office and home telephone numbers of these persons will be maintained at the nursing station. These numbers are also located in the A.F. Whitsitt Center Emergency Management Notebook (**Incident Commander, Section Chiefs** only) and the database is available from the **Safety and Security Officer**, and the **Communications/Information Technology Leader**. Refer to the HICS/NIMS chart when notifying staff. Radio communications are restricted to those related to the emergency.

6. The **Nursing Unit Leader**, depending on the code, responding to the code will assess the situation to determine if the code response is adequate to handle the emergency. If the initial code response is inadequate, the **Facilities Manager** will decide whether an internal disaster response is needed, in consultation with the Director.

7. The Director may confer with the Clinical Director and other management staff such as the R.N. Manager and Maintenance if time permits. The Director will call the emergency operator and direct that a code be announced, giving the location and nature of the disaster.

8. The Director/**Incident Commander** may also receive information from outside agencies that will necessitate the implementation of HICS/NIMS caused by an external event.

9. The Incident Commander maintains an updated list of HICS/NIMS members and their confidential contact information. This list is also maintained at the nurses' station and the To Go Bag notebook of each section chief. The list includes office, home, cell phone, pager and fax numbers. Regular updates to the confidential directory are coordinated through the Kent County Health Department.

10. A roster of language interpreters is maintained by Human Resources and distributed center wide on an annual basis.

11. The Incident Command Center is set up in the Conference Room 204, across from the Director's Office. In the event of the destruction of the designated Incident Command Center or an event that would render it unsafe to remain there, the A.F. Whitsitt Center will be designated as an alternate site.

12. **Only emergency calls will be handled.** The **Communications/Information Technology Leader** may elect to provide prescript messages that may include self-care information for consumers and descriptions of the steps the center is taking to minimize risk to consumers. The messages would explain the details of the emergency. For example, in the event of suspected anthrax contamination, the message could explain anthrax detection and treatment methods, along with toll free numbers of other organizations to pass along to callers for further info.

The **Incident Commander**, in collaboration with the Section Chiefs, makes an initial determination is made regarding how many staff are required to stay at the initial phase of the emergency.

ESSENTIAL STAFF

1. When HICS/NIMS is activated, all A.F. Whitsitt Center staff designated as essential are required to stay until directed by the Incident Commander.

    a. The Incident Commander directs the **Communication Leader** to announce via the overhead speakers and pager system as follows:

2. *"Code _____is in progress. The Center Incident Emergency Operations Plan has been implemented. All staff that have been mobilized per out emergency operations plan are required to remain on duty until_____. All others should_____."*

08/2020 – A.F. Whitsitt Center's essential staff designation is as follows:

Accounting: **Fiscal Staff**

Addiction Services: **All Staff and Nurses**
Admissions: **All Staff**
Clinical Director's Office: **Administrative Staff and Director**

3. When notified by the Incident Commander that the disaster response is over, the operator shall announce over the paging and radio systems: **"Code (Plain Language Code), All clear"** at least 2 times.

4. The **Communications/Information Technology Leader** will assess the status of the internal and external communication devices and report immediately to the **Logistics Section Chief** and **Buildings/Grounds Damage Unit Leader**.

5. A pool of **runners** will be established with paper and markers in case of communication failure. A supply of campus maps, county maps, and state maps will be kept in the Incident Command Center "To Go Bag" showing key areas for emergency operations. In an emergency, it is imperative that the runners also check the non- consumer occupied areas for communicating information, too.

6. The **Communications/Information Technology Leader** will assist with the call down for HICS/NIMS as requested by the **Incident Commander**.

COMMUNICATION LINKS WITH OTHER AGENCIES IN THE COMMUNITY COMMAND STRUCTURE

It is essential that communication between staff, external organizations and consumers is effective to ensure that the organization can provide a high quality of care during a disaster. At the direction of the Incident Commander, the Liaison Officer/PIO will contact the county EOC (Emergency Operations Center) to request that ham operators be deployed to A.F. Whitsitt Center.

The Kent County Emergency Preparedness Planner uses the **EMStel** in the Kent County Health Department to communicate with MIEMSS (Maryland Institute for Emergency Medical Systems), Shore Regional Health Center in Chestertown and any other hospital in the State.

The **FRED (Facilities Resource Emergency Database)**, also at Kent County Health Department is a 2-way web based communications system. In an emergency, this system will notify the hospital of a situation or will query our facility for resources. FRED is monitored continuously by the health department staff. This is the primary means of shared information management for emergency response and management organizations in Maryland. It is supplemented by WEB-EOC which is the primary source for general emergency information.

ALTERNATIVE COMMUNICATION DEVICES INVENTORY - PREPAREDNESS

- A portable Radio is located in each unit's nurse's station, in the security office, in the maintenance office, and at the front reception desk.
- An overhead paging system can be accessed at the front reception desk.
- Each telephone can be utilized as a paging device.

COMMUNICATIONS DEVICES TESTING-PREPAREDNESS

Every three months the paging system and the portable radios are tested and checked for spare battery availability. The tests are coordinated through the Office Secretary.

A list of telecommunications contractors is maintained by the Office Secretary for use in repairing non-functioning communications equipment. The center maintains replacement equipment/supplies for the immediate repair of inside telephone equipment and cabling. All exterior cabling repairs are made by telecommunications contractors. Written records are available for quick reference of equipment and line locations.

EMERGENCY COMMUNICATION PROCEDURES
FOR WHEN THE TELEPHONE SYSTEM IS INOPERABLE

The staff will immediately contact the Communications/Information Technology Leader that the system has become inoperable.

The **Communications/Information Technology Leader** will then:

1. Notify Incident Command Staff via portable radio. After hours notification shall be made to the name positions via radio and/or pager.
2. Issue a mass email blast notification for all staff and Kent County Health Department through computer email blast.
3. The Communications/Communications/Information Technology Leader will contact tenants/neighbors regarding the emergency

The **Logistics Section Chief** will:

1. Evaluate, initiate and oversee the emergency communication procedure.

The **Safety & Security Officer** will:

1. Report to the Incident Command Center.
2. Assign a designee to report to the front receptionist office for paging capabilities.

3. Assign portable radios as needed. Deposit radios back to charging cradles (one in each nurse's station, security office, maintenance office, front receptionist office) when no longer needed.

Note: Areas with portable units are Each Unit's Nursing Station, The Front Reception Office, Director's Office, Maintenance Office, Security Office will:

1. Assume responsibility for their assigned geographic area
2. Advise the nursing supervisor via portable radio of assigned areas.

The Unit Staff with Assigned Radios will:

1. Notify associated areas of telephone system shutdown and location of portable radio.
2. Use the portable radio to report any emergency to:
   - Safety and Security Supervisor
   - Nursing Supervisor

3. Radio locations and associated areas of coverage:
   - Front Reception Desk –Front Area
   - East Unit Nursing Station – East unit
   - North Unit Nursing Station – North unit
   - Maintenance Office – External and Internal building
   - Security Office – External and Internal building

The **Communications/Information Technology Leader** will:

1. Access telephone system to determine if repairs can be made in-house and system restored to normal operations.

If repairs cannot be made in-house, contact will be made immediately with the appropriate contracted outside vendor for repair services.

CENTER ACCESS

A.F. Whitsitt Center has the following means of access from State and County roads. We are a dead-end road with one way in and out. In the event of a center lockdown or emergency closures, Fire, Police and Security may close and/or block access at their discretion.

DISASTER SITE
(Primary Triage/Tagging Team)

OPERATIONS SECTION CHIEF

The **Operations Section Chief** is responsible for the overall direction of the disaster site. The Clinical Director, when available, will report directly to the disaster site with a two-way radio to evaluate the situation. The **Operations Section Chief** will maintain contact with the Incident Command Center to coordinate deployment of A.F. Whitsitt Center medical staff and services. The **Operations Section Chief** will be responsible for the operation of medical care rendered and triage.

Unaffected areas shall continue normal operations if possible. All departments should be ready to assist in the emergency response effort when instructed by the **Incident Commander** or **Operations Section Chief**.

DISASTER RESPONSE - TRIAGE AND FIRST AID TO INJURED

1. All nursing staff have received emergency first aid training. All clinical staff will take an active role in providing care as needed.

2. Place a disaster tag on each consumer, tags on crash carts. The disaster tag will identify the consumer and record his/her movement and indicate a priority level for treatment.

3. Contact 911 for transport to outside facilities such as Shore Regional Hospital Center in Chestertown, University of Maryland Medical Systems or other state or community hospitals, depending on the severity of the medical condition.

Emergency Equipment and Location for Emergency Stabilization

Item	Location
Defibrillator	Nurses Station - East
Thermometer	Nurses Station - East
Thermometer	Nurses Station - West
Blood Pressure Cuff	Nurses Station - East
Blood Pressure Cuff	Nurses Station - West
Stethoscope	Nurses Station - East
Stethoscope	Nurses Station - West
Crutches	Nurses Station - East
Wheelchair	Nurses Station - East
Medical supplies i.e. 4x4/ Ace bandages, alcohol	Rx room both units

Accucheck	Rx room both units

SITES OF OPERATION

1. There will be three sites of operation during a Code (plain language) of a sudden and sustained overwhelming nature:
   - Disaster Site
   - Casualty Stabilization Site
   - Command Center- Conference Room 204

2. All physicians and Licensed Independent Practitioners will report to the disaster site. All available nurses, as directed by the **Operations Section Chief** in consult with the Nursing Supervisor, will report to the disaster site. The **Operations Section Chief** will coordinate with the **Logistics** and **Planning Section Chiefs** to obtain necessary disaster equipment.

3. Once the Incident Command Center has been established by the **CEO/Incident Commander**, the **Nursing Unit Leader** will decide who to send to the hospital after triage. If a physician is assigned through the appropriate channels to assist, he/she will be in charge of triage.

CASUALTY STABILIZATION SITE

(Brown Unit) (Alternative site (KCHD designated site)

Operations Section Chief: After the first hour, the Operations Section Chief will meet with the Operation Unit Leaders and the Consumer Tracking Manager to plan and project consumer/victim treatment and care needs. The Operations Section Chief makes recommendations to the Incident Commander on how to best serve the needs of the consumers/victims and how to either increase or decrease services and relocation recommendations, if warranted.

Unit Leaders: The Nursing Unit Leader will meet regularly with the Operations Section Chief to assess current and project future consumer/victim care conditions. They will brief the Operations Section Chief on the status and quality of medical care.

Duties: Provide medical stabilization and secondary triage of casualties.

1. **First to arrive:** Immediately assist in the unloading of equipment going to disaster site.

2. **Nursing Staff:** Open clinical room doors, set up equipment, become familiar with equipment and supplies in kits, get suction, oxygen and other equipment/supplies ready for consumers/victims as they arrive from the disaster site. An Emergency Box is available in each nursing station.

3. **Nursing Unit Leader:** Direct activities to set up the lobby and clinic. Check with the Planning **Section Chief** to assure adequate coverage with the Labor **Pool Unit Leader**. Assign staff as needed. Assist with comforting consumers/victims and directing traffic until the **Counselor Support Unit Leader** responds to the site. Obtain information from consumers/victims for records.
   The **Nursing Unit Leader** in cooperation with the Facilities Unit Leaders will set up alternate consumer service locations, if necessary. They will inform the Section Chiefs. They will coordinate resources, staffing and supply needs; coordinating with the **Logistics Section Chief, Labor Pool Unit Leader** and the **Procurement Unit Leader**.

4. **Physicians: (When available)** Provide and direct consumer treatment and triage.

5. **Social Workers/ Counselors:** Find short-term placement sites for consumers who may need to be relocated, both injured and non-injured consumers. Contact families, custodians, etc. to provide information regarding consumers as appropriate. Provide counseling and support to all consumers.

6. **Consumer Flow/Surge Capacity:** Those needing cots or medical treatment will be sent with staff to Chester River Hospital Center. Those needing more intensive care and those whose condition turns critical will be transferred to neighboring hospitals. The coordination of needed emergency beds will be through MIEMSS and KCHD with the Incident Commander.

EXTERNAL PROCEDURES AND SURGE CAPACITY

This plan will also be used to cope with any external disaster whereas the hospital facilities may be needed in the event of outside emergencies in the community at large. However, for external disasters, some degree of variation may be necessary due to the specific circumstances. For example, a mass casualty emergency at the A.F. Whitsitt Center would probably require the assistance of our medical facilities, KCHD and other external responders with sub-capabilities as defined by DHMH:

Level One Sub-capabilities

- Interoperable Communications System
- Bed Tracking System
- Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP)
- Fatality Management Plans
- Medical Evacuation/Shelter in Place
- Partnership/Coalition Development

Level Two Sub-capabilities

- Alternate Care Sites (ACS)
- Mobile Medical Assets
- Pharmaceutical Caches
- Personal Protective Equipment
- Decontamination
- Medical Reserve Corps (MRC)
- Critical Infrastructure Protection

1. In such a case, the Incident Command Center would be set up to determine the required needs and plan the necessary action to be taken. A staging area to receive the surge capacity consumers and /or staff or volunteers may be utilized to accommodate consumer flow. In all cases, every effort should be taken to maintain reasonably normal hospital routine, taking into consideration the key elements of care to ensure adequate and appropriate care for admitted consumers in temporary locations.

2. Any actions taken during these emergencies will be taken in conjunction with the Kent County Emergency Operations Center (EOC), and the Kent County Health Department who is leader for Emergency Support Function (ESF) 8.

3. The coordination of surge beds will be through KCHD and BHA with the Incident Commander.

4. HICS/NIMS, emergency assembly points and evacuation procedures apply to internal and external procedures.

ADDITIONAL PROCEDURES FOR IDENTIFYING AND ASSIGNING VOLUNTEER STAFF

1. Primary source verification of licensure, certification or registration of volunteer practitioners (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to A.F. Whitsitt Center unless the emergency is extended. The volunteer practitioners must present:

2. A valid government issued photo identification issued by a state or federal agency (for example, a driver's license or passport) and at least <u>one</u> of the following:

a. A current hospital picture identification card that clearly identifies professional designation
b. A current license, certification or registration
c. Primary source verification of licensure, certification or registration of volunteer practitioners (if required by law and regulation to practice a profession)
d. Identification indicating that the individual is a member of a BHA Health Professional Volunteer Corps, Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group.
e. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
f. Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications

3. The center may assign disaster responsibilities to volunteer practitioners. Disaster responsibilities are assigned only when the HICS/NIMS have been activated and the organization is unable to meet the immediate patient needs. Responsibilities are assigned as outlined in the HICS/NIMS organization chart, as directed by the Incident Commander in collaboration with the **Operations Unit Leaders**. Each volunteer practitioner will be assigned to an A.F. Whitsitt Center staff to assist them and to supervise their work.

4. When the disaster's impact is significant and the immediate needs of the patients cannot be met, the organization may implement a modified process for determining qualifications and the competence of volunteer practitioners. The usual process to determine the qualifications and competence of these practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services due to the length of time it would take to complete the process. The qualifications and competence of these practitioners will be streamlined so that adequate care, treatment and services can be provided.

5. Current licensure, certification, or registration as required by laws or regulation to practice a profession, such as a nurse, pharmacist, physician, technician and social worker, is verified through the DHMH Healthcare Professional Volunteer Corps (PVC). The DHMH (PVC) has issued identification to everyone who has registered and been trained to be a part of the PVC. The primary source verification for the DHMH PVC has already been addressed for the organization because the State of Maryland's licensing boards are the agencies doing the call down for the volunteers. They only call practitioners who have current licenses as part of their procedure. The process contains:

   - Licensure, certification or registration required to practice a profession.

- Oversight of the care, treatment and services will be provided by the hospital. **Operations Unit Leaders** by direct observation, mentoring and clinical record review.

6. All A.F. Whitsitt Center staff must wear their identification badges facing out. All volunteer practitioners must wear photo identification and colored wristbands.

EVACUATION PROCEDURES AND EMERGENCY ASSEMBLY POINTS (EAP)

In case of an emergency and a general building evacuation, all center departments shall evacuate patients and staff to various staging areas (called Emergency Assembly Points) nearest their location. The Incident Command Center along with the Safety and Security Officer will coordinate all efforts to relocate patients. This could involve mass transporting to other hospital and/or state facilities. Visitors are not required to go to EAP's but must evacuate along with staff, staff, consumers and others participating in facility operations. The pre-identified EAP is the gazebo. If the gazebo is compromised, the alternative EAP will be the tree line on the side of the parking lot. The EAP is determined by the incident commander and announced through the EOP notification procedures.

INTERNAL EVACUATION

Internal evacuation will be determined by the Director/Incident Commander, the R.N. Manager and the nurse in charge. They will notify the **Logistics Section Chief** to have the **Transportation Unit Leader** report immediately to the evacuation site. Internal evacuation will depend on the extent of the incident and how it is confined. Evacuation may consist of moving people to a safe room/area internally or externally to the involved structure. The local emergency responders may be called to help with the decision to evacuate as well as the evacuation process. Note: During a life threatening situation, such as an out-of-control fire, if there isn't time to enact the HICS/NIMS, then security and/or safety staff, supervisors, department heads, would take charge and make the evacuation call.

IMMEDIATE INTERNAL EVACUATION

1. In an emergent situation, all staff should report to their assigned work area to assist with the evacuation. Organize consumers to leave. Non-ambulatory consumers will be transported by wheelchair and/or stretcher. Ambulatory patients will be led as a group to the emergency assembly point or other area of refuge as ordered by the **Incident Commander**. Medically

and/or physically challenged consumers should be moved by nursing staff in consumer care areas.

2. Determine the best door for exiting. If time allows and the weather is inclement, quickly get coats. The charge nurse should take the rolodex of addressograph cards. Take the roll call of consumers and staff and give it to **Operations Section Chief** as well as the names of any consumers or staff that reported for duty that day and are not present.

3. In case of fire, close all doors and windows. Go to the area outside the building designated for fire evacuation unless instructed to go to Emergency Assembly Point (EAP).

4. In a bomb threat open all doors and windows. Use marked "exit" stairways. Added security may be needed for exiting the building safely. If any staff or consumer has been injured, triage as quickly as possible. Do not use cell phones for communication.

5. **Safety and Security Officers** will post signage that the building has been evacuated and no entry is allowed. This is enforced by Security.

SHORT TERM INTERNAL EVACUATION – SEVERAL HOURS TO PREPARE

Follow these procedures if evacuation is imminent and you have several hours to prepare.

1. Make a list of items to be taken immediately and what can be taken later. Give these lists to the unit leaders to give to the **Planning Section Chief**. Remove consumer records and medication from the building.

2. Only authorized staff are allowed to re-enter the building. Security accounts for each person entering and exiting the building through the same door if possible.

3. If the area is accessible, the **Maintenance Director** will make a brief assessment to see if any damage can be minimized and report findings to the Incident Commander.

4. Depending on the type of emergency, the utilities to the area may be shut down.

5. Organize consumers to leave.

6. Evacuate people who can walk first, so staff can prepare immobile consumers.

7. Non-ambulatory consumers will be transported by wheelchair and/or stretcher. Ambulatory consumers will be led or transported as a group to the emergency assembly point or other area of refuge as ordered by the **Incident Commander**.

8. Medically and/or physically challenged patients should be moved by nursing staff in consumer care areas.

9. The charge nurse should take the rolodex of addressograph cards. Take roll call of consumers and staff and give it to the Nursing **Unit Leaders** or **Operations Section Chief** as well as the names of any consumers or staff that reported for duty that day and are not present.

INTERNAL EAP (EMERGENCY ASSEMBLY POINTS)

- *Dining Area*
- *Safe rooms located in the center of building*

When a large-scale evacuation (several buildings, entire campus) is imminent, the Incident Command Center will confer with Kent County Emergency Operations Center to identify and utilize various holding areas and arrange for additional transportation as needed. **These may differ from the Internal EAPs.** The **nursing unit leaders, labor pool leaders, transportation leaders and unit staff** will be given clear direction when alternative holding areas are arranged.

EXTERNAL EVACUATION

1. **External evacuation** may be warranted by a condition either on or off campus. There are several emergency situations that may require the evacuation of all or part of Kent County. Small scale or localized evacuations might be needed as a result of flood, hazardous materials events, nuclear facility events or a major fire or transportation accident. A large-scale evacuation could be required in the event of a hurricane or other natural disaster.

2. It shall be determined by the **Incident Commander in conjunction with the community emergency services representative, the KCHD and the Operations Section Chief**. Kent County Emergency Management will be responsible for coordinating evacuations in the county. The County Emergency Management Coordinator or his/her designee shall coordinate all evacuation operations for the Kent County Emergency Operations Center. MIEMSS (Maryland Institute for Emergency Medical Systems may also be involved in the coordination involving several hospitals.

3. All staff should report to their assigned work areas. The **Labor Pool Leader** may be asked to obtain additional staff to assist with the evacuation. If the labor pool is formed, all staff members not involved with consumer care will report to the labor pool when directed by their supervisor. The labor pool will be located in the Nursing Supervisor.

4. A.F. Whitsitt Center drivers (**Transportation Unit Leader** if HICS/NIMS is implemented) and transportation assigned by Kent County Emergency Operations Center will respond.

5. Planned evacuation routes have been pre-designated throughout the county. The **Transportation Unit Leader will** coordinate the availability and arrival of the vehicles with the Kent County EOC, if needed.

6. The charge nurse(s) under the direction of the **Nursing Unit Leaders** and **Operations Section Chief** will conduct the evacuation procedures once the order to evacuate has been given by the **Incident Commander**.

7. All staff should be familiar with all of the exits that can be used for evacuation.

EXTERNAL EAP (EMERGENCY ASSEMBLY POINTS)

External EAPs will be identified by the **Incident Commander** in conjunction with the community emergency services representative. The site should be outside of the center and away from power lines, traffic and other hazards.

ADDITIONAL EXTERNAL EVACUATION PROCEDURES

1. The **Logistics Section Chief** will communicate the evacuation site to the **Transportation Unit Leader.** The **Operations Section Chief** will work with the **Unit Leaders** to prepare for external evacuation. It is imperative that in the event of an evacuation, everyone reports to the designated EAP to insure being accounted for.

2. The **Logistics Section Chief** organizes and directs operations associated with the maintenance of a safe and secure physical environment (facilities, roads, utilities, maintenance, fuel, transportation, communications and nutritional supply). They arrange for the needs of those responding to the emergency such as supplies, beds, food and shelter.

3. The **Planning Section Chief** is responsible for compiling scenario/resource project needs from all section chiefs and effecting long range planning.

4. **NO OTHER STAFF SHALL REPORT TO THESE SITES UNLESS SPECIFICALLY DIRECTED.** Access to areas involved in an emergency situation shall be limited to authorized staff only. Security is tasked with the primary responsibility of controlling access. However, it is every employee's responsibility to limit access to authorized staff.

5. Members of **the media** will receive a color coded wristband and will be escorted to the pre-established press area and will be instructed to remain there. For the safety of all involved as well as maintenance of confidentiality, security will enforce the containment of the media. All staff shall wear their picture identification badges.

POST EVACUATION - RECOVERY

Once unit evacuations wrap up, direct remaining staff members to the labor pool and report the unit's status to the Incident Command Center and the various holding areas.

GENERAL TRIAGE PLAN

1. Primary triage will occur at the disaster site. Emergency care will be provided to save life and limb. Major casualties will be transferred to Chester River Hospital accompanied by licensed nursing staff if EMS is unable to respond.

2. Other casualties, as determined by triage at the disaster site, will be sent to a Casualty Stabilization Center, located in the Brown Unit (when there are fewer casualties – up to about 15-20) or in the area determined by KCHD. (If so directed due to a large number of casualties).

3. If the immediate needs of the consumers cannot be met, the center may implement a modified process for determining qualifications and competence of volunteer practitioners.

4. All victims, volunteers, and others coming into the hospital will go through the building security checkpoint in the lobby before entering the locked areas of the building.

RESPONSIBILITIES OF UNIT LEADERS

NOTE: This is an overview of responsibilities during an emergency (*see job action sheets for details*)

1. During the A.F. Whitsitt Center HICS/NIMS activation, A.F. Whitsitt Center staff are to follow the same policies and procedures as outlined in the Center's Plans and Programs Manual to the degree possible. The Incident Commander is responsible for the overall disaster response operations.

2. The **Nursing Leader** or their designees along with other program lead staff will see that psychiatric and medical care of the patients continue in their respective areas. The contact phone will be in the Nursing Supervisor. In case that is not in operation, the Nursing Office will be the contact.

3. **Other Nursing Staff:** All available medical and nursing staff will be responsible for the welfare of the consumers. The individuals in charge of the buildings at the time of the emergency will be responsible for their areas. Consumers who are at "Off Unit" locations should be reassured and kept there by staff members who will report the consumers' name and Unit to the Incident Command Center. If the consumer cannot remain at the "Off Unit" location, staff members will escort them back to the consumer's home Unit or to the evacuation site and report to the unit leader in charge.

4. **All other A.F. Whitsitt Center Staff on duty or as called in**, report to regular assigned areas, unless otherwise instructed, and await further instructions. Staff designated as essential are reminded that they may be held or released depending on the exact nature of the situation. In addition, staff not designated as essential may be temporarily designated essential if the facility is already at or near minimum staff. If liberal leave is authorized, staff are reminded that normal call-in procedures remain in effect for all staff, regardless of their essential or non-essential status. In situations when mandatory closure is announced, essential staff must still report for work as scheduled and call-in requirements remain in effect.

5. **Those responsible for maintaining center records** of any sort (Medical records, staff records, financial records) will be responsible for safeguarding existing records. They will also record all relative data using HICS/NIMS forms as appropriate pertaining to a disaster. [Forms available from **Finance & Procurement Section Chief**]. Records should not be relocated without prior coordination with the Incident Command Center.

6. The **Operations Chief** will assure the continued provision of addiction services to the consumers of the hospital and any others who may be transferred here from other facilities.

7. **Human Resources** will immediately cancel all classes. Human Resources staff will be available for reassignment by the **Labor Pool Unit Leader**.

8. The **Operations Chief** will communicate with **Logistics Section Chief** for deliveries and the **Operations Section Chief** and other unit leaders in Operations with regard to current and

future needs for pharmaceuticals. The **Nursing Unit Leader** will inform the **Operations Section Chief** and in turn, the **Incident Commander**, if the supply is low, or if supplies are unavailable in order to access other local supplies, Strategic National Stockpile or other sources as needed.

9. **The Social Worker Leader** will designate a secluded area where individual and group intervention may take place. This will be coordinated with the **Staff Support Unit Leader**. Assist the **Staff Support Unit Leader** in the establishment of staff information/status board. Social worker staff will remain in their unit areas subject to call.

10. **A.F. Whitsitt Center Security** will immediately report to the disaster site to establish communication with the **Safety and Security Officer** and act as a liaison between outside emergency forces and the Incident Command Center. They will communicate with the **Buildings/Grounds Damage Unit Leader** to secure and post non-entry signs around unsafe areas. They will secure the Incident Command Center, the triage area, morgue area and other sensitive or strategic areas from unauthorized access. Other building guards can be directed by the **Safety and Security Officer**. Security shall respond to the disaster scene and/or to the receiving hospital to assist in any way possible, particularly in crowd control and traffic. The Incident Command Center may assign other functions as necessary. In general, uniformed police and security shall:

    a. Direct ambulances and other vehicles with casualties
    b. Direct vehicles with food, supplies and equipment
    c. Direct authorized staff to proper entrances
    d. Set up roadblocks to keep unauthorized staff away
    e. Post guards at entrances to give directions to discourage unauthorized staff
    f. Keep one side of corridors free at all times
    g. Control and direct traffic at all critical points for smooth flow of transfer of casualties
    h. Patrol buildings to ensure the safety and security
    i. For Homeland Security Threat Advisory Orange Alert or Red Alert, security will monitor the center's entrance and maintain security checks for all vehicles entering and exiting the center. The entrance/exit surveillance will be communicated to tenants and neighbors.

11. Uniformed police and security may not always be available for several reasons. Therefore, items 5-8 could be assigned to staff drawn from the **Labor Pool**. Where additional uniformed police and security officers are needed, the senior security officer should request police mutual aid through the **Liaison Officer/PIO** from the community/county.

12. **Transportation** will be the responsibility of the **Transportation Leader**, in close communication with the **Logistics Section Chief**. Drivers will be directed to assist by the Logistics Section Chief as needed. When the emergency plan is implemented, all pre-

approved drivers will report to the Transportation Unit Leader. Vehicles will be assembled and assigned by the Transportation Unit Leader. It may become necessary to use trucks and buses to transport injured or relocate consumers from the emergency area. When the area is deemed Homeland Security Threat Advisory Orange Alert or Red Alert, the Whitsitt Center fleet shall never let the gas tank go below ½ and if at all possible should remain full. All emergency vehicles and other vehicles identified to be used during evacuation procedures should have the gas tanks filled at the end of each day. Staff with a valid bus driver's license may be asked to report to the Transportation Leader.

13. Emergency Food Service will be the responsibility of the Food **Service Leader** In the event that the Dietetics Services Center is destroyed in the disaster, the center maintains a stockpile of meals ready to eat and water in an alternate site. Community restaurants and grocery stores may also provide emergency cooked and uncooked food for a period of 48 hours or until we are able to receive food delivery. The Food Services Leader will communicate with the Food Service Contractor and the Logistics **Section Chief** to organize food and water stores for preparation and rationing, particularly during periods of anticipated or actual shortage. If there is a need for food and beverages for volunteers, this will be provided. Foods that are to be made available are listed in the Diets and Nourishments Section of the Emergency Plan.

14. **Emergency portable water** can be obtained by contacting the KCHD. The tankers will be located at the health department's discretion for cooking and distribution of drinking water as needed. The **Safety and Security Officer** will assign staff to guard the food and water supplies.

15. **Finance & Procurement Chief** will facilitate purchasing of needed resources to respond to the disaster/emergency. They oversee the acquisition of supplies and services necessary to carry out the hospital's mission. They supervise the documentation of expenditures and staff time relevant to the emergency. The **Finance & Procurement Chief** meets with the **Incident Commander** to discuss the items identified as procurement needs on the action plan. During regular hours, **all Section Chiefs and Unit Leaders** will maintain an ongoing inventory and issue medical supplies in bulk as needed. They will obtain items directly from the storeroom or coordinate deliveries with the Transportation Unit Leader.

16. **After hours, the Nursing Leader** will coordinate deliveries with the **Transportation Unit Leader**. Through the **Logistics Chief**, the **Facilities Unit Leader** will be responsible for issuing clothing, blankets, and other associated items, as directed by the Incident Command Center. The **Finance & Procurement Chief** will monitor the utilization of financial assets.

17. **Maintenance and Utilities** – the **Buildings/Grounds Damage Unit Leader** will provide information regarding the operational status of the facility. **All** maintenance staff will report

to the **Buildings/Grounds Damage Unit Leader** and await further instructions. A damage survey team will be formed to do an assessment and apprise the **Facilities Unit Leader** and **Nursing Leader** of building conditions and potential and actual hazards. Staff will be assigned duties as directed by **the Buildings/Grounds Damage Unit Leader**, **the Safety and Security Officer**, the **Logistics Section Chief** and/or the **Incident Commander**.

18. **Routine maintenance procedures for non-critical repairs** will be suspended until the emergency is ended by the **Incident Commander**. In the aftermath of a catastrophic event such as a fire, explosion, earthquake or flood, it is vital to determine the serviceability and damage to that facility for operations, repair and insurance, and FEMA reimbursement. As soon as possible after a catastrophic event, a damage assessment team shall be dispatched by the **Incident Commander** through the **Logistics Section Chief** to conduct a thorough damage assessment survey of the facility.

19. **The Buildings/Grounds Damage Unit Leaders** evaluates and monitors the potency of existing sewage and sanitation systems and reports to the **Logistics Section Chief**. They implement an alternative waste disposal collection plan if necessary. They assure that all sections and areas of the buildings are informed of alternatives i.e. portable toilets. Confer with the **Planning Section Chief and Operations Section Chief** for placement of alternative sites for hand washing and toilets.

20. **Labor Pool Unit Leader** will make available a current roster of A.F. Whitsitt Center staff to the Incident Command Center, including the essential employee designations. Staff will be assigned from the labor pool to organize and coordinate consumer care staffing and to align with the available labor pool or access services from DHMH Volunteer Corps or other county resources.

21. **Major Tenant Organization on the A.F. Whitsitt Center Campus** if necessary designated individuals of tenant organizations on campus, such as the Carter *Center and Kent County Behavioral Health Outpatient Mental Health* will be contacted by the Incident Command Center for initial guidance when a "Code (COLOR CODE)" is called.

22. The **Patient Tracking Manager** will be responsible for removing the consumer records. Those responsible for maintaining center records of any sort (medical records, staff records, financial records) will be responsible for safeguarding the existing records. They will also record all relative data pertaining to a disaster. Records should not be relocated without prior coordination with the Incident Command Center, unless time is of the essence.

23. Working with the **Social Worker Unit Leader**, every effort is made to provide information to families regarding status and location of consumers. The **Consumer Tracking Manager** assists with admission/registration of any consumers transferred to the hospital and assures

accessibility/confidentially of medical records as much as possible. Information is collected that is necessary to complete the disaster welfare injury process in cooperation with the American Red Cross.

24. **Staff Support Unit Leader** assists with staff needs in order that they can report to work or remain at work during the disaster/emergency. The **Staff Support Unit Leader** communicates with staff regarding the hospital response and what is going on in the community and larger geographic area with regard to the disaster/emergency where applicable. They work with the **Logistics Section Chief** to provide for child/elder care issues. Arrange for shelter and food, if necessary. **The Staff Support Unit Leader** will contact volunteers if the situation warrants and is approved by the **Incident Commander** or if a request is made from the Labor **Pool Unit Leader**. **The Labor Pool Unit Leader** collects and inventory volunteers at a central point. The volunteers assist in the maintenance of staff morale and establish dependent care if the situation dictates. They report concerns for staff and volunteers to the **Social Work Support Unit Leader.**

25. **Social Work Support Unit Leader** assures the provision of psychological, spiritual and emotional support to the center staff, volunteers and dependants, as necessary throughout the incident and as long as necessary afterwards. Core Service and MDH PVC can also assist if needed. Depending on the type of disaster, an on-site information center which may include pastoral care workers, social workers and other consumer relations staff may be set up to provide information and support for families and friends waiting for information on the condition of disaster victims. Fact sheets addressing topics from how to cope with emergencies to symptoms of post-traumatic stress syndrome can be distributed at the information center.

STAFF/VISITOR/VOLUNTEER SUPPORT

In the event of a large-scale disaster, it may be necessary to provide short-term shelter for staff, volunteers and visitors and others in the hospital. Short-term shelter is intended to provide basic food and shelter needs for staff and visitors.

1. As warranted, the **Incident Commander** will coordinate staff accommodations including meals, bathroom facilities and sleep rooms.

2. Staff transportation needs will be coordinated through the **Incident Commander** who will utilize existing staff and volunteers to fulfill staff transportation needs.

3. The Facilities Unit Leader along with the other **Section Chiefs** will establish a support area for staff and visitors.

4. The **Incident Commander** will determine the best locations for emergency shelters and arrange for long-term housing of victims as the situation dictates.

5. Each officer, chief and unit leader in the HICS structure is responsible for assessing the staff he/she is working with for the need for psychological support/incident stress debriefing. The hospital will maintain a staff person(s) in the **Social Work Support Unit** trained in Critical Incident Stress Debriefing.

STAFF TRANSPORTS TO AND FROM CENTER

1. Staff transports are usually made within fifteen (15) mile radius of the center after a determination is made that it is safe to do so.

2. The **Incident Commander** will provide, as necessary, direction and authorization for actions such as pick-up and transport of staff to the **Safety and Security Officer**.

3. The **Incident Commander**, utilizing the HICS/NIMS structure, shall be responsible to insure that under extreme conditions, adequate staffing is arranged, snow removal operations are on-going and necessary deliveries (food and pharmaceuticals) are being made.

4. During normal working hours (8 AM to 4:30 PM, Monday through Friday), If additional staff is needed, the **Labor Pool Unit Leader**, stationed in the Nursing Supervisor, will coordinate with the **Nursing Unit Leader** and report an assessment of staffing needs to the **Operations Section Chief**. The **Labor Pool Unit Leader** will give this information to the **Planning Section Chief**, who will contact the **Incident Commander** with the briefings and updates in regards to staffing.

5. The **Safety and Security Officer** will contact the **Transportation Leader** to arrange for utilization of 4-wheel drive vehicles and center cell phones. Cell phones shall accompany staff transporting staff as available. However, first priority for cell phone use shall be for emergency consumer transports.

6. The **Safety and Security Officer** will arrange for and request additional drivers and riders to transport staff to and from the center. Transports shall be made by two (2) members per vehicle.

7. The **Labor Pool Unit Leader** will coordinate contacting staff to arrange for transportation to the center. The drivers will be given the name, address and phone number of the employee to pick up. Staff will be asked to come prepared with additional clothing and food.

8. If additional support is needed, the **Liaison Officer/PIO** may contact Kent County Emergency Operations or the DHMH Emergency Management Team.

EMERGENCY ACCOMMODATIONS FOR STAFF

All emergency accommodations are arranged by the **Staff Support Unit Leader**. The Administrative Office and Security Office will have the proper keys to access these areas. The **Staff Support Unit Leader** will obtain the count from the **Labor Pool Leader** of how many staff are utilizing available accommodations and will also keep the **Safety and Security Officer** apprised of room occupancy status. The **Finance & Procurement Chief** is to be apprised of all related expenses with receipts.

RECOVERY- DEACTIVATION AND POST EMERGENCY REPORTS

1. The Emergency Operations Plan will be deactivated only by the **Incident Commander** after it is determined that the incident is under control and special operating procedures are no longer required. A limited response may still be required to return to normal operations. As soon as the emergency situation has been met and controlled, every effort will be made to return A.F. Whitsitt Center to normal operations.

2. Recovery will include an inspection of the entire campus by the **Safety & Security Officer**, **Buildings and Grounds Damage Unit Leader** and other designated staff to insure that all departments and programs are functioning properly and that the necessary actions are being taken to restore normal services.

3. The **Planning Section Chief** will develop a recovery plan in conjunction with the **other Sections Chiefs** and finalize the plan with the **Incident Commander**.

4. **Debriefing** - Each department supervisor will submit a written report to the Director explaining the function they served and the current status of their department, in addition to any comments or suggestions for improvement to the Emergency Operations Plan within the timeframe designed by the Director.

5. A written report will be submitted to the Kent County Health Department Emergency Preparedness Planner. This report will include all pertinent data concerning casualties, evacuations from the center grounds, estimates of the extent of damage, requisitions for emergency replacement of supplies, materials and equipment.

6. The **Finance & Procurement Chief** will total costs associated with the emergency and recovery and pursue avenues to recover funds (KCHD, FEMA, etc.)

HAZARD VULNERABILITY ANALYSIS OVERVIEW

A **Hazard Vulnerability Analysis** is the identification of potential emergencies, and the direct and indirect effects these emergencies may have on the center's operations and the demand for its services.

An emergency is a natural or manmade event that significantly disrupts the workplace (for example; damage to the center's building [s] and grounds due to severe winds, storms, or earthquakes) that significantly disrupts care, treatment, and services for example, loss of utilities such as power, water, or telephones due to floods, civil disturbances, accidents, or emergencies within the center or in its community); or that results in sudden, significantly changed, or increased demands for the center's services (for example bioterrorist attack, building collapse, plane crash in the center's community). Some emergencies are called "disasters" or "potential injury creating events. The hazards are rated on a scale based on probability and impact, and then scored using a matrix tool. After the scores are totaled, the center can then take the next step to evaluate preparedness and analyze what care, treatment and services can be provided; and then what is needed in terms of supplies, equipment, community support, manpower, transportation, shelter, etc. when the regular hospital service is overwhelmed. The higher the number, the greater the threat to the overall function and safety of the facility.

Mitigation, preparedness, response and recovery phases are assessed for each event identified by the Hazard Vulnerability Analysis.
(See HVA Grid)

EVENT	MITIGATION	PREPAREDNESS	RESPONSE	RECOVERY
An emergency, which may initiate activation of Emergency Operations Plan.	Activities, which eliminate or reduce the chance of occurrence or the effects of a disaster. Effective mitigation can decrease the impact of an event.	Planning how to respond to an emergency. Working to increase resources available to the event. Preparedness activities are designed to help save lives and minimize damage by preparing staff to respond appropriately.	Activities, which occur during and immediately following a disaster. Provides emergency assistance to victims of the event and reduces the likelihood of secondary damage. Involves search and rescue, mass care, access control, consumer relocation and bringing	Continues until the debriefing stage and all systems return to normal. This includes services, communications, utilities and operations.

			damaged services and systems back online. Outside agencies may be included in the response phase.	

CODE SPECIFIC PROCEDURES

MITIGATION, PREPAREDNESS, RESPONSE AND RECOVERY PLANS AS PER ANNUAL HAZARD VULNERABILITY ANALYSIS

For A.F. Whitsitt Center's Hazard Vulnerability Analysis, the Code Specific Procedures are divided into three types of disasters: **Natural, Manmade/Technical and Homeland Security**. Specific procedures are outlined for each of the codes, with references to the more detailed sections of the Emergency Operations Plan.

FEMA/NIMS suggest plain language codes. Each Code Procedure describes the rationale for the score of the Hazard Vulnerability Analysis. Next, mitigation, preparedness, response and recovery phases are listed for each type of disaster.

Weather Events and Natural Disasters

CODE SEVERE WEATHER RESPONSE

These procedures are designed to assist staff to prepare, respond and recover from severe weather events (such as electrical/thunderstorms, hurricanes and tornadoes) and other natural disasters in order to minimize the possibility of harm to consumers and staff.

SEVERE WINTER WEATHER

Snow and ice storms in this area are usually forecast well in advance. A.F. Whitsitt Center work crews are assigned with the intention of keeping A.F. Whitsitt Center roads open and buildings accessible so that food, prescriptions and other services needed for consumer care will be available. However, streets off grounds may not be cleared as well or not at all. Therefore, commuting to work may be the biggest hazard of all in a winter storm.

This section has been developed to provide guidelines for emergency operations during a blizzard or heavy snow conditions occurring at this facility.

Mitigation Strategies, Actions and Responsibilities

1. Monitoring of NOAA weather radio is conducted by the Kent County Emergency Operations Center during regular business hours (Monday-Friday, 8AM- 4:30 PM) and by the Police/Security Staff all other times.

2. Equipment for snow removal is available and maintained in working order. The Department of Maintenance inspects the snow removal equipment to assure that it is in good working condition prior to the winter season. Any repairs needed are communicated by the Director of Maintenance to necessary staff. Supplies such as salt or "Ice Melt" are maintained at the center.

3. Four-wheel drive vehicles are available for transportation of staff to and from the Center. The Transportation Leader inspects vehicles as initiated by the department head to which the vehicle is assigned.

4. Staff are educated about their respective roles and responsibilities through a variety of training activities and familiarity opportunities with this plan. The center policy entitled "Essential Staff" designates who meets the criteria for essential staff and their responsibilities for reporting to work in inclement weather emergencies. It is the responsibility of each employee to know what their duties are in inclement weather emergencies and take appropriate measures to fulfill those duties.

5. Emergency generators are maintained as per related Maintenance procedures.

6. Building maps directing staff and consumers to safe area for shelter in place.

Preparedness Strategies, Actions and Responsibilities

Items on Hand for Hurricane/Storm Preparation		
Item	Quantify	Location
Blankets	40	Consumers units
Flashlights & Batteries	20	Nurses Stations & Storage
Food & Water	(see Emergency Prepared food on hand- page 8)	Kitchen and dining area

1. The four-wheel drive vehicles stationed at the parking lot with keys and cellular phones located in the nurses 'station are utilized during transport when inclement weather is predicted.

2. A list of potential drivers for staff transport is maintained in the Nurses station.

3. The Nursing Supervisor maintains a database of the addresses of nursing staff so that staff transportation can be arranged in a geographically efficient manner.

4. Emergency food supply is maintained as outlined in the Emergency Plan Section *Diets and Nourishments.*

5. Medications shall be maintained by the center with at least one week's supply of commonly used medications. Other medications are ordered as needed.

6. Communications will be maintained through the computer email blast, cellular phones and two-way radios.

7. As in all other inclement weather situations, check flashlights, radios, and any other emergency equipment for operation and keep available if needed.

8. Prepare in advance for winter travel with emergency supplies in state and personal vehicles including blankets, additional clothing, flashlight, sand or traction mats, shovel, booster cables, road flares, windshield wiper fluid, de-icer spray, tool kit, tow lines, first aid supplies, matches and candles, and some high calorie non-perishable food (granola bars, raisins, etc.) and bottled water.

9. Dress for cold weather (staff and consumers) OSHA recommendations:
   - Layer clothing with several light layers instead of two heavy layers
   - Keep your head covered to prevent heat loss
   - Wear appropriate footwear and layered socks
   - Mittens are better for cold than gloves; the contact of fingers keeps hands warmer
   - Cover the lower part of the face and ears; these are the first to frostbite

10. Don't go outside if not needed or not dressed for conditions. If you do go out remember that walking conditions will be difficult.

11. If you must shovel snow do not overexert. Cold weather itself without exertion puts additional strain on your heart and body, working in those conditions can be dangerous to your health.

12. If driving on grounds, all staff should be aware that even plowed roads can have icy spots and be slippery in general. Go slower than usual and allow additional stopping distance.

Response Strategies, Actions and Responsibilities

1. Upon knowledge of a potential or actual snow emergency, the Director (if HICS/NIMS is activated the Incident Commander) will make a determination if the conditions are severe enough to activate the HICS/NIMS. After normal working hours (weekdays after 4:30PMand before 7:00AM, weekends and holidays), the security guard is responsible for assessing and monitoring the road conditions as well as walkways, ramps, steps, etc.

2. Staff is made aware to keep patients indoors during snowstorms/blizzards to prevent injury.

3. At the beginning of the snow event, snow removal equipment and supplies shall be immediately employed.

4. Security evaluates the situation and then notifies the Risk Management Officer to contact the Director. The Director determines if the Incident Command should be activated and if so, will decide whether to direct the **Safety and Security Officer**, to report for duty. Those individuals will, in turn, contact additional staff to assist in snow removal and transportation.

5. At the beginning of the snow event, snow removal equipment and supplies shall be immediately employed.

6. Once appropriate measures have been taken to clear roads, walkways, ramps, etc., the **Incident Commander** will determine if the staff have to remain on grounds or if they may be released. Should the incident escalate, the transfer of command shall follow procedural order and HICS/NIMS, based on the decision of the **Incident Commander.**

7. Depending upon the level of activation the operator will communicate “CODE WEATHER RELATED EVENT” to the appropriate staff, using notification procedures outlined in the emergency plan.

8. It is imperative that clear and continuous communication be maintained between Police, the **Safety and Security Officer** and **the Planning Chiefs** with regards to road conditions and snow/ice removal from the hospital grounds.

9. During normal working hours, the **Public Information Officer** will contact the Police Department at least one (1) hour prior to the end of shift to receive an update on the road and weather conditions in order to give information to the **Incident Commander** to determine if staff may be released or remain. The same procedure shall apply to Housekeeping. The **Incident Commander** is provided with staffing resource updates.

10. In the event of a power outage during a snow emergency, emergency generators shall operate to maintain a comfortable environment for patients and staff. If a building is

incapable of maintaining its environment, consumers and staff shall be safely moved to another building.

11. Follow procedures for Staff Transport and Emergency Staff Accommodations

Recovery

1. Snow and ice removal to clear parking lots, access and egress to continue throughout the emergency.

2. Housekeeping to leave ice melt and shovels near doors in a safe place for continued ice/snow removal efforts.

3. **Maintenance/Buildings/Grounds Damage Unit Leader** will survey grounds for damage, downed wires, fallen trees, etc. and clear the areas.

4. Emergency supplies and vehicles are restocked.

5. Evaluation of the event - deactivation, hotwash and post emergency reports

TORNADOS, HIGH WINDS AND EARTHQUAKES

In some very severe thunderstorms, tornadoes are possible. Hopefully this will be forecast or an alert given, and allow time to take additional precautions beyond these for thunderstorms.

TORNADO WARNING – a tornado has been spotted or detected on radar and could be coming your way.

EARTHQUAKES in the area of the hospital are low in magnitude (2.5-2.6 on the Richter scale) and very shallow. Although the probability of a quake of increased magnitude is low, an earthquake would create a high disruption to the hospital's ability to provide services.

Mitigation Strategies, Actions and Responsibilities

1. Monitoring of NOAA weather radio is conducted by the Kent County Emergency Preparedness Office during regular business hours (Monday-Friday, 8AM- 4:30 PM) and by Police/Security staff at other times.

2. The Nursing Supervisor which can provide advance warning of severe weather conditions.

3. Liaison with Kent County Emergency Operations Center, HERC and other outside agencies as required by state and federal regulations.

4. Building maps directing staff and patients to safe areas for shelter in place.

Preparedness Strategies, Actions and Responsibilities

1. Staff are educated on safe evacuation plans and high wind areas.

2. Sometimes these types of conditions occur so quickly that there may not be time to receive notification. If outside conditions quickly change, take appropriate action yourself.

Response Strategies, Actions and Responsibilities

TORNADO ALERT – TORNADO WARNING

1. The Nursing Supervisor will notify each unit via telephone. The nurse on duty will announce "CODE TORNADO ALERT" on radios and computer email blast and alert the facility as outlined in the A.F. Whitsitt Center Emergency Plan.

2. The Charge Nurse will account for all consumers and as many staff as possible.

3. Secure any articles that may act as projectiles.

4. Seek shelter in interior hallways, restrooms, or other enclosed small areas. Safe rooms are the interior offices and conference areas.

5. Close all doors and windows.

6. Ensure that all building occupants get to the shelter areas.

7. Take the position of greatest safety. Building maps direct staff and consumers to safe areas for shelter in place.

8. If possible, crouch down on knees with head down and hands locked at the back of the neck.

9. Staff and consumers are to protect their head/body with pillows or mattress, coats, etc. to protect their faces and bodies from flying debris. Staff will take measures as they can to protect consumers whose condition precludes their ability to protect themselves.

10. If necessary, set up triage and stabilization areas as outlined in this plan. (See Triage and Stabilization)

11. If a building is damaged and an evacuation has been called for, relocate all building occupants to pre-identified locations within the building that are interior rooms or hallways without windows until further instruction is received from the Incident Command Center. Occupants should sit on the floor with their backs to the wall and if pillows, coats, etc.are available, protect their face and eyes from possible flying debris. Follow evacuation methods as outlined in the A.F. Whitsitt Center Emergency Operations Plan.

Recovery

1. Account for all consumers and staff and inform the Liaison Officer/PIO.

2. **Maintenance/Buildings/Grounds Damage Unit Leader and/or Safety and Security Officer** will survey grounds with state officials for damage, downed wires, fallen trees, etc. and clear the areas.

3. Clear parking lots, access and egress to continue throughout the emergency.

4. Flooding may occur after a storm-evaluated damage to basements and lower level buildings.

5. Account for and replenish materials and supplies expended.

6. Evaluation of the event - deactivation, hotwash and post emergency reports

HURRICANES

Hurricanes are big long lasting storms and are forecast for an area days before they occur allowing time for preparation. Hurricanes have high-sustained winds, lots of rain with lightning and flooding, and may even have tornadoes within the storm.

Mitigation Strategies, Actions and Responsibilities

1. Monitoring of NOAA weather radio is conducted by the Kent County Emergency Operations Center during regular business hours (Monday-Friday, 8AM- 4:30 PM) and by Police/Security staff at other times.

2. Liaison with Kent County Emergency Operations Center, HERC, Kent County Health Department and other outside agencies as required by state and federal regulations.

3. Four-wheel drive vehicles are available for transportation of staff to and from the Center. The Transportation Unit Leader inspects vehicles as initiated by the department head to which the vehicle is assigned. All necessary repairs are made by the Auto Shop and/or contracted services.

4. Staff is educated about their respective roles and responsibilities through a variety of training activities and familiarity with this plan. The center's policy entitled "Essential Staff" designates who meets the criteria for essential staff and their responsibilities for reporting to work in inclement weather emergencies. It is the responsibility of each employee to know what their duties are in inclement weather emergencies and take appropriate measures to fulfill those duties.

5. Building maps directing staff and consumers to safe areas for shelter in place.

6. Emergency generators are maintained and checked regularly.

Preparedness Strategies, Actions and Responsibilities

1. In the event of a Hurricane, maintenance crews and other work groups will be taking measures to protect A.F. Whitsitt Center buildings and other property from damage. All A.F. Whitsitt Center staff are responsible for assisting those crews in any way they can, for identifying potential problems, and taking measures to protect equipment, furnishings, supplies, and records from any possible flooding or other damage.

2. Windows and glass in doors may be boarded over or taped. Certain outside doors may be sandbagged or otherwise sealed to prevent entry of water. All possible outside equipment and outdoor furniture will need to be moved inside or secured.

3. In addition to protecting property, measures must be taken to assure that there will be sufficient food and water for the duration of the storm. This will be coordinated through the A.F. Whitsitt Center Department/ or Logistics Section Chief if HICS/NIMS is activated. These supplies must be secured and controlled to prevent misuse or waste.

4. An adequate amount of prescription medication for consumers must be obtained to last through the predicted duration of the storm. Obtain ice, and place in unit refrigerators to keep refrigerators cool if electricity goes out. Open the door only when absolutely necessary and monitor temperature.

Response Strategies, Actions and Responsibilities

1. Adequate staff shall be provided for each consumer building to meet the needs of consumers through the duration of the storm. (See SEVERE WINTER WEATHER for details).

2. Expect disruption of electrical service. Continue to check flashlights, radios, and any other emergency equipment for operation. Inform **Logistics Section Chief** if additional flashlights and batteries are needed.

3. Draw shades and curtains on windows. This will help protect from shattered glass.

4. Stay inside buildings and away from windows during the storm. Relocate to inner areas identified on the Evacuation Plans located in the hallways of all buildings, if necessary. Shelter in interior hallways, restrooms, or other enclosed areas without windows when possible. Keep interior doors closed.

5. Telephone lines, electrical wires, and piping can conduct electricity from lightning. Refrain from using phones, electrical appliances, or taking showers as much as possible.

6. The “eye” of the storm is deceptive. The worst damage will occur when the eye passes and the wind blows from the opposite direction. Trees, shrubs, and other objects damaged by the first winds may now break off and become projectiles.

7. If a particularly bad storm is predicted, the decision may be made to evacuate consumers to another location. Staff to accompany consumers will be selected on short notice. Be prepared with clothing changes and other personal needs readily available if you are selected.

8. If consumers are being evacuated, there is the possibility that authorities will order the evacuation of the center and part or all of the areas where staff reside. Action of that nature will be undertaken following the State of Maryland Emergency Operation planning and movement of our patients will be accomplished with emergency forces assisting our staff and directing their actions.

Recovery

1. Account for all consumers and staff and inform the **Liaison Officer/PIO**.

2. **Maintenance/Buildings/Grounds Damage Unit Leader and/or Safety and Security Officer** will survey grounds with state officials for damage, downed wires, fallen trees, etc. and clear the areas.

3. Clear parking lots, access and egress to continue throughout the emergency.

4. Flooding may occur after a storm-evaluated damage to basements and lower level buildings.

5. Account for and replenish materials and supplies expended.

7. Evaluation of the event - deactivation, hotwash and post emergency reports

FLOODING

During and after severe thunderstorms and hurricanes there is usually some flooding.

Mitigation Strategies, Actions and Responsibilities

1. Monitoring of NOAA weather radio is conducted by the Kent County Emergency Operations Center during regular business hours (Monday-Friday, 8AM- 4:30 PM) and by the Police/Security Staff all other times.

2. Liaison with Kent County Emergency Operations Center, HERC and other outside agencies as required by state and federal regulations.

3. Four-wheel drive vehicles are available for transportation of staff to and from the center. The **Transportation Unit Leader** inspects vehicles as initiated by the department head to which the vehicle is assigned.

4. Staff are educated about their respective roles and responsibilities through a variety of training activities and familiarity with this plan. The hospital policy entitled “Essential Staff” designates who meets the criteria for essential staff and their responsibilities for reporting to work in inclement weather emergencies. It is the responsibility of each employee to know what their duties are in inclement weather emergencies and take appropriate measures to fulfill those duties.

5. Emergency generators are maintained and checked regularly.

6. Building maps directing staff and patients to safe areas for shelter in place.

Preparedness Strategies, Actions and Responsibilities

1. In the event of flood conditions, maintenance crews and other work groups will be taking measures to protect A.F. Whitsitt Center buildings and other property from damage. All A.F. Whitsitt Center staff are responsible for assisting those crews in any way they can, for identifying potential problems, and taking measures to protect equipment, furnishings, supplies, and records from flood or other damage.

2. Certain outside doors may be sandbagged or otherwise sealed to prevent entry of water. All possible outside equipment and outdoor furniture will need to be moved to the second floor, if possible.

3. In addition to protecting property, measures must be taken to assure that food and water supply is sufficient food and water is protected against standing water. This will be coordinated through the **Food Service Leader** and the **Logistics Section Chief** if HICS/NIMS is activated. These supplies must be secured and controlled to prevent misuse or waste.

4. An adequate amount of prescription medication for consumers must be obtained to last through the predicted duration of the storm. Obtain ice, and place in unit refrigerators to keep refrigerators cool if electricity goes out. Open the door only when absolutely necessary and monitor temperature.

Response Strategies, Actions and Responsibilities

1. Adequate staff shall be provided for each consumer building to meet the needs of consumers through the duration of the water emergency. (See SEVERE WINTER WEATHER for details).

2. Expect disruption of electrical service. Continue to check flashlights, radios, and any other emergency equipment for operation. Inform **Logistics Section Chief** if additional flashlights and batteries are needed.

3. Do not go into the water, running or standing, unless you are absolutely certain it is safe. During a flood or heavy storm conditions, areas can “washout” leaving a deep hole with standing water that is much deeper than you might think.

4. Running water, even as shallow as your ankles, exerts a tremendous force and could sweep you off your feet and wash you away.

5. Floodwaters are Dangerous! Do not go into the water. Leave that to staff who are equipped to do so.

6. If rising waters and more storms are predicted, the decision may be made to evacuate patients to another location. Staff to accompany consumers will be selected on short notice. Be prepared with clothing changes and other personal needs readily available if you are selected. *See evacuation procedures.*

Recovery

1. Account for all consumers and staff and inform the **Liaison Officer/PIO**.

2. **Maintenance/Buildings/Grounds Damage Unit Leader and/or Safety and Security Officer** will survey grounds with state officials for damage, downed wires, fallen trees, etc. and clear the areas.

3. Clear parking lots, access and egress to continue throughout the emergency.

4. Account for and replenish materials and supplies expended.

5. Evaluation of the event - deactivation, hotwash and post emergency reports.

SEVERE ELECTRICAL THUNDERSTORMS

These types of storms are usually short in duration: a few minutes to a few hours, but can contain high winds, a lot of rain, and severe lightning. These conditions are usually forecast and allow time to prepare.

Mitigation Strategies, Actions and Responsibilities

1. Monitoring of NOAA weather radio is conducted by the Kent County Emergency Operations Center during regular business hours (Monday-Friday, 8AM- 4:30 PM) and by the Police/Security Staff all other times.

2. Emergency generators are maintained and tested regularly.

3. Building maps directing staff and patients to safe area for shelter in place.

Preparedness Strategies, Actions and Responsibilities

1. Secure or put into storage equipment, outdoor furniture, trash cans that may be blown about and damaged or cause damage.

2. Check flashlights, radios, and any other emergency equipment for operation and have available if needed.

3. In the event of a severe and sustained electrical storm, maintenance crews and other work groups will be taking measures to protect A.F. Whitsitt Center buildings and other property from damage, i.e. checking patency of flood drains.

4. An adequate amount of prescription drugs for consumers must be obtained to last through the predicted duration of the storm. Obtain ice, and place in unit refrigerators to keep refrigerators cool if electricity goes out. Open the door only when absolutely necessary and monitor temperature.

Response Strategies, Actions and Responsibilities

1. Account for all patients and assure they will be in shelter. Cancel privileges.

2. Close all outside doors and windows.

3. Stay away from windows during the storm.

4. If you can hear thunder, you are close enough to the storm to be struck by lightning. Find shelter as soon as possible.

5. Find shelter in a building, or a car if you can't get to a building.

6. Stay inside and relocate to inner areas of a building as possible.

7. Telephone lines, electrical lines, and piping can conduct electricity from a lightning strike. Refrain from using phone, electrical appliances, showering, etc.

8. If caught outside, find shelter as soon as possible. Do not stand under trees, next to posts, light poles, or next to fences; they can attract lightning.

9. If you cannot get to a shelter; try to get to a low place that will not flood and make yourself a small target for lightning. Squat or sit low to the ground. Do not lie flat.

Recovery

1. **Maintenance/Buildings/Grounds Damage Unit Leader and/or Safety and Security Officer** will survey grounds with state officials for damage, downed wires, fallen trees, etc. and clear the areas.

2. Clear parking lots, access and egress to continue throughout the emergency.

3. Flooding may occur after a storm-evaluated damage to basements and lower level buildings.

4. Account for and replenish materials and supplies expended.

5. Evaluation of the event - deactivation, hotwash and post emergency reports.

HEAT ADVISORY AIR QUALITY INDICES

Mitigation Strategies, Actions and Responsibilities

1. Monitor the Maryland Health Department Hot Weather Advisories for heat index. Monitor DHMH Air-Watch.net for Air Quality index. This will provide several hours and/or days to advise staff and patients on conditions in advance.

2. Observe consumers and teach them to report symptoms for heat stroke and heat exhaustion.

3. Assess consumers for vulnerability to effects of hot, humid conditions including older adults, obese, heart disease, diabetes and other chronic health conditions.

Preparedness Strategies, Actions and Responsibilities

1. Consumer education regarding heat advisory measures.

2. Consumer protection measures – including accounting for all consumers and holding privileges.

3. Providing consumers with loose fitting, lightweight and light colored clothing and/or medication.

4. Have fluids available to prevent dehydration.

5. Application of sunscreens, encourage wearing hats, sunglasses.

Response Strategies, Actions and Responsibilities

1. Cancel privileges and outdoor activities.

2. Safety and security to patrol grounds; both on and off road for victims of heat related illness.

3. Observe consumers, staff and visitors for symptoms of heat related/respiratory distress. Provide care, treatment and services to relieve symptoms as necessary.

Recovery

1. Provide consumer care, treatment and services until recovery is complete.

2. Evaluation of the event - deactivation, hotwash and post emergency reports.

DROUGHT

Mitigation Strategies, Actions and Responsibilities

1. Monitor the Maryland Department of Environment Water Report. This will provide information and advise staff and patients on conditions in advance.

Preparedness Strategies, Actions and Responsibilities

1. State of Maryland Level 1 Conservation Orders from the Governor.

Response Strategies, Actions and Responsibilities

1. State of Maryland Level 1 Conservation Orders from the Governor.

Recovery

1. State of Maryland Level 1 Conservation Orders from the Governor.

LANDSLIDE, TIDAL WAVE, VOLCANIC ERUPTION

A.F. Whitsitt Center is positioned 22 feet above sea level. No areas identified as vulnerable to landslide, tidal wave or volcanic activity.

ANIMAL DISEASE OUTBREAK INCLUDING WEST NILE VIRUS (WNV) *EXCLUDING AVIAN INFLUENZA*

Example: Animal disease outbreak, blight, or infestation may occur in any atmospheric or soil condition. Kent County does have a large percentage of agricultural acreage, and a moderate percentage of wetlands. The Maryland Department of Agriculture (MDA) announced the first detection of West Nile Virus (WNV) activity in Maryland in 2005 approximately 40 miles from the center.

Effective July 23, 2009, the Secretary of DHMH integrated the Maryland AIDS Administration and the Community Health Administration into a new administration called the *Infectious Disease and Environmental Health Administration (IDEHA).*

Maryland DHMH - Office of Epidemiology and Disease Control Programs

MARYLAND LOCAL HEALTH DEPARTMENTS: Addresses & Telephone Numbers for Communicable Disease Reporting KENT

Ph. 410-778-1350
Fax 410-778-7913
T 410-778-1241
125 S. Lynchburg Street
Chestertown MD 21620

Mitigation Strategies, Actions and Responsibilities

Monitor the CDC and MDH Health Alerts for outbreaks, blight or infestations. This will provide information and advise staff and consumers on conditions in advance. State of Maryland Foreign and Emerging Animal Disease Plan. State of Maryland Public Health and Emergency Preparedness Bulletins.

Preparedness Strategies, Actions and Responsibilities

Educate staff to understand that an animal disease outbreak is a potential disaster because of the rural agrarian location of the hospital.

Response Strategies, Actions and Responsibilities

1. Report animals on the grounds at the Hospital that seemed distressed/diseased or dead. Secure area of animals to prevent contagion.

Recovery

1. Provide consumer care, treatment and services until recovery is complete.

2. Follow up with Kent County Health Department.

3. Evaluation of the event - deactivation, hotwash and post emergency reports.

PANDEMIC INFLUENZA

COVID-19 A global pandemic outbreak in 2019 with potential to affect millions of people. A respiratory flu-like illness initially wide spread throughout China in late 2019. This pandemic occured when the novel influenza virus emerged to which human beings have little or no immunity. This virus will be easily spread amongst humans and can be fatal. A flu pandemic is unlike any other public health emergency or natural disaster in terms of complexity, distribution, and ability to completely devastate Maryland, the United States, and the world. This pandemic will be widespread, with outbreaks occurring simultaneously throughout the state. Consequences of a severe pandemic will include: high rates of worker absenteeism, a surge on Maryland's healthcare system, and morbidity and mortality among residents.

The Maryland Department of Health's Office of Preparedness & Response has been planning for a pandemic event. Plans and activities include:

- A current Pandemic Influenza Plan
- Annual pandemic influenza exercises for emergency personnel
- Partnering with local, state, federal, and private agencies to form a comprehensive approach to abating and mitigating a flu pandemic
- A stockpile of Personal Protective Equipment and medical supplies for the A.F. Whitsitt Center staff and consumers.

H5N1 An influenza pandemic would be a global disease outbreak with potential to affect millions of people. A flu pandemic occurs when a novel influenza virus emerges to which human beings have little or no immunity. This virus will be easily spread amongst humans and can be fatal. A flu pandemic is unlike any other public health emergency or natural disaster in terms of complexity, distribution, and ability to completely devastate Maryland, the United States, and the world. A pandemic will be widespread, with outbreaks occurring simultaneously throughout the state. Consequences of a severe pandemic will include: high rates of worker absenteeism, a surge on Maryland's healthcare system, and morbidity and mortality among residents.

The Maryland Department of Health's Office of Preparedness & Response has been planning for a pandemic event. Plans and activities include:

- A current Pandemic Influenza Plan
- Annual pandemic influenza exercises for emergency personnel
- Partnering with local, state, federal, and private agencies to form a comprehensive approach to abating and mitigating a flu pandemic
- A stockpile of antiviral medications and medical supplies for Maryland residents

H1N1

Per DHMH influenza surveillance indicators, the first wave of Maryland H1N1 activity peaked in mid-May 2009. The much larger second wave of H1N1 activity peaked in late-October/early-November 2009. Since that time, there has remained sporadic low-level H1N1 activity in Maryland, and it is estimated that, to date, more than 1 million Maryland residents have been infected with H1N1. Forty-three H1N1-associated deaths have been confirmed. In addition, two oseltamivir (Tamiflu) - resistant H1N1 cases were identified in Maryland: one by on-going DHMH surveillance; the other by astute Maryland clinicians reporting to DHMH. No other major virus mutations have been identified among Maryland H1N1 cases. Only sporadic seasonal influenza activity has been identified in Maryland thus far this influenza season.

HVA Update: As of August 10, 2010, the head of the World Health Organization (WHO) declared the H1N1 influenza pandemic over, saying worldwide flu activity has returned to typical seasonal patterns and many people have immunity to the virus.

Mitigation Strategies, Actions and Responsibilities

1. Coordinate planning with Kent County Health Department and the DHMH.
2. Identify critical functioning and what services are needed. Identify how many consumers the hospital can handle. Identify the essential staff and how many need to be on site for critical functioning.
3. Provide planning guidance to **Operations Section Chief.**
4. Identify major gaps in current ability to effectively respond to pandemic; explore and resolve gaps
5. Maintain surveillance for influenza, staying current on the local, national and worldwide situation.
6. Encourage and track annual influenza vaccination for consumers and staff. This would be implemented at the Kent County Health Department.

Preparedness Strategies, Actions and Responsibilities

1. Review the State of Maryland Pandemic Flu Plan.

2. Educate hospital providers about appropriate infection control procedures for influenza as well as how to care for consumers suffering from influenza and complications; develop brochures for distribution

3. Educate staff to pay extra careful attention to hand hygiene before and after all consumer contact or contact with items potentially contaminated with respiratory secretions. Disseminate materials covering pandemic fundamentals (e.g. signs and symptoms of influenza, modes of transmission, personal and family protection)

4. Develop recommendations for or use recommendations provided by Kent County Health Department for the use of masks, gloves and other infection control measures during a pandemic

5. Prepare facts sheets or obtain them from Kent County Health Department on guidelines for general public (for use of staff) and guidelines for health care providers on appropriate use of antiviral medications and vaccines
6. Obtain information from Kent County Health Department and DHMH on legal authority/jurisdiction during a pandemic.

7. Purchasing to investigate "surge" procurement of supplies (especially gowns, gloves, masks, respirators, goggles, face shields, disinfectant etc.) needed during an outbreak from vendors.

8. Begin making plans to obtain additional staff.

Novel Virus Alert:

1. Monitor bulletins or other communications from Kent County Health Department, DHMH and CDC regarding the clinical, epidemiological and virologic characteristics of the virus.

Pandemic Alert:

1. Work with Kent County Health Department with regard to staff/consumers at high risk of morbidity/mortality

2. Work with Kent County Health Department and the Pharmacy to assure high risk groups and others receive vaccine and antiviral medications as appropriate.

3. Increase surveillance for influenza among staff and consumers. List consumers/staff that have traveled in the previous 10 days to countries with avian flu activity. List consumers and staff who have shown symptoms of a severe febrile respiratory illness in the past 10 days.

Isolate these consumers and inform staff not to report to work. Strongly advise staff and consumers against travel to countries that have avian flu activity.

4. Inventory pharmaceutical cache of Tamiflu and other medications that might be needed and arrange for increased supplies through the Kent County Health Department.
5. Security staff to prepare to reduce the number of entry exit points to the facility.

Pandemic Imminent:

1. Continue to monitor bulletins from Kent County Health Department, MDH and CDC regarding the clinical, epidemiological and virologic characteristics of the virus.
2. The Director of Medical Services and the Kent County Emergency Preparedness Planner will keep all staff members, physicians and pharmacists informed on the latest news, hospital conditions and directives from within, as well as Kent County Health Department, DHMH and CDC.
3. The Director of Medical Services will review and revise as necessary, any brochures, fact sheets etc. for staff and providers and distribute.
4. Discuss control measures regarding admissions and discharges of patients. Factor into decision to discharge the consumer , if the area the consumer is being discharged to, would increase the consumer's chances of exposure. Consumers will determine whether they wish to stay or leave.
5. Prepare for an influx of consumers from other hospitals that may need their psych beds for acute physically ill consumers.
6. Put housekeeping and maintenance departments on alert.
7. Discuss control measures regarding visitors to the campus, particularly consumer buildings.
8. Discuss discontinuation of group activities and planned outings, etc.
9. Discuss isolation of consumers with symptoms. (see Triage)
10. Secure sufficient supplies of personal protective equipment including surgical masks, gowns, gloves and respirators, along with disinfectant cleaners and alcohol based hand gels. Educate unit staff to order more supplies immediately to keep ample supply.
11. Center security to protect clinical caregivers and secure the center against intruders and stockpile thievery.

Pandemic Response Strategies, Actions and Responsibilities

1. Report cases of influenza to Kent County Health Department/MDH
2. Treat consumers and staff as appropriate.
3. Transfer consumers to local hospitals if necessary and if possible.
4. Monitor supply of antiviral medications and vaccines, gloves, masks, etc.; contact suppliers and/or Kent County Health Department /MDH if more are needed
5. Monitor adequate staffing carefully; contact other sources for staffing if needed.
6. Maintain continuous cleaning of consumer areas, using disinfectant cleaners to wipe down all equipment in common use, including communication devices, keyboards, etc.
7. Implement control measures and isolation measures as decided upon as appropriate.

Recovery

1. Inventory loss.
2. Disinfection and inventory of equipment and supplies.
3. Thorough laundering of clothing.
4. Clean rooms
5. Dispose of food and other supplies that may have become contaminated or was identified as the contaminant.
6. Direct consumers, staff and visitors who may need critical incident stress debriefing to appropriate unit
7. Post exposure management requires extensive, long term care; mostly due to exposure to external radiation.
8. Evaluation of the event - deactivation, hotwash and post emergency reports

Man Made and Technical Disasters

CODE BOMB THREAT – Bomb threat/Suspicious Package

PROCEDURES

All bomb threats must be treated seriously and are reported immediately to the A.F. Whitsitt Center by calling the Director/designee. The director/designee will determine the need for:

1. Performing building searches and reporting unfamiliar vehicles.

2. Involving the bomb squad once a suspicious item has been located.

3. Restrict cell phone/beeper/radio use until directed by the **Incident Commander** since bombs can be rigged to activate within 1000 feet using a certain radio frequency.

Evacuation of building

4. Determining whether a CODE BOMB THREAT should be declared and announced by overhead speaker system, computer blast, electronic mail and voicemail.

5. The Director or Incident Commander designee determines the necessity to implement HICS/NIMS.

6. The Director or Incident Commander Designee will consult with the responding law enforcement or other responding authority, A.F. Whitsitt Center supervisory staff, and other available authorities as necessary.

7. Bomb threat forms are available, at a minimum, in each nursing station, in each office by phone. Extra forms are available?

Mitigation Strategies, Actions and Responsibilities

1. Staff should be alert as they go about their daily routine and learn the normal routines within the workplace. Understanding routines will help staff spot things out of the ordinary.

2. Staff should be vigilant of suspicious activities in their work area. Learn to spot suspicious vehicles, packages and mail.

3. Any staff member who overhears a conversation regarding harming people or violent attacks should immediately report this to the Security staff.

Preparedness Strategies, Actions and Responsibilities

- Staff training
- Tabletop drills with community, neighbors and tenants
- Emergency Plan Disaster Exercises
- Bomb Threat Forms located by phones

Response Strategies, Actions and Responsibilities

1. Immediate action to be taken at the site of incident upon receipt of a bomb threat (whether by telephone, upon discovery of what appears to be a bomb, or by the statement of a known individual), staff in the building affected will do the following:

2. The person receiving the bomb threat will use the Bomb Threat Form to gather as much information as possible from the person making the bomb threat, they should also take note of the phone number using caller ID. After the threat conversation has been terminated, the individual will immediately call the Director/designee. The Bomb Threat Form will be given to the responding police or designee at the scene.

3. CODE BOMB THREAT should be declared and announced by overhead speaker system, computer blast, and landline phone voicemail.

4. When CODE BOMB THREAT procedures are implemented, **all staff are to restrict cell phone/beeper/radio use** until directed by the Incident Commander, since bombs can be rigged to activate within 1000 feet using a certain radio frequency.

5. Other staff in the affected building will begin getting ready for a building evacuation in case it is needed. Staff will open all internal doors and windows—if possible—and keep all outside doors locked. Report anything unusual (such as an outside door unlocked, a package/luggage that is out of place) to the police.

6. Building Search – If and when the Director or designee orders a building search. The police and local fire departments will be in charge of the search. Staff familiar with the building will assist with the search, using a visual sweep method of the room for suspicious objects.

7. The Security Officer and receptionist will identify staff that are familiar with the everyday operations and contents of the building to perform the search along with a staff member and/or the police officer. A typical search team would be the A.F. Whitsitt Center Clinical Director and the unit or building charge nurse, or a A.F. Whitsitt Center Police Officer and nursing staff from the unit/building or senior staff member with an outside police officer.

8. If a staff member finds a suspicious article during a building search, he/she will notify the **Safety and Security Officer** immediately. Staff will not disturb the article. If staff is suspicious of a letter or piece of mail do not touch the item.

9. The **Safety and Security Officer** will immediately report these findings to the director/designee who will then implement the Incident Command Center. The **Safety and Security Officer** will report these findings to the Incident Commander who will decide the appropriate actions for identification and disposal of the article, using resources at hand or available through outside police or Bomb Squad staff. The **Incident Commander** will decide whether to continue the search once such an article has been found.

10. After the incident is cleared or the building is searched and nothing is found, the **Safety and Security Officer** will declare the building safe to re-enter.

EVACUATION INSTRUCTIONS FOR CODE BOMB THREAT

Refer to internal and external evacuation procedures for details and bomb distance chart

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If and when the Incident Commander orders evacuation of a building, staff shall implement the following procedures:

Non-Patient Buildings

1. All persons in the building will immediately leave the building and go to a safe location. Leave all doors and windows <u>open</u> if possible except the outside door, which shall be locked.
2. Safe shelter locations are buildings which are at least 1000 feet from the involved building and have communication facilities. **The Safety and Security Officer** will inform staff where they are to assemble and designate someone in charge of the site to make sure no one re-enters the building.
3. The person in charge at the site will take action to assure there is no re-entry into the evacuated building and keep onlookers at a safe distance (at least 1000 feet).

Consumer Buildings

1. Evacuate all consumers, staff and visitors to a safe area that is at least 1000 feet from the involved location.
2. Take the Consumer Kardex outside when evacuating.
3. The Nursing Leader orders all staff to perform checks and searches of **all** areas for consumers and staff .
4. The Nursing Leader conducts a head count of all consumers, staff, and visitors. Consumers are verified against unit Kardex. Staff are verified using sign-in sign out.
5. Disabled consumers– do not wait for a stretcher or wheelchair. Either roll the beds out of the unit or slip the mattress and/or blanket to the floor and drag it with the consumer to safety. Wheelchair consumers– Wrap in blankets and wheel to a safe exit. Walking consumers– Wrap in blankets and lead to a safe exit.
6. Lock all exterior doors after all the building occupants are out to prevent unauthorized entry. All other doors and windows should be left open if possible.

7. The person in charge at the site will take action to insure there is no re-entry into an evacuated building and to keep onlookers at a safe distance (at least 1000 feet).

EVACUATION AREA

Safe evacuation areas must be located at least 1000 feet from the site of the incident and should provide shelter for all persons evacuated. (See distance chart)

When a building with a large number of persons or more than one building is threatened

All persons from a threatened building must evacuate to the same safe location in order to determine that all persons are accounted for. The following list of safe evacuation sites is provided for patient occupied buildings:

EXTERNAL EMERGENCY AREAS OF ASSEMBLY POINTS

1. Gazebo in back of building.
2. Tree line at front of building

Duties of Staff

1. **Staff familiar with the normal surroundings** will immediately report to the scene and along with the responding authorities, assess the situation. The **Safety and Security Officer** will provide consultation to the **Incident Commander**. Those not involved in the search will work to control crowds, escort outside police and fire department staff to the site, control media access, and other functions as needed.

2. If the HICS has been activated, refer to the Emergency Operations Plan for evacuation procedures in detail.

3. Upon hearing CODE BOMB THREAT, each unit will send all available staff to the site where they will report to the **Nursing Unit Leader** for duties.

4. The **Nursing Unit Leader** will proceed to the scene of the emergency immediately if a consumer building is involved. The **Nursing Unit Leader** will assess consumer safety and provide consultation to the **Incident Commander**

Notification Procedures

1. Whenever someone on the facility receives a bomb threat, the receiver of the call shall stay calm, getting as much information as possible using the FBI bomb threat card as a guide and record this information directly on the FBI Bomb Threat Form.

2. Immediately call 911 and notify the supervisor.

3. Notify the Director, A.F. Whitsitt Center, Security and A.F. Whitsitt Center senior staff call down by landline phone immediately. Avoid using electronic devices for notification. After hours, notify these individuals at home.

4. If a patient building is involved, notify the Nursing Supervisor available.

5. Make the CODE BOMB THREAT announcement when directed by **Incident Commander**.

6. Clear all calls not related to the emergency. Do not resume normal operations until instructed by the **Incident Commander** or the **Safety and Security Officer** that the situation is "all clear".

7. As directed by the Incident Commander, call 911.

8. Call the director, the Clinical Director and the (Position in charge of safety); call home after hours.

9. Call the Maintenance Supervisor; including home after hours; who will in turn call all other needed maintenance staff.

10. As directed by the **Incident Commander**, the **Communications/Information Technology Leader** will call the other units/buildings to advise them of the situation and advise the units of needed action.; utilizing all communication methods necessary as outlined in the notification section of the plan.

Call other key staff as directed or as noted below:

1. Call the Director of the Admissions Division— or at home after hours.

2. Call everyone on the tenants and neighbors list to notify them of the situation.

3. The Incident Commander will direct the **Public Information Officer** (PIO) to contact one or more of the following: Kent County EOC, Kent County Health Department, DHMH Emergency Team and MEMA.

Recovery

1. Following the incident, the center's leadership, in conjunction with all agencies involved, will review the operation and make the needed plan revisions. The Safety and Security Officer will evaluate damaged buildings and grounds and will submit a report to the CEO.

2. A general information session, conducted by the Director should be considered for all staff. The purpose of such a meeting would be to alleviate fears and concerns that may exist as a result of this incident. This will be evaluated at the time of the hotwash.

3. Consumers, staff, visitors and others coming into the hospital, which may need continued critical incident stress debriefing, will be referred to the social work unit.

4. Evaluation of the event - deactivation, hotwash and post emergency reports.

5. Responsibility for review and maintenance of CODE BOMB THREAT procedures is assigned to the PSEC designated integrated workgroup. These procedures will be reviewed by the PSEC Committee prior to approval.

CODE DISRUPTIVE CONSUMER/VISITOR – Disruptive Consumer or visitors

Definition: A disruptive consumer or visitor is defined as one whose behavior is agitated and potentially harmful to himself/herself or others

Policy: In the event a consumer or visitor becomes disruptive, the staff person who is present with the disruptive individual will assess and evaluate the acuity of the situation. Methods to control/contain the disruptive behavior may be handled by one of the following procedures.

Mitigation Strategies, Actions and Responsibilities

- Staff is trained in appropriate response procedures
- Police and Security staff are trained in appropriate response procedures
- Coordination with mental health, law enforcement agencies and local government.

Preparedness Strategies, Actions and Responsibilities

- Staff education regarding A.F. Whitsitt Center's Emergency Operations Plan
- Community Law Enforcement training regarding firearm safety when entering the hospital
- Coordination with community EMS

Response Strategies, Actions and Responsibilities

In the event a consumer/visitor becomes agitated, verbally abusive or hysterical, the staff member will take the following action

1. Move other consumers/visitors away from the area, if possible. The staff member should stay with the consumer and be positioned closest to the door.

2. Notify the receptionist/security to announce a "**CODE DISRUPTIVE CONSUMERS/VISITOR**" in effect over the public address system or have another employee do so.

3. Calm the disruptive consumer/visitor. Occasionally it may be an advantage to enlist the aid of another staff member.

4. Make referrals accordingly, depending on the circumstances of the disruptive consumer/visitor (i.e., Kent county Behavioral Health – Mental Health or Prevention, Kent County Social Services, etc.).

5. Complete an ***Unusual Occurrence Report Form*** according to the Unusual Occurrence Report Procedure found in the Risk Management Policy and Procedure Manual.

6. Give the completed ***Unusual Occurrence Report Form*** to the Risk Management Coordinator.

In the event a consumer/visitor is *outside* the building and poses a threat to the staff or other consumers, staff members will take the following action:

1. Move towards the center of the building, away from windows.

2. Close and lock all outside doors and windows to prevent entry of the disruptive consumer/ visitor.

3. Notify the receptionist/security to announce a "**CODE DISRUPTIVE CONSUMER/VISITOR"** in effect over the public address system or have another employee do so.

4. Call "911" and inform the proper authorities of the situation.

5. Await arrival of proper authorities.

6. Complete an ***Unusual Occurrence Report Form*** according to the Unusual Occurrence Report Procedure found in the Risk Management Policy and Procedure Manual.

7. Give the completed ***Unusual Occurrence Report Form*** to the Risk Management Coordinator.

Security Staff shall:

1. The **Safety and Security Officer** will respond to establish a secure zone around the incident site.

2. All persons must be cleared from the surrounding areas of the incident and protected from danger. All other persons are to remain where they are and avoid movement throughout the center.

3. The **Safety and Security Officer** will be prepared to brief responding law enforcement authorities and appropriate administrative staff upon their arrival if deemed necessary. **NOTE:** Security shall ensure the safety zone is large enough to provide for the safety of staff, visitors and consumers.

Recovery

1. Following the incident, hospital leadership, in conjunction with all agencies involved, will review the operation and make the needed plan revisions as outlined in the A.F. Whitsitt Center Emergency Operations Plan. The **Maintenance Unit Leader** will evaluate any damaged buildings and grounds and will submit a report to the Director.

2. A general information session, conducted by Administration should be considered for staff. The purpose of such a meeting would be to alleviate fears and concerns that may exist as a result of this incident. This will be evaluated at the time of the review.

3. Consumers, staff, visitors and others coming into the hospital, of who may need continued critical incident stress debriefing, will be referred to the **Kent County Mental Health**.

4. Evaluation of the event - deactivation, hot-wash and post emergency reports

5. Responsibility for review and maintenance of CODE DISRUPTIVE CONSUMER/VISITOR procedures is assigned to the A.F. Whitsitt Center. This policy/procedure will be reviewed by the PSEC prior to approval or changes.

CODE SILVER - Armed Assailant, Hostage Situation

If an armed person should enter our facility, the center will respond in the most appropriate manner possible to protect our consumers, staff and others coming into the hospital. Staff identifying the situation should immediately go to a safe area and contact the Police by dialing 911. Update to HVA: September 2010, an armed assailant entered a Maryland hospital and committed murder/suicide. The emergency operations plan will be reviewed and revised when lessons learned from this event are published.

Mitigation Strategies, Actions and Responsibilities

- Police and Security staff are trained in appropriate response procedures
- Coordination with law enforcement agencies and local government.
- Coordination with neighbors and tenants
- Identified EAPs (Emergency Assembly Points)
- A.F. Whitsitt Center Contraband List
- Signage of center's weapons policy

Preparedness Strategies, Actions and Responsibilities

- Staff education regarding A.F. Whitsitt Center's Emergency Operations Plan
- Community Law Enforcement training regarding firearm safety when entering the hospital
- Staff Reserve Pool
- Maintenance of adequate emergency supplies, food, water, emergency beds, pharmaceuticals, etc.

Coordination with community EMS

Response Strategies, Actions and Responsibilities

The staff member with knowledge shall immediately contact the on duty Police/Security officer and clear radio channel for emergency broadcast. While obtaining information from the caller, the staff member shall relay the following information from the caller in order that the officer will receive it directly:

1. Location and number of assailants.
2. Entrance locations to the area.
3. Description of the assailant and type of weapon (if known).
4. Approximate number of people being held, or in the danger area.
5. Contact 911 give a brief description and location of incident.
6. Contact tenants/neighbors.

Security Staff shall:

4. Determine whether CODE SILVER should be declared and notify the Director/designee and send email blast.

5. The Director/**Incident Commander** will implement HICS/NIMS.

6. The **Safety and Security Officer** will respond to establish a secure zone around the incident site. No one is to enter the secure zone except police officers.

7. All persons must be cleared from the surrounding areas of the incident and protected from danger. All other persons are to remain where they are and avoid movement throughout the center.

8. The **Safety and Security Officer** will meet with the responding law enforcement authority and brief them on the situation and advise the building/area that the police are to report to in the center. The location of the incident command center may vary depending on the location of the event. The incident command center will not be part of the center command post. When the responding law enforcement authority arrives, it becomes a police incident and the responding law enforcement authority will assume responsibility of managing the incident. However, the responding law enforcement authority will request and expect cooperation and assistance from the hospital staff.

9. The **Safety and Security Officer** will be prepared to brief responding law enforcement authorities and appropriate administrative staff upon their arrival. **NOTE:** Security shall insure the safety zone is large enough to provide for the safety of staff, visitors and consumers. (Modern high-powered rifles and handguns could transit as many as four to six walls or partitions). Evacuate departments as necessary.

10. The **Incident Commander** shall contact essential department heads and brief them regarding the situation and will receive instructions and assignments from the administration in charge of the incident.

11. When the responding law enforcement authority arrive, center staff will assist under direction. Police may require assistance from staff in securing the building and may request sharing of center radios in order to stay informed of hospital activity.

12. The **Logistics Section Chief** will make certain that an assembly area is set up in a safe location for those who escape the incident areas and those evacuated. All persons evacuated must be scanned to rule out a “hand off” of any weapon to another person. This area will be used by police for interviews which will assist in providing police with realistic information on the situation. This area should have a telephone, water, power, and rest-rooms, since the situation could last for several hours. A.F. Whitsitt Center’s support team should be deployed to this location if safe to do so.

13. The **Safety and Security Officer or designee** shall report to the police command point with appropriate maps and blueprints of the incident area. The **Safety and Security Officer or**

designee will be required to provide information such as, location and number of doors, power shutdown procedures, phones in the area, chemicals in area, etc.

14. If consumers, staff or physicians have an emergency that requires movement of consumer or staff through the secured area, the police must be notified. When appropriate, an armed escort will be sent.

15. If the severity of the situation warrants, entry and exit to and from the building(s) shall be prohibited by order of the **Safety and Security Officer** in collaboration with the **Incident Commander and the responding law enforcement authority**.

16. All media coverage must be directed by the **PIO/Liaison Officer**, in cooperation with the **Safety and Security Officer or designee and Kent County Health Department**. Media shall be escorted to the right hand parking area or the dining hall and prevented from roaming the campus. Staff should be instructed to give no information to the media. Media representatives are often aggressive and may not have an ID. The incident is not to be a topic of discussion between the staff and press, and patient privacy must be respected.

17. The **PIO/Liaison Officer,** with the approval of the Incident Commander, MHA and the **responding law enforcement authority**, will debrief all parties involved with this situation. Hospital wide communication will be as often and as widespread as possible, using every means of internal communication as approved by the **Safety and Security Officer** and the **responding law enforcement authority**.

Recovery

6. Following the incident, hospital leadership, in conjunction with all agencies involved, will review the operation and make the needed plan revisions as outlined in the A.F. Whitsitt Center Emergency Operations Plan. The **Maintenance Unit Leader** will evaluate damaged buildings and grounds and will submit a report to the Director.

7. A general information session, conducted by Administration should be considered for all staff. The purpose of such a meeting would be to alleviate fears and concerns that may exist as a result of this incident. This will be evaluated at the time of the review.

8. COnsumers, staff, visitors and others coming into the hospital, of who may need continued critical incident stress debriefing, will be referred to the **Kent County Mental Health**.

9. Evaluation of the event - deactivation, hotwash and post emergency reports

10. Responsibility for review and maintenance of CODE SILVER procedures is assigned to the Chief of Police, A.F. Whitsitt Center. This policy/procedure will be reviewed by the PSEC prior to approval or changes.

CODE PURPLE – Cybercrime, Security, Break-ins

CYBERCRIME

A.F. Whitsitt Center is networked to serve 60 employees. Consumers and staff have access to personal computers.

Mitigation Strategies, Actions and Responsibilities

1. HIPAA compliant policies and procedures for offsite data backup.
2. Firewalls, anti-virus with centrally managed updates.
3. Strong password policy.
4. Intrusion detection run.
5. Hospital wide training on network access policies.
6. Conduct periodic retrieval of back up data.

Preparedness Strategies, Actions and Responsibilities

1. Information Technology Disaster Recovery Plan(KCHD).
2. Retrieve Data during or after an emergency.

Response Strategies, Actions and Responsibilities

1. Perform shutdown on all network servers and infrastructure.
2. Report to DHMH Computer Operations Center.
3. Report to FBI as directed.

Recovery

1. Follow IT emergency recovery plan
2. Evaluation of the event - deactivation, hotwash and post emergency reports.
3. Responsibility for review and maintenance of CODE PURPLE cybercrime procedures is assigned to the Director of Information Technology, A.F. Whitsitt Center. This policy/procedure will be reviewed by the PSEC prior to approval or changes.

SECURITY- BREAK-INS, SUSPICIOUS PEOPLE/SUSPICIOUS VEHICLES

The likelihood of implementing HICS/NIMS procedures for break-ins, suspicious people and vehicles is slight.

CODE ORANGE – Hazardous Materials and Waste Spills

A F Whitsitt Center does not generate large amounts of chemical hazardous wastes. However, the need for cleanup of large chemical spills and/or disposal of hazardous waste can occur. Usually

disposal is needed for unused or old chemicals still in original containers or materials used to clean up small spills occurring during normal operations (spilled cleaning materials, oil, or fuel) and disposal procedures are a part of day to day operating procedures.

Purpose
To assure safe clean up of chemical spills and safe disposal of hazardous wastes.

Policy
This procedure will be followed when there is a chemical spill/exposure of a nature outside the day to day operating procedures, internally and externally, for use of that chemical (large/bulk spills, chemicals mixed, unknown chemical, fire or explosive hazard) and for disposal of hazardous wastes generated at A.F. Whitsitt Center and not covered in or other procedures.

Mitigation Strategies, Actions and Responsibilities

A.F. Whitsitt Center will maintain liaison with Kent County Emergency Operations Center and other outside agencies as required by state and federal regulations. Staff are trained in Emergency Operations Plan and CODE ORANGE procedures. Staff are taught to use standard precautions as recommended by the CDC until the substance is identified.

Preparedness Strategies, Actions and Responsibilities

- Community wide drills utilizing HICS/NIMS with evaluation.
- The A.F. Whitsitt Center essential staff have been identified.
- Adequate emergency supplies, food, water, emergency beds, pharmaceuticals, etc. are maintained in alternative sites.
- Personal protective equipment, including gloves and masks..
- Bioterrorism Readiness Plan
- Kent County Health Department laboratory support.

Response Strategies, Actions and Responsibilities

Emergency responses will be conducted in accordance with 29CFR part 1910-120 OSHA regulation and other regulations applicable to the situation. If needed, the HICS/NIMS procedures will be initiated.

Immediate Action: HICS/NIMS procedures will be initiated

1. The **Safety and Security Officer or designee** will respond immediately to site of chemical spill.

2. Police and security will assume control and secure site.
3. Assess spill and determine if spill can be contained and cleaned up with in house resources.
4. If an outside contractor is needed or if there is a need to initiate the Kent County Hazardous Materials response procedures.
5. Initiate proper action, including if needed HICS/NIMS Procedures if there is widespread danger; or CODE ORANGE if the problem is localizing.
6. Notify Director, Clinical Director and other appropriate supervisors based on situation and location of incident.
7. Control scene of incident until clean-up complete or relieved by qualified Supervisor, Contractor, Fire Department, or other agency assuming control of clean up.
8. Coordinate clean up and disposal with outside agency and environmental agencies.
9. Make proper notifications to environmental agencies.
10. Complete reports on incident as required.
11. Arrange for health monitoring of affected consumers/staff/volunteers.

Staff Response

12. If you are told to shelter in-place, go inside if you are outdoors.
13. Close all windows and doors and tape cracks for extra protection.
14. The Safety and Security Officer orders shut down all vents on cooling, heating or ventilation systems as necessary
15. The Incident Commander orders all staff and consumers to central interior of safe area of the building and to stay inside until the Code Orange emergency is over.

Continued Action

Subsequent actions will be taken as directed by the (Name Area Here) or outside agency person in charge of the spill/clean-up site, and will depend on the location, nature of the chemical, and the size of the spill. In certain types of spills it can be anticipated that operations of the hospital may be jeopardized and building evacuations might be needed.

16. If ordered to evacuate, all staff and consumers are to immediately move to a location designated by the Incident Commander when so directed.

17. The Public Information Officer will notify the Kent County Health Department, emergency responders and others as directed by the Incident Commander that the building has been evacuated.

Maintenance Staff

Some maintenance staff may be called on to help in containment and clean up of a spill depending on the situation and their individual skills. This will be directed by **Safety & Security Officer** in coordination with Incident Commander.

Maintenance Director

Respond to site immediately to assist maintenance in utilizing available A.F. Whitsitt Center resources to control the situation. Be prepared to assume control of site if the **Safety and Security Officer** is not available and coordinate clean up and disposal of spill with outside agencies.

Security

All on-duty officers will immediately report to the scene to assist in any way needed. Anticipated duties include assisting in securing the site, traffic and crowd control, and escorting outside responders to site. All unauthorized staff and other persons should be kept at least 1000 feet from any substantial chemical spill and farther as directed by persons in control of spill site. In some circumstances building evacuations may be needed.

Notification Procedures

When a spill is discovered or odor is detected, the person finding the potentially hazardous material and waste spill will stay clear of the area and:

1. Immediately call their supervisor to give their name and location and report the spill. If not in a contaminated/malodorous area, reporting staff are to wait by the phone for further instructions. Staff is not to jeopardize their own health if there is any question that the area may be contaminated. Note: If the spill is noxious, call 911 and contact someone to immediately secure the site.

2. The receptionist/operator immediately contacts the Director or Clinical Director. If the Director or Clinical Director cannot be contacted immediately, contact the **Safety and Security Officer**.

3. If there is any question that the spill may be a threat to health and safety, the Incident Command Center is set up and HICS/NIMS implemented. The **Safety and Security Officer**

briefs the **Incident Commander** to assess the potential impact. Points of consideration include; the necessity of immediate evacuation and other immediate safety concerns for staff, consumers and others in the center, containment efforts necessary to manage the spill.

4. If CODE ORANGE procedures are determined to be necessary, the **Public Relations Officer** also notifies other persons as directed by responding hazmat authorities, Kent County Health Department, Kent County Health Officer **and the following if not already notified:**
    - Director
    - RN Supervisor
    - Clinical Director
    - Security
    - Safety and Security Officer
    - Other Staff as directed by the Incident Commander
    - Campus tenants and neighbors if appropriate

5. The **PIO** will prepare a communication for center wide distribution stating what happened, who is affected, how the spill will be contained, if evacuation is necessary and who is to be evacuated, precautions addressed in the MSDS sheet and any other safety concerns.

6. Staff should stay in their regular duty locations until directed otherwise by persons in authority. *See essential staff designation.*

Hazardous Waste Management

1. Some hazardous wastes are disposed of by prior agreement/contact with a supplier or waste removal contract (example: parts cleaner fluid at garage). A copy of any manifests (EPA Form 8700-22) resulting from those disposals must be sent to the **Safety and Security Officer**.

2. For other wastes, the **Safety and Security Officer** will assure that the material is properly secured and/or stored and A.F. Whitsitt Center staff is in no danger.

3. The **Safety and Security Officer** will apprise the **Incident Commander** of the situation and arrange for removal by certified/licensed contractor and transported to an appropriate disposal site utilizing proper procurement methods, and assuring receipt of manifest using EPA Form 8700-22 with signature of carrier and receiving agent.

4. All manifests will be kept in a permanent file at the Kent County Health Department and the administrative offices at the A.F. Whitsitt Center.

Recovery

1. Dispose of hazardous materials following manifest agreement.
2. Decontaminate and inventory equipment and salvageable supplies.
3. Disposal of food, clothing, and other supplies that may have become contaminated or was identified as the contaminant.
4. Clean rooms and other areas affected.
5. Direct consumers, staff and visitors who may need critical incident stress debriefing to appropriate unit.
6. Post exposure management procedures followed as directed by the Kent County Health Department.
7. Administer vaccinations if recommended by the Kent County Health Department.
8. Evaluation of the event - deactivation, hotwash and post emergency reports.

CODE WHITE - Utility Failures

A.F. Whitsitt Center has not experienced water main failures, HVAC failures or generator failures, electrical failures in the past , but understands that utility systems are essential to the proper operation of the workplace and significantly contribute to the effective, safe and reliable provision of care to consumers in the center. For this reason continuous maintenance and testing of operational reliability is necessary to minimize the potential risks of utility system failures. Through contingency planning, backup systems that can be used in an emergency are in place in case a system fails.

A utility system provides buildings and site with basic operational needs such as, but not limited to, electricity, water and sanitary sewer . These items are either obtained from a public utility company/supplier or are generated by hospital equipment.

Utility systems have a significant impact on the overall environment of patient care. The following systems are included in the Utility Management Plan due to the effect that their total or partial loss could have on infection control, environmental support, equipment support or communications:

- Electrical Distribution
- Emergency Power
- Domestic Hot and Cold Water
- Heating and Cooling Systems
- Sanitary Sewer
- Telecommunications
- Computer Network Cabling

Emergency Maintenance Problems

Emergency maintenance problems, which interfere with the provision of necessary consumer care, have the potential of creating safety and/or security dangers have the potential to cause property damage. The utilities include the following:

- Emergency power
- Electrical Distribution
- Water Distribution
- Sanitary Sewers

Mitigation Strategies, Actions and Responsibilities

1. A.F. Whitsitt Center maintains liaison with Kent County Emergency Operations Center and other outside agencies as required by state and federal regulations.

2. Maintenance responds to facility brown-outs or black-outs as symptoms of marginal power supply.

3. Generator backup for consumer occupied areas.

4. Testing and inspection procedures are defined and maintained in the Maintenance Department Policies and Procedures Manual and emergency procedures for utility system disruptions. If a test(s) fails, interim measures to compensate for the risk to consumers, visitors, and staff until necessary repairs or corrections are completed.

5. Contracts for maintenance

Preparedness Strategies, Actions and Responsibilities

1. Center staff is trained during new employee orientation and annual training to report a power outage, sewer failure, water failures and leaks and HVAC failures.

   Maintenance staff are trained in the following:
   - Components of the Utility System
   - Department Response to System Failure
   - Special risks and safety precautions associated with the Utility System
   - Alarms and Warning Indicators
   - Preventive Maintenance Procedures
   - Testing and Inspection Procedures
   - Diagrams and Emergency Shutdown

2. Coordination with MHA, MIEMSS for emergency needs beyond the facility's capabilities.

3. Maintenance staff on 24 hour call; staff ready to implement power failure contingency plans.

4. The Director of Maintenance shall establish and maintain written policies and procedures for the management of the utility systems at the facility. These policies shall be in the Maintenance Department Policy and Procedure Manual located at the Maintenance Office.

5. Orientation and Education regarding emergency procedures to be followed in the event of system failure and Processes for reporting problems, failures and user errors are outlined in the Utilities Management Plan.

6. Emergency equipment and supplies; flashlights, extension cords, etc. Emergency ice packs for medications and limited amounts of food are stored in the freezer of the individual consumer unit refrigerators. *For complete list see Equipment and Supply list.*

7. Hazard Vulnerability Analysis conducted with an assessment of emergency power system to match the critical equipment and systems needed in an extended emergency against the equipment and systems actually on the emergency power system. Analysis includes assessment of emergency power feeds, sewer, heating, air conditioning and fan units, and air handling issues.

8. Procedures are established that address the detection of potential biological agents, such as Legionella in cooling towers, domestic hot water and other aerosolizing water systems

Response Strategies, Actions and Responsibilities

1. All staff are responsible for reporting any type of utility system failure or malfunction to the Maintenance Supervisor or Director.

2. The Maintenance Director issues a hospital wide email notifying staff that system(s) have been compromised and the estimated time to bring the system(s) back up.

3. The Center should be notified every time a systems failure occurs, even if CODE WHITE has not been implemented and the situation is corrected.

4. If the systems failure is critical, the Director or next available person in the chain of command is notified per emergency management notification procedures to determine if HICS/NIMS needs to be implemented. The capabilities and limitations of the emergency power supply system are relayed to the **Incident Commander**. These communications should cover how long emergency power will be available, how long it will take the generators to provide power if and when the utility company's power is lost, and what locations within the facility will and will not be powered by the emergency power.

5. The maintenance staff calls (local power company) for gas leaks and senior staff members assesses situation for possible evacuation. *See Evacuation Procedures.*

6. If a utility systems failure occurs while A.F. Whitsitt Center HICS/NIMS command structure is in operation, the **Logistics Section Chief** is responsible for coordinating the services that maintain the integrity of the physical facility to the best level. These include but are not limited to: water, electricity, and ventilation and fuel sources.

7. The **Nursing Unit Leader** reports the need for rapid deployment of any battery- powered equipment needed to the **Operations Section Chief**. The **Operations Section Chief** coordinates assessment of critical equipment to ensure it is plugged into back-up power outlets.

8. The **Maintenance Unit Leader** will be responsible for providing information to the **Logistics Section Chief** regarding the failure.

Recovery

1. A report is submitted if CODE WHITE procedures were not implemented.

2. Assess damage and utility functions. Inventory equipment and salvageable supplies.

3. Dispose of food and other supplies that may have become contaminated.

4. Evaluation of the event - deactivation, hotwash and post emergency reports

5. Failures, user errors, as well as, the affects those incidents had on the consumer workplace are reported.

COMMUNICATION SYSTEMS FAILURE

A.F. Whitsitt Center 's main communication avenues are through a dedicated land wired telephone system, computer network for electronic mail, and overhead speakers.

Mitigation Strategies, Actions and Responsibilities

1. Pre-determined designation of alternate portable communication devices.

2. Meeting with contractors prior to disruption of infrastructure.

Preparedness Strategies, Actions and Responsibilities

ALTERNATIVE COMMUNICATION DEVICES INVENTORY

- A portable Radio is located in each unit's nurse's station, in the security office, in the maintenance office, and at the front reception desk.

Response Strategies, Actions and Responsibilities

1. Notification procedures – key staff to obtain radios and assume responsibility for communications in their geographic areas.
2. Notification of loss of communication through alternative communication device(s).
3. Distribute available portable radios to predetermined areas.

Recovery

1. Administrator assessment of malfunction.
2. If repairs cannot be made in-house contact appropriate outside vendor for repair services
3. Evaluation of the event - deactivation, hotwash and post emergency reports

CODE RED - FIRE

Mitigation Strategies, Actions and Responsibilities

1. Regular inspection and maintenance of fire detection and alarm systems, sprinklers, connections, smoke barriers, etc.
2. Regular building inspections to identify develop and enforce storage, housekeeping and debris removal and practices.
3. Exit signage installed throughout the hospital.
4. Signage for RACE, PASS and evacuation procedures are posted throughout the hospital.
5. A.F. Whitsitt tobacco free policy for A.F. Whitsitt property.

   The fire marshal performs a regular inspection and makes recommendations to compensate for significant fire hazards identified in the HVA.

Preparedness Strategies, Actions and Responsibilities

1. Every officer and employee shall acquaint themselves with the location of fire extinguishers, fire alarm boxes in their building. They shall familiarize themselves with operation and use of such apparatus.

2. Staff who are not in their immediate work area when the fire alarm is received should return immediately. Unit staff from other areas should report to the charge nurse of the affected unit to assist in the evacuation of consumers. CAUTION: Never leave any unit completely unattended. Unit staff (at least minimum staffing requirements) must remain with each unit.

3. Each unit supervisor is to make sure each and every employee under his/her supervision is familiar with the instructions and procedures contained in this fire procedure. A review of the contents of this plan should insure the safety of the consumers and staff should a fire/emergency occur.

4. Staff will receive orientation upon hire and annual updates in the proper use of fire extinguishers and other fire procedures. Additional in-service in fire procedures may be requested by Department Heads.

5. Fire watch procedures are implemented when necessary.

6. Fire drills held each quarter on each shift. Response to fire drills is evaluated for improvement.

7. Maintenance of lit exit signs and hazard free access and egress.

Preparedness through fire drills

1. The most essential point in the event of a fire is to have all consumers and staff quickly leave the building in an orderly and safe manner to reach a point of safety uninjured. To accomplish this it is necessary to have frequent drills that are planned, adequately supervised and properly coordinated.

2. When an actual fire occurs, the selection of the proper exit should be made without hesitation. Therefore, fire drills will be held on all shifts with no fixed time set and no advance notification given except for those staff normally given notice.

3. It is imperative that all staff be thoroughly familiar with the contents of this plan and to immediately execute them when it is required.

4. Since it is the essence of drills to represent actual fire conditions, staff and patients should not be allowed to obtain clothing or other articles or to loiter for any reason when the alarm is sounded. In the event of inclement weather, staff and patients may assemble at an exit – ready for evacuation if required.

5. In non-consumer occupied areas, upon hearing the alarm, staff will proceed with drill requirements.

6. It shall be the responsibility of unit staff to inspect exit facilities in order to make sure that all doors and other exits are in proper operating condition and to see that outside exits are free from obstructions, snow and ice, that may prevent rapid escape

Response Strategies, Actions and Responsibilities

R	**Rescue**	Remove persons from immediate danger and notify others in the area.
A	**Alarm**	Activate alarm by pulling the nearest fire alarm.
C	**Confine**	Confine the fire by closing doors and windows. If possible, turn off electric and gas appliances.
E	**Evacuate or Extinguish**	Proceeding to the nearest refuge area or exit and direct responding units to location of fire or extinguish only if you can do so without endangering yourself or others.

REMEMBER

When using a fire extinguisher, use the P.A.S.S. method

Pull Pin – Aim – Squeeze – Sweep

Upon receiving an alarm of fire by fire annunciator panel or telephone, the **Maintenance Unit Leader or Director**

1. Advise Safety Officer and Security via two-way radio, telephone or pager.
2. Announce “CODE RED.”
3. Set off fire siren by means of switch in hallways.
4. During working hours, announce the location of the fire on pager system continuously for the duration of the evacuation.
5. When directed by someone in authority, contact Kent County Emergency Operations Center (Central Alarm) on the direct line.

6. If fire is of significant nature, the following will be notified immediately by the **Communications/Information Technology Leader**:

    - Director
    - Clinical Director
    - Nursing Supervisor
    - Maintenance Supervisor

7. The Incident Commander contacts others as outlined in Internal Communications Procedures.

8. The Communications/Information Technology Leader stands by for placing emergency calls or establishing other communication as necessary. During the period of emergency, accept only emergency calls. Until 1-6 above have been completed, no calls will be handled.

9. Should the fire be of such magnitude that consumers must be relocated or essential services altered, the HICS/NIMS will be placed into effect and the staff will begin notification of additional staff in accordance with the plan. Center wide communication regarding the status of the fire, safety concerns, essential staff duties, etc. will be made as often and as widespread as communication devices are capable.

10. In the event of a fire in the A.F. Whitsitt Center, the operator will call Kent County Emergency Operations Center (Central Alarm) on the direct line and then evacuate. Refer to evacuation procedures. The Incident Command Center will be located in the Kent County Health Department.

CAUTION: When evacuation is necessary, all staff are to keep clear of all entrances to the affected building. Arriving fire department staff must have clear and unhampered access to the fire area. *Refer to evacuation procedures.*

Security

1. The Security officers will respond immediately to the fire area and insure communication has been made to the staff concerning the status of the fire.

2. Set up a perimeter for safe traffic and cordoning off affected area.

3. Upon completion, security shall control traffic insuring a clear passage for authorized emergency vehicles.

4. During evening hours, weekends and holidays, security will notify the Kent County Emergency Operations Center (Central Alarm) if so required.

Consumer Protection and Accounting

1. Organize consumers for evacuation near a safe exit.
2. If possible, attempt to extinguish the fire with a fire extinguisher located near the fire.
3. One person will take the list of consumers and the daily report before leaving the building in order to obtain a consumer count once they have been reassembled.

EVACUATION

Should the size of fire or density of smoke and heat require, quickly commence total evacuation of the building by the nearest safe exit. *Refer to evacuation procedures* – page 28

Recovery

1. The Center should be notified every time a fire occurs even if the fire is out. When a fire occurs, every effort shall be made to leave the area undisturbed until the Security staff have investigated.
2. Assess damage and utility functions. Inventory equipment and salvageable supplies. Clean smoke damage areas.

Dispose of food and other supplies that may have become contaminated.

3. Direct consumers, staff, visitors, and others that were in the hospital affected by the event for critical incident stress debriefing to the Psychological Support Unit Leader.
4. Evaluation of the event - deactivation, hotwash and post emergency reports

Threats to Homeland Security

Improving biosurveillance is one of the Governor's Core Goals for a Prepared Maryland. OP&R is leading the effort to enhance biosurveillance capabilities in the state of Maryland. OP&R conducts biosurveillance activities to detect the early presence of disease or illness which may be indicative of a threat to public health and well-being. Biosurveillance data sources are reviewed and analyzed on a daily basis – 24/7/365. Because of our proximity to the Washington, D.C. area, railroads, waterway traffic, military bases and nuclear facilities—all known targets for terrorist groups and because the preparedness is low (A.F. Whitsitt is not a medical facility) the hospital has been rated moderate on the hazard and vulnerability scale. The State of Maryland publishes weekly briefings on current Homeland Security status.

CODE BLACK – Weapons of Mass Destruction (WMD)

Bioterrorism Incident

Bioterrorism Incident (BTI), actual or suspected: either a threat of release of a biological agent, or a situation in which someone believes a biological agent of mass destruction has been or will be released. *Examples* include:

1. A phone call saying that a biological agent has been or will be released.

2. A note in a package or letter claiming that the person who opened the letter or package has been exposed to anthrax or some other agent.

3. An unknown substance, for example, an unlabeled powdery material, found in or near ventilation equipment (air ducts, blowers, air inlets, etc.)

4. A verified release of a biological agent as communicated by law enforcement or public safety authorities.

5. Upon suspicion of any possible bioterrorism, incident detection, notification and management procedures outlined in the attached Bioterrorism Readiness Plan.

6. Individuals involved in any incident will remain available to assist responders in the investigation.

7. Individuals involved may not leave campus until cleared by the Incident Commander or Kent County Emergency Operations Authority.

Mitigation Strategies, Actions and Responsibilities

Coordination with the Kent County Emergency Operations Center, Kent County Health Department, DHMH Emergency Planning

Preparedness Strategies, Actions and Responsibilities

1. Staff trained in safe mail handling procedures.

2. Staff trained in recognition of symptoms of biological disasters.

Response Strategies, Actions and Responsibilities

Immediate Procedures to be followed at the Scene for Specific Incidents:

(DO NOT PANIC)

Notify 911 immediately in all cases:

The principle is to minimize contact/exposure and keep the agent from spreading on surfaces or in the air. Therefore, if suspicion is noted while object still being held, place immediately in a plastic bag and double bag it. If the object is not in hand, leave it be, vacate the room, prevent re-entry, and call 911.Responders can move the object more safely with special protective equipment.

Prevention of Contamination from Anthrax Spores:

1. Administrative controls strategies will be adopted to limit the number of persons working at or near where mailbags are unloaded. Restrictions will be in place to limit the number of persons (including support staff and non-staff, e.g., contractors, business visitors) entering areas where aerosolized particles may be generated.

2. **Sanitations System Control Officers** controls mail-handling sites. **Sanitations System Control Officers** will not dry sweep or dry-dust in mail handling areas. These areas will be wet-cleaned and vacuumed with HEPA-equipped vacuum cleaners.

3. Personal protective equipment for workers in mail-handling sites. All staff who handle mail in mail-rooms or mail-sorting areas will wear protective, impermeable gloves. Staff may wear cotton gloves under their protective gloves for comfort and to prevent dermatitis. Latex gloves should be avoided because of the risk of developing skin sensitivity or allergy. Gloves will be provided in appropriate sizes to ensure proper fit.

4. The Kent County Health Department will determine the necessity to furnish approved respirators to mail handling areas for use by mail-handlers.

5. Staff working with mail should avoid touching their skin, eyes, or other mucous membranes since contaminated gloves may transfer anthrax spores to other body sites.

6. Staff should consider wearing long-sleeved clothing and long pants to protect exposed skin.

7. Staff may discard gloves and other personal protective clothing and equipment in the regular trash once they are removed or it they are visibly torn, unless a suspicious piece of mail is recognized and handled.

8. If a suspicious piece of mail is recognized and handled, the staff member's protective gear should be handled as potentially contaminated material and placed in a red plastic bag.

9. Staff should thoroughly wash hands with soap and water when removing, gloves, before eating, and when replacing torn or worn gloves. Soap and water will wash away most spores that may have contacted the skin; disinfectant solutions are not needed.

Unopened suspicious letter, letter that appears empty, or package marked with threatening message such as "ANTHRAX":

1. If still in hand, double bag envelope in plastic bags. (May use trash container, if that is all that is available.)
2. Prevent re-entry. Shelter in place until receiving further direction.
3. Exposed persons should stay together, shelter in place and away from non-exposed persons
4. Exposed persons should remain available to responders
5. Wash hands with SOAP and WATER
6. Notify supervisor immediately

Envelope with powder and powder spills out onto surface:

1. Do not clean up the powder.
2. Prevent re-entry.
3. Exposed persons should stay together and away from non-exposed persons
4. Exposed persons should remain available to responders
5. WASH hands with soap and water
6. Call 911
7. If clothing is heavily contaminated, carefully REMOVE it and place in plastic bag. DO NOT SHAKE CLOTHING TO MINIMIZE the SPREAD OF POTENTIAL AGENT. Avoid contaminating others!
8. Emergency responders will direct affected person(s) to Kent County De-Con Van.
9. PUT ON fresh clothing.

Aerosolization, or letter stating "anthrax in heating system":

1. Vacate ROOM IMMEDIATELY and prevent re-entry.
2. Exposed persons should stay together and away from non-exposed persons Shelter in place.
3. Exposed persons should remain available to responders.
4. Notify 911.
5. Cooperate fully with Incident Command staff, including police, fire, and emergency response staff. Provide access to buildings to emergency response staff.

Immediately notify:

1. Director, and the following individuals, in order:
    a. The Clinical Director
    b. the R.N. Manager,

c. the Maintenance Unit Leader
d. the Director of Nursing,
e. the Safety and Security Officer
f. the physician

2. Implement notification procedures specified in plan as directed by the **Incident Commander**.

Incident Commander

1. Directs all facility resources to ensure an effective response.
2. With consultation by the physician, determine whether exposed staff should be removed to a safe area and determine the location of that area, if needed.
3. Authorize release of exposed persons and return of staff into affected area.
4. Contact the Kent County Health Department or CCEDE for immediate testing of the area.

A.F. Whitsitt Center Police/Security

1. Respond to site.
2. Secure areas.
3. Make a list of all the people who were in the area at the time and give to appropriate authorities.
4. Coordinate with operator to maintain liaison with the Incident Commander and maintain continuous control of the site.

Safety and Security Officer

1. Respond to site.
2. Assess situation with Incident Commander and determine the level of response.
3. Contact the Kent County Health Department with evaluation of situation.
4. Use appropriate equipment and materials to remove or control suspicious items or affected area as determined by Kent County Health Department.
5. Determine necessity of shutting down air handling system and direct shut down if needed.
6. Direct exposed persons to safe area determined in consultation with Incident Commander.
7. No person who may have been exposed should be released to resume their normal activities, or released from the facility, until an authorization to leave is given by the Incident Commander or Kent County Health Department.

R.N. Manager

1. Minimize panic by clearly explaining risks, offering careful but rapid medical

evaluation/treatment, and avoiding unnecessary isolation or quarantine.

2. Treat anxiety in unexposed persons who are experiencing somatic symptoms (e.g., with reassurance, or diazepam-like anxiolytics as indicated for acute relief of those who do not respond to reassurance).

3. For up-to-date information and recommendations for therapy, contact the local and state health department and the CDC.

Recovery

1. Decontaminate and inventory equipment and salvageable supplies.
2. Contaminated waste should be sorted and discarded according to A.F. Whitsitt Center's Preventative Health and Infection Control Department Disposal of Infectious Waste Policy and direction from the Health Department.
3. Assess the environment for hazards related to the event.
4. Dispose of food and other supplies that may have become damaged.
5. Direct consumers, staff and visitors who may need critical incident stress debriefing to appropriate unit.
6. Evaluation of the event - deactivation, hotwash and post emergency reports

Nuclear, Chemical or Radiological

Nuclear – an outcome from nuclear fission created by a nuclear bomb, producing a mushroom cloud, extreme heat, wind and radiation. It can affect several miles in one detonation.
Chemical – The use of chemicals such as Serine, mustard and other gases, and chemicals into the air, food or water systems with the express intent of killing people.
Radiological – The intentional release of radiation sources into the air to intentionally kill and/or maim people.

Mitigation Strategies, Actions and Responsibilities

Established Liaison with Kent County Emergency Operations Center and other outside agencies as required by state and federal regulations.

Staff Trained to be vigilant of your surroundings at all times and to be aware of suspicious persons or activities, public disputes and confrontations and report them to the proper authorities by calling 911.

In addition, all staff should:

- Carry a photo ID showing your blood type and any special medical conditions.
- Refrain from unnecessarily divulging home address, phone number, or family information.
- Increase security and awareness at the center and other public facilities.
- Be alert to vehicles left unattended.
- Be aware of unattended packages, briefcases and other suspicious looking objects, including delivery procedures.
- Be alert to letters and parcels that may be dangerous and should be treated with care.
- Be aware of surroundings, including emergency exits and larger gatherings.

Preparedness Strategies, Actions and Responsibilities

· Conduct Community wide Drills utilizing HICS/NIMS
· Staff Reserve Pool
· Maintain adequate emergency supplies; food, water, emergency beds, pharmaceuticals, etc.
· Coordination with community EMS
· Personal protective equipment, gloves, face shields, PAPRs, etc.
· Haz-mat equipment
· Staff training: recognition of suspicious material and appropriate response.
· Staff training in Emergency Operations Plan and CODE BLACK procedures.
· Standard Precautions
· Prophylaxis as recommended by the CDC. Current guidelines will be followed
· Threat Level Orange or Red A.F. Whitsitt Center fleet should never let the gas tank go below ½ and if at all possible should keep them full

Response Strategies, Actions and Responsibilities

1. Upon the confirmation that a nuclear, chemical or radiological attack has taken place, the Communications/Communications/Information Technology Leader and/or operator shall, through computer email blast, telephone and hospital siren, announce a “CODE BLACK.”

2. The Director or Incident Commander in his/her stead, shall immediately institute the Emergency Operations Plan and set up the Incident Command Center. All patients shall be immediately accounted for and returned to the facility if possible. An immediate lockdown of the center grounds shall be instituted by Police and Security officers.

3. In a chemical attack, the Maintenance Unit Leader or R.N. Manager shall call 911 to summon the Kent County Health Department and advise the need for the County Chemical Decontamination Unit.

4. In nuclear and radiological attack, all staff and consumers should be given Potassium Iodide (KI) according to proper dosing requirements and await instruction from county authorities.

5. If radiological plume is approaching the campus, immediate evacuation should take place moving in a 90º angle to the approaching plume.

6. When at Homeland Security threat level orange or red we will close off all exits and keep one open with security checks. The exit left open will be decided with tenants and neighbors input.

7. *Refer to General Triage and Evacuation*

Recovery

- Authorities identify and seal off highly radioactive areas.
- Decontaminate and inventory equipment and salvageable supplies
- Disposal of clothing
- Clean rooms
- Dispose of food and other supplies that may have become contaminated or was identified as the contaminant.
- Direct consumers, staff and visitors who may need critical incident stress debriefing to appropriate unit
- Post exposure management requires extensive, long term care; mostly due to exposure to external radiation.
- Evaluation of the event - deactivation, hotwash and post emergency reports

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Kent County
Health Department

Infectious Disease Plan

Version 2.0

January 2020

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i.REVISIONS

Date	Sections Revised	Page #	Name (printed)	Signature

ii.ACRONYMS

CDC	Centers for Disease Control and Prevention
CHE	Catastrophic Health Emergency
CISM	Critical Incident Stress Management
COMAR	Code of Maryland Regulations
COOP	Continuity of Operations
DBM	Department of Budget and Management
DGS	Department of General Service
DHR	Department of Human Resources
DNR	Department of Natural Resources
DOC	Departmental Operations Center
EMAC	Emergency Management Assistance Compact
eMCM	emergency Medical Countermeasure
eMEDS	electronic Maryland Emergency Medical Services Data System
EMS	Emergency Medical Services
EMSOP	Emergency Medical Services Operational Program
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
ESF	Emergency Support Function
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
HAI	Healthcare Associated Infection
HHS	Department of Health and Human Services
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSEEP	Homeland Security Exercise and Evaluation Program
ICS	Incident Command System
IDEORB	Infectious Disease Epidemiology and Outbreak Response Bureau

IND	Investigational New Drug
JIC	Joint Information Center
KCHD	Kent County Health Department
MCM	Medical Countermeasure
MD NBS	Maryland NEDSS Base System
MDA	Maryland Department of Agriculture
MDE	Maryland Department of the Environment
MDH	Maryland Department of Health
MEMA	Maryland Emergency Management Agency
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MSP	Maryland State Police
NEDSS	National Electronic Disease Surveillance System (NEDSS)
NIMS	National Incident Management System
OP&R	MDH Office of Preparedness and Response
OSHA	Occupational Safety and Health Administration
POE	Ports of Entry
PPE	Personal Protective Equipment
PUI	Person Under Investigation
SCO	State Coordinating Officer
SEOC	State Emergency Operations Center
SNS	Strategic National Stockpile
SOP	Standard Operating Procedures
USDA	United States Department of Agricultur

iii.DEFINITIONS

Bioterrorism: The deliberate use of infectious agents to sicken or kill people. Bioterrorism can involve a range of agents, including bacteria, viruses, and toxins, and can potentially result in high morbidity and mortality in a short time period.

Catastrophic Public Health Emergency: An urgent and critical situation of a temporary nature that seriously endangers the lives, health and/or safety of the population. It would require prompt action beyond normal procedures to prevent or limit health consequences to the affected population. Such events are usually promptly recognized and lead to the initiation of emergency responses by virtually all involved authorities. (See Table 2 regarding legal authorities for non-pharmaceutical interventions.)

Emerging Infectious Disease: An infectious disease that has newly appeared in a population or has existed previously in a population but is rapidly increasing in incidence or geographic range.

Endemic: The constant presence of a pathogen or health condition within a given geographic area or population.

Infectious Disease: Diseases caused by pathogenic microorganisms, such as bacteria, viruses, parasites, or fungi.

Infectious Disease Emergency: When an infectious disease has the potential to significantly impact a community, and requires a response beyond the normal capabilities of the responsible agencies. An infectious disease emergency may exist in the absence of a declared State of Emergency.

Infectious Disease Outbreak: The occurrence of more cases of an infectious disease or condition than expected in a given area or among a specific group of persons during a specific period. Usually, the cases are presumed to have a common cause or to be related to one another in some way. Reference the outbreak definitions as specified in COMAR 10.06.01.02(B)(18).

Novel Pathogen: A pathogen that was previously unknown or has never previously infected humans; it is likely that the majority of the population will be susceptible to the pathogen.

State of Emergency: The Governor declares a State of Emergency when it is believed that a disaster has occurred or may be imminent and is severe enough to require state aid to supplement local resources in preventing or mitigating damages, loss, hardship or suffering. This declaration gives state government broad powers to make resources immediately available to assist in a response.

Zoonotic Disease: An infectious disease that can be transmitted between animals and humans.

I. INTRODUCTION

A. MISSION

The mission of the Maryland Department of Health (MDH) and the Kent County Health Departments (KCHD) during an infectious disease outbreak or emergency is to:

- Detect and monitor the occurrence of cases or outbreaks of infectious diseases of public health significance
- Prevent disease transmission and reduce morbidity and mortality related to infectious disease
- Provide community partners with guidance and assistance for infectious disease management and control including diagnosis, treatment, prophylaxis, infection control, and isolation and quarantine
- Provide the coordination, centralization, and facilitation of multi-agency support and resources

II. OVERVIEW

A. PURPOSE

The purpose of this document is to provide a framework for the coordination of local, state, and federal efforts to prevent, control, and/or stop the spread of infectious diseases. The plan addresses public health responsibilities for state and local organizations during infectious disease outbreaks and emergencies.

B. SCOPE

The Maryland Infectious Disease Response Plan is scalable and applicable to any infectious disease emergency of public health significance. Typically, activation of this plan occurs when an infectious disease outbreak has the potential to significantly impact a community and requires a response beyond the normal capabilities of the KCHD. However, even if a disease detected in the community does not stretch the capabilities of the KCHD, activation of this plan may still be advisable.

This plan also may be activated when no disease has been detected in the community or the State of Maryland, but there is the threat of an infectious disease emergency to the state or a jurisdiction. The following may increase the likelihood of plan activation:

- A lack of scientific knowledge about the etiology of the disease
- Novelty of the disease or pathogen
- Greater transmissibility and communicability of the disease
- Unavailable countermeasures
- Heightened media attention

C. SITUATION

An infectious disease outbreak is typically a cluster of cases of a disease that occurs in individuals who are epidemiologically linked (share connections by person, place, or time). The number of cases indicating an outbreak can vary based on the infectious agent, the size and type of the population exposed, and the time and place of the occurrences.

An infectious disease outbreak may become an infectious disease emergency when it has the potential to significantly affect a community and requires a response beyond the normal capabilities of the KCHD or other responsible agency.

An infectious disease emergency may involve: a) an infectious disease that is novel or new to a geographic area; b) an existing infectious disease that is causing a marked increase in cases or geographic spread; or c) a biological agent used to cause harm or death in a population (bioterrorism).

An infectious disease that is novel or new to a geographic area often requires a rapid public health response. The population may not have an inherent resistance to the disease, and many people may become ill quickly. Early public communication and education is critical during infectious disease response, even when public health authorities are not sure what is causing illness or how it is spreading. Honest, open risk communication will help partners and the public take appropriate actions. It will also build trust as more is learned about the disease, and as countermeasures are made available.

Known infectious diseases may have countermeasures such as vaccines, antibiotics, or antiviral treatments, but the diseases can cause illness in areas where these countermeasures are not available, or not used widely enough to prevent the spread of the disease. Genetic mutations in infectious agents can result in resistance to existing countermeasures, which may also cause an infectious disease emergency.

While there are many different ways an infectious disease may be introduced to a population, the method of transmission and communicability shapes the nature of the public health response. Respiratory diseases such as influenza may be quickly spread through social contact, requiring social distancing measures. Hemorrhagic fevers and related diseases such as Ebola Virus Disease (EVD) that are spread through infected body fluids necessitate strict guidelines for patient care and the use of personal protective equipment. Other diseases transmitted through sexual contact and other body fluid exchanges require targeted education and outreach to change infection-spreading

behaviors. Vector-borne diseases call for public education on protective actions, and possible vector-control measures.

In addition to disease transmission and communicability, other factors may shape infectious disease emergency response. Public concern, which is often driven by media coverage, as well as political considerations, can elevate the urgency and level of response required.

This plan will address response protocols for various types of infectious disease scenarios, while the annexes will provide disease-specific guidance and plans, as well as other plans related to infectious disease response.

D. ASSUMPTIONS

- Infectious disease emergencies may occur with little to no warning.
- Electronic surveillance may not always detect or connect illnesses or events until an outbreak is occurring. It is possible that community partners will be the first to identify an infectious disease emergency.
- Increased access to international travel may result in the introduction of a novel infectious agent and lead to an infectious disease emergency.
- KCHD is responsible for initial investigation and control of infectious disease emergencies in their jurisdiction, but can request assistance from partner agencies, including MDH, as needed.
- MDH will use Centers for Disease Control and Prevention (CDC) guidance and other best practices to inform their actions and inform KCHD response and community partner actions through Health Officer Memos, clinician letters, and other communications.
- Risk communication will be an essential part of the public health response, to spread information and to dispel myths and misinformation.
- Multi-jurisdictional infectious disease emergencies will be coordinated according to existing emergency operations plans, and Emergency Support Function 8 (Public Health and Medical Services) partners will be activated, as required.
- Infectious disease emergency response will incorporate the use of ICS/NIMS.
- Infectious disease emergencies caused by bioterrorism will immediately require a federal response, and related disease investigations will require cooperation with federal authorities.
- An infectious disease response requiring social distancing and quarantine measures may involve law enforcement assistance to enforce quarantine orders. Law enforcement assistance may also be requested to provide protection from

discrimination and violence against suspected patients, contacts, and others who might transmit an infectious disease.

- The number of ill people in an infectious disease emergency could initially overwhelm public health, first responders, and health care resources, resulting in a need for local and state emergency operations center activation to manage resource requests.
- An infectious disease emergency could significantly reduce the number of public health and healthcare partners available to assist due to illness, family illness, and fear of infection, which may trigger the activation of COOP plans.
- The characteristics of the infectious disease, such as severity, virulence, affected populations, and symptoms, may vary and change through the course of the emergency.
- The infectious agent may undergo genetic changes, and these mutations may affect the response.
- Vaccines and other countermeasures may exist but may not be available in sufficient quantities to meet the need during an emergency, and they may not be effective if the infectious agent mutates significantly.
- It may take several months to develop countermeasures for a novel infectious disease.
- Countermeasures may need to be distributed to certain priority groups as determined by public health and other authorities.
- Infectious disease emergencies may cause stress and fear, which may require behavioral health support for affected individuals, their families, and other members of the community.

III. CONCEPT OF OPERATIONS

A. PREPAREDNESS

Effective preparedness includes establishing plans, policies, and procedures; training and exercising periodically to identify gaps; acquiring adequate resources to be available during a response; and establishing risk communication messages and protocols.

1. General Activities
    - Develop, exercise, evaluate and update infectious disease response plans;
    - Train and equip sufficient numbers of staff to assure competencies and capacities needed to respond to an infectious disease emergency;
    - Develop strategic partnerships with local community health care partners and providers along with local, state and federal response agencies and their staff;

- Assess surveillance and reporting procedures/strategies to ensure ongoing capability to detect illness patterns in the population;
- Educate stakeholders about infectious disease and recommend protective measures;
- Establish a Risk Communications Plan that addresses a variety of potential infectious disease threats;
- Inform and update stakeholders about the potential impacts of an infectious disease outbreak or emergency on providing essential services and on city, county, and school infrastructure;
- Stockpile necessary equipment and supplies that will be needed to respond to an infectious disease emergency;
- Maintain contact systems in each local health department, as well as epidemiology, laboratory, preparedness and response planners and informatics teams at MDH, for availability on a 24/7 basis, 365 days per year; and
- Document and update all emergency contact phone numbers and systems on a regular basis within specified locations of local and state communication networks.

2. Reportable Conditions:
   Disease in Humans:
   Reporting cases of known or suspected infectious diseases to public health authorities in Maryland serves to protect the public's health by ensuring the proper identification and follow-up of cases. Public health workers at both local and state levels follow individual cases to ensure proper treatment, identify potential sources of infection, and provide education to reduce the risk of transmission, identify susceptible contacts, and take other measures aimed at reducing the spread of disease.

   Additionally, Maryland Code Health-Gen. §§ 18-201, 18-202, and 18-205 require that healthcare providers, clinical laboratories, health care facilities, and others report specific disease conditions to local and state health authorities.

   Reportable diseases and conditions list in Maryland by Healthcare Providers:
   https://phpa.health.maryland.gov/IDEHASharedDocuments/ReportableDisease_HCP.pdf

   Disease/Conditions Specific Forms:
   https://phpa.health.maryland.gov/Pages/disease-conditions-case-report-forms.aspx

Maryland Confidential Morbidity Report (MDH1140): to report an infectious disease that endangers public health and has been designated by the MDH Secretary as report at:
https://phpa.health.maryland.gov/Documents/DHMH-1140_MorbidityReport.pdf

Infectious Disease Fact sheets:
https://phpa.health.maryland.gov/Pages/fact-sheets.aspx

Guidelines for long term care, daycares, schools, shelters:
https://phpa.health.maryland.gov/Pages/guidelines.aspx

Disease in Animals:
Local health departments are required to investigate reports of contagious or infectious disease of livestock or poultry. Furthermore, local health departments and veterinarians are required to report contagious or infectious diseases among livestock or poultry to the Secretary of Agriculture under Md. Code Agriculture § 3-104. Veterinarians may be required to report certain illnesses or diseases in animals to the MDH Secretary. Md. Code Health-Gen. §18-904(b)(6).

B. RESPONSE

1. Notification and Communication
   KCHD is the primary point of contact for confirmed or suspected cases of reportable disease. KCHD maintains a functioning 24/7/365 contact system. The MDH works with the KCHD to maintain, periodically test, and publicly post an up-to-date list of these contact phone numbers.

   Following notification of Health Officer, KCHD will notify the appropriate state-level staff within MDH, which maintains procedures for having a person available to contact 24/7/365.

   KCHD has redundant communication platforms that are found in the All Hazards Plan, Command Center Guidance. The Maryland Health Alert Network automatic system is used for quick notification of Command Center staff, nurses, and all staff if needed.

2. Public Health Surveillance and Epidemiological Investigation
   The goals of routine infectious disease surveillance and investigation are:
   - To detect disease, initiate case and contact investigations, and determine the source of infectious diseases in accordance with reportable conditions, reporting requirements, and recommendations

- To ensure early detection of clusters of disease that might signal an infectious disease outbreak
- To inform and assist local, state, and federal agencies involved in detection, investigation, and control of infectious diseases including monitoring the effectiveness of interventions

3. Surveillance Platforms:
   The Maryland Department of Health uses several platforms to conduct infectious disease surveillance including:

   NEDSS and MD NBS:
   The National Electronic Disease Surveillance System (NEDSS) is a system designed to facilitate electronic transfer of public health surveillance data from the healthcare system to public health departments. The Maryland NEDSS Base System (NBS) is built to meet the national standards defined by the CDC Public Health Information Network (PHIN) and NEDSS. The MD NBS system is used by state and local health department staff to store and share case records for the purpose of electronic disease surveillance for all infectious disease conditions that are "reportable" in Maryland.

   PRISM:
   Patient Reporting Investigating Surveillance Manager (PRISM) is used by state and local health department staff to report chlamydia, gonorrhea, and syphilis morbidity and monitor STI and HIV partner services case management activities performed by Disease Intervention Specialists (DIS).

   ESSENCE:
   The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) is a web-based platform used in Maryland for syndromic surveillance. The system is designed for the early detection of disease outbreaks, suspicious patterns of illness, and public health emergencies. ESSENCE incorporates traditional and non-traditional health indicators from multiple data sources (e.g. emergency department chief complaints, over-the-counter medication sales, and poison control center data). Data are categorized into syndromes to detect aberrations in the expected level of disease. Automated statistical algorithms are run on each syndrome and alerts are generated when the observed counts are higher than expected.

   ImmuNet:

The Maryland ImmuNet is a computerized Internet database application that was developed to record and track immunization dates of Maryland children and adults. It is a free web based system that any health provider can utilize through the State of Maryland. It provides assistance in keeping everyone on track for their recommended immunizations to help eliminate vaccine preventable diseases. It also works to prevent over immunization, which may occur when healthcare providers are unaware of immunizations administered by other providers. During a vaccine preventable disease outbreak, it can help surveillance staff to determine who is at risk based on an individual's immunization history.

Cluster Investigations and PulseNet:
A cluster of infectious disease may be identified either by report or by review of routine surveillance data if there is an unusual occurrence of more than one case of an infectious disease epidemiologically linked by person, place, or time. PulseNet is a network of laboratories that use Pulsed-field gel electrophoresis (PFGE) to create DNA fingerprints for foodborne pathogens. These fingerprints are used to detect clusters of illness associated with these pathogens. State, local, and federal labs upload PFGE patterns to the database. Patterns with higher than normal incidence are identified and investigations initiated. Local clusters in Maryland are investigated by IDEORB and Laboratories Administration staff and are routinely discussed.

3. Public Health Surveillance
   Regular reporting of disease data by all institutions that see patients (or test specimens) and are part of a reporting network is called passive surveillance.
   - Monitors national surveillance via CDC Health Alert Network (alerts, advisories), National News, Morbidity and Mortality Weekly Report, and the National Electronic Disease Surveillance System.
   - Monitors state surveillance via Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE), ESSENCE School Absenteeism, Results of Laboratory specimens, MDH's Health Officer Memos, Weekly Public Health Preparedness and Situational Awareness Report, Maryland Weekly Influenza Surveillance Activity Report, Cold-Related Illness Surveillance Report and Heat-Related Illness Surveillance Report.

   Active Surveillance
   Enhanced surveillance measures, direct monitoring and controlling, may be enacted in the presence of one or more persons meeting outbreak reporting or case definition. These enhanced (active) surveillance measures may include:

- Conducts and monitors local surveillance daily/weekly or as needed via telephone contacts and/or in person with hospital (Infection Control Practitioners, Laboratory and Emergency Room), Emergency Medical Servcies (EMS), Long Term Care Facilities and physicians.
- Contact schools (public, private college), daycares, long- term care facilities, correctional facilities as listed on the Healthcare Emergency Response Coalition (HERC) directory using email or HAN alert.
- Heighten monitoring of high-risk populations. Focus investigation on groups most likely at risk for severe outcomes or causing severe impact to the community (guidance from the CDC and MDH).
- Other active surveillance activities include pharmacies and dentists.
- Reports any unusual surveillance data and trends to Health Officer.

4. Case Identification and Investigation
    - A case definition must be established before the start of case screening and case investigations. Case classifications (e.g. confirmed, suspect or probable cases) may also be defined as appropriate. Case definitions and case classifications may change over the course of an outbreak or emergency, as more information is gathered about the disease and the situation.
    - Screening a population at risk for disease can identify persons potentially infected or infectious with the implicated disease.
    - In a public health emergency, surveillance can be enhanced by changing methods used to screen persons at risk (e.g. use of more specific or less specific screening criteria), screening of healthcare workers, visitors and patients in healthcare facilities, and screening of departing and/or arriving travelers.
    - Collecting uniform screening data is critical for consistent implementation of public health interventions and epidemiologic analysis.
    - Investigations that involve direct contact with potentially infected persons should always be conducted using appropriate personal protective equipment and infection control precautions.
    - Case investigation may require collection of data from multiple sources, which may include:
        - Patient interviews
        - Interviews with patient proxies
        - Medical record review
        - Employment records and workplace information
        - Transportation records such as flight passenger manifests
        - Information from other agencies and partners

Data elements in a case reporting form should include, at a minimum:

- Case demographics and contact information
- Clinical information including symptoms and dates of onset
- Risk factors for exposure including high risk setting (e.g. daycare, patient care, food service)
- Contacts and travel during infectious period, including dates and locations
- Laboratory data
- Case classification
- Food history, if suspected foodborne illness emergency

Case investigation data collected at the local and regional level should be directed to MDH, Infectious Disease Epidemiology and Outbreak Response Bureau (IDEORB), during multi-jurisdictional outbreaks.

Data should be entered into a standard case report or investigation form developed or modified for the specific situation.

5. Source Investigation

   Attempts to identify the source of an infectious disease outbreak or emergency may include epidemiologic studies, environmental sampling and testing, clinical specimen collection and testing, plan or protocol review, and/or review of logs or documentation of routine processes. Resources may be deployed at the local, state, or federal level to conduct these activities. Methods will vary depending on the disease, suspected source of infection, and nature of the suspected or confirmed pathogen.

   Investigation of potential sources of infection in a public health emergency may require collaboration among multiple agencies. State and local public health will collaborate with agencies appropriate to the nature of the threat. Partner agencies should be cooperative and willing to disclose relevant information during such investigations to identify the source and subsequently intervene and implement appropriate control measures.

   Partner agencies may include:

   - Maryland Department of Agriculture (MDA)
   - Department of Natural Resources (DNR)
   - Food and Drug Administration (FDA)
   - U.S. Department of Agriculture (USDA), for trace-back and investigation of food or animal sources

- Federal, State and local law enforcement for forensic investigations of intentional events
- CDC for suspected importation by travel

6. Contact Investigation and Management
   KCHD will lead contact investigations with the assistance of MDH, IDEORB staff and other agencies as needed, especially if multiple jurisdictions are involved. Contact investigations are extremely resource intensive and pre-event planning should identify investigative teams with personnel skilled in:
   - Contact tracing
   - Interviewing
   - Data management
   - Evaluation and monitoring of contacts

   Identification of contacts may include:
   - Members of the case's household, workplace, social network, and others who might be able to provide identifying and/or locating information
   - Mass gatherings and public spaces or events (schools, malls, concerts, churches, etc.)
   - Vessels for transportation (trains, planes, ships, etc.)
   - Collection forms for information on contacts to be developed ad hoc dependent upon existing information regarding the infectious disease. An existing case investigation forms may be used to collect the same information from contacts.

7. Monitoring Potentially Exposed Persons
   For certain infectious diseases of concern, the public health authority (KCHD or MDH) assumes responsibility for establishing and maintaining communication with potentially exposed people, or monitorees, in accordance with guidance issued by CDC and MDH. The purpose of monitoring is to prevent the infectious disease of concern from spreading by ensuring that monitorees receive appropriate healthcare if they develop any symptoms. The monitoring period will vary depending on the infectious disease of concern.

   Local and state health department responsibilities may include:
   - Establishing contact with potentially exposed persons and verifying contact information and addresses
   - Establishing a process to obtain information such as symptoms and travel plans during the monitoring period

- Confirming details of potential exposure including the date of the last contact with the source of infection
- Contacting monitorees with a frequency appropriate to the risk level, types of exposure, and disease of concern
- Coordinating the transfer of monitoring responsibilities to the appropriate jurisdiction if monitoree is traveling during monitoring period
- Coordinating with MDHIDEORB, healthcare facilities, and other partners to arrange healthcare evaluation if the monitoree becomes symptomatic
- Conducting home visits of monitorees lost to follow up during monitoring period
- Recording monitoring information using forms provided by CDC or MDH and entering data into a line list or database provided by MDH

Types of Monitoring

- Active Monitoring - the monitoree reports symptoms status to the public health authority on a regular basis
- Direct Active Monitoring - the public health authority directly observes the monitoree to review symptom status and monitor health on a regular basis
- Self-Monitoring - monitorees watch their health for possible symptoms consistent with infection of concern; there is no regular contact with the public health authority

Symptomatic Potentially Exposed Persons:
Any individual with possible symptoms consistent with infection of concern should be reported to MDH IDEORB. KCHD and MDH, and other partners will arrange healthcare evaluation as appropriate. These individuals are referred to as Persons Under Investigation (PUIs).

Whenever possible, PUIs should be referred to pre-identified facilities that have the capability and are prepared to isolate and treat PUIs. Any individual needing emergency medical treatment should report to the nearest emergency facility immediately.

8. Public Health Laboratory Testing

   Notification and Receiving:
   Staff of the MDH Laboratories Administration, Office of Laboratory Emergency Preparedness & Response and IDEORB work together to ensure the ability to receive notification of urgent lab testing requirements and coordinate arrival of specimens needing immediate action, 24 hours a day, 365 days per year. Laboratory staff maintain a 24/7/365 on-call schedule.

   Specimen Collection and Testing:
   Specimen collection and testing will be done in coordination between the KCHD and MDH, unless other arrangements are made. The type of specimen needed and type

of collection kit will vary based on the infectious agent. At the start of an outbreak or emergency, many specimens may be collected to better characterize the pathogen. CDC and MDH will issue specific guidance on specimen collection and packaging.

Epidemiology and Laboratory Coordination:
MDHIDEORB staff notify laboratory staff of incoming specimens, special instructions, and other pertinent information related to specimens arriving at the MDH Laboratories Administration.

For additional guidance regarding MDH laboratory testing:

- MDH Laboratory Administration site: http://MDH.maryland.gov/laboratories/Pages/home.aspx

- MDH Laboratory Administration Guide to Public Health Laboratory Services: http://MDH.maryland.gov/laboratories/docs/guide.pdf

- MDH Laboratory Serological Testing Form: http://MDH.maryland.gov/laboratories/docs/Serological%20Testing.pdf

9. Non-Pharmaceutical Interventions

Non-pharmaceutical interventions are non-medical strategies and recommendations for reducing the spread of an infectious disease, by decreasing contact between uninfected and infected individuals. Strategies may include personal hygiene (hand washing) and other protective behaviors, social distancing measures such as canceling events or closing facilities, restrictions on movement and travel advisories and warnings, and isolation and quarantine. Non-pharmaceutical interventions may be recommended or required, and may target individuals, families, or entire communities.

Non-pharmaceutical interventions may be critical in preparing for, responding to, and recovering from an outbreak or infectious disease emergency, especially if vaccine and antimicrobial or antiviral drugs are unavailable, in limited supply, or ineffective.

While the timely adoption of non-pharmaceutical interventions is expected to reduce transmission of an infectious disease, and limit morbidity and mortality rates, they are not always perceived positively. MDH and KCHD must use surveillance, laboratory testing, epidemiologic and clinical data to identify the most appropriate non- pharmaceutical measures to minimize the spread of disease as well as disruption to the community.

Planning Responsibilities for Non-Pharmaceutical Intervention Strategies:

MDH and KCHD will:

- Collaborate with local entities, state agencies, other states, military, and federal partners in non-pharmaceutical intervention planning.
- Encourage local jurisdictions to identify community partners such as educational facilities, public gathering sites, corporations, businesses, faith-based organizations, community centers, etc. that may be impacted by the implementation of social distancing strategies.
- Review procedures, forms, laws, and statutes related to suspension of rules and necessary limitations of freedoms to contain an outbreak or emergency.
- Assist state and local school system leadership in outbreak and emergency planning regarding:
    - Triggers for school closures,
    - Plans for parent/guardian notification,
    - Business continuity planning,
    - Distance learning,
    - Education of staff, parents, and students
    - Continued communications during dismissal period
    - Continuation or cancellation of extramural school activities
- Identify non-pharmaceutical interventions relevant to jurisdictional needs and capacity.
- Develop and disseminate educational information and materials about social distancing and other non-pharmaceutical intervention strategies.
- Work with healthcare providers to increase the number of individuals receiving seasonal/routine vaccinations, especially among target groups including those identified for maintaining critical infrastructure, health care workers, schoolchildren, and persons at high risk for secondary infections.
- Work with healthcare providers to develop plans for management of community containment strategies to include:
    - Education about when and how to seek emergency and non-emergency medical care
    - Tools for triage for both professionals and the general public regarding follow-up of known or suspected cases of illness
- Coordinate with and educate partners and stakeholders who may be involved in enforcing isolation or quarantine orders.
- Work with CDC to develop travel-related containment measures to include drafting Ports of Entry (POE) infectious disease response plans. Plans should include: establishing and maintaining quarantine facilities, screening passengers,

providing treatment and referral to ill persons, arranging the conditional release of exposed persons, and coordinating public and media communication.

- Brief governor and state legislature leadership as requested.
- Educate the public about providing care to ill household contacts and seeking medical care.
- Work with appropriate partners to develop Standard Operating Procedures (SOPs) for ensuring the availability and distribution of medications, vaccine, and other subsistence items to households in isolation or quarantine in the jurisdiction.
- Conduct Homeland Security Exercise and Evaluation Program (HSEEP)-compliant exercises of those strategies.
    - Revise strategies, plans, and SOPs as appropriate based on after-action reports of the exercises.

Maryland Leadership Authorities Matrix for Non-Pharmaceutical Intervention Strategies

Taking into account the complex issues associated with implementing various non-pharmaceutical interventions, the MDH and KCHD have created a Leadership Decision Matrix (Table 1) to help clarify issues and guide decision-makers. This table outlines critical non-pharmaceutical intervention strategies that could be implemented. Table 2 indicates the person or persons who have the authority to implement the given strategy.

Table 1 Maryland Leadership Authorities Matrix for Non-Pharmaceutical Intervention Strategies A = Authority E = Enforce

Intervention Strategy / Decision	Governor	MDHSecretary of Health	Local Health Officer	County Executive/ Mayor	Circuit Court[1]	School Board	State/Local Law Enforcement
Declaration of Catastrophic Health Emergency (CHE)	A						
Declaration of State of Emergency	A			A			
Restrictions of Movement							
• Isolation of Person	A	A	A		A		E
• Quarantine of Person	A	A	A		A		E[2]
• Group Quarantine	A	A	A		A		E
• Area Quarantine	A		A				E
• Isolation and Quarantine w/o Emergency Declaration		A	A		A		E
Curfew							
• Declare a Curfew	A			A			E
• Declaring/Enforcing w/o Emergency Declaration				A[3]			E
Closure of Public Places							
• Businesses	A		A	A			E
• Schools	A		A	A[4]		A	E
• Public Events	A		A	A			E
• Closing of public places w/o Emergency Declaration	A		A				E

[1] When someone is ordered into isolation or quarantine, that person may appeal to the Circuit Court, which in turn may affirm or deny the appeal.
[2] When acting to prevent a CHE, the MDH Secretary has the power and authority to order any law enforcement office at the state or local level to carry out isolation and quarantine orders. Md. Code Health-Gen. § 18-905(a)(3).
[3] The County Executive/Mayor can declare a curfew in absence of a declared emergency in some counties; however, this applies only to juveniles. Local codes should be consulted also.
[4] The Maryland Code itself does not allow the County Executive to close schools; however, this could be a local jurisdictional authority.

Table 2 Legal Authorities Pertaining to Non-Pharmaceutical Interventions

Intervention/Strategy	Legal Authority
Declaration of Catastrophic Health Emergency (CHE)	Pub. Safety §14-3A-02
Declaration of State of Emergency	Pub. Safety §§14-101 et seq.; 14-301 et seq. ; Pub. Safety §14-111[5]
Isolation or Quarantine of a Person or Group	Pub. Safety §14-3A-03(b)(3)(iv) (during CHE w/ Gov. order); Health-Gen § 3-306(f) (Health Officer under MDH Sec. direction); Pub. Safety 14-3A-05 (Circuit Court upon appeal); Health Gen. §18-906(b) (upon appeal); Health-Gen §18-905(a)(3)(law enforcement before or during CHE)
Area Quarantine	Pub. Safety §14-107(d)(1)(i), (ii), (iv) (St. of Em.); Pub. Safety §14-113(b) (execute Gov.'s orders)
Isolation and Quarantine w/o Emergency Declaration	Health-Gen. §§18-905(a)(1)(ii) , (a)(3), and (b)(1)[6]; Health-Gen. §3-306 (under MDH Sec. direction); Pub. Safety 14-3A-05(c)(Circuit Court upon appeal)
Declare a Curfew	Pub. Safety §§ 14-3A-03(d)(2) (CHE); 14-303(b)(6)
Declare a Curfew w/o Em. Decl	Local Govt § 11-303 (juveniles only in home-rule counties)
Close Businesses	Pub. Safety §§ 14-3A-03(d)(1)(during CHE); 14-107(d)(1);14-303(b)(2), 14-307; Pub. Safety § 14-113(b) (law enforcement execution of Gov.'s orders under MEMA Act)
Close Schools	Pub. Safety §§ 14-3A-03(d)(1)(during CHE); 14-107(d)(1); 14-303(b)(2), 307; Pub. Safety § 14-113(b) (law enforcement execution of Gov.'s orders under MEMA Act)
Cancel Public Events	Pub. Safety §§14-3A-03(d)(2)(during CHE); 14-107(d)(1);14-303(b)(2), (b)(4), 14-307; Pub. Safety § 14-113(b) (law enforcement execution of Gov.'s orders under MEMA Act)
Closing of public places w/o Emergency Declaration	Pub. Safety §14-307; Health-Gen § 20-308 (abatement of nuisance)

[5] See also county codes, e.g. P.G. Co. Code §§6-134 – 137; Mont. Co. Code §2-17.

[6] An isolation or quarantine order without an emergency declaration must be ordered in preparation of such a declaration, and MDHmust be able to "medically contain" the disease or outbreak with the help of appropriate health care providers.

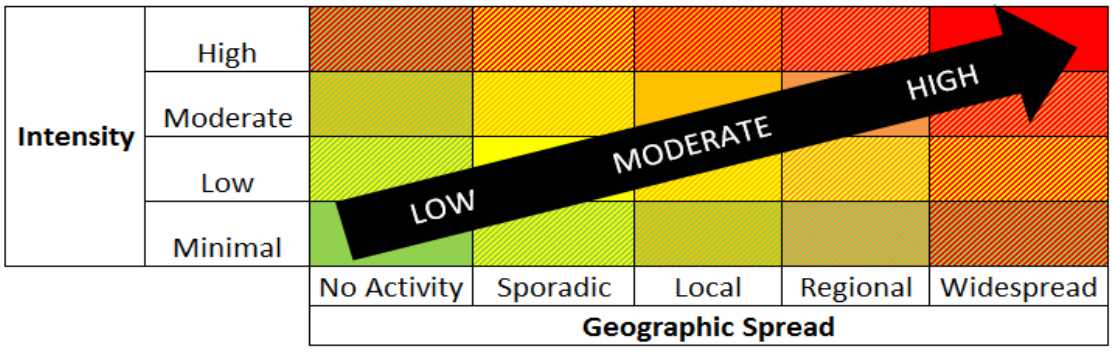
Potential Triggers for Implementation of Non-Pharmaceutical Interventions using Intensity level and Geographic Spread

The choice of non-pharmaceutical intervention strategies and when and how they are implemented is determined on case-by-case basis by the KCHD, MDH and other cooperating partners. While each pathogen may render a different threshold for the adoption of non-pharmaceutical intervention strategies, typically the intensity level and geographic spread of transmission, as verified by a laboratory-confirmed case, or cluster of cases, and evidence of person-to-person or community transmission (i.e. epidemiologically linked cases from more than one household), play the most significant role in the adoption of interventions.

Figure 1 below depicts how the spread of disease is generally monitored and categorized based on available surveillance data in Maryland. As intensity and/or spread increase, the potential for adopting non-pharmaceutical intervention strategies also increases. This is indicated by the upward arrow across the figure.

Other factors that may contribute to the adoption of non-pharmaceutical interventions include the ability of the pathogen to cause infection (infectivity), the ability of a pathogen to cause disease after infection (pathogenicity), the ability of the pathogen to cause severe disease (virulence), and the availability of countermeasures to combat the pathogen. Additionally, the impact interventions have on infrastructure and the economy may also play a role in the decision to implement intervention strategies. In all categories of outbreak or emergency severity, MDHIDEORB in coordination with KCHD will activate appropriate interventions when a threshold is met, which will vary based on the disease of concern.

Figure 1 Considerations for Non-Pharmaceutical Interventions Based on Intensity and Spread

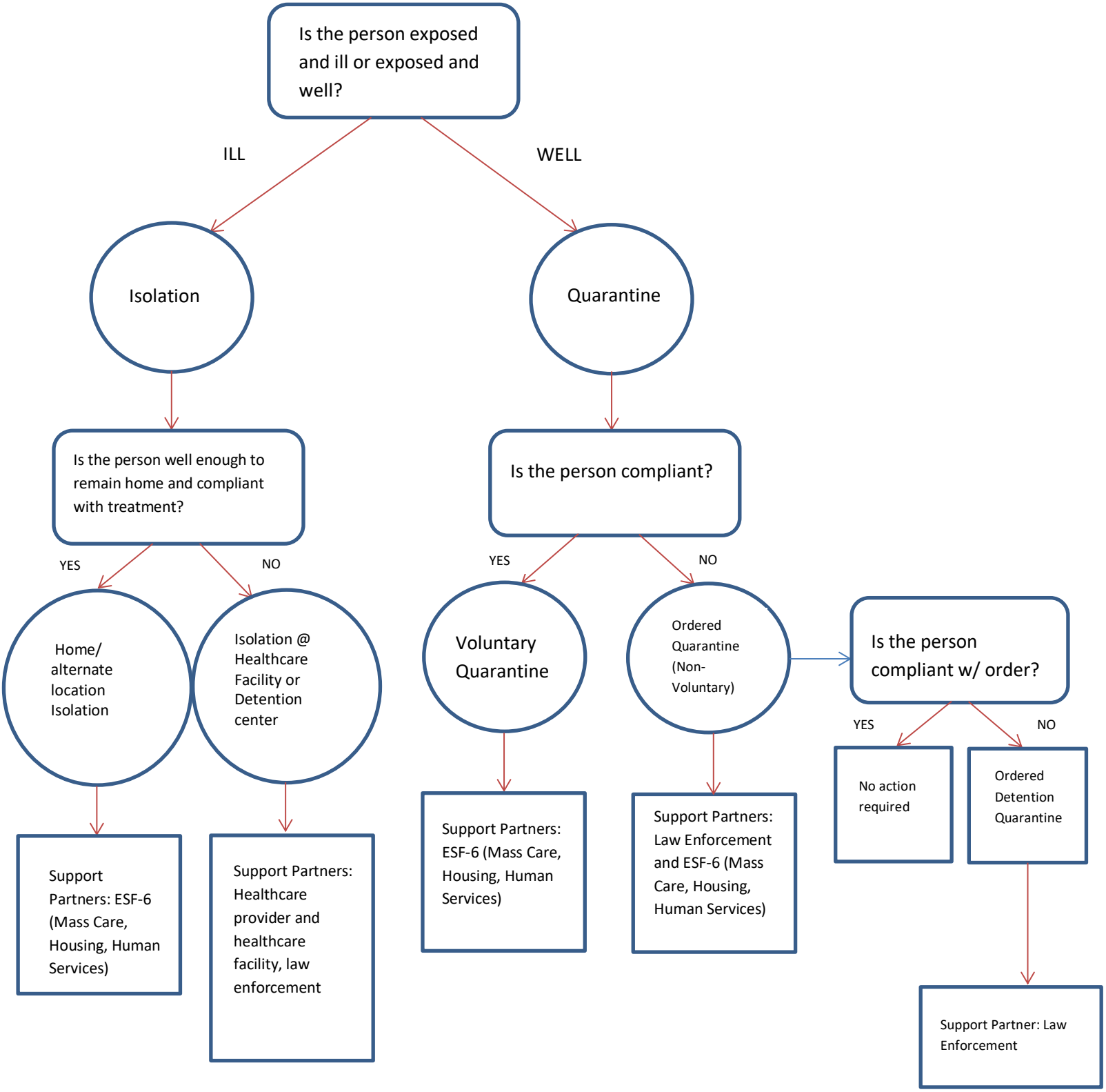


The arrow indicates low, moderate, and high need to consider and implement non-pharmaceutical interventions as intensity increases and/or geographic spread expands.

Considerations for Isolation and Quarantine Decision Making

The algorithm below (Figure 2) is intended to assist in the decision of how to best handle an individual's behavior in order to reduce the spread of disease. In all scenarios, the least restrictive alternative should be utilized. This algorithm serves as general guidance and may not be applicable to all infectious disease scenarios. Refer to additional plans as needed, such as the Maryland TB Guidelines for Prevention and Treatment of Tuberculosis: http://phpa.MDH.maryland.gov/OIDPCS/CTBCP/CTBCPDocuments/tbguidelines.pdf

Figure 2 Isolation and Quarantine Decision Making Algorithm



10. Pharmaceutical Interventions and Emergency Medical Materiel

    Medical countermeasures (MCMs):

    MCMs such as vaccines, antibiotics, or antivirals, may or may not be available and/or developed for an infectious disease outbreak. MDH, in consultation with CDC, will provide guidance on the preferred MCM to use and prioritization recommendations for an infectious disease outbreak where MCM quantity is in limited supply. These recommendations may change rapidly for a novel or genetically-changing pathogen, if it shows resistance to available MCMs. Insufficient or ineffective MCM will place greater emphasis on non-pharmaceutical strategies to control the spread of the disease in Maryland.

    In addition to medical countermeasures, other emergency medical materiel including personal protective equipment (PPE), ventilators, IV fluids, and other equipment may be needed to treat the disease and provide adequate infection control. Shortages of surgical masks, respirators, gloves, gowns, and other PPE at healthcare facilities may result as equipment distributors and manufacturers might not be able to keep up with demand.

    Post-Exposure Prophylaxis:

    Some infectious diseases will have MCM available not only for treatment, but also for chemoprophylaxis (to prevent an individual from getting sick). Chemoprophylaxis will be made available to exposed persons to protect and prevent exposures when available, according to state and federal guidance.

    Request and Receipt of Emergency Medical Materiel:

    Stockpiled emergency MCM assets and PPE may be available at the local, regional, state, or federal level; however, quantity may be extremely limited. Unlike pandemic influenza, which may trigger Strategic National Stockpile (SNS) asset delivery to MDH from CDC without a request, other types of public health emergencies require a request for emergency medical materiel to MDH and possibly the federal government.

    The process for requesting emergency medical materiel, including the identification of authorized requestors, is outlined in Maryland's local and state eMCM Plans. Local requests for emergency medical materiel will always go first to the local jurisdiction, and then to the state. Due to high demand and possible limited quantities, a request for assets might not result in receipt of materiel. Federal and state governments may need to allocate supplies in the event of shortages.

Distribution and Dispensing of Emergency Medical Materiel:
CDC and MDH may need to develop how assets are shipped, received and dispensed just-in-time, based on resources and needs.

Distribution:
Distribution of medications will be under the guidance of Federal authorities and MDH. Emergency medical countermeasures arriving from the State will be distributed in accordance with the State distribution plan. If eMCM is available, it may arrive either through State distribution processes, or maybe delivered through a third party/private vendor or directly from the manufacturer. If requested, KCHD may need to identify and provide the names and locations of those sites to where eMCM will be distributed (i.e. physician's offices, retail pharmacies, health department clinics, etc.). Ancillary supplies for the dispensing of eMCM locally may not always be provided with the delivery of the medical countermeasure from CDC and/or MDH.

Because assets such as PPE, intravenous fluids and ventilators are expected to be in high demand but low in availability during a widespread outbreak, CDC and/or MDH will determine the quantity and time-frame in which a local jurisdiction receives any assets from state or federal caches.

Dispensing:
KCHD maintains an eMCM plan to operate Points of Dispensing (PODs) when needed for dispensing of emergency MCM in their local eMCM plans. Local Maryland eMCM plans list sites that can receive materiel directly from the State Receiving, Staging & Storing Site (RSS) during an outbreak response. It may be necessary for alternate drop sites to be determined if PODs are not implemented, or to alter which POD sites will be used for the response to best meet the needs of the jurisdiction. Detailed operational plans for operating PODs are available in local jurisdiction eMCM Plans and have variations throughout Maryland.

Emergency Use Authorizations and Investigational New Drugs:
An Emergency Use Authorization (EUA) or Investigational New Drug (IND) protocol will be required by the CDC through the Food and Drug Administration (FDA) to authorize use of all antivirals, antibiotics and vaccine received in Maryland through the Strategic National Stockpile (SNS), State/County private local caches of medication, and from vaccine received from the federal government through the manufacturer. The FDA in coordination with CDC will issue Fact Sheets and other

documentation to MDH, to be distributed to any recipient of medication/vaccine from these sources, particularly when MCM will be utilized for off-label use.

11. Medical Care Coordination

When a disease has the potential to impact the state of Maryland, a communication campaign will be launched between MDH, KCHD, hospitals, and community providers to ensure healthcare response partners remain educated on aspects of the disease, response protocols, and the most appropriate mechanism to provide medical care to the persons infected.

Healthcare facilities and/or systems have established clinical protocols to identify, isolate and inform public health authorities of any persons with an infection of concern. Once a potential infection of concern has been identified in the community, providers are encouraged to first consult with local health departments to confirm signs and symptoms are consistent with the infection in question. KCHD will coordinate with MDH to ascertain the most appropriate response needed and to provide medical care based on the likely infection present, particularly when dealing with a novel or emerging pathogen.

For most infections, a patient will be advised to self-transport to the nearest emergency department or healthcare facility to obtain the required medical care. In the event that an individual cannot self-transport, Emergency Medical Services (EMS) may be required to provide transport.

In a scenario where the infection in question is extremely virulent or highly pathogenic, guidance on the most appropriate transport and care will be provided by MDH, to ensure the health and safety of responders. See Maryland EVD Response Plan (Annex). Depending on local resources and infrastructure, this could require the need for local healthcare entities to activate their Medical Surge Plans. *{Local guidance – refer to Medical Surge plan if appropriate.}*

12. Fatality Management

A large number of fatalities could result from a naturally occurring infectious disease emergency or intentional biological attack. The characteristics of a mass fatality incident will dictate the type of response and resources necessary to effectively manage the fatalities. The factors that are generally used to describe or characterize the magnitude of a mass fatality incident include: the number of fatalities, the rate of recovery, condition of the remains, and geographic extent of the incident.

The magnitude and scope of the event will dictate the need for regional and state coordination. An event may occur within the boundaries of a single jurisdiction and have impacts on surrounding jurisdictions or the event may directly affect multiple jurisdictions, simultaneously. Additionally, any mass fatality event that occurs as a result of an intentional biological attack will automatically trigger the need for state and federal assistance.

Local resources will likely become depleted very quickly and mutual aid from neighboring jurisdictions, the state, and/or federal authorities will be needed. In a localized, acute event, mutual aid may be available; however, for an incident with regional or national impacts and a high number of fatalities, the mutual aid available to both the local jurisdiction and the state may be extremely limited or not available.

In the event of an incident that results in mass fatalities, the Maryland Office of the Chief Medical Examiner will assume jurisdiction of human fatalities and investigate the deaths as authorized under Title 5 of the Health General Article of the Annotated Code of Maryland.

- Special provisions may need to be coordinated just in time for the handling and investigation of highly infectious remains.
- Special provisions for handling the remains of individuals infected with Ebola Virus Disease (EVD) can be found in the *Maryland Ebola Virus Disease Response Plan.*
- Additional protocols for preparing and responding to mass fatality incidents can be found in State, Regional and Local Mass Fatality Management Plans.

13. Responder Safety and Health

Overview:

Any infectious disease response that involves direct contact with potentially infected persons should be conducted using appropriate infection control precautions to include:

- Training
- Administrative controls (e.g. isolation policies and procedures, procedures for recognizing patients with infectious diseases before they expose workers)
- Engineering controls (e.g. negative pressure rooms with patients with airborne diseases)
- Work practice controls (e.g. not recapping needles)

- Personal protective equipment.[7]

Types and Components of Personal Protective Equipment (PPE):
A very important component of ensuring responder safety and health during an infectious disease incident will be personal protective equipment (PPE), which is defined as "specialized clothing or equipment worn by an employee for protection against infectious materials."

The type of PPE to be employed during an infectious disease response will depend on the following factors:

- Type of anticipated exposure (e.g. touch / direct physical contact, splashes and sprays, or large volumes of blood or body fluids that might penetrate clothing)
- Durability and appropriateness for the task (e.g. length of exposure, permeability of PPE material)
- Fit (e.g. N95 fit testing and appropriate sizes for gloves and gowns)

There are four levels of PPE based on the degree of protection needed:

- Level A for the greatest level of skin, respiratory, and eye protection;
- Level B for the highest level of respiratory protection but lesser skin protection;
- Level C for when the concentration(s) and type(s) of airborne substance(s) is known and the criteria for using air purifying respirators are met; and
- Level D for minimal protection (usually for nuisance contamination).[8]

PPE can consist of the following components:

- Gloves
- Gowns or aprons
- Face protection (i.e. masks, goggles, face shields)
- Respiratory protection (e.g. particulate respirators, powered air purifying respirators [PAPR])

[7] CDC, Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare Settings, http://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf (PDF) or http://www.cdc.gov/HAI/ppt/ppe/PPEslides6-29-04.ppt (PowerPoint presentation).
[8] For more detailed information on the kinds of equipment needed for each of these levels, see https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9767 and https://www.remm.nlm.gov/osha_epa_ppe.htm.

Further information on the various options for each component of PPE, how to use them, and how to fit them are available from the CDC: http://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf

Proper Donning and Doffing of PPE

It is important to keep in mind that there is no "one way or sequence" for donning and doffing PPE that must be adhered to in all circumstances. Individuals may obtain a variety of methods to don and doff PPE throughout their ongoing professional training that are appropriate and protect the individual from exposure. It is important that the staff member follow a sequence that they are comfortable with, practice routinely and eliminates risk of exposure.

The four key points about PPE use are:

- Don PPE before any contact with a patient, which is generally before entering the patient's room
- Once donned, use PPE carefully to prevent spreading contamination
- When tasks are completed, remove the PPE carefully and discard it in the receptacles provided
- Immediately perform hand hygiene before moving to the next patient

More detailed information on the donning and doffing of PPE is available from the CDC: http://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf http://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf.

{Local guidance – could add notes about any interactions with local partners, esp, first responders, on PPE use, training, etc.}

14. Decontamination / Waste Disposal

{Local guidance – consider adding information on any local waste disposal policies, procedures, or companies with whom you work.}

Decontamination

Decontamination guidelines for facilities and transport vehicles will vary depending on the infectious agent and its method of spread, infectious fluids, and contaminated surfaces, as well as facility and agency protocols. MDH in consultation with federal agencies will provide guidance on decontamination, especially for novel agents.

The level of decontamination required in other community settings, such as homes, will also depend on the infectious agent, illness, and extent of the patient's illness

while in the home. For diseases of lower transmissibility and/or lower severity, home residents may complete decontamination themselves using normal disinfectants and detergents. For more severe or contagious diseases, such as Ebola, a contract company may be required to ensure safe decontamination and disposal of waste.

Guidelines for the decontamination of persons exposed to a potentially infectious agent vary according to the agent and facility protocols. Decontamination must only be undertaken by trained persons with appropriate PPE and disinfectant supplies. Guidance is provided in the above section, *Responder Safety and Health*.

Waste

The treatment and management of infectious diseases often creates substantial amounts of potentially infectious disease medical waste materials. Infectious disease medical waste must be properly handled, treated if appropriate methods are available, and properly disposed of in order to minimize both the risk and the public's perceived risk of spreading of infection.

Handling Waste:

Proper handling of potentially infectious disease medical waste includes placing the waste in appropriate, leak-proof containers, as close as possible to the site where the waste was generated. PPE should be placed in red biohazard bags if available, or marked heavy trash bags; sharps should be placed in sharps containers. Bags and containers should not be overly filled, to avoid breakage or leakage.

The number of people handling the waste should be minimized, and PPE should be worn when handling some waste, such as Ebola waste. Waste should be kept in a safe designated storage area and should be labeled appropriately.

Most potentially contaminated human waste may be safely disposed of in a sanitary sewer system, according to the CDC, as sewage handling processes in the United States are designed to inactivate infectious agents.
http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html

Treating Waste:

The treatment of infectious disease medical waste, when appropriate for the infectious agent and available for use, can make waste disposal simpler, as treated waste can usually be disposed of with regular medical waste.

Methods of treatment include autoclaving and incineration, which may be subject to state, local, and OSHA regulations.

Waste that has been appropriately treated according to regulations is not considered infectious or a health risk, and is not considered regulated medical waste or hazardous material under federal law.

Waste Disposal:
Contaminated infectious disease medical waste that has not been treated must be disposed of according to federal, state, and local laws.

Waste that is potentially contaminated with a Category A agent, such as Ebola, is regulated as a hazardous material under the U.S. Department of Transportation's Hazardous Materials Regulations (HMR: 49 CFR, Parts 171-180). Category A waste that has not been properly treated is subject to extensive handling and packaging requirements. Also, waste that is potentially contaminated with a novel infectious agent may need to be treated as Category A waste and subject to the same requirements until more is known about the agent.

The requirements regarding the disposal of Category A agents are subject to change. MDH, along with the Maryland Department of the Environment, will monitor changing waste disposal guidance and will provide guidance to KCHD and community partners in determining how to safely dispose of Category A waste.

Many waste disposal companies and facilities may not accept Category A or novel agent waste. MDHwill also work with the Department of General Services to develop specifications for model "just in time" procurement of both decontamination services and management of wastes in pre-hospital settings, to ensure these services are available when needed.

In some jurisdictions, EMS providers, local health departments, urgent care facilities, and other facilities or agencies without the capacity to properly treat, store, or dispose of Category A waste may be permitted to bring their waste to a hospital system with that capacity. It is highly recommended that these facilities develop a Memorandum of Understanding regarding this issue.

For more information on waste management and disposal for Category A waste:
http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/waste-management.html
http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html

http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/handling-waste.html
http://www.cdc.gov/vhf/ebola/prevention/cleaning-us-homes.html
http://www.ajicjournal.org/pb/assets/raw/Health%20Advance/journals/ymic/YMIC_3269.pdf

15. Behavioral Health Support

An infectious disease emergency may cause anxiety and fear in the general public, individuals affected by the disease, and responders. This is particularly true in the event of an infectious disease resulting in very serious illness or mass fatalities.

Individuals who become sick with the infectious disease, whose family members are ill, or who are contacts of ill persons and may become ill, may experience higher levels of stress than the general public, and require substantial mental health support. Responders who come in contact with affected individuals may also experience high levels of concern about their health, and that of their family. Affected individuals may experience critical stress and other mental health issues, and may further increase stress due to unhealthy coping behaviors such as the use of alcohol or drugs.

Mental health services will need to be provided in a way that keeps mental health providers from being exposed to the infectious disease. Public messaging through mass and social media can help spread clear information, dispel stress-causing misinformation, and connect the general public with resources. A call center may also be used to allow anyone to speak with a trained and informed individual about their concerns. Telephonic counseling may be appropriate for PUIs, contacts, affected families, and responders. In-person counseling appointments may require the use of PPE.

In the event of an infectious disease emergency with significant impact on the mental health of the public and/or responders, MDHwill work with local health departments to coordinate appropriate mental health support services in the affected areas. KCHD with Mental Health Response Plans and/or Memoranda of Understanding or Agreement with mental health support providers may choose to activate these plans and resources based on their local infrastructure and plans. Other resources will vary by jurisdiction and may include Critical Incident Stress Management (CISM) teams and other trained agency volunteer teams.

{Local guidance – reference any formal or informal agreements and local resources for mental health services.}

16. Emergency Public Information and Warning / Risk Communication

    Clear communication among public health professionals, health care providers, community partners, and the public is critical to prevent both the spread of disease and the spread of misinformation and fear during an infectious disease emergency. The KCHD leading an investigation in a single jurisdiction will be the primary point of contact regarding public communications about the investigation. However, other partners and MDH may assist with creating and distributing messaging. Local health departments should refer to their risk communication plan to guide their communication response to an infectious disease emergency.

    In certain situations, as designated by the Secretary of Health, MDH may be the primary point of contact for public communications regardless of whether the investigation includes more than one jurisdiction. If this is the case, MDH shall notify the appropriate local Health Officer(s) prior to public communication.

    In a larger-scale event led by MDH, all communications with the public and media will follow the *MDH Public Information Communications Plan for Public Health Emergencies.* MDH or the Joint Information Center (if activated) will coordinate to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among partners, including those in the field.

    Communications must be inclusive of special needs such as English as a second language, foreign languages, and deaf and hearing-impaired messaging.

    {Local guidance – reference local Risk Communication plan, communication resources.}

17. Operational Coordination

    To coordinate during an infectious disease outbreak or emergency KCHD and MDH will determine the most appropriate location to coordinate the response. MDH may operate out of the MDH Departmental Operations Center (DOC), or the State Emergency Operations Center (SEOC). Likewise, KCHD may operate out of their Department Operations Center (DOC), or the County Emergency Operations Center (EOC).

    Appropriate personnel to staff the Operations Center will be chosen based on the Incident Command Structure (ICS) established for the agency, where the MDH Secretary of Health and the Local Health Officer (or designees) lead the State and local response. The procedures for activating and staffing Operations Centers can be found in agency, local and state Emergency Operations Plans (EOP), including:

- Decision to request additional assistance for local communicable disease staff
- Decision to activate the local Operations center, at what level, and location
- Resource requests
- Communication with partners
- Requesting emergency medical materiel, if needed

Costs associated with an infectious disease outbreak or emergency will be accounted for and documented according to established local, state and federal procedures.

Should a State of Emergency be declared, legal authorities exist for reimbursement to counties or municipalities, mutual aid, and continuity of government operations.

{Local guidance – reference agency and county/jurisdiction EOPs and other relevant plans and procedures.}

C. Recovery

Similar to other emergency response scenarios, the Recovery Phase for an infectious disease outbreak or emergency begins soon after the response starts. During recovery, ESF-8 Health will:

- Transition back to normal operations, providing ongoing disease surveillance, investigation, and control
- Prepare and disseminate public health information in coordination with the Public Information Office
- Assist to make available the appropriate mental health services for victims, emergency responders, and their families
- Continue coordination with state and federal response partners
- Document department resources expended and recovery costs
- Maintain records for reference and reports
- Demobilize department resources
- Inventory lost or damaged equipment
- Record personnel or equipment accidents
- Assess the economic and educational impact of the infectious disease response
- Replenish and/or restock depleted caches of PPE, pharmaceuticals, and supplies
- Conduct the ESF #8 After Action Review
- Implement Improvement Plan activities and review existing planning as necessary to address any deficiencies.

{Local guidance – refer to local recovery plans if available.}

IV. Roles and Responsibilities in an Outbreak or Emergency

The Secretary of Maryland Department of Health is responsible for the investigation and control of infectious disease outbreaks, pursuant to Md. Code Ann., Health-General § 18-101 and §18-102. The Code of Maryland Regulations (COMAR) 10.06.01 delegates this responsibility to local Health Officers, as described in COMAR.
KCHD Communicable Disease staff, under the authority of the Health Officer, will collect preliminary information on the infectious disease outbreak and notify the MDH and IDEORB within 24 hours of the outbreak report, or immediately for diseases noted in the MDH Policy on Outbreak Investigation. In turn, IDEORB is responsible for informing other MDH units, States, the CDC, and other federal agencies of significant outbreaks, as well as other local health departments as needed.

Roles and Responsibilities in an Infectious Disease Emergency:
The public health response to an infectious disease most often starts at the local level. However, an infectious disease emergency resulting from a case or cases of a novel or unidentified infectious disease, a large number of cases or rapid spread, a particularly virulent or contagious disease, or spread across multiple jurisdictions or states will likely require state support from both IEDORB and the Office of Preparedness and Response (OP&R) at MDH.

Federal assistance will be required for any infectious disease incident considered a possible act of bioterrorism, as well as any infectious disease emergency that involves multiple states or countries or a particularly virulent disease such as Ebola. A prolonged or intense infectious disease emergency response may require a presidential disaster declaration.

Other state agencies will also provide support to MDH (Table 3). In addition to helping their staff and constituents to be prepared for infectious disease emergencies, these agencies will communicate information from MDH to staff and constituents.

Table 3 State Agency Roles and Responsibilities in an Infectious Disease Outbreak or Emergency

State Agency	Primary Support Functions for Infectious Disease Response
Maryland Emergency Management Agency (MEMA)	• Support both local government and state agency emergency operations pre-outbreak planning. Ensure fire, public works and emergency management organizations complete emergency response plans, especially taking into account absenteeism, employee protective measures, infection control policies, and maintaining services. • Coordinate the overall emergency planning, preparedness and response of all state agencies as needed in an infectious disease emergency. The Director of the Maryland Emergency Management Agency shall serve as the State Coordinating Officer (SCO). • Maintain communication with MDH regarding imminence or status of an infectious disease emergency in Maryland. • Support communications via an in-person or virtual Joint Information Center as appropriate. • Coordinate the activation of the State Emergency Operations Plan in accordance with guidance from MDH. • Inform the Governor, the Superintendent of the Maryland State Police, Executive Council, and the Legislature, as appropriate, of emergency operations. • Facilitate the request for a presidential disaster declaration as appropriate. • Facilitate any Emergency Management Assistance Compact (EMAC) requests. • Support MDH/DHR response to accommodate contained individuals, as requested.
Governor's Office of Homeland Security	• Monitor the progress of emergency preparedness planning and exercising in state agencies. • Liaison with the Federal Department of Homeland Security regarding the state's infectious disease emergency preparedness.
Office of the Attorney General	• Provide legal advice and opinions in support of MDH infectious disease emergency operations to include preparing and reviewing proclamations and special regulations issued by the governor. • Represent the State on legal issues for isolation and quarantine and other public health measures.

Office of the Judiciary	• Establish policies regarding justice system continuity during and after an infectious disease emergency. In particular, address modification of court schedules and operations (such as jury duty) to accommodate containment strategies. • Provide guidance regarding civil rights and statutory issues. • Ensure maintenance of civil and criminal court systems.
Comptroller of Maryland	• Coordinate and arrange for emergency funds to assist in purchasing resources needed for isolation or quarantined individuals and overall infectious disease emergency response efforts. • Assist state and local governments in determining the value of losses sustained because of isolation or quarantine of individuals and infectious disease emergencies.
Department of Budget and Management	• Assist state agencies in identifying potential additional costs associated with supporting local agencies for isolation or quarantine of individuals and during an infectious disease emergency, and proposing strategies to request appropriation authority for such additional costs.
Department of Commerce	• Develop procedures to provide unemployment assistance to eligible individuals whose unemployment results from isolation, quarantine, or hospitalization due to an infectious disease emergency. • Provide an estimate of the immediate economic impact of an infectious disease emergency, as requested by the Maryland Emergency Management Agency. Where possible and applicable, the Department shall provide estimated projections of long-range effects of each instance including residents, businesses, and local, state, and federal agencies.
State Department of Education	• Coordinate with MDH to develop a communication protocol between school systems and public health at the state and local level. • Coordinate with MDH to develop protocols for closing and opening schools; canceling or suspending school activities; repurposing of school facilities, equipment, and vehicles; reassignment of non-school system employees (e.g., school nurses); screening of students and staff; and recommendations regarding prophylaxis, vaccines, and antivirals for staff and students. • Provide support and cooperation for mass vaccination of children and staff if required for mitigation in response to an infectious disease emergency.

Maryland Department of Natural Resources	• Take the lead in coordinating response to zoonotic diseases in wild animals that have not yet led to human cases. • Coordinate with MDH for response to zoonotic diseases in wild animals likely to or having caused human cases. • Assist in management of vectors in vector-borne disease outbreaks, including vectors associated with State Parks
Department of General Services	• Ensure information regarding service suspensions due to an infectious disease emergency is provided to the public. • Identify any services, personnel, equipment, supplies, or buildings that could be useful resources to other departments, agencies, or organizations. • Establish procedures for giving organizations access and use of services, personnel, equipment, supplies, or buildings.
Maryland Department of Agriculture	• Take the lead in coordinating response to zoonotic diseases in agricultural animals that have not yet led to human cases. • Coordinate with MDH for response to zoonotic diseases in agricultural animals likely to or having caused human cases. • Assist in management of mosquitoes and other vectors in vector-borne disease outbreaks.
Department of Housing and Community Development	• Upon the declaration of an infectious disease emergency in Maryland, inventory available rental property suitable for housing isolated or quarantined individuals.
Department of Human Resources	• Coordinate with local social service agencies to shelter isolated or quarantined individuals not currently hospitalized or housed in a MDH Facility. • Coordinate with local social service agencies to meet the childcare needs of isolated or quarantined individuals unable to care for their children. • Provide USDA donated food to disaster relief agencies and emergency feeding programs, and assist with its distribution and storage through the Emergency Food Assistance Program.

Maryland Institute for Emergency Medical Services System	• License all EMS providers and commercial ambulance services and coordinate the statewide EMS system • Monitor the operation of the statewide EMS System to identify suspected PUIs for infectious disease emergencies if needed, and conduct the appropriate notifications/activate resources outlined in this plan. • Coordinate with EMSOPs to conduct all transportation and emergency medical services for PUIs/patients with the infectious disease requiring ambulance transportation to a hospital. • Coordinate operational communications associated with PUIs as appropriate for the individual operations. • Provide guidance to EMSOPs, medical directors and individual EMS providers on the proper care and treatment of PUIs, personal protective practices associated with that care and transportation, and resources available for this response. • Modify Maryland Medical Protocols (Annex G) for EMS providers and COMAR Title 30 as required to ensure appropriate care and transportation of PUIs and the protection of personnel associated with that care and transportation. • Inform EMSOPs and medical directors of status of public health emergency plans and when to activate associated EMS emergency operational plans. • Approve applications for Waiver to Licensing Requirements for Inter-facility Transfer for infectious disease PUIs to ensure the appropriate plans and procedures are adequate to meet waiver standards.
Maryland State Police	• Make field agents available, when possible, to assist other state agencies with PUIs as needed and security for PUIs, at-risk contacts, and individuals in isolation or quarantine. • Review state and local authorities and protocols for maintaining public order during an infectious disease emergency. • Be responsible for law enforcement and traffic control on all interstate and state trunk highways during an infectious disease emergency and during mass vaccination or mass prophylaxis if available. • Assist the Secretary of Health and Mental Hygiene with enforcement of isolation and quarantine orders and other infectious disease-related orders and directives of the Secretary when authorized by Maryland statute

Department of Public Safety and Corrections	• Coordinate public health emergency plans for correctional facilities, particularly prophylaxis, vaccination and antiviral plans. • Develop and implement control measures to prevent the introduction and spread of the infectious disease within correctional facilities, to include policies and procedures for restricting visitors, encouraging staff absences, and isolation and quarantine.
Department of Juvenile Services	• Coordinate public health emergency plans for juvenile detention facilities, particularly prophylaxis, vaccination and antiviral plans. • Develop and implement control measures to prevent the introduction and spread of the infectious disease within juvenile detention facilities, to include policies and procedures for restricting visitors, encouraging staff absences, and isolation and quarantine.

V. Legal Authorities

Table 4 serves as an overview of the most relevant State and local legal powers that may apply during an infectious disease response affecting the State of Maryland and its local jurisdictions. For more detailed information regarding laws that impact public health emergencies in Maryland, reference the *Maryland Public Health Emergency Preparedness*

Handbook

Table 4 General Legal Authorities

Legal Authorities	Description
General Authority and Duties of the DHMS Secretary, Md. Code Ann., Health-Gen § 2-104	Local Health Officer Powers: • Under the direction of the MDH Secretary, a local health officer shall enforce State health laws, the policies, rules, and regulations of the MDH Secretary, and the rules and regulations of the county board of health. Md. Code Ann., Health-Gen § 3-306. - A county health officer shall perform an investigation or other duty or function as directed by the Secretary or county board of health. • A local health officer must report to the County Board of Health when there is reason to believe that there are diseases that endanger public health. With the approval of the Board, the local health officer must investigate and act properly to prevent the spread of the disease. Md. Code Ann, Health-Gen. § 18-208. • The local Health Officer may enter and inspect any private house if they have obtained consent or warrant; or does not have time or opportunity to obtain a warrant and an exceptional or emergency situation exists. Md. Code Ann, Health-Gen. § 3-307. - In the performance of official duties, a local health officer may enter any place of business or employment.
Catastrophic Health Emergencies Act, Md. Code Ann., Pub. Safety § 14-3a	• Authorizes the Governor to proclaim a catastrophic health emergency (CHE) in which extensive loss of life or serious disability is threatened imminently because of exposure to a deadly agent. A deadly agent includes biological agents (e.g. anthrax, Ebola, plague, smallpox), chemical agents, and radiation. • During a CHE, the Governor may order the Secretary or other designated official to: - Seize immediately or control, restrict, or regulate the use of anything needed to respond to the medical consequences of the CHE; - Control, restrict, or regulate the use, sale, dispensing, distribution, or transportation of anything needed to respond to the medical consequences of the CHE; and

	- Require individuals to submit to medical examination, testing, vaccination, medical treatment, isolation, or quarantine.[9]
Maryland Emergency Management Agency (MEMA) Act, Md. Code Ann., Pub. Safety §§ 14-101 – 115	• Authorizes the Governor to declare and terminate a state of emergency to protect the public health, welfare, or safety. The Governor's powers during a state of emergency include the suspension of any statute, rule, or regulation of the State or a political subdivision and the appropriation and management funds to respond to an emergency. § 107.
Governor's Emergency Powers Subtitle, Md. Code Ann., Pub. Safety §§ 14-301 et seq.	• Authorizes the Governor to proclaim a state of emergency during a "public emergency".
Maryland Emergency Management Assistance Compact, Md. Code Ann., Pub. Safety §§ 14-801 – 803	• Provides for mutual assistance between jurisdictions in order to manage an emergency.
General Responsibilities of the MDHSecretary Regarding Infectious Diseases, Md. Code Ann., Health-Gen. § 18-101 et seq.	• Among other responsibilities, the MDHSecretary shall adopt rules and regulations to prevent the introduction and spread of an infectious or contagious disease. The secretary shall also investigate a suspected infectious or contagious disease and act properly to prevent its spread. § 18-102.
Required Infectious or Contagious Disease Reports,	• The following people and institutions must submit a report to their local health officer when they have reason to suspect that a patient or human specimen has a condition or

[9]The Governor's power to order the Secretary to require individuals to submit to vaccination or medical treatment does not apply if there is likelihood of serious harm to the individual. The Supreme Court has affirmed that the state is permitted to mandate vaccinations during extenuating circumstances, but medical exemptions must be available for those who may be adversely affected by the vaccine. Furthermore, a fine or imprisonment for those who refuse vaccinations is permissible, but people cannot ultimately be forced to be administered a vaccination against their will. Jacobson v. Massachusetts, 197 U.S. 11 (1905).

Md. Code Ann., Health-Gen. § 18-201 et seq.	an infectious or contagious disease (except HIV and AIDS) that endangers public health and that has been designated by the MDHSecretary as reportable: - Physicians (§ 18-201); - Hospitals and lodging facilities (§ 18-202); and - Medical laboratories (§ 18-205). • For list of reportable diseases, see COMAR 10.06.01.03 or http://phpa.MDH.maryland.gov/IDEHASharedDocuments/ReportableDisease_HCP.pdf. • Treatment for specific diseases is provided in COMAR 10.06.01.08 - .22. • Attending physicians and medical examiners must notify fire fighters, EMTs, law enforcement officers, etc. who have transported a patient subsequently diagnosed with a contagious disease. §§ 18-213 – 213.2.
MDHSecretary's Catastrophic Health Emergency Disease Surveillance and Response Powers, Md. Code Ann., Health-Gen. § 18-901 et seq.	• The DHMS Secretary has the power to: - Treat, prevent, or reduce the spread of a disease or outbreak believed to have been caused by exposure to a deadly agent; and - Order those who may have been exposed to a deadly agent to be placed in evaluation, treatment, isolation, or quarantine with the assistance of law enforcement if necessary. - See also COMAR 10.59.01, which includes an outline of the authority

(See Table 2 regarding legal authorities for non-pharmaceutical interventions.

VI. Plan Exercise and Maintenance

All MDH and KCHD plans are exercised in collaboration, where possible, with other local, state, and federal preparedness partners. Exercises aim to bring a diverse representation of statewide preparedness partners together representing several dimensions of a public health and medical response.

All MDH and KCHD exercises must be planned and evaluated following the guidelines of the Homeland Security Exercise and Evaluation Program (HSEEP). Exercise Evaluation Guides should be used when appropriate as they provide standards for assessing objectives through the execution of tasks and activities linked to each target capability. All Statewide exercises should be designed to include the appropriate jurisdictions/agencies, senior officials, and other local/state/federal preparedness partners. All exercises must also include a project management timeline, activity milestones, and an exercise planning team.

This plan will be reviewed annually and updated as needed. The plan and any subsequent changes will be distributed to designated statewide partners as listed in the Roles and Responsibilities table.

VII. Appendices

VIII. Annexes (as available)

- Maryland EVD Response Plan
- Zika Response Plan
- eMCM Mass Distribution Plan
- Continuity of Operations Plan (COOP)
- Medical Surge Plan
- Mass Fatality Plan
- Disaster Health Services Plan
- Respiratory Protection Plan
- Risk Communications Plan

Appendices 1

Kent County Health Department
Communicable Disease Surveillance Program

Protocol for Investigating Reports of Communicable Disease for Major Outbreaks

I. Statement of Purpose

The investigation and control of diseases in the community is one of the fundamental responsibilities of public health. The Communicable Disease Program surveillance staff will:

- Promptly investigate reports of suspect and confirmed cases and outbreaks of communicable diseases.
- Take the lead for communicable disease investigations except when another program has a priority or dual role (e.g. Environmental Health, Emergency Preparedness).

II. Initial contact and response

Communicable disease reports (including labs) are typically received via regular mail or fax from hospitals, private medical providers, or laboratories. Additional reports may be received via telephone from the medical community, schools, daycares, long term care facilities, or private citizens.

1. Upon receipt of information and/or reports, answer two key questions:
   - Is it reportable?
     - Consult *Diseases, Conditions, Outbreaks, & Unusual Manifestations Reportable but Maryland Healthcare Providers and Laboratories.*
   - Is case a Kent County resident? If not:
     - And lab is phone reportable: phone surveillance in the respective county and fax results.
     - And lab is not phone reportable: have secretary fax to respective jurisdiction.

   In either case, assess the impact of the event to the public health and safety of Kent County residents.
     - Notify others for disease with serious implications to supervisor and possibly others including MDH EDCP Program e.g. measles, N. meningitis, BT-related, smallpox, anthrax, glanders, plague, Influenza H5:N1

2. Affirm case definition

   Consult CDC Case Definitions for Infectious Conditions Under Public Health Surveillance. The case definition consists of a clinical description, laboratory criteria for diagnosis, and case

classification (e.g. suspect, probable, and confirmed) of the disease in questions. Contact the physician of the individual who is ill if necessary to verify and augment information to determine if case meets case definition. https://wwwn.cdc.gov/nndss/conditions/

III. Investigation

A. Single cases are typically handled from beginning to end by one CD nurse.

B. Clusters, outbreaks, or a single case of a high profile disease may require a wider effort:

- The CD nurse will confer with supervisor and Public Health Emergency Planner.
- The Health Officer should be notified via email, and/or phone. Notification to the Health Officer may be necessary for consultation and recommendations on the action plan and steps in (C), below.

C. Possible steps may include but are not limited to the following, and may be carried out at any point in the investigation:

a. Laboratory confirmation of the diagnosis.
b. Review resources i.e., Control of Communicable Diseases Manual, MDH and CDC website and other sources.
c. The Communicable Disease Team will convene to notify appropriate parties and may include but are not limited to:
    - Health Officer
    - Other county agencies (e.g. OEPR)
    - Maryland Department of Health's Office of Epidemiology Disease Control Program Division.
    - County notifications outside of the Community Health Division must be done with the knowledge of the CD Program Manager and Health Officer.
d. Creation of outbreak case definition.
e. Development of line listing to keep track of cases.
f. Create a survey for suspect cases and/or contacts and accompanying database to enter survey data.
g. Create a letter for contacts of case.
h. Provide in person site visit to the affected facility, to educate administrators and to underscore control and prevention measures.
i. Institute active surveillance to find additional cases.
j. Provide data graphing and other analysis as appropriate.
k. Broadcast fax to appropriate healthcare personnel.

l. Ask the Communicable Disease Program Manager or designee for additional resources, e.g., school or environmental health personnel, state epidemiologists, mutual aid.
m. Daily emails or conference calls to update all parties.
n. Document decisions made and actions taken.

D. Indicate who the lead investigator is when communicating and giving updates about an investigation. The lead investigator or agency may change and this information is crucial for an efficient investigation.

E. The CD nurse may ask other staff for help in the investigation. The role of the Epidemiologist is likely to be technical and involve such tasks as:
   a. Creating the questionnaire
   b. Creating a spreadsheet or database
   c. Performing graphing and other data analysis
   d. Creating a broadcast fax
   e. Sending update emails

F. Gastrointestinal illnesses and possible food borne outbreaks typically involve both the Communicable Disease Program and Environmental Health staff. Refer to protocols from Environmental Health for food borne outbreaks.

G. As investigation continues and winds down, continue updating all involved parties with updates, laboratory results, etc. until investigation is declared over.

H. All outbreaks should include a final report to review actions taken and outcomes.

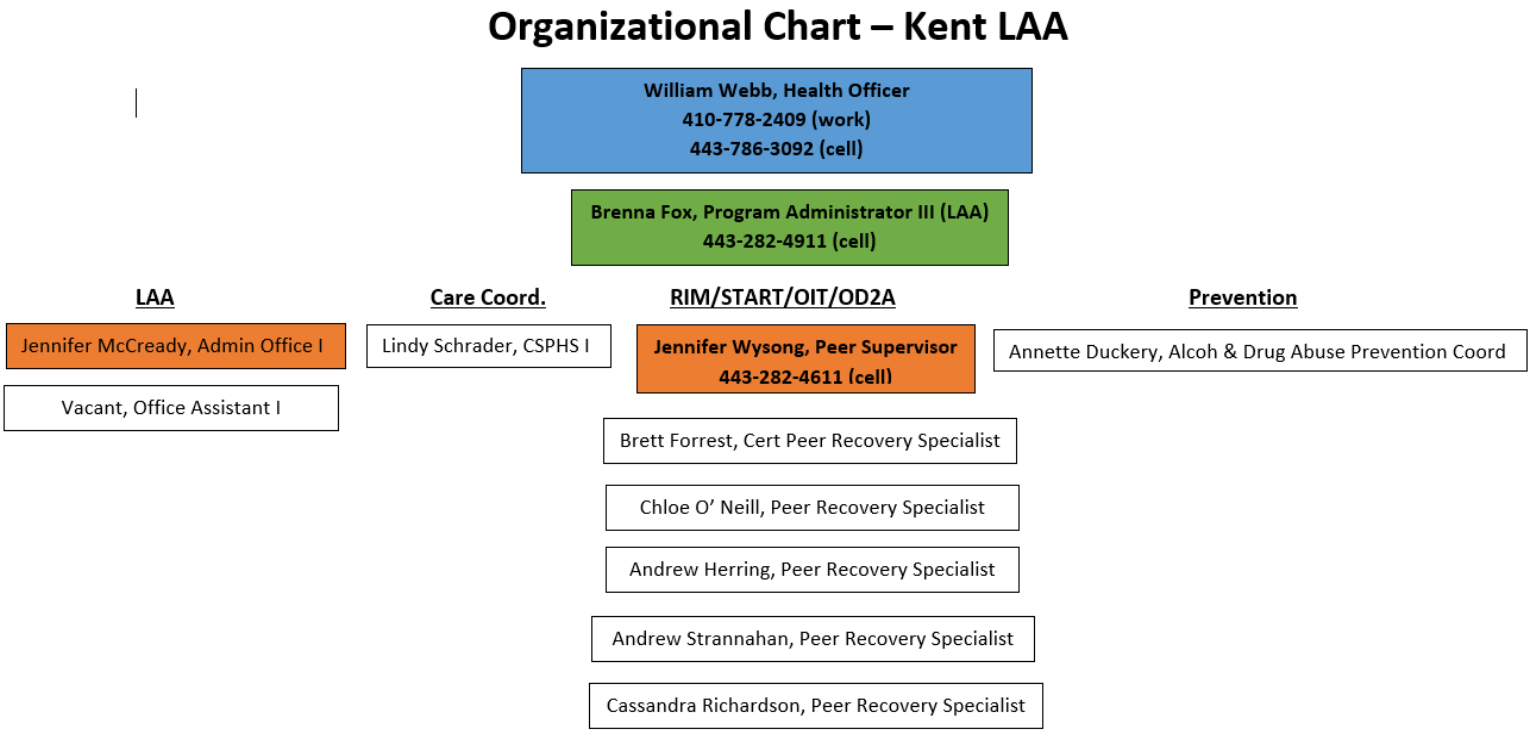
I. For all major outbreaks, an after action report should be completed to document strengths and weaknesses of the health department response.

KENT COUNTY ALL HAZARD PLAN

Kent County's emergency preparedness plan consists of the coordinated response of the department of emergency services and department of health personnel through the Kent County Department of Emergency Services, Kent County Health Officer, county officials, the public information officer, and close collaboration with other local state agencies and responders. The emergency plan is included in the Appendix section. Covid-19 pandemic emergency preparedness in Kent County will follow infectious disease protocol. This plan is attached in Appendix section.

Kent County Local Addictions Authority Organizational Structure:

The organizational structure of the Local Addictions Authority (LAA) for Kent County at present time is as follows:



There is a Memorandum of Understanding (MOU) with Caroline County LAA to mitigate conflicts of interest. Identified as conflicts of interest for Kent and Caroline County are: LAA exemption requests for treatment payment from ASO, critical incident reports, audits of providers in LAA's jurisdiction and investigations of programs in the LAA's jurisdiction. The Kent LAA will handle exemptions for Caroline County and vise-a-versa.

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

Organizational Chart LDAAC-OIT-Local Advisory Councils

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

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2021 RESOURCE GUIDE

PUBLIC BEHAVIORAL HEALTH SERVICES IN CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S & TALBOT COUNTIES OF MARYLAND

24-Hour Crisis Hotlines

Eastern Shore Operations Center (ESOC) 1-888-407-8018
Serves as the behavioral health emergent, urgent information and referral call center for all nine counties of the Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties. ESOC is available 24 hours a day, 7 days a week to assess and respond to calls from consumers, family members, community members, businesses, and human services agencies. ESOC staff provides linkage to community resources through referral to all appropriate and existing behavioral health and human services.

Suicide Hotline 1-800-273-TALK (8255) or 1-800-SUICIDE (784-2433)
Provides counseling for suicide prevention.

Life Crisis Center Hotline 410-749-HELP
Provides counseling for victims of domestic violence or sexual assault, suicide prevention, support groups, emergency shelter, shelter referral, medical care, and assistance with the process of prosecution.

Maryland Crisis Connect – Dial 211 & Press 1
Crisis intervention, support, and referrals.

Maryland Crisis Online Chat www.Help4MDYouth.org.
Available Monday – Friday, 4pm - 9pm. If you are in immediate crisis and a chat specialist is unavailable, please call the Maryland Crisis Hotline at 1-800-422-0009, or if you are not in Maryland, please call the National Suicide Prevention Lifeline at 1-800-273-8255.

For All Seasons, Inc. Hotline 1-800-310-7273 Spanish Hotline 410-829-6143
Counseling, advocacy, and education to victims of rape, sexual assault, and abuse.

Mid-Shore Council on Family Violence 1-800-927-4673
Provides direct services for victims of family violence including a 24-hour hotline, crisis intervention, counseling, support groups, emergency shelter, client advocacy, children's program, court accompaniment, information, and referral.

Postpartum Depression (PPD) Hotline 1-800-PPDMOMS (773-6667)
Provides peer support and referrals for mothers suffering from postpartum depression.

Problem Gambling Helpline 1-800-GAMBLER (426-2537)
The Maryland Center of Excellence on Problem Gambling provides support for those struggling with a gambling addiction.

Trevor Project Crisis Line 1-866-488-7386
The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people ages 13-24. Visit www.thetrevorproject.org for more information on TrevorChat and TrevorText - trained volunteer counselors are ready to listen.

Veterans Crisis Lines 1-800-273-8255, Press 1 or 1-877-VET2VET (838-2838)
The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline. VET2VET is a confidential connection which utilizes trained peer veterans ready to provide hope and help 24 hours a day, 7 days a week. In addition, the peer counselor will help the soldier or veteran navigate the often-complex VA system to access the mental health resources that are being sought.

Mid Shore Core Service Agency Overview

INTRODUCTION TO THE GUIDE

Mid Shore Behavioral Health, Inc. (MSBH), formally Mid-Shore Mental Health Systems, Inc., is pleased to present the revised 2021 edition of the *GUIDE TO BEHAVIORAL HEALTH SERVICES IN CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT COUNTIES, MARYLAND*. This guide, while not inclusive of every service or behavioral health provider in the five-county area, represents our effort to help the citizens of the region become more aware of the services that are available to them.

MSBH is a private, not-for-profit 501(c)(3) organization, serving Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. MSBH was incorporated in 1992 through a collaboration of the five county governments and mental health stakeholders.

Some MSBH programs serve the nine-county region of Maryland's Eastern Shore.

The Board of Directors consists of members appointed by the five local governments, five at-large members, and two charter members representing all stakeholders, specifically consumers, family members, or other residents of the five counties who possess some expertise in the field of behavioral health.

Mission

To continually improve the provision of behavioral health services for residents of Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties through effective coordination of care in collaboration with consumers, their natural support systems, family members, providers, and the community at large.

Vision

A rural behavioral healthcare delivery system that is clinically and culturally competent. This system will ensure access, have a community focus, be cost-effective, and be integrated to serve the community.

What We Do

We strive to enhance a regional behavioral health system of care through effective collaboration with consumers, their natural supports, providers, and community leaders. It is our goal to develop a full array of accessible services and **resources** for the consumer through partnership with our providers and other agencies. We offer **guidance** in understanding and navigating all that is available in our community. Beyond our primary responsibility for local publicly funded mental health services, MSBH understands that behavioral health is essential to overall health, and many domains of life contribute to one's behavioral health, especially having a home, purpose, and community connection. As such, MSBH seeks to address the needs of the **whole** person and collaborates to improve the systems of care of the whole community throughout the region. The most important core value of our organization is **hope**: the belief that resiliency and recovery are real provides the essential and motivating message of a better future – that people and communities can and do overcome the internal and external challenges, barriers, and obstacles that confront them to achieve wellness.

What is a Core Service Agency?

A Core Service Agency (CSA) is a state funded agency, as part of local health departments, local county governments, or non-profit organizations that operates under contract with the State of Maryland's Behavioral Health Administration (BHA), a division of the Maryland Department of Health (MDH). The Annotated Code of Maryland Health General Article 10-1201 through 1203 mandates Core Service Agencies, Local Addictions Authorities, and Local Behavioral Health Authorities. Mid Shore Behavioral Health, as a CSA, functions under the MDH Secretary's authority. Mid Shore Behavioral Health (MSBH) is a regional, non-profit CSA that serves

five counties (Caroline, Dorchester, Kent, Queen Anne's, and Talbot), and is the only regional CSA in the State. Our primary responsibility is for community planning, management, and monitoring of publicly funded medically necessary mental health services in the five-county region for consumers across the life span: children, adolescents, adults, and the aging population.

Optum Maryland Behavioral Health is the organization under contract with the MDH Medicaid Office to process claims, enroll consumers, pre-authorize medically necessary services, credential providers and pay claims.

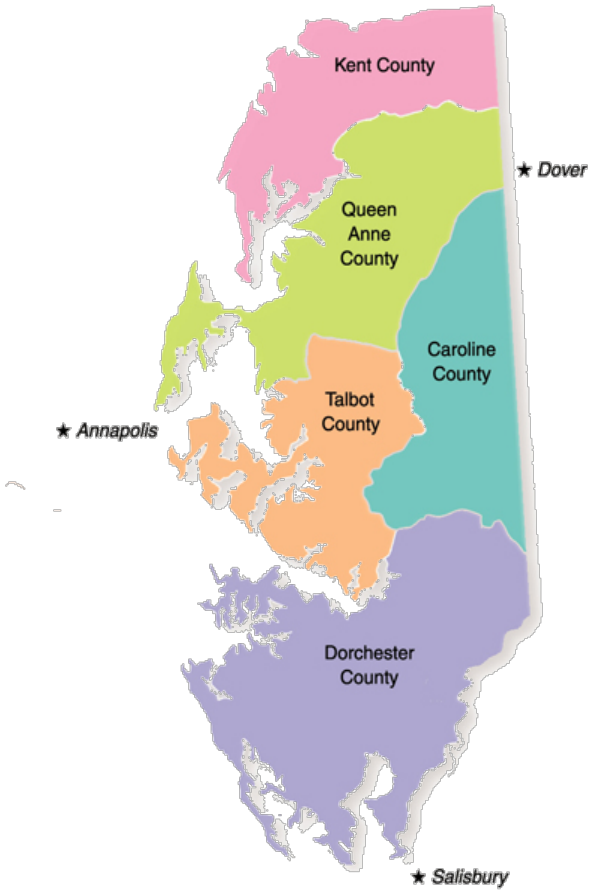
Who are the Consumers in the PBHS?

The Public Behavioral Health System (PBHS) provides for medically necessary services for the Medical Assistance recipient and for some individuals who are uninsured (Medical Assistance Ineligible).

Who are the Providers in the PBHS?

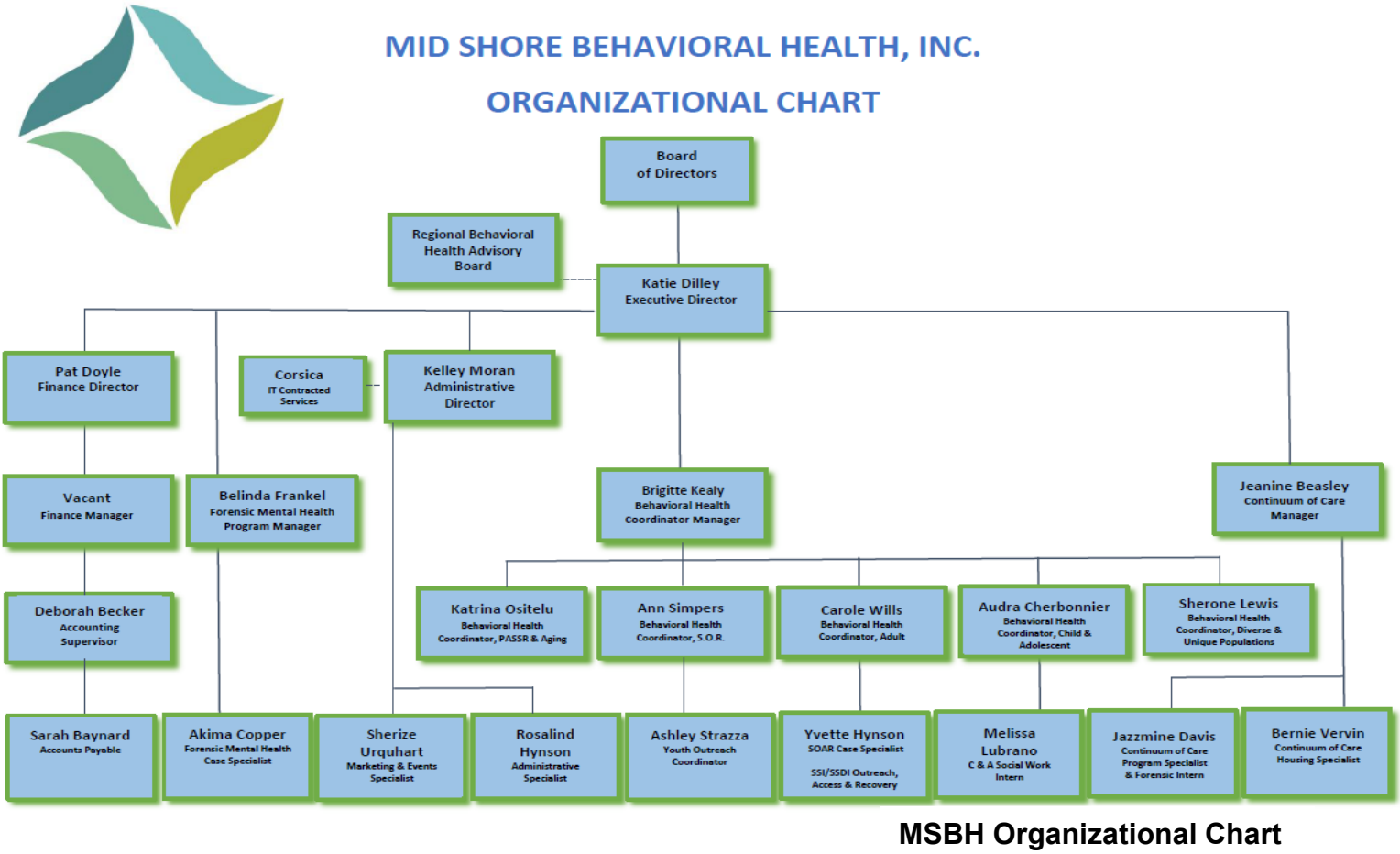
Providers in our system include state psychiatric hospitals, acute hospitals, residential treatment centers, outpatient mental health clinics, psychiatric rehabilitation programs, partial hospitalization services, intensive outpatient services and private providers

For information on how the Public Behavioral Health System works go to page 74.



MID SHORE BEHAVIORAL HEALTH

28578 Mary's Ct., Suite 1
Easton, MD 21601
P: 410.770.4801 F: 410.770.4809
Website: midshorebehavioralhealth.org
Facebook: /midshorebehavioralhealth



MSBH Organizational Chart

Visit www.midshorebehavioralhealth.org/our-team for a list of current staff.

Mid Shore Behavioral Health, Inc. (formally Mid-Shore Mental Health Systems, Inc.) can assist you by providing information regarding area resources and other agencies in the area.

MSBH aids consumers of the public behavioral health system receiving behavioral health treatment and rehabilitation services within the fee for service network. This assistance is obtained via a "Consumer Support Services" Request for pharmacy assistance, transportation to behavioral health-related appointments, laboratory costs as it relates to behavioral health treatments, and other support needs that help to achieve or stabilize community placement, which include one-time annual help with first month's rent, security deposit, utility turn on or deposit, basic household goods to establish a residence, or past due utility, rent, or mortgage if the applicant can show sustainability, referred to as a "special needs." All applications are subject to evaluation and approval. Incomplete applications will be denied and returned.

MSBH can also assist with concerns you may have regarding the services you or a family member are receiving. We first encourage you to discuss your concerns directly with the provider. However, if you feel you need further assistance, please call our office.

If you have been denied a service by Optum Maryland Behavioral Health (formerly Beacon Health), the Administrative Services Organization (ASO), you have the right to appeal that decision. Please refer to the *Grievances and Appeals* section of this guide for more information.

MSBH has a Behavioral Health Services Network (BHSN) that meets quarterly to discuss trends, changes, and issues concerning behavioral health on the Eastern Shore. The network comprises six workgroups whose members include providers, consumers, and behavioral health professionals.

These workgroups are:

- Diversity and Inclusion Workgroup
- Child and Adolescent Workgroup
- Adult Services Workgroup
- Crisis Response Workgroup
- Forensic Workgroup
- Continuum of Care Roundtable on Homelessness

Those interested in helping us build the best Public Behavioral Health System are encouraged to participate in these groups and can call 410-770-4801 or visit our website: www.midshorebehavioralhealth.org/ for more information. If you would like to be added to our weekly Mid Shore Behavioral Health Newsletter, please email your request to: Sherize Urquhart at surquhart@midshorebehavioralhealth.org.

Acronyms and Other Terms

ACA – Affordable Care Act
ACT – Assertive Community Treatment
AHAR – Annual Homeless Assessment Report
ASO – Administrative Services Organization
BHA – Behavioral Health Administration
BHSN – Behavioral Health Services Network
CAF – Community Alternatives Framework
CCO – Care Coordination Organization
CMHP – Community Mental Health Plan
CIT – Crisis Intervention Team
CME – Case Management Entity for the 1915C RTC waiver. The Local CME is Maryland Choices until June 2016.
COC – Continuum of Care (Mid-Shore Roundtable)
COMAR – Code of Maryland Regulations
CQT – Consumer Quality Team
CSR – Client Service Representative
CVI – Chesapeake Voyagers Inc.
EBP – Evidence Based Practice
ESOC – Eastern Shore Operations Center
FFS – Fee for Service
HSAM – Human Services Agreement Manual
HMIS – Homeless Management Information System
IAC – Inter-Agency Committee - The purpose of this committee is to discuss children who are causing concern in the school or the community and develop plans to improve his/her function in these areas.
IFPS – Interagency Family Preservation Services - This service is to help prevent out-of-home placement for youth who are at imminent risk of removal from their homes.
IOP – Intensive Outpatient Program
LAA – Local Addiction Authority
LBHA – Local Behavioral Health Authority
LCT – Local Care Team - The role of the LCT is to ensure that community alternatives have been exhausted before a child is placed in institutional care. If appropriate, community services will be developed to prevent placement in institutional care.
LMB – Local Management Board
MA – Medical Assistance
MAI – Medical Assistance Ineligible (formerly called and still referred to as Gray Zone or GZ)
MACSA – Maryland Association of Core Service Agencies
MCO – Managed Care Organization
MCSS – Mobile Crisis Stabilization Services
MCT – Mobile Crisis Teams
MDH -- Maryland Department of Health
MSBH – Mid Shore Behavioral Health, Inc.

Licensure Acronyms

APRN – Advanced Practice Registered Nurse
ATR – Art Therapist Registered
ATR-BC – Art Therapist Registered – Board Certified
CAC – Certified Addictions Counselor
CADAC – Certificated Alcohol and Drug Abuse Counselor
CAP – Certified Addictions Professional
CAS – Certified Addictions Specialist
CCADC – Certified Clinical Alcohol and Drug Counselor
CCDP – Certified Chemical Dependency Professional
CRNP – Certified Registered Nurse Practitioner
CSC-AD – Certified Supervised Counselor - Alcohol and D
CPC – Certified Professional Counselor
LCADC – Licensed Clinical Alcohol and Drug Counselor
LCMFT – Licensed Clinical Marriage and Family Therapis
LCPAT – Licensed Clinical Professional Art Therapist
LCPC – Licensed Clinical Professional Counselor
LCSW-C – Licensed Certified Social Worker – Clinical
LMSW – Licensed Masters Social Worker
MD – Doctor of Medicine
PhD – Doctor of Philosophy
PsyD – Doctor of Psychology

MTT/MTS – Mobile Treatment Team / Mobile Treatment Services
Multi-D – The Multi-Disciplinary Team - the purpose is to discuss cases from Child Protective Services or IAC that had multi-agency involvement.
OHCQ – Office of Health Care Quality
OMHC – Outpatient Mental Health Clinic
PATH – Projects for Assistance in Transition from Homelessness
PHP – Partial Hospitalization Program
PIP – Performance Improvement Plan
PBHS – Public Behavioral Health System
PRP – Psychiatric Rehabilitation Program
RBHAC – Regional Behavioral Health Advisory Committee
RRP – Residential Rehabilitation Program
RTC – Residential Treatment Center
SEP – Supported Employment Program
SSDI – Social Security Disability Insurance
SSI – Supplemental Security Income
TAY – Transitional Age Youth Project - A state funded grant to assist youth from 16 to 22 in transitioning to independent living. Youth are to have been in RTC or at risk of going to RTC. Emphasis is on education, community integration and building a natural support system.
UCC – Urgent Care Clinic

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Behavioral Health Services

Arundel Lodge – Deaf and Hard of Hearing Services					
Address:	2600 Solomons Island Rd Edgewater, MD 21037	**Phone:** **Video Phone:** **Fax:**	443-433-5900 443-569-6947 410-841-6045	**Website:** www.arundellodge.org	**Hours of Operation:** Mon. – Fri. 8:30am to 5pm
ARUNDEL LODGE behavioral health *hope re-imagined*	Arundel Lodge provides services for Deaf and hard-of-hearing individuals who seek community behavioral health treatment. We employ sign language interpreters to facilitate communication with hearing staff members and other community providers, and staff members who are themselves deaf and/or are knowledgeable about the needs of Deaf and hard-of-hearing individuals communicate using American Sign Language (ASL). Through these services, Arundel Lodge makes programs accessible to Deaf and hard-of-hearing individuals to support their recovery. Programs include: Supported Employment, Day Program, Residential Services, Outpatient Mental Health Clinic, First Step Recovery, Health Home, Peer Support, Supportive Living, and Teletherapy Videoconferencing.				

Bridge's Behavioral Health & Wellness

Address:	Phone: / Fax: / Website: / Email:	Hours of Operation:	Payment Types Accepted:
207 N. Liberty Street, Suite B Centreville, MD 21617	410-758-8750 410-758-8751 www.bridgesbehavioral.com staff@bridgesbehavioral.com	Mon., Wed., Thurs. 8am to 5pm, Tues. 8am to 7pm, Fri. 8am to 2pm	Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LMSW ☑ LCSW-C ☑ LCPC ☑ PhD ☑ MD ☑ RN	☑ Anger Management Group ☑ Certified Trauma Therapy ☑ Clinical Psychiatric Evaluation ☑ Court-ordered Therapy ☑ Dual-Diagnosis Groups ☑ Geriatric Assessment ☑ Mental Health Evaluation & Treatment ☑ Parent Education Groups ☑ Psychiatric Medication Services ☑ School-based Services ☑ Tele-psychiatry Services ☑ Veteran Services ☑ Women's Grou	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors	☑ Anger Management ☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Eye Movement Desensitization & Reprocessing ☑ Family Counseling ☑ General Counseling ☑ Grief Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Progressive Counting ☑ Psycho Educational Groups ☑ Trauma-Focused CBT
Translator?			
No			

Caroline Behavioral Health

Address:	Phone: / Fax:	Hours of Operation:	Website: / Payment Types Accepted:
403 S. 7th Street Denton, MD 21629	410-479-3800 410-479-1882 410-479-0052	Mon. – Fri. 8 am to 5 pm, Mon., Tues., Thurs. – evenings by appointment only	www.carolinehd.org Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ CRNP ☑ Nurse	☑ Clinical Psychiatric Evaluation ☑ DUI Offender Programs ☑ Ex-Offender Reentry Programs ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Medication Services ☑ Substance Abuse Education/Prevention ☑ Substance Abuse Outpatient ☑ Veteran Services ☑ Youth Development	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Developmental Dissabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Physical Disabilities ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Substance Abuse/ Dependence	☑ Art Therapy ☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Disability Related Counseling ☑ Family Counseling ☑ LGBTQ Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Sex Offender Counseling ☑ Tele psychiatry/Telemental Health ☑ Trauma Informed
Translator?			
Yes. Spanish			

Coastal Counseling & Wellness, LLC

Address:	10 S. Hanson Street, Unit #5 Easton, MD 21601	**Phone:** 443-786-5437 **Fax:**	**Hours of Operation:** Mon. – Fri. 8am to 5pm, Sat. 8am to 11 am **Email:** coastalcounselingwellnessctr@gmail.com **Website:** www.coastalcounselingwellness.com	**Payment Types Accepted:** Sliding Scale Fee, Self-Pay, Public Behavioral Health, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCPC	☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Depression ☑ Developmental Disabilities ☑ Post-Traumatic Stress Disorder	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy ☑ Family Counseling ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Mental Health Support Groups ☑ Play Therapy ☑ Art-based Therapy
Translator? No			

For ages 6 and up, the following services are available in office: Individual (may be available in school), Family, Couples & Groups. For those seeking traditional talk therapy in a non-traditional setting, Walk-about sessions are available.

Community Behavioral Health

Dorchester:	426 Dorchester Avenue Cambridge, MD 21613	**Phone:** 844-224-5264 **Fax:** 888-509-0010	**Hours of Operation:** Mon. – Thurs. 8am to 6pm, Fri. 8am to 5pm, Sat. please call **Email:** info@communitybehavioralhealth.net	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance **Website:** www.communitybehavioralhealth.net
Queen Anne:	202 Coursevall Dr, Ste.7 Centreville, MD 21617	**Phone:** 844-224-5264 **Fax:** 888-509-0010		
Kent:	400 S. Cross St, Ste. 4, Chestertown, MD 21620			
Talbot:	8614 Ocean Gateway Easton, MD 21601			
Wicomico:	809 & 821 Eastern Shore Dr. Salisbury, MD 21804	**Phone:** 844-224-5264 **Fax:** 888-509-0010		

Providers:	Services:	Conditions Served:	Treatment Modalities:

☑ LCSW-C ☑ LMSW ☑ LCPC ☑ LGPC ☑ PhD ☑ MD ☑ CRNP ☑ PA-C ☑ Nurse ☑ APRN/PMH **Translator?** Yes. Spanish, Hindi, Gujarati, and Urdu	☑ Clinical Psychiatric Evaluation ☑ Court Ordered Substance Use Testing ☑ Health Home ☑ Job Search/Placement ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation ☑ Psychiatric Case Management ☑ Psychiatric Day Treatment ☑ Psychiatric Rehabilitation Program Off-Site ☑ Psychiatric Rehabilitation Program On-Site ☑ Psychological Testing ☑ Respite Care ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Intensive Outpatient ☑ Substance Use Outpatient ☑ Case Management ☑ Urgent Care Appointment ☑ Veterans	☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy ☑ Dialectical Behavior Therapy ☑ Eye Movement Desensitization & Reprocessing ☑ Family Counseling ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Telepsychiatry/Telemental Health ☑ Transcranial Magnetic Stimulation (TMS) ☑ Trauma Informed

Corsica River Mental Health Services

Dorchester:	403 High Street Cambridge, MD 21613	**Phone:** 443-225-5780 **Fax:** 443-225-5783	**Hours of Operation:** Admin/Billing: Mon. – Fri. 8:30am to 5pm Dorchester: Mon. – Thurs. 8:30am to 5pm, Fri. 8:30am to 4pm Queen Anne's: Mon - Thurs. 8:30am to 7pm, Fri. 8:30am to 4pm Talbot: Tue. 8am to 4:30pm Caroline: Tue. And Thurs. 8:30am-5pm	**Email:** CorsicaClinic@crmhsinc.com **Website:** www.crmhsinc.com **Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance
Queen Anne:	120 Banjo Lane Centreville, MD 21617	**Phone:** 410-758-2211 **Fax (main):** 410-758-0698		
Talbot:	933 S. Talbot Street St. Michaels, MD 21663	**Phone:** 410-745-8028 **Fax:** 410-745-0492		
Caroline:	322 N. Main Street Federalsbury, MD 21632	**Phone:** 410-479-0511 **Fax:** 410-754-6080		

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ MD ☑ CRNP ☑ Nurse **Translator?** Yes. Spanish	☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ Deaf Services ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Mobile Treatment/ACT ☑ Psychiatric Medication Services ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Outpatient ☑ Urgent Care Appointments ☑ Veterans ☑ Walk-in (registration only) ☑ Homeless Outreach ☑ Targeted Case Management Adults	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Developmental Disabilities ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Dialectical Behavior Therapy (DBT) ☑ Family Counseling ☑ General Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed

Dorchester County Wellness Center Program

Mailing Address / Admin Office: 3 Cedar Street, Cambridge, MD 21613	**Phone:** 410-228-3223 **Fax:** 410-901-8181 **Website:** www.dorchesterhealth.org	**Hours of Operation:** Monday – Friday 8am to 5pm	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance

Dover Behavioral Health Systems

Address: 725 Horsepond Road, Dover, DE 19901 **Georgetown Campus:** 404 S Bedford Street, Georgetown, MD 19947	**Phone:** 302-741-0140 / 855-609-9711 **Fax:** 302-741-8551 **Website:** www.doverbehavioral.com	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Self-Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW ☑ PhD ☑ MD ☑ PA-C ☑ Nurse ☑ APRN/PMH	☑ Clinical Psychiatric Evaluation ☑ Detoxification ☑ Hotline ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Day Treatment ☑ Psychiatric Hospitalization ☑ Substance Use Intervention Program ☑ Substance Use Inpatient Co-Occurring Capable (<30 days) ☑ Substance Use Intensive Outpatient ☑ Veterans ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Mental Health Related Support Groups ☑ Psycho Educational Groups ☑ Trauma Informed

Translator?

Yes. Spanish

Dover Behavioral Health System
Caring, Consistent, Collaborative Healthcare

Eastern Shore Hospital Center

Address: 5262 Woods Road, P.O. Box 800, Cambridge, MD 21613	**Phone:** 410-221-2300 / 888-216-8110 **Fax:** 410-221-2497 **Website:** www.health.maryland.gov/ESHC	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Self-Pay, Public Behavioral Health

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LMSW ☑ PhD ☑ MD ☑ Psy D ☑ Nurse	☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ General Mental Health Info/Education ☑ Geriatric Assessment ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Older Adult/Aging Issues ☑ Psychiatric Case Management ☑ Psychiatric Hospitalization ☑ Psychiatric Medication Services ☑ Psychological Testing ☑ Substance Use Education/Prevention	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Art Therapy ☑ Cognitive Behavioral Therapy (CBT) ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Mental Health Related Support Groups ☑ Pet Assisted Therapy ☑ Psycho Educational Groups ☑ Trauma Informed

Translator?

Use language line & interpreters.

ESHC's mission is to serve citizens of the State of Maryland by providing the highest quality continuum of adult inpatient care, transitional mental health services, and forensic evaluations and treatment based on principles of recovery, wellness, and trauma informed care.

Eastern Shore Psychological Services

Kent:	315 High Street, Suite 201 Chestertown, MD 21620	**Phone:** **Fax:**	443-282-0102 / 0104 443-480-0121	**Website:** www.espsmd.com		**Hours of Operation:** Mon. – Thurs. 8am to 8pm, Fri. 8am to 6 pm, Sat. 8am to 4pm	
Talbot:	29520 Canvasback Drive Easton, MD 21601	**Phone:** **Fax:**	410-822-5007 410-822-5569	**Email:** infoprincessanne@espsmd.com infoeaston@espsmd.com infosalisbury@espsmd.com		**Payment Types Accepted:** Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance	
Wicomico:	1113 Healthway Drive Salisbury, MD 21801	**Phone:** **Fax:**	410-334-6961 410-334-6960				

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ MD ☑ CRNP ☑ LCADC ☑ Addictions Counselors	☑ Clinical Psychiatric Evaluation ☑ DUI Offender Programs ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Case Management ☑ Psychiatric Medication Services ☑ Psychiatric Rehabilitation Program Off-site ☑ Psychiatric Rehabilitation Program On-site ☑ Psychological Testing ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Outpatient ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Deaf and Hard of Hearing ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Emotionally Focused Therapy (EFT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Sex Offender Counseling ☑ Trauma Informed / Trauma-Focused CBT
Translator? No			

ESPS provides psychotherapy, psychological evaluation, psychiatric assessment and medication management, addiction treatment, as well as family advocacy (PRP) services to children, adolescents, and adults in the Mid Shore area. The agency's licensed mental health providers offer individual, couples, family, and group therapy at our outpatient location and in all of the Talbot County public schools. Their interdisciplinary team can help with all mental health and substance use disorders, trauma reactions, and problems of living within a holistic framework.

For All Seasons, Inc

Caroline:	114 Market Street, Suite 207 Denton, MD 21629	**Phone:** 410-822-1018 **Fax:** 410-479-0067	**Email:** info@forallseasonsinc.org **Website:** www.forallseasonsinc.org **24/7 Hotline Number:** 1-800-310-7273 410-829-6143 **(Spanish Hotline and Text)** **Hours of Operation:** Mon. – Thurs. 8am to 5pm Fri. 8am to 4:30pm M-F evenings and Saturdays by appointment only.	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance, EAP, United Way
Dorchester:	208 Cedar Street Cambridge, MD 21613	**Phone:** 410-822-1018 **Fax:** 410-228-2529		
Kent:	516 Washington Avenue, Suite 4 Chestertown, MD 21620	**Phone:** 410-822-1018 **Fax:** 410-778-7595		
Queen Anne:	141 Log Canoe Circle Stevensville, MD 21666	**Phone:** 410-822-1018 **Fax:** 443-249-3237		
Talbot:	300 Talbot Street Easton, MD 21601	**Phone:** 410-822-1018 **Fax:** 410-820-5884		
	8221 Teal Drive, Suite 427	**Phone:** 410-822-1018 **Fax:** 410-690-7345		

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ LMSW ☑ LCPAT ☑ MD ☑ CRNP ☑ Nurse ☑ RN ☑ PMHNP-BC (Psychiatric & Mental Health Nursing)	☑ Crisis Intervention ☑ DUI Offender Programs ☑ General Mental Health Info/Education ☑ Hotline – Sexual Assault/Rape Victims ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Mobile Crisis Stabilization Services (Youth) ☑ Psychiatric Medication Services ☑ Latino Programs and Groups ☑ School Based Mental Health ☑ Substance Use Outpatient ☑ Urgent Care Appointments ☑ Veterans ☑ Victims of Human Trafficking	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Crime Victim/Witness Counseling ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Trauma Informed
Translator? Yes. Spanish and Language Line			

FAS is a private, not for profit, licensed outpatient mental health clinic offering a full continuum of outpatient mental health treatment with offices in Easton, Denton, Cambridge, Stevensville, and Chestertown. FAS also serves as the Sexual Assault/Rape Crisis Center, providing 24/7 Hotline, Advocacy and Crisis Counseling for child and adult victims of sexual violence. Many victim services are provided at no charge and mental health treatment is offered regardless of an individual's ability to pay. In these circumstances, FAS assists individuals in obtaining public insurance or accesses grants to cover treatment.

Kent County Behavioral Health

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
300 Scheeler Road Chestertown, MD 21620	410-778-5783 Fax: 410-778-7344 Website: www.kenthd.org	Mon. – Thurs. 8 am to 6pm Fri. 8am to 5pm	Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare,

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ Nurse ☑ CRNP ☑ PMH	☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ General Mental Health Info/Education ☑ Geriatric Assessment ☑ Mental Health Evaluation & Treatment ☑ Older Adult/Aging Issues ☑ Psychiatric Medication Services ☑ Urgent Care Appointments ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups

Translator?
No

Lower Shore Clinic, Inc.

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
505 E. Main Street Salisbury, MD 21804	410-341-3420 Fax: 443-859-7774 (referral) Website: 410-341-3397 www.lowershoreclinic.org	Mon. and Thurs. 8am to 8pm, Tues. and Wed. 8am to 5pm, Fri. 8am to 4pm	Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ CRNP ☑ PA-C ☑ Nurse ☑ APRN/PMH	☑ Clinical Psychiatric Evaluation ☑ General Mental Health Info/Education ☑ Mental Health Evaluation & Treatment ☑ Mobile Treatment/ACT: 410-341-9696 ☑ Psychiatric Medication Services ☑ Same Day Access ☑ Urgent Care Appointments ☑ Veterans	☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management ☑ Cognitive Behavioral Therapy (CBT) ☑ Dialectical Behavior Therapy (DBT) ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ General Counseling ☑ Group Therapy ☑ Family Counseling ☑ Individual Therapy ☑ Individual Counseling ☑ Psycho Educational Groups ☑ Telepsychiatry/Telemental Health

Translator?
Yes

lower shore clinic

Lower Shore Clinic's mission is to provide caring, effective, and highly accessible healthcare through evaluation, screening, referral, healthcare treatment, and community support to all the persons of the Eastern Shore of Maryland who seek services.

Marshy Hope Family Services, LLC

Address:	Phone: / Fax: / Email: / Web:	Hours of Operation:	Payment Types Accepted:
813-1 Chesapeake Dr. Cambridge, MD 21613	410-221-2266 410-221-2878 marshyhope@marshyhope.com www.marshyhope.com	Mon. – Thurs. 8am to 6pm, Fri. 8am to 5pm, every other Sat. 8am to 3pm	Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ CRNP-PMH	☑ Clinical Psychiatric Evaluation ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Medication Services	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Play Therapy ☑ Psycho Educational Groups ☑ Telepsychiatry/Telemental Health
Translator? No			

Rebirth, Inc.

Address:	Phone: / Website: / Email:	Hours of Operation:	Payment Types Accepted:
225 N Division St Salisbury, MD 21801	410-264-1441 www.Rebirth4hope.org rebirth4hope@gmail.com	Monday, Wednesday, Friday 9am to 2pm	Grant Funds, Donations

Providers:	Services:	Resources Provided:	Resources Continued:
☑ Community Health Healthcare Major	☑ Adult Day Programs ☑ General Mental Health Information/Education ☑ Job Search/Placement ☑ Protection and Advocacy for Individuals with Disabilities ☑ Substance Abuse Education/Prevention ☑ Youth Development .	☑ Virtual School Technology Access Support Center ☑ WRBY | 100.5FM Radio Oasis: An FCC licensed community base Radio Station ☑ Opioid Outreach | Education, prevention, and treatment ☑ OSHA / Workers Health & Safety Program ☑ Advocacy | Immigrant / workers rights, health & safety issues locally ☑ Financial Literacy	☑ Interpreting & translation: Bridging the gap for people & orgs ☑ Flag Day Heritage Celebration | An annual cultural festival & Official Proclamation ☑ Backpacks Giveaway | back to school giveaway to low income & Partner with County ☑ Soccer Program | children soccer clinic & family leisure, Partner with Parc & Rec
Translator? Yes. Haitian/Creole			

School-Based Locations

Mace's Lane Middle School:
1101 Maces Lane
Cambridge, MD 21613
410-228-0973
Fax: 410-228-0513

North Dorchester High School:
5875 Cloverdale Road
Hurlock, MD 21643
410-943-3316
Fax: 410-943-3397

North Dorchester Middle School:
5745 Cloverdale Road
Hurlock, MD 21643
410-943-3275
Fax: 410-943-3397

Cambridge - South Dorchester High School:
2475 Cambridge Beltway
Cambridge, MD 21613
410-228-3825
Fax: 410-228-7916

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ CRNP ☑ MD	☑ Acute Somatic Care ☑ Crisis Intervention ☑ Mental Health Evaluation & Treatment ☑ School Based Monitoring of Chronic Illness ☑ Urgent Care Appointments ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Self-Injurious Behaviors	☑ Anger Management Counseling ☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Play Therapy ☑ Psycho Educational Groups ☑ Trauma Informed
Translator? No			

Additional mental health and support services are available in some elementary schools for children impacted by incarceration. Please call 443-521-1662 for eligibility criteria. Hours and staff availability at each Wellness Center vary, please call for more information. The program is administered by the Dorchester County Health Department in collaboration with Dorchester County Public Schools.

Shore Behavioral Health

Address: 300 Byrn Street
Cambridge, MD 21613

Phone: 410-228-5511 ext. 2147
Fax: 410-476-5105
Website: www.shorehealth.org

Hours of Operation:
24 hours a day,
7 days a week

Payment Types Accepted:
Self-Pay, Medicaid, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ MD ☑ CRNP ☑ LCADC ☑ Nurse ☑ APRN/PMH	☑ Clinical Psychiatric Evaluation ☑ Mental Health Evaluation & Treatment ☑ Mental Health & Substance Use Services ☑ Mental Health Intensive Outpatient Therapy, ext. 2147 ☑ Psychiatric Emergency Room Care ☑ Psychiatric Hospitalization, ext. 2112 ☑ Psychiatric Medication Services ☑ Substance Use Outpatient and Intensive Outpatient, ext. 5452	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Dialectical Behavior Therapy (DBT) ☑ Emotionally Focused Therapy (EFT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ Individual Counseling ☑ Milieu Therapy ☑ Mindfulness Based Therapy Approaches
Translator? Use telephone interpreter.	UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH		

SBH offers emergency room evaluations, inpatient mental health and dual diagnosis treatment, intensive outpatient treatment for both mental health and addictions issues, as well as outpatient individual addictions treatment.

SUN Behavioral Delaware

Address: 21655 Biden Ave **Georgetown** Georgetown, DE 19947	**Phone:** 302-604-5600 **Fax:** 302-450-1177 **Website:** www.sundelaware.com **Email:** info@sundelaware.com	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Self-Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW ☑ PhD ☑ MD ☑ PA-C ☑ Nurse ☑ APRN/PMH	☑ Adult Day Programs ☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ Detoxification ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Day Treatment ☑ Psychiatric Hospitalization ☑ Psychiatric Medication Services ☑ Substance Abuse Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Inpatient Co-Occurring Capable (<30 days) ☑ Substance Use Intensive Outpatient ☑ Veterans ☑ Walk-in	☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Substance Use/Dependence	☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Dialectical Behavior Therapy (DBT) ☑ Emotionally Focused Therapy (EFT) ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Psycho Educational Groups ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed

Translator?

No, we use a translator machine

Upper Bay Counseling & Support Services

Administration: 200 Booth Street Elkton, MD 21921 **Cecil:** 1275-B W. Pulaski Hwy. Elkton, MD 21921	**Phone:** 410-996-5104 410-996-5197 **Phone:** 410-620-7161 410-620-7168	**Website:** www.upperbay.org **Email:** info@upperbay.org	**Hours of Operation:** Mon. – Thurs. 8am to 6pm, Fri. 8am to 3pm **Payment Types Accepted:** Grant Funds, Self-Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ MD ☑ CRNP ☑ Nurse ☑ Psy.D.	☑ Adult Day Programs ☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Mobile Treatment Team/ACT ☑ Psychiatric Medication Services ☑ Psychiatric Rehabilitation Program Off-site ☑ Psychiatric Rehabilitation Program On-site ☑ Psychological Testing ☑ Residential Rehabilitation Program ☑ Supported Employment ☑ Urgent Care Appointments	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Disability Related Counseling ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Play Therapy ☑ Psycho Educational Groups ☑ Trauma Informed

Translator?

Yes. Spanish

Warwick Manor Behavioral Health

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
3680 Warwick Road East New Market, MD 21631	410-943-8108 410-943-3976 www.warwickmanor.org	MH: Mon., Wed., Fri. 8am to 5pm, Tues. and Thur. 8am to 7:30pm, weekend hrs. available as needed	Self-Pay, Public Behavioral Health, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LMSW ☑ LCPC ☑ MD ☑ Nurse ☑ CRNP ☑ DO ☑ Addictions Counselors	☑ Ambulatory Detoxification ☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ Detoxification ☑ General Mental Health Info/Education ☑ Hotline ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Medication Services ☑ Substance Use Education/ Prevention ☑ Substance Use Inpatient (<30 days) ☑ Substance Use Inpatient Co-Occurring Capable (<30 days) ☑ Substance Use Intensive Outpatient ☑ Substance Use Outpatient ☑ Substance Use Partial Hospitalization Program	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Substance Use/Dependence ☑ Trauma Warwick Manor Behavioral Health, Inc.	☑ Age-Related and Gender-Related Groups ☑ Anger Management Counseling ☑ Behavioral Modification ☑ Cognitive Behavioral Therapy (CBT) ☑ Dialectical Behavior Therapy (DBT) ☑ Emotional Regulation Therapy ☑ Existential Psychology ☑ Family Counseling ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Mindfulness Based Therapy ☑ Motivational Interviewing ☑ Psycho Educational Groups ☑ Rational Emotive Behavioral Therapy ☑ Trauma Informed and Trauma Groups

Translator?
No

Warwick Manor Behavioral Health (WMBH) specializes in co-occurring diagnosis and treatment and provides inpatient, PHP, IOP and outpatient services.

Worcester County Health Department

Main Office:	6040 Public Landing Road P.O. Box 249 Snow Hill, MD 21863	**Phone:** **Fax:**	410-632-1100 410-632-5682	**Website:** www.worcesterhealth.org		**Payment Types Accepted:** Grant Funds, Self-Pay, Public Behavioral Health, Medicare, Private Insurance	
Berlin Health Department:	9730 Healthway Drive Berlin, MD 21811	**Phone:** **Fax:**	410-629-0164 410-629-0185	**Hours of Operation:** Mon. – Fri. 8am to 5pm, Evenings and Saturdays by appointment only, Pocomoke Health Center closed on Fridays.			
Pocomoke Health Center:	400 Walnut Street Pocomoke City, MD 21851	**Phone:** **Fax:**	410-957-2005 410-957-2417				

Worcester County Health Department

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ MD ☑ LCADC ☑ Nurse	☑ Case Management ☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ Detentions Center Case Management ☑ DUI Offender Program ☑ Emergency Dept. Care Coordination ☑ Family Law Courts ☑ General Mental Health Info/Education ☑ Homeless Outreach ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Narcan Education and Distribution ☑ Peer Support ☑ Primary Care Services ☑ Psychiatric Medication Services ☑ Psychiatric Mobile Response Teams ☑ Psychiatric Rehabilitation Program Off-site ☑ Psychiatric Rehabilitation Program On-site ☑ Schoolbased Therapy ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Intensive Outpatient ☑ Substance Use Outpatient ☑ Urgent Care Appointments ☑ Veterans ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post-Traumatic Stress Disorder ☑ Schizophrenia ☑ Self-Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Play Therapy ☑ Psycho Educational Groups ☑ Sex Offender Counseling ☑ Telepsychiatry/Telemental Health ☑ Trauma-Focused CBT
Translator? No			

PRIVATE PROVIDERS

Anne Arundel Counseling, Inc.

Main Office: 7310 Ritchie Highway, Suite 1009 Glen Burnie, MD 21061 **Queen Anne's:** 633 Railroad Avenue Centreville, MD 21617 101 Log Canoe Circle, Suite C-3 Stevensville, MD 21666	**Phone:** 410-768-5988 **Fax:** 410-768-5989 **Phone:** Call main # **Fax:** Use main fax **Phone:** Call main # **Fax:** Use main fax	**Email:** info@annearundelcounseling.com **Website:** www.annearundelcounseling.com	**Hours of Operation:** Mon. – Fri. 8am to 9pm, Sat. 8am to 5pm **Payment Types Accepted:** Sliding Fee Scale, Self-Pay, Private Insurance	

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ CRNP ☑ LCADC	☑ Clinical Psychiatric Evaluation ☑ DUI Offender Programs ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Older Adult/Aging Issues ☑ Psychiatric Medication Services ☑ Psychological Testing ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Intensive Outpatient ☑ Substance Use Outpatient ☑ Urgent Care Appointments ☑ Youth Development	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring Disorders ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Crime Victim/Witness Counseling ☑ Death and Dying Counseling ☑ Dialectical Behavior Therapy (DBT) ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Emotionally Focused Therapy (EFT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Imago Relationship Therapy ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Sex Offender Counseling ☑ Trauma Informed

Translator?

No

Balance Point – Brighton Laznovsky, CHT, LCADC, LCSW-C & Ann H. Wilson, LCSW-C

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
408B North Washington Street Easton, Maryland 21601	443-786-2768 (B), 410-310-3403 (A) Fax: 410-770-7176 Email: b.laznovsky@gmail.com annhwilson@gmail.com	By appointment only	Sliding Fee Scale, Self Pay, Public Behavioral Health

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCADC	☑ Clinical Psychiatric Evaluation ☑ DUI Offender Program ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Outpatient	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Co-Occurring ☑ Complex Trauma ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Mood Disorders ☑ Obsessive Compulsive Disorder ☑ Post Traumatic Stress Disorder ☑ Relationship Issues ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Cognitive Behavioral Therapy (CBT) ☑ Couples and Relationship Counseling ☑ Equine Assisted Psychotherapy (see page 23) *The Horse Inspired Growth & Learning Center* ☑ Family Counseling ☑ General Counseling ☑ Group Counseling ☑ Grief Counseling ☑ Hypnotherapy ☑ Individual Counseling ☑ Life Counseling ☑ Marriage Counseling ☑ Parental Counseling ☑ Psychotherapy Counseling
Translator? No			

Bee Well
Sasha Whiting, LCSW-C

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
3 N. Harrison St. Suite 200 Easton, MD 21601	443-602-1269 Email: sashawhitingtherapy@gmail.com	By Appointment Only	Sliding Scale Fee, Self Pay, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Crisis Intervention ☑ General Mental Health Information/Education ☑ Mental Health and Substance Abuse Services ☑ Mental Health Evaluation ☑ Mental Health Evaluation & Treatment ☑ Substance Abuse Outpatient ☑ Urgent Care Appointments ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ ComplexTrauma ☑ Depression. ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Mood Disorders ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Abuse/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Dialectical Behavior Therapy (DBT) ☑ Emotive Memory Desensitization and Reprocessing (EMDR) ☑ Emotionally Focused Therapy (EFT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed
Translator? No			

Bee Well Holistic Healing and Mental Health Services takes an integrative approach to wellness. Sasha Whiting, LCSW-C is a certified Yoga Teacher who used holistic practices to address mental health concerns.

Kim Chase, LCSW-C

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
Contact for information	410-725-6965 Email: Kimchase.associates@gmail.com Web: https://kimchase-lcswc.com	Virtual Sessions By appointment only Tue 9 am – Noon Wed 9 am – 5 pm Thurs 9 am – 5 pm	Self Pay, Public Mental Health (MA/Uninsured Eligible), Medicare

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Mental Health Evaluation & Treatment	☑ Anxiety/Phobias ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Post Traumatic Stress Disorder	☑ Christian/Pastoral Counseling ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ General Counseling ☑ Geriatric Counseling ☑ Individual Counseling ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed
Translator?			
No			

Chesapeake Bay Psychological Services, LLC

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
155 Log Canoe Circle Stevensville, MD 21666	Phone: 410-604-0226 Fax: 877-643-0126 Website: www.chesapeakebaypsychological.com Email: questions@chesapeakebaypsychological.com	Mon. – Fri. Vary and by appointment only	Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ PhD ☑ LCPC	☑ Children & Family Services ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Older Adults/Aging Issues ☑ Psychological Testing	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Trauma Informed
Translator?			
No			

Chesapeake Bay Psychological Services provides a range of services for adults, adolescents, and children. They provide individual, couples and family therapy, psychological testing, consultation services for educational accommodations in grade school or college, and resolution of parenting differences. Please see their website for more information on their staff and areas of experience.

Chesapeake Counseling, LLC - Catherine Cripps, LCPC, LCPAT

Address:	Phone: / Fax: / Website: / Email:	Hours of Operation:	Payment Types Accepted:
506 Goldsborough Street Easton, MD 21601	410-819-8832 410-819-8832 www.psychologytoday.com cscripps410@gmail.com	Mon. – Thurs. 9am to 7pm, Fri. 9am to 12pm	Grant Funds, Sliding Fee Scale, Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCPC ☑ LCPAT	☑ Offers a continuum of verbal and non-verbal Processing for ages 6 and up. ☑ Mental Health Evaluation & Treatment ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Depression ☑ Eating Disorders ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors	☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Emotionally Focused Therapy (EFT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Psycho Educational Groups ☑ Trauma Informed
Translator? No			

Chester River Behavioral Health

Address:	Phone: / Fax: / Website: / Email:	Hours of Operation:	Payment Types Accepted:
952 Washington Avenue Chestertown, MD 21620	410-778-5550 410-778-0984 www.chesterriverbehavioral.com crbh@verizon.net	Mon. and Thurs. 9am to 7pm, Tues. 9am to 8pm, Wed. 9am to 6pm, Fri. 9am to 5pm	Self Pay, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ LCADC	☑ Conflict Resolution ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Older Adults/Aging Issues ☑ Pre-Employment Evaluations ☑ Pre-Surgical Evaluations ☑ Private Drug Testing ☑ Psychological Services for Cancer Patients & Caregivers ☑ Psychological Testing ☑ Sports Psychology ☑ Substance Use Education/Prevention ☑ Substance Use Outpatient ☑ Treatment for Adult Children of Alcoholics	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Personality Disorders ☑ Physical Disabilities ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Dialectical Behavior Treatment (DBT) ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Family Counseling ☑ General Counseli ☑ Geriatric Counsel ☑ Group Counselin ☑ Hypnotherapy ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy
Translator? Yes, Spanish			

J. David Collins & Associates – J. David Collins, LCSW-C

Dorchester:	828 Airpax Road Building B, Suite 300 Cambridge, MD 21613	**Phone:** 410-901-1333 **Fax:** 410-901-1366	**Website:** www.jdavidcollins.com **Hours of Operation:** Mon. – Fri. 9am to 8pm, Sat. 9am to 2pm	**Payment Types Accepted:** Self Pay, Public Behavioral Health, Medicare, Private Insurance
Wicomico:	540 Riverside Drive, Suite 8 Salisbury, MD 21801	**Phone:** 410-548-3333 **Fax:** 410-548-3341		
Somerset:	30256 Mt. Vernon Road Unit A Princess Anne, MD 21853	**Phone:** 410-548-3333 **Fax:** 410-621-5389		

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Case Management ☑ Crisis Intervention ☑ DUI Offender Program ☑ General Mental Health Info/Education ☑ Geriatric Assessment ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Substance Use Education/Prevention ☑ Substance Use Intervention Program ☑ Substance Use Intensive Outpatient ☑ Substance Use Outpatient	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Crime Victim/Witness Counseling ☑ Death and Dying Counseling ☑ Disability Related Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling
Translator? No			

Discovering Serenity Counseling Services, LLC

Address:	208 Devon Dr. Chestertown, MD 21620	**Phone:** **Fax:**	443-331-4708 443-926-9597	**Website:** www.discoveringserenity.com **Email:** rdemattia@discoveringserenity.com **Hours of Operation**: By appointment only (Mon, Tue, Wed, Fri)	**Payment Types Accepted:** Private Insurance, Self Pay

Provider:	Services:	Conditions Served:	Treament Modalities:
☑ LCSWC	☑ Mental Health Evaluation/ Treatment	☑ Anxiety/ Phobias ☑ Depression ☑ Grief ☑ Bereavement ☑ Stress	☑ Behavioral Treatment ☑ Christian/Pastoral Counseling ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Disability Related Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Individual Counseling ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed
Translator: No			

Specialing in grief, anxiety, stress, depression, and other life-altering experiences. This agency also offers Christian/Faith based counseling services.

G.W. Associates – Gail J. Weissert, LCSW-C

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
23627 Willow Pond Road Denton, MD 21629	410-479-0434 Fax: 410-479-2723 Email: weissert.gail@gmail.com Website: www.gweissert.com	Mon., Thurs. 8am to 5pm, Tues. and Wed. 8am to 9pm	Self Pay, Medicare, EAP Program, Private and Most Insurances

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Mental Health Evaluation & Treatment ☑ Older Adults/Aging Issues	☑ ADHD ☑ Anxiety/Phobias ☑ Depression ☑ Eating Disorders ☑ Post Traumatic Stress Disorder	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Emotionally Focused Therapy (EFT) ☑ Family Counseling ☑ General Counseling ☑ Hypnotherapy ☑ Individual Counseling ☑ Marriage Counseling ☑ Trauma Informed
Translator?			
No			

Harvesting Hope Youth and Family Wellness, INC. – Omeaka Jackson, M.A., LCPC

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
204 Cedar Street, Suite 102 Cambridge, MD 21613	443-351-4846 Fax: 443-378-8475 Website: www.harvestinghopeinc.org	Mon. 9am to 5pm, Tues. 1pm to 7pm, Wed. 10pm to 6pm, Thurs. 10am to 6pm	Sliding Fee Scale, Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCPC	☑ Anger Management Groups ☑ Crisis Intervention ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Mentoring/Mentor Training Program ☑ Parenting Groups ☑ Self Esteem Building Groups ☑ Social Skills Groups ☑ Substance Use Education/Prevention ☑ Urgent Care Appointments ☑ Veterans ☑ Youth Development ☑ Youth and Family Development Services ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Bullying ☑ Co-Occurring Disorders ☑ Depression ☑ Domestic Violence ☑ Post Traumatic Stress Disorder ☑ Substance Use/Dependence ☑ Trouble Teens	☑ Anger Management Counseling ☑ Art Therapy ☑ Behavioral Treatment ☑ Christian/Pastoral Counseling ☑ Cognitive Behavioral Therapy (CBT) ☑ Crime Victim/Witness Counseling ☑ Death and Dying Counseling ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Parental Counseling ☑ Play Therapy ☑ Psycho Educational Groups ☑ Sandplay Therapy ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed
Translator?			
No			

Harvesting Hope, Inc. is a youth and family services program sowing seeds of hope in the community. We work with a local high school to provide mentoring and peer leadership skills to the next generation of leaders and providing community-based training opportunities to local youth and families in partnership with local community agencies. Our Mission is to uplift the community by working in the community. Our youth are our greatest asset. When we invest in them, we invest in the future of our communities. Some people are born leaders while others need guidance and the tools to become leaders. Harvesting Hope, Inc. sow these seeds while our youth and community reap the benefits. When we invest in youth we invest in their family.

R. Hutchison, LLC - Rebecca Hutchison, LCSW-C

Address:	Phone: / Fax: / Email:	Hours of Operation:	Payment Types Accepted:
8221 Teal Dr. Suite 429. Easton, MD 21602	410-253-2824 855-273-7002 r.hutchisonLLC@outlook.com	Mon. 9am to 5pm Tue. 12pm to 7pm Wed. 8am to 5pm Thurs. 8am to 7pm Fri. by appt. only	Self Pay, Public Behavioral Health, Private Insurance (limited)

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors	☑ Cognitive Behavioral Therapy (CBT) ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Individual Counseling ☑ Trauma Informed ☑ Trauma Focused CBT
Translator? No			

R. Hutchison, LLC d/b/a R. Hutchison Behavioral Health & Consultation Services seeks to provide mental health consultation, assessment, and treatment to people of all ages and cultural backgrounds. Targeted populations include, but are not limited to, trauma survivors and LGBTQ individuals/couples.

Greenbrook TMS NeuroHealth Center

Address:	Phone: / Fax: / Email: / Web:	Hours of Operation:	Payment Types Accepted:
900 Bestgate Rd. Suite 121 Annapolis, MD 21401 218 N. Washington Street Suite 050 Easton, MD 21601	855-950-4867 855-721-4867 info@greenbrooktms.com www.greenbrooktms.com	Mon. – Fri. 7am-7pm	Self Pay, Public Behavioral Health, Medicaid, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD	☑ Transcranial Magnetic Stimulation	☑ Depression	☑ Transcranial Magnetic Stimulation
Translator? No			

Greenbrook TMS is the nation's leading and most experienced provider of Transcranial Magnetic Stimulation (TMS) Therapy. Greenbrook TMS provides an FDA-cleared treatment for Major Depressive Disorder (MDD). Transcranial Magnetic Stimulation (TMS Therapy) is a safe and effective treatment for those diagnosed with MDD who have not experienced satisfactory relief with their antidepressant medication.

Martha Gale Tucker, LCSW-C

Address:	Phone: / Fax: / Email:	Hours of Operation:	Payment Types Accepted:
104 Church Alley Chestertown, MD 21620	410-310-8414 410-778-2179 gale@chesarch.com	Mon. – Thurs. 8am to 6pm, Fri. – Sun. upon special request	Self Pay, Medicare, Public Behavioral Health, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C (over 20 years experience)	☑ Crisis Intervention ☑ General Mental Health Info/Education ☑ Older Adult/Aging Issues ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Depression ☑ Developmental Disabilities ☑ Physical Disabilities	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Disability Related Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Individual Counseling
Translator? No			

			☑ Marriage Counseling ☑ Play Therapy ☑ Trauma Informed

Julie Parsons, LCSW-C

Address:	Phone: / Email: / Web:	Hours of Operation:	Payment Types Accepted:
7675 Tred Avon Circle Easton, MD 21601	202 641 3465 julie4therapy@gmail.com www.julie4therapy.com	Hours vary depending on client needs	Self Pay, Private Insurance **(Only accept Carefirst BCBS)**

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C		☑ Anxiety/Phobias ☑ Depression ☑ Eating Disorders	☑ Cognitive Behavioral Therapy (CBT) ☑ Emotionally Focused Therapy (EFT) ☑ Individual Counseling ☑ Psychodynamic Psychotherapy
Translator?			
No			

Katharine Petzold, LCSW-C

Address:	Phone: / Email: / Web:	Hours of Operation:	Payment Types Accepted:
3 North Harrison St Ste 206 Easton, MD 21601	410-819-2150 klp@klptherapy.com www.KLPtherapy.com		Self Pay, Medicaid, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Mental Health Evaluation & Treatment	☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illnessg ☑ Depression ☑ Personality Disorder ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors	☑ Cognitive Behavioral Therapy (CBT) ☑ General Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed
Translator?			
No			

Valerie Lamont, PhD, LCPC

Address:	Phone: / Fax: / Email:	Hours of Operation:	Payment Types Accepted:
114 N. Washington Street, Room 30 Easton, MD 21601	410-819-0001 410-819-0001 docval114@aol.com	Closed Monday and Tuesday Wednesday 9 to 3 Thursday. 9 to 3 Friday. 9 to 3 Saturday morning by appointment	Sliding Fee Scale, Self Pay, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCPC ☑ PhD	☑ Career Counseling ☑ EAP Referrals ☑ Mental Health Evaluation & Treatment ☑ Life Stage Aging	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Depression ☑ Personality Disorders ☑ Relationship Issues	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Individual Counseling ☑ Marriage Counseling

Translator?

No

Catherine Molz, LCSW-C

Address:	Phone: / Fax: / Website: / Email:	Hours of Operation:	Payment Types Accepted:
104 S. Cross Street Chestertown, MD 21620 Mailing: P.O. Box 193 Worton, MD 21678	410-778-0234 410-778-2665 www.catherinewmolz.com catherinewmolz@msn.com	By appointment only	Sliding Fee Scale, Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Mental Health Evaluation & Treatment	☑ ADHD ☑ Anxiety/Phobias ☑ Co-Occurring ☑ Personality Disorders ☑ Post Traumatic Stress Disorder	☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ General Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Play Therapy

Translator?

No

Manuel L. Morales, PhD

Address:	Phone: / Fax:	Hours of Operation:	Payment Types Accepted:
116 Sout Piney Road Chester, MD 21619	410-643-8077 410-643-3777	Tuesday and Thursday 3pm to 8pm	Sliding Fee Scale, Self Pay, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ PhD	☑ Mental Health Evaluation ☑ Psychological Testing	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Depression ☑ Post Traumatic Stress Disorder	☑ Behavioral Therapy ☑ Cognitive Behavioral Therapy (CBT)

Translator?

Yes. Spanish

Peace of Mind Mental Health Services

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
29315 Erickson Dr Easton, MD 21601	410-690-8181 410-690-8185 www.peaceofmindmhs.com	By appointment only Mon. – Thurs. 9am to 7pm, Fri. 9am to 6pm, Sat. 9:30am to 3:30 pm	Sliding Fee Scale, Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ CRNP ☑ LCPC	☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Medication Services	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Depression ☑ Developmental Disabilities ☑ Personality Disorders ☑ Perinatal Mood Disorder ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders	☑ Anger Management Counseling ☑ Anixiety Treatment ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Couples Counseling ☑ Death and Dying Counseling ☑ Dialectical Behavior Therapy (DBT) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issue ☑ Geriatric Counseling ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Trauma Informed
Translator?			
No			

Peace of Mind Mental Health Services started with a simple premise: Make available to every person the mental health resource needed to live a healthy life. Visit the web for more information and a current list of available therapists.

Rhythmic Foundations, LLC – Amanda McEntegart, MT-BC

Address:	Phone: / Email: / Website:	Hours of Operation:	Payment Types Accepted:
Call for Information	410-829-9281 info@rfmusictherapy.com www.rfmusictherapy.com	Call for information	Private Pay, LLC Network Provider

Music therapy is the clinical and evidenced-based practice in which non-musical goals are achieved within a therapeutic relationship using various music interventions. Services are facilitated by a Board-Certified Music Therapist. Rhythm is the "organizer and energizer." Like a home that needs a strong foundation upon which to stand, or a tree's roots that must be firmly planted in the ground, rhythm helps to establish that strong foundation to begin to explore, express, and develop.

Rhythmic Foundations, LLC's goal is to provide that foundation for individuals to accomplish various goals in order to maintain and enhance quality of life.

Serves Caroline, Queen Anne's, and Talbot counties.

Project Chesapeake

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
114 Market Street, Suite 103 Denton, MD 21629 34 Defense Street, Suite 100 Annapolis, MD 21401 5710 Ritchie Highway Brooklyn Park, MD 21225 202 Coursevall Drive, Suite 104 Centreville, MD 21617	**Phone:** 443-448-5070 **Fax:** 443-448-5070 **Website:** www.projectchesapeake.com	Mon-Thurs 9:00am-9:30pm Fri- 9:00am-3:00pm Sat & Sun - Closed	Sliding Fee Scale, Self Pay, Public Behavioral Health, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ MD ☑ LCPC ☑ LMSW **Translator?** No	☑ Clinical Psychiatric Evaluation ☑ DUI Offender Programs ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Methadone Maintenance ☑ Psychiatric Medication Services ☑ Psychiatric Rehabiliation Program Off-site & On-site ☑ Suboxone Maintenance/Therapy ☑ Substance Use Education/Prevention ☑ Substance Use Outpatient & Intensive Outpatient	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring Disorders ☑ Dementia ☑ Depression ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Substance Use/Dependence	☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Telepsychiatry/ Telemental Health

Shore Neurocognitive Health, LLC Beth Parker- Obrien, LCSW-c

Address	Phone: / Fax: / Website: / Email:	Hours of Operation:	Payment Types Accepted
29466 Pintail Drive#9 Easton, MD 21601	443-746-3698 410-862-3013 snhealth.net bethpo@snhealth.net	Mon-Thur. 8:00am-5:00pm Friday 8:00am-12:00pm	Self Pay, Medicare

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ CRNP ☑ PsyD **Translator?** No	☑ Geriatric Assessment ☑ Older Adult/ Aging Issues ☑ Psychological Testing	☑ Anxiety/ Phobias ☑ Dementia ☑ Depression ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ PTSD	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Psycho Education Groups

Specializing in dementia and anxiety/ depression disorders affecting the older adult, *Shore Neurocognitive Health*, in collaboration with local providers and organizations, assists in providing comprehensive care to individuals, families and caregivers facing the challenges of dementia.

Brenda C. Scribner, MD

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
10 S. Hanson Street, Suite 5 Easton, MD 21601	**Phone:** 331-223-9262 **Text:** 331-223-9262 **Fax:** 866-266-4480 **Website:** www.scribner.yourmd.com **Email:** Brenda.Scribner@gmail.com	Monday – Friday 8:30am to 4:30pm	Self Pay, Sliding Scale Fee (for pregnant and postpartum women)

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ MD	☑ Clinical Psychiatric Evaluation ☑ Mental Health Evaluation & Treatment ☑ Private Psychotherapy ☑ Psychiatric Medication Services ☑ Private Psychotherapy	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Co-Occurring Disorders ☑ Depression ☑ Eating Disorders ☑ Mood Disorders ☑ Obsessive Compulsive Disorder ☑ Post Traumatic Stress Disorder ☑ Relationship Issues ☑ Sexual Disorders ☑ Substance Use Disorders	☑ Anger Management Counseling ☑ Cognitive Behavioral Therapy (CBT) ☑ Couples Therapy ☑ Death and Dying Counseling ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Family Counseling ☑ Individual Counseling ☑ Life Counseling ☑ Parent Counseling
Translator? No			

Kaitlin M. Waldrip, LCSW-C

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
5 E. Earle Avenue Easton, MD 21601	**Phone:** 443-786-0073 **Email:** kwaldrip@goeaston.net **Website:** www.kwaldriptherapy.com	Mon. – Tues. 8am to 9pm, Thurs. 10am to 9pm, Fri. 8am to 5pm	Sliding Scale Fee, Self Pay, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Mental Health Evaluation & Treatment ☑ Private Psychotherapy	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Depression ☑ Eating Disorders ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Relationship Issues ☑ Sexual Disorders	☑ Adult Bonding/Attachment Issues ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Crime Victim/Witness Counseling ☑ Death and Dying Counseling ☑ Eye Movement Desensitization & Reprocessing (EMDR) ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Trauma Informed
Translator? No			

The Visiting Counselor, Lisa May LCSW-C

Address	Phone:	Hours of Operation:	Payment Types Accepted:
27203 Chipmans Lane Federalsburg, MD 21632 (no office visits)	**Phone:** 410-754-9141 **Email:** thevisitngcounselor@gmail.com **Website:** www.thevisitingcounselor.com	Mon-Fri by appointment only	Grant Funds, Sliding Scale Fee, Self Pay, Medicare

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ CT - Grief	☑ General Mental Health Information/Education ☑ Geriatric Assessment ☑ Mental Health Evaluation and Treatment	☑ Depression ☑ Physical Disabilities ☑ Post Traumatic Stress Disorder	☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Disability Related Counseling ☑ Family Counseling ☑ Individual Counseling ☑ Trauma Informed
Translator? No			

House calls for individuals and their families dealing with chronic or terminal illness.

Paul J. Washo, LCSW-C					
Address: **Mailing** **Physical**	P.O. Box 744, Easton, MD 21601 770 Port Street, Easton, MD 21601	**Telephone:** **Fax:** **Website:** **Email:**	410-819-8272 410-763-8758 http://therapists.psychologytoday.com/35897 mycoachpaul@comcast.net	**Hours of Operation:** Mon, Thurs. 8:00am-5:00pm Tues, Weds. 2:00pm- 8:00pm	**Payment Types Accepted** Self Pay, Employee Assistance Program (EAP)

Provider	Services:	Condtions Served:	Treatment Modalities:
☑ LCSW-C **Translator?** No	☑ General Mental Health Education ☑ Mental Health Evaluation ☑ Veteran Services	☑ Anxiety/Phobias ☑ Bipolar Disorder ☑Co-Occuring ☑ Depression ☑ Personality Disorders ☑ Physical Disabilities ☑ PTSD ☑ Schizophrenia ☑ Self- Injurious Behaviors	☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ Gay/Lesbian/Transgender Issues ☑ Individual Counseling ☑ Marriage Counseling ☑ Grief and Grieving Issues

EQUINE ASSISTED THERAPY

Bridges at Worthmore					
Address:	11570 Still Pond Road Worton, MD 21678	**Phone:** **Website:** **Email:**	410-708-8973 www.bridgesatworthmore.org bridges21678@hotmail.com	**Hours of Operation:** Mon. – Sat. 8am to 7pm, Sun. 10am to 3pm	**Payment Types Accepted:** Grant Funds, Self Pay

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ P.A.T.H. Certified Professionals ☑ EAGALA Certified Teams ☑ LCPC ☑ LCADC ☑ LCSW-C **Translator?** No	☑ General Mental Health Info/Education ☑ Therapeutic Riding ☑ Youth Development	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Personality Disorders ☑ Physical Disabilities ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy ☑ Equine/ Pet Assisted Therapy ☑ Trauma Informed ☑ Therapeutic Horsemanship BRIDGES

Bridges is the therapeutic arm of Worthmore Equestrian Center. Founded in 2004, Bridges supports individuals experiencing learning, developmental and emotional challenges in the mid-Atlantic region. Therapies are customized to meet a person's individual needs beginning with and individualized assessment and development of a goal oriented program.

Over Fences, LLC

Address: 8845 Teal Point Road, Easton, MD 21601 **Glendale Farm:** 30485 Matthewstown Road, Easton, MD 21601 **Royal Oak Farm:** 6448 Patridge Lane, Royal Oak, MD 21162	**Phone:** 410-878-7820 **Fax:** 410-770-7176 **Email:** annehwilson@gmail.com	**Hours of Operation:** Monday – Friday 9am to 5pm	**Payment Types Accepted:** Grant Funds, Sliding Fee Scale, Self Pay, MD Choices Provider

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Equine Assisted Psychotherapy ☑ Equine Assisted Learning ☑ Mental Health & Substance Use Services ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Self Injurious Behaviors ☑ Substance Use/Dependence	☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling

Translator?

No

The Horse Inspired Growth & Learning Center Inc. was established in 2005 for the purpose of providing an ethical, powerful resource for improving lives. After researching certification programs for equine assisted therapy/learning they chose EAGALA *www.eagala.org* because of its worldwide support of professionals working in the field of Equine Assisted Psychotherapy and Learning.

Equine Assisted Psychotherapy and Learning can address any issue related to mental health such as, but not limited to, depression, anxiety, PTSD, mood disorder or relationship issues. The staff has worked extensively with clients who have experienced or witnessed trauma in their lives as a result of physical, sexual or emotional abuse.

Idylwild Therapeutic Horsemanship – Lisa May, LCSW-C

Address: 27203 Chipmans Lane, Federalsburg, MD 21632	**Phone:** 410-754-9141 **Website:** www.idylwildfarm.com **Email:** thevisitingcounselor@gmail.com	**Hours of Operation:** Mon. – Fri. 4pm to 6pm, Sat. 9am to 2pm	**Payment Types Accepted:** Grant Funds, Sliding Fee Scale, Self Pay

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ P.A.T.H. Certified Instructors	☑ Mental Health Evaluation & Treatment ☑ Older Adult/Aging Issues ☑ Substance Use Outpatient ☑ Therapeutic Riding ☑ Vocational Education	☑ ADHD ☑ Anxiety/Phobias ☑ Aspergers ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Trauma ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sensory Processing ☑ Substance Use/Dependence	☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Dialectical Behavioral Therapy ☑ Equine/Pet-Assisted Therapy ☑ Family Counseling ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Pet Assisted Therapy ☑ Play Therapy ☑ Therapeutic Horsemanship/Adventure Challenge ☑ Trauma Informed

Translator?

No

Lisa May is a PATH (Professional Association of Therapeutic Horsemanship) International registered instructor offering outdoor Experiential and Equine Therapy, which often is successful with disorganized, hard to reach, withdrawn, aggressive, minimally verbal individuals, and trauma survivors.

Talbot Special Riders, Inc.

Address: P.O. Box 391 Easton, MD 21601 **Timber Grove Farm:** 6292 Statum Road Preston, MD 21655	**Phone:** 443-239-4963 or 410-673-7450 **Website:** www.talbotspecialriders.org **Email:** tsrhopkins@gmail.com	**Hours of Operation:** Monday – Saturday various times AM and PM	**Payment Types Accepted:** Grant Funds, Self Pay, Sliding Fee Scale, Scholarships	

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ P.A.T.H. Certified Instructors **Translator?** No	☑ Therapeutic Riding ☑ Veteran Services	☑ ADHD ☑ Anxiety/Phobias ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Developmental Disabilities ☑ Personality Disorders ☑ Physical Disabilities ☑ Veterans	☑ Equine/Pet-Assisted Therapy ☑ Hippotherapy ☑ Occupational Therapy

Founded in 1981, Talbot Special Riders in Preston, Maryland has been a leader in therapeutic horseback riding, enhancing the lives of people who are "special". TSR is a certified member of PATH, Professional Association of Therapeutic Horsemanship International. The program's overall goal is to build confidence, self-esteem, and a sense of accomplishment. We work on coordination and spatial relationships as well as stretching and strengthening exercises. Our goal is to build confidence, self-esteem, and a sense of accomplishment, increase attention span, and develop the ability to take, understand, and follow directions. We conduct both group riding sessions with our certified instructors and one-on-one Hippotherapy sessions with our occupational therapist.

Talisman Therapeutic Riding (TTR)

Address: 172 Blue Ribbon Lane Grasonville, MD 21638 **Mailing** 300 Talisman Farm Circle P.O. Box 300 Grasonville, MD 21638	**Phone:** 443-239-9400 **Website:** www.talismantherapeuticriding.org **Email:** Wendy@talismantherapeuticriding.com	**Hours of Operation:** Mon. – Fri. 9am to 6pm, Sat. 9am to 1pm	**Payment Types Accepted:** Grant Funds, Self Pay, Scholarship Assistance	

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ P.A.T.H. Certified Instructors **Translator?** No	☑ Therapeutic Riding ☑ Youth Development ☑ Veterans	☑ ADHD ☑ Anxiety/Phobias ☑ Developmental Disabilities ☑ Psychical Disabilities ☑ Post Traumatic Stress Disorder	☑ Art Therapy ☑ Family Counseling ☑ Equine/Pet-Assisted Therapy ☑ Hippotherapy ☑ Occupational Therapy ☑ Physical Therapy ☑ Play

Talisman offers equine assisted activities and learning, which include therapeutic riding and Hippotherapy to children and adults with physical, cognitive, social, behavioral, and emotional conditions / disabilities. We are a PATH (Professional Association of Therapeutic Horsemanship) International registered center and a 501(c)(3) and instructors are nationally certified in therapeutic riding; therapists are licensed in the state of Maryland. Volunteers and horses are carefully selected and trained for their roles. Talisman's mission is to partner with the horses to positively and permanently change the mind, body, and spirit of clients/ riders.

Substance-Related Disorders & Addiction Services

Anne Arundel Counseling, Inc.

Main Office: 7310 Ritchie Highway, Suite 1009 Glen Burnie, MD 21061 **Queen Anne's:** 633 Railroad Avenue Centreville, MD 21617 101 Log Canoe Circle, Suite C-3 Stevensville, MD 21666	**Phone:** 410-768-5988 **Fax:** 410-768-5989 **Phone:** Call main # **Fax:** Use main fax **Phone:** Call main # **Fax:** Use main fax	**Email:** info@annearundelcounseling.com **Website:** www.annearundelcounseling.com	**Hours of Operation:** Mon. – Fri. 8am to 9pm, Sat. 8am to 5pm **Payment Types Accepted:** Sliding Fee Scale, Self Pay, Private Insurance

*** For a full listing of services, please see page 20 ***

A.F. Whitsitt Center

Address: 300 Scheeler Road Chestertown, MD 21620	**Phone:** 410-778-6404 **Fax:** 410-778-7002 **Website:** www.kenthd.org	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Grant Funds, Medicaid, Self Pay, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ CRNP ☑ LMSW ☑ CAC-AD ☑ ADT ☑ Nurse ☑ RN ☑ LPN ☑ DCA ☑ CHOW ☑ Peers	☑ Crisis Intervention ☑ Crisis Residential Treatment for Opiate and Stimulant Use Disorder ☑ Detoxification ☑ Withdrawal Management ☑ MAT ☑ Telepsychiatry ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Clinical Psychiatric Evaluation ☑ Psychiatric Medication Services ☑ Substance Use Inpatient (<30 days) ☑ Substance Use Inpatient Co-Occurring Capable (<30 days) ☑ Substance Use Inpatient Co-Occurring Capable (>30 days) ☑ Veterans ☑ Limited Physical Disability Capable	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Co-Occurring ☑ Depression ☑ Physical Disabilities ☑ Post Trauma Stress Disorder ☑ Substance Use/Dependence ☑ Telepsychiatry ☑ Trauma Informed Care	☑ Art Therapy ☑ Behavioral Treatment ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ MAT ☑ Interactive Groups ☑ Gender Specific Groups ☑ Peer Support ☑ Exercise ☑ Solution Focused ☑ Social Learning ☑ Cognitive Behavioral ☑ Motivational Interviewing ☑ Relapse Prevention

Translator?

Yes. Spanish (on-call)

Crisis Opiate Beds (COB) are federally funded (SOR) residential crisis beds to assist adults stabilizing from an Opiate Use and Stimulant Use Disorder. We can admit 24/7 and the stay is up to 4 nights at which time we can initiate MAT and implement a transfer to treatment or develop an aftercare plan prior to discharge

Balance Point – Brighton Laznovsky, CHT, LCADC, LCSW-C

Address: 408B North Washington Street Easton, Maryland 21601	**Phone:** 443-786-2768 **Fax:** 410-770-7176 **Email:** b.laznovsky@gmail.com	**Hours of Operation:** By appointment only	**Payment Types Accepted:** Sliding Fee Scale, Self Pay, Public Behavioral Health

*** For a full listing of services, please see page 21***

Care Coordination

Talbot County 410-819-5602	Care coordinators offer resource management support to individuals with substance related disorders. There are care coordinators in each county health department that can assist with: funding/connection with housing, transportation, employment, etc.	**Caroline County** 410-479-8189
Dorchester County 410-228-7714 ext. 108	**Queen Anne's County** 410-758-1306	**Kent County** 443-282-4911

Caroline County Behavioral Health

Address: 403 South 7th Street Denton, MD 21629	**Phone:** 410-479-1882 **Fax:** 410-479-4918 **Website:** www.carolinehd.org	**Hours of Operation:** Monday – Friday 8am to 4:30pm	**Payment Types Accepted:** Medicaid, Self Pay

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCADC ☑ LCSW-C ☑ CAC-AD ☑ CSC- AD	☑ DWI Offender Programs ☑ Jail Based Substance Use Treatment ☑ Substance Use Education/Prevention ☑ Substance Use Outpatient ☑ Narcan Trainings on-site ☑ Care Coordination Referral Services ☑ Tele-Medicine ☑ Walk-in ☑ School-based Mental Health and SUD Education ☑ Care Coordination ☑ Case Management	☑ Co-Occurring ☑ Substance Use Disorders ☑ Opioid Use Disorder ☑ Pregnant Women ☑ Veterans	☑ Cognitive Behavioral Therapy (CBT) ☑ General Counseling ☑ Individual Counseling ☑ Suboxone Program ☑ Family Counseling ☑ Medication-Assisted Treatment (MAT) ☑ Mobile Treatment Unit - MAT

Translator?

No

Chester River Behavioral Health

Address: 952 Washington Avenue Chestertown, MD 21620	**Phone:** 410-778-5550 **Fax:** 410-778-0984 **Website:** www.chesterriverbehavioral.com **Email:** crbh@verizon.net	**Hours of Operation:** Mon. and Thurs. 9am to 7pm, Tues. 9am to 8pm, Wed. 9am to 6pm, Fri. 9am to 5pm	**Payment Types Accepted:** Self Pay, Medicare, Private Insurance

*** For a full listing of services, please see page 23 ***

Community Behavioral Health

Dorchester:	426 Dorchester Avenue Cambridge, MD 21613	**Phone:** **Fax:**	844-224-5264 888-509-0010	**Hours of Operation:** Mon. – Thurs. 8am to 6pm, Fri. 8am to 5pm, Sat. please call	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare, Private Insurance
Kent:	401 South Cross Street Chestertown MD	**Phone:** **Fax:**	844-224-5264 888-509-0010	**Email:** info@communitybehavioralhealth.net	**Website:** www.communitybehavioralhealth.net
Queen Anne:	142 Coursevall Drive Centreville, MD 21617	**Phone:** **Fax:**	844-224-5264 888-509-0010		
Wicomico:	809 & 821 Eastern Shore Dr. Salisbury, MD 21804	**Phone:** **Fax:**	844-224-5264 888-509-0010		

Addictions Services: Patients with co-occurring disorders can expect a drug and alcohol clinic, individual and group addictions counseling, outpatient mental health therapy, and psychiatric medication management.

*** For a full listing of services, please see page 9 ***

Corsica River Mental Health Services

Caroline:	322 N. Main Street Federalsbury, MD 21632	**To make an appointment, please call any of the following numbers:** 443-225-5780 410-758-2211 410-745-8028 **Main Fax:** 410-758-0698	**Hours of Operation:** Caroline: Tue. And Thurs. 8:30am-5pm Dorchester: Mon. – Thurs. 8:30am to 5pm, Fri. 8:30am to 4pm Queen Anne's: Mon - Thurs. 8:30am to &pm, Fri. 8:30am to 4pm Talbot: Tue. 8am to 4:30pm, Wed. by appt. only Admin/Billing: Mon. – Fri. 8:30am to 5pm	**Email:** CorsicaClinic@crmhsinc.com **Website:** www.crmhsinc.com **Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self Pay, Public Behavioral Health, Private Insurance
Dorchester:	403 High Street Cambridge, MD 21613			
Queen Anne:	120 Banjo Lane Centreville, MD 21617			
Talbot:	933 S. Talbot Street St. Michaels, MD 21663			

*** For a full listing of services, please see page 10 ***

Dorchester County Behavioral Health – Addictions Programs (DCAP)

Address:	524 Race Street Cambridge, MD 21613	**Phone:** **Fax:** **Website:**	410-228-7714 410-228-8049 www.dorchesterhealth.org	**Hours of Operation:** Mon. – Thurs. 8am to 8pm, Fri. 8am to 5pm	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare, Private and Most Insurances

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ CSC/CAC	☑ DUI Offender Program ☑ General Mental Health Info/Education ☑ Substance Use Education/Prevention ☑ Substance Use Intensive Outpatient ☑ Substance Use Outpatient ☑ Veterans ☑ Walk-in	☑ Co-Occurring ☑ Substance Use/Dependence	☑ Cognitive Behavioral Therapy (CBT) ☑ General Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Trauma Informed
Translator?			
No			

DCAP provides assessments, referrals, client education, and outpatient treatment for those identified as having some form of alcohol or other drug use issue. These services emphasize the importance of a thorough assessment to determine if an individual is abusing or dependent on alcohol or other drugs.

Dover Behavioral Health Systems

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
725 Horsepond Road Dover, DE 19901	302-741-0140 / 855-609-9711 302-741-8557 www.doverbehavioral.com	24 hours a day, 7 days a week	Self Pay, Public Behavioral Health, Medicare, Private Insurance

*** For a full listing of services, please see page 11 ***

Hudson Health Services

Address:	Phone: / Fax: / Email: / Website:	Hours of Operation:	Payment Types Accepted:
1505 Emerson Avenue Salisbury, MD 21801	410-219-9000 410-742-7048 info@hudson-health.org www.hudson-health.org	24 hours a day, 7 days a week	Grant Funds, Self Pay, Public Behavioral Health, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ MD ☑ PhD ☑ CRNP ☑ LCSW-C ☑ RN ☑ LPN ☑ CAD-AD ☑ CSC-AD ☑ ADT ☑ Peer Support	☑ Case Management ☑ Detoxification ☑ Discharge Planning ☑ Employment Readiness ☑ Life Skills Training ☑ Partial Hospitalization ☑ Substance Use Inpatient (<60 days) ☑ Substance Use Inpatient Co-Occurring Capable (<60 days) ☑ Recovery Housing for Substance Use Clients in Recovery ☑ Vocational Training ☑ Residential Treatment ☑ Transitional Housing	☑ Co-Occurring ☑ Substance Use Disorders	☑ Art Therapy ☑ Cognitive Behavioral Therapy (CBT) ☑ Family Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Matrix Model ☑ Motivational Enhancement ☑ Peer Support ☑ Psycho Educational Groups ☑ Relapse Prevention ☑ Recovery Support Groups ☑ Therapuetic Drumming ☑ Yoga

Hudson Health Services provides residential treatment for Substance-Use Disorders and other co-occurring disorders in Salisbury, Maryland. The private, non-profit is licensed by the State of Maryland and accredited by The Joint Commission. The organization also operates recovery housing in Georgetown, Delaware and in Salisbury, Maryland

J. David Collins & Associates – J. David Collins, LCSW-C

Dorchester:	828 Airpax Road Building B, Suite 300 Cambridge, MD 21613	**Phone:** **Fax:**	410-901-1333 410-901-1366	**Website:** www.jdavidcollins.com **Hours of Operation:** Mon. – Fri. 9am to 8pm, Sat. 9am to 2pm
Wicomico:	540 Riverside Drive, Suite 8 Salisbury, MD 216801	**Phone:** **Fax:**	410-548-3333 410-548-3341	

Payment Types Accepted: Self Pay, Public Behavioral Health, Medicare, Private Insurance

*** For a full listing of services, please see page 24 ***

Life's Energy Wellness Center, Inc.

Mailing Address: P.O. Box 123 Easton, MD 21601 **Salisbury Address:** 2324 West Zion Rd. Suite 112 Salisbury, MD 21801 **Cambridge Address:** 514 Poplar Street Cambridge, MD 21613 **Easton Address:** 8737 Brooks Drive. Suite 108 Easton, MD 21601	**Phone:** (800) 867-2395 **Fax:** (410) 443-0842 **Website:** www.lewcinc.org **Email:** lewcinc@lewcinc.org	**Hours of Operation:** Monday – Friday 8 am – 8 pm Saturday - by Appointment Sunday - Closed	**Payment Types Accepted:** Grant Funds, Sliding Fee Scale, Medicaid, Medicare, Public Mental Health (MA/Uninsured Eligible), Self Pay, Private Insurance, Care First, Blue Cross Blue Shield, Aetna

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ LCPC ☑ PhD ☑ CRNP ☑ PsyD ☑ LGADC ☑ CAC-AD ☑ CSCAD ☑ ADT	☑ Detoxification ☑ DUI Offender Programs ☑ Ex-Offender Reentry Programs ☑ Homeless Outreach ☑ Medication Assisted Treatment ☑ Mental Health and Substance Abuse Services ☑ Mental Health Evaluation ☑ Mental Health Evaluation & Treatment ☑ Pyschiatric Case Management ☑ Psychiatric Medication Services ☑ Psychiatric Rehabilitation Program Off-site/Onsite ☑ Substance Abuse Education/Prevention ☑ Substance Abuse Intervention Program ☑ Substance Intensive Outpatient ☑ Substance Abuse Outpatient ☑ Targeted Case Management ☑ Urgeent Care Appointments ☑ Veterans ☑ Vocational Education ☑ Youth Development ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Anger Management ☑ Art Therapy ☑ Behavioral Treatment ☑ Christian/Pastoral Counseling ☑ Cognitive Behavioral Therapy (CBT) ☑ Crime Victim/Witness Counseling ☑ Death and Dying Counseling ☑ Dialectical Behavioral Therapy (DBT) ☑ Disability Related Counseling ☑ Emotive Memory Desensitization and Reprocessing (EMDR) ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Individual Counseling ☑ Marriage ☑ Mental Health Related Support Groups ☑ Play Therapy ☑ Psycho Educational Groups ☑ Sex Offender Counseling ☑ Telepsychiatry/Telemental Health ☑ Trauma Informed
Translator? Yes. Spanish, Korean			

LIfe's Energy Wellness Center in is a 501 (c) 3 non-profit organization, CARF accredited and licensed by Maryland Behavioral Health Administrations integrated outpatient mental health clinic and substance use disorder facility providing caring and compassionate person centered, family centered care that promotes wellness.

Lower Shore Clinic, Inc.

Address: 505 E. Main Street Salisbury, MD 21804	**Phone:** 410-341-3420 **Fax:** 410-341-3397 **Website:** www.lowershoreclinic.org	**Hours of Operation:** Mon. and Thurs. 8am to 8pm, Tues. and Wed. 8am to 5pm, Friday 8am to 4pm	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare

*** For a full listing of services, please see page 14 ***

Maryland Center of Excellence on Problem Gambling

THE MARYLAND CENTER *of* EXCELLENCE
on PROBLEM GAMBLING

1-800-426-2537
Website: www.mdproblemgambling.com

For most people gambling is a form of entertainment. Many, if not most people, do not realize that gambling may pose the same risk as alcohol and other drugs for becoming an addiction. A gambling addiction can have the same devastating consequences as alcohol and drug addictions, destroying families, finances, careers, and lives. For some people, the desire to gamble becomes so strong it overtakes moral values and results in crimes to obtain more money for gambling. As a gambling problem develops, it becomes more and more devastating, potentially evolving into a crisis impacting family members and friends. It is very important to get help as soon as possible as this condition escalates rapidly even resulting in incarceration and suicide. The Center's 24/7 free and confidential helpline is a great way to start getting help. Call *1-800-GAMBLER.*

Maryland QUITline

Maryland's 1-800 QUIT NOW

1-800-QUITNOW (784-8669)
It's free. It's confidential. It works.
Visit: www.SmokingStopsHere.com or www.mdquit.org .

Methadone Maintenance

Chesapeake Treatment Services
402 Marvel Court
Easton, MD 21601
410-822-7150
Website: www.chesapeaketreatmentservices.com

Hours: Mon. – Fri. 5:30am to 2:00pm, Sat. 5:30am to 8:30am

CTS offers Suboxone and daily doses of methadone and provide affordable care in a respectful and welcoming environment for individuals who are suffering with the disease of addiction.

BNJ Health Services
505 Dutchmans Lane, B-2
Easton, MD 21601
410-763-9040
Fax: 410-763-9041

Hours: Mon. – Fri. 5am to 11am, Sat. 6am to 9:30am

BNJ offers methadone maintenance, counseling, and referrals

Narcotics Anonymous

Narcotics Anonymous Hotline: 1-800-317-3222

Mid Shore:		Lower Shore:
Mid-Shore Intergroup: P.O. Box 643 Easton, MD 21601 410-822-4226 **Email**: info@midshoreintergroup.org **Website**: www.midshoreintergroup.org	**East of the Bay NA:** P.O. Box 30 Queenstown, MD 21658 1-800-317-3222 **Website:** www.eastofthebayna.org	**Ocean Gateway Area of NA:** P.O. Box 2740 Salisbury, MD 21802 410-548-0894 Email: oceangatewayarea@gmail.com **Website:** www.ogana.org

Queen Anne's County Health Department – Alcohol and Drug Abuse Services

Nielsen Center:	205 N. Liberty Street Centreville, MD 21617	**Phone:** **Fax:** **Website:**	410-758-1306 410-758-2133 www.qahealth.org	**Hours of Operation:** Monday – Friday 8am to 4:30pm		**Payment Types Accepted:** Self Pay	

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCADC ☑ CSC-AD	☑ Care Coordination ☑ Referrals (Assessment, Treatment, and Medication Treatment)	☑ None	☑ None
Translator?			
No			

Recovery in Motion – Kent County Health Department

300 Scheeler Road
Chestertown, MD 21620
410-778-5895
Website: www.kenthd.org

Recovery in Motion offers a wide range of services that provide our community with the tools to increase their wellbeing. Support includes individual & group counseling, behavioral health education/prevention, peer support and care coordination to assist persons in recovery with behavior and addiction issues. Visit their website for the monthly schedule of meetings and activities. Other services include 1-on-1 peer support, job search assistance, computer skills, prevention/education, recovery housing, and support groups.

Recovery for Shore

219 S. Washington Street
Easton, MD 21601
Email: recoveryforshore@gmail.com or sdundon@shorehealth.org

Recovery for Shore is a Mid Shore group that promotes the right and resources to recover through advocacy, education and demonstration of the power and proof of long-term recovery. Look for Recovery for Shore on Facebook!

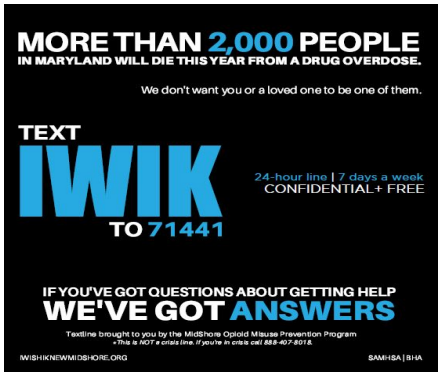
Shore Behavioral Health

Dorchester:	300 Byrn Street Cambridge, MD 21613	**Phone:** **Fax:**	410-228-5511, ext.5452 410-476-5105	**Website:** www.shorehealth.org **Hours of Operation:** Mon. – Fri. 8am to 5pm, Evening IOP	**Payment Types Accepted:** Self Pay, Public Behavioral Health, Medicare, Private Insurance
Talbot:	219 S. Washington Street Easton, MD 21601	**Phone:**	410-822-1000 ext. 5452		

*** For a full listing of services, please see page 16 ***

Substance Abuse and Mental Health Services Administration (SAMHSA)

5600 Fishers Lane
Rockville, MD 20857
1-877-SAMHSA-7 (726-4727)
Website: www.samhsa.gov



SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use and mental illness on America's communities.

Talbot County Health Department - Alcohol and Drug Services (TCAP)

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
100 S. Hanson Street Easton, MD 21601	410-819-5600 410-819-5691 www.talbothealth.org	Monday – Friday 8am to 4:30pm	Grant Funds

Providers:	Services:	Conditions Served:
☑ N/A **Translator?** Yes. Spanish	☑ Care Coordination ☑ Peer Support ☑ Substance Use Education/Prevention ☑ Tobacco Cessation ☑ Narcan Program ☑ County Navigator for Pregnant Women/ Women with Children ☑ Buprenorphine Initiative /Referral	☑ Substance Use/Dependence ☑ Co-Occuring

Talbot Partnership

Address:	Phone:	Email: / Website:	Hours of Operation:
28712 Glebe Road, Suite 5 Easton, MD 21601	410-819-8067	info@talbotpartnership.org www.talbotpartnership.org	Mon. – Fri. 8am to 3pm

Providers:	Services:	Conditions Served:
☑ N/A **Translator?** No	☑ Substance Use Education/Prevention ☑ Life Coaching for Youth ages 11 to 21 ☑ Emotion Coaching for Parents/Guardians/Caregivers	☑ Adolescent Substance Use/ Dependence

Talbot Partnership helps kids feel better, do better, fit in and have fun – without drugs.

Warwick Manor Behavioral Health

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
3680 Warwick Road East New Market, MD 21631	410-943-8108 410-943-3976 www.warwickmanor.org	24 Hours Admission by Appointment	Self Pay, Public Behavioral Health, Private Insurance

*** For a full listing of services, please see page 17 ***

Worcester County Health Department

	Address:	Phone: / Fax:	Website: / Hours of Operation:	Payment Types Accepted:
Main Office:	6040 Public Landing Road P.O. Box 249 Snow Hill, MD 21863	410-632-1100 410-632-5682	www.worcesterhealth.org	Grant Funds, Self Pay, Public Behavioral Health, Medicare, Private Insurance
Berlin Health Department:	9730 Healthway Drive Berlin, MD 21811	410-629-0164 410-629-0185	Mon. – Fri. 8am to 5pm, Evenings and Saturdays by appointment only, Pocomoke Health Center closed on Fridays.	
Pocomoke Health Center:	400 Walnut Street Pocomoke City, MD 21851	410-957-2005 410-957-2417		

*** For a full listing of services, please see page 19***

RECOVERY CENTERS

ARC – The Active Recovery Center of Hope

Mailing Address:	4514 Preston Road Preston, MD 21655	**Hotline:** **Email:**	410-754-4299 arcofhope21632@gmail.com

HOURS
Thursdays - 7:00PM until 9:00PM
Celebrate Recovery
First Church of God
101 Bloomingdale Ave, Federalsburg
Saturdays - 6:30PM until 8:00PM
Hope Beyond Hope
Greater New Hope Church & Ministries
4514 Preston Road, Preston

An active collaboration effort of community partners (Greater New Hope Church & Ministries, First Church of God, Men for Change and Rebirth) working to increase access to prevention, treatmentreferrals and recovery support services in Caroline County, MD.

At ARC you will find: Prevention Activities, Treatment Referrals,,and Recovery Support. Peer Support Services. Free transportation for prevention activities. Referred treatment and recovery support program appointments. NARCAN and Substance Use 101 training.

Avenues Recovery Center at Eastern Shore

Mailing Address:	821 Fieldcrest Rd Cambridge, MD 21613	**Hotline:** **Fax:** **Toll Free:** **Email:** **Website:**	410 673 4600 410-673-4800 888-683-0333 admissionsesmd@avenuesrecovery.com https://avenuesrecoverymaryland.com/locations/eastern-shore-drug-rehab-detox-center/

Payment Types Accepted:
Anthem, BCBS, Carefirst, Cigna · DE, Highmark · DE, Medicaid, Johns Hopkins, MD Medicaid, UMR · United Healthcare, Tricare

Hours of Operation
24 Hours Admission by Appt

AVENUES
A RECOVERY COMMUNITY

Avenues Recovery Center offers the most patient-centered clinical treatment available. The Avenues Recovery team is exceptionally qualified for the most at risk and vulnerable, staffed with full-time physicians, psychiatrists, and licensed counselors. Our case managers will address any legal, family, or FMLA complications, and most of all focus on workforce reentry.

About our facility:

- 60 day residential and outpatient treatment programs
- Dual diagnosis treatment program
- Withdrawal management
- Sprawling campus with state of the art 104 bed facility
- Gender specific wings
- Licensed therapists and counselors
- Co-occurring disorder treatment: Managing substance use and mental health
- Individual and group therapies including family counseling
- Mindfulness-based relapse prevention program
- Yoga, Meditation and Outdoor activities
- Personal and Professional Relationship management Workshops
- Skills Groups
- Psychoeducational Training
- Workforce Re-entry Education

DRI-Dock Recovery and Wellness Center

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
524 Race St. Second Floor Cambridge MD 21613	**Phone:** 410-228-3230 **Fax:** 410-228-7086 **Website:** www.dri-dock.org	Monday – Friday 8am to 6pm	Free Services

The Dorchester Recovery Initiative (DRI), in conjunction with Chesapeake Voyagers, Inc., promotes personal recovery for all, no matter what path one takes to recovery. They also help to strengthen the recovery community and the services and structures that help folks get and stay in recovery worldwide! They are there for those seeking help for mental health, co-occurring, and addictions concerns.

Services with in Dri-Dock Recovery and Wellness Center but not limited to;

- Peer Support
- Peer Support Groups
- Referrals to Inpatient Treatments
- Referrals to Outpatient Treatments
- Referrals to Community Resources
- Limited Internet Access
- Narcan Training
- State Care Coordination Services
- HIV/HVC Services

Maryland Addiction Recovery Center

Address:	Phone: / Fax: / Email: / Website:	Hours of Operation:	Payment Types Accepted:
8600 LaSalle Road Carroll Building, Suite 212 Towson, MD 21286	**Phone:** 410-773-0500 **Fax:** 410-773-0501 **Email:** info@marylandaddictionrecovery.com **Website:** www.marylandaddictionrecovery.com	Monday – Friday 8am to 9pm	Private Insurance, Self Pay

Maryland Addiction Recovery Center provide a safe, caring and therapeutic environment for those suffering from drug and alcohol addiction. We offer patients and their families a customized, individualized and patient-centered treatment approach that promotes long term recovery and provides the tools necessary to reconstruct their lives free from alcohol and drugs. Services include opiate detox, IOP/Outpatient Treatment, adolescent treatment, family and individual counseling, PHP and community living treatment, vocational/life skills training, drug assessments, evaluations, and interventions.

Chesapeake Voyagers

Website:
www.chesapeakevoyagers.org
Email:
dianelane@chesapeakevoyagers.org

Chesapeake Voyagers Inc. (CVI) is a Peer Support Wellness & Recovery Center which is a place where adults experiencing difficulty with mental health and/or addiction can connect with others who have similar life experiences, learn about wellness and recovery, receive one on one and group peer support and have fun – all for free! CVI serves residents in all five Mid-Shore counties at various locations. They offer a safe and comfortable environment where you can make friends who will become like family to you. They are open to EVERYONE! No referral, insurance or specific diagnosis is needed to attend. Stop by or call to learn more.

*** For a full listing of services and locations, please see page 53 ***

The Nielson Center

205 North Liberty Street
Centreville MD
Phone: 1-410-758-1306
Website: https://health.maryland.gov/qahealth/substance-abuse/Pages/Substance_Abuse.aspx

The Addictions Treatment and Preventions Services offer assessments; individual, group, and family counseling; referrals and prevention services for adults. Since alcoholism and drug addiction are chronic, progressive, potentially fatal diseases, a personal commitment with the support of community resources helps individuals and their families in this lifelong recovery process.

The following services are available:

- Adult Assessment
- Referrals to other resources
- Individual and group counseling
- Alcohol and another drug education
- Family counseling
- Co-occurring disorder referrals
- Treatment planning
- Recovery groups/after care groups
- Breathalyzer testing
- Urinalysis
- Speakers bureau
- Intervention and assistance
- Video loan library
- Awareness campaigns
- Resource materials for individuals/organizations
- Technical assistance for community prevention projects
- Alcohol, tobacco, and other drug education workshops
- Underage drinking prevention

*Fees are based on ability to pay

Recovery in Motion
125 South Lynchburg Street Chestertown, MD 21620 Telephone: 410-778-1350 Fax: 410-778-6119 Website: http://kenthd.org/adult-health/addictions/recovery-in-motion/ Offers a wide range of services that provide our community with the tools to increase their well-being. Support includes individual & group counseling, behavioral health education/prevention, peer support and care coordination to assist persons in recovery with behavior and addiction issues. 1-on-1 peer support is available Monday and Friday by appointment only. Contact Lindy Schrader 443.480.2376 to schedule an appointment.
*** For more info, see on page 41 & 54 ***

Certified Recovery Houses

County	Recovery House
Caroline:	**Riverside Rentals, LLC** www.liveatriversiderentals.com
Dorchester:	**Dorchester County** **The Gratitude House** Owner, Sara Rissolo Contact: sara.realslow@gmail.com **443-618-0296** **Awaken Recovery Foundation** **(For Women Only)** Owner**, Ashley Rogers & Sean Baker** Contact: ashleyrogers@awakenrecovery.org & seanbaker@awakenrecovery.org **http://www.awakenrecovery.org/** **410-762-9977**
Kent:	**Mission House, Inc.** Owner, Chrissy Chisolm Contact: missionhousechestertown@gmail.com **516-314-8460** **Humble House Recovery** **Humble House Recovery, All About Improvement, Inc.** Owner, Jeremy Savin Contact: humblehouserecovery@gmail.com **410-562-7111** **New Heights, LLC** Owner, Steven Jones Contact, stevenj020386@gmail.com

	410-441-1435
Queen Anne's:	**Mission House, Inc.** Owner, Chrissy Chisolm Contact: missionhousechestertown@gmail.com **516-314-8460** **Oxford House** Barry Stuart, Outreach Services Email: barry.stewart@oxfordhouse.org **240-457-2094**
Talbot:	**Humble House Recovery** **Humble House Recovery, All About Improvement, Inc.** Owner, Jeremy Savin Contact: humblehouserecovery@gmail.com **410-562-7111** **Foundations Recovery House LLC** Owner, Tabitha Groce Contact: info@foundationsrecoveryhouse.com **240-626-4933** **Gratititude Behavioral Health** **The Gratitude House** **The Gratitude House for Women** **The Gratitide House II** Owner, Sara Rissolo Contact: sara.realslow@gmail.com **443-618-0296**

Support Services

PSYCHIATRIC REHABILITATION PROGRAMS

Psychiatric Rehabilitation Services facilitate the individual's recovery and develop or restore an individual's independent living and social skills, including the individual's ability to make decisions regarding self-care management of illness, life, work, and community participation; and promote the use of resources to integrate the individual into the community. Services may be provided in an on-site facility, or in a setting most conducive to promoting the participation of the individual in community life.

Channel Marker, Inc.

Administrative Office:	8865 Glebe Park Drive, Unit 1 Easton, MD 21601	**Phone:** 410-822-4619 **Fax:** 410-822-0984		**Payments Accepted:** Grant Funds, Self Pay, Public Behavioral Health
Caroline:	508 Kerr Avenue Denton, MD 21629	**Phone:** 410-479-2318 **Fax:** 410-820-0124	**Email:** cmarker@channelmarker.org	
	613 S. 5th Avenue Denton, MD 21629	**Phone:** 410-479-0240 **Fax:** 410-479-0250	**Website:** www.channelmarker.org	
Dorchester:	420 Dorchester Avenue Cambridge, MD 21613	**Phone:** 410-228-8330 **Fax:** 410-221-6459	**Hours of Operation:** Monday – Friday 8am to 5pm	
Talbot:	8865 Glebe Park Drive, Unit 2 Easton, MD 21601	**Phone:** 410-822-4611 **Fax:** 410-822-6186		

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ Health Home Nurse ☑ Psych Rehab Staff	☑ Adult Day Programs ☑ Clinical Group Practice ☑ General Mental Health Info/Education ☑ Health Home Services ☑ Job Search/Placement ☑ Mental Health & Substance Use Services ☑ Psychiatric Rehabilitation Program Off-Site ☑ Psychiatric Rehabilitation Program On-Site ☑ Residential Rehabilitation Program ☑ Supported Employment ☑ Transitional Age Youth (TAY) Program ☑ Vocational Education ☑ Youth Development	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Substance Use/Dependence	☑ Mental Health Related Support Groups ☑ Psycho Educational Groups
Translator? Use language line			

Channel Marker, Inc. is a non-profit organization serving the Caroline, Dorchester, and Talbot county communities since 1982. Established and licensed as a psychiatric rehabilitation program, the organization has worked toward reducing the stigma of mental illness and providing programs to enhance the functioning of individuals with psychiatric disorders. Channel Marker creates a healthy Mid-Shore community by providing mental illness treatment and prevention programs, wellness support, and community services to individuals and their families.
The agency provides a variety of support services in independent living skills, social skills, coping strategies, and health promotions to clients with serious mental illness such as major depression, bi-polar disorder, mood disorders, ADHD, and schizophrenia, as well as co-occurring substance-related disorders. Channel Marker, Inc. operates day, residential, health home, vocational, clinical group practice, and community support services in all three counties for adults. Channel Marker also has community support services in Dorchester, Talbot and Caroline counties for youth and adolescents.

Children's Choice

Queen Anne:	1563 Postal Road, Suite 3B P.O. Box 535 Chester, MD 21619	**Phone:** **Fax:**	410-643-9290 410-643-9293	**Website:** www.childrenschoice.org **Hours of Operation:** Mon. – Fri. 8:30am to 4:30pm	**Payment Types Accepted:** Grant Funds, Public Behavioral Health
Wicomico:	230 Florida Avenue Salisbury, MD 21801	**Phone:** **Fax:**	410-546-6106 410-219-2640		

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C	☑ Psychiatric Rehabilitation Program Off-Site ☑ Respite Care ☑ Treatment Foster Care	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Depression ☑ Developmental Disabilities ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Post Traumatic Stress Disorder	☑ General Counseling
Translator?			
No			

Community Behavioral Health

Dorchester:	426 Dorchester Avenue Cambridge, MD 21613	**Phone:** **Fax:**	844-224-5264 888-509-0010	**Hours of Operation:** Mon. – Thurs. 8am to 6pm, Fri. 8am to 5pm, Sat. please call **Email:** info@communitybehavioralhealth.net	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance **Website:** www.communitybehavioralhealth.net
Queen Anne:	202 Coursevall Dr, Ste.7 Centreville, MD 21617	**Phone:** **Fax:**	844-224-5264 888-509-0010		
Kent:	400 S. Cross St, Ste. 4 Chestertown, MD 21620				
Talbot:	8614 Ocean Gateway Easton, MD 21601				
Wicomico:	809 & 821 Eastern Shore Dr. Salisbury, MD 21804	**Phone:** **Fax:**	844-224-5264 888-509-0010		

Psychiatric Rehabilitation Program (PRP) provides a therapeutic case manager referred by your therapist to assist you in the community with your treatment goals. Patients receive self-care skills, social skills, housing, money management, mobility and transportation skills, employment assistance, wellness, self-management, and access to available resources.

*** For a full listing of services, please see page 9 - 10 ***

Crossroads Community, Inc.

Dorchester:	404 LeCompte Street Cambridge, MD 21613	**Phone:** **Fax:**	410-221-7540 410-221-7541	**Email:** cci@ccinconline.com **Website:** www.cccinconline.com	**Hours of Operation:** Monday – Friday 8am to 4pm **Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health
Kent:	937 Gateway Drive Chestertown, MD 21620	**Phone:** **Fax:**	410-778-9200 410-778-9622		
Queen Anne's:	120 Banjo Lane Centreville, MD 21617	**Phone:** **Fax:**	410-758-3050 410-758-1223		

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ CPRP ☑ Home Health Nurse ☑ Psych Rehab Staff	☑ Adult Day Programs ☑ General Mental Health Info/Education ☑ Health Home Services ☑ Job Search/Placement ☑ Mental Health and Substance Use Services ☑ Older Adults/Aging Issues ☑ Psychiatric Rehabilitation Program Off-Site ☑ Psychiatric Rehabilitation Program On-Site ☑ Residential Rehabilitation Program ☑ Respite Care ☑ Supported Employment ☑ Transitional Age Youth (TAY) Program ☑ Vocational Education ☑ Youth Development	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Substance Use/Dependence	☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ Evidence Based Practice ☑ Mental Health Related Support Groups ☑ Psycho Educational Groups

Crossroads Community, Inc. established in 1983, is a non-profit whose mission is to teach skills and access resources that empower people with behavioral health needs to live satisfying and productive lives. Crossroads promotes community acceptance through advocacy and community education. Services are provided to those residing in the mid-shore region out of our locations in Chestertown, Centreville and Cambridge. Crossroads is accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF) for its Psychiatric Rehabilitation & Health Home Programs for Adults, Young Adults and Youth, Residential Rehabilitation Program & Supported Employment for Adults and Respite Care program for children. Crossroads is working with BHA and MSBH to expand TAY supports and services to those 16 – 25 YO in the mid-shore region. Our Healthy Transitions Program is supported by a grant from SAMSHA.

Eastern Shore Psychological Services

Kent:	315 High Street, Suite 201 Chestertown, MD 21601	**Phone:** **Fax:**	443-282-0102 / 0104 443-480-0121	**Website:** www.espsmd.com **Email:** infoprincessanne@espsmd.com infoeaston@espsmd.com infosalisbury@espsmd.com	**Hours of Operation:** Mon. – Thurs. 8am to 8pm Fri. 8am to 7 pm Sat. 8am to 4pm **Payment Types Accepted:** Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare, Private Insurance
Talbot:	29520 Canvasback Drive Easton, MD 21601	**Phone:** **Fax:**	410-822-5007 410-822-5569		
Wicomico:	1113 Healthway Drive Salisbury, MD 21801	**Phone:** **Fax:**	410-334-6961 410-334-6960		

*** For a full listing of services, please see page 12 ***

Go-Getters, Inc.

Address: 716 N. Division Street Salisbury, MD 21801	**Phone:** 410-546-7754 443-859-7774 (referral) **Fax:** 410-334-3710 **Website:** www.gogettersinc.org **Email:** richard.bearman@gmail.com	**Hours of Operation:** Varies by program	**Payment Types Accepted:** Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare

Programs/Locations:

Newark Location:
7033 Worcester Highway
Newark, MD 21841
(410) 632-3737

Princess Anne Location:
11559 Somerset Ave
Princess Anne, MD 21853
(410) 651-1547

Main Street:
Offers community support, residential and day program services.
(410) 546-0381

Beacon Place Crisis Services:
Offers short term Residential Crisis Services in a community-based setting 24 hours a day, every day of the year.
(410) 749-2578

Friendship Network:
Offers high quality mental health rehabilitation services to people over the age of 55, living in Somerset, Wicomico, and Worcester counties.
(410) 546-3619

Peer Connection:
An established rehabilitation program for people with co-occurring disorders.
(410) 546-1822

Providers:

- ☑ LCSW-C
- ☑ LCPC
- ☑ PhD
- ☑ MD
- ☑ CRNP
- ☑ Nurse
- ☑ PA-C
- ☑ APRN/PMH

Translator?

Yes.
French, German, Creole, Farsi

Conditions Served:

- ☑ Anxiety/Phobias
- ☑ Bipolar Disorder
- ☑ Chronic Mental Illness
- ☑ Co-Occurring
- ☑ Depression
- ☑ Eating Disorders
- ☑ Hoarding Behaviors
- ☑ Personality Disorders
- ☑ Post Trauma Stress Disorder
- ☑ Schizophrenia
- ☑ Self Injurious Behaviors
- ☑ Substance Use/Dependence

Go-Getters

Treatment Modalities:

- ☑ Anger Management Counseling
- ☑ Art Therapy
- ☑ Behavioral Treatment
- ☑ Cognitive Behavioral Therapy (CBT)
- ☑ Dialectical Behavior Therapy (DBT)
- ☑ Disability Related Counseling
- ☑ Emotive Memory Desensitization & Reprocessing (EMDR)
- ☑ Family Counseling
- ☑ General Counseling
- ☑ Geriatric Counseling
- ☑ Group Counseling and Individual Counseling
- ☑ Mental Health Support Groups
- ☑ Psycho Educational Groups
- ☑ Telepsychiatry/Telemental Health

Services:

- ☑ Adult Day Programs
- ☑ Clinical Psychiatric Evaluation
- ☑ Crisis Intervention
- ☑ Crisis Residential Treatment
- ☑ Ex-Offender Halfway House
- ☑ General Mental Health Info/Education
- ☑ Geriatric Assessment
- ☑ Homeless Outreach
- ☑ Independent Living Communities for Older Adults
- ☑ Job Search/Placement
- ☑ Mental Health & Substance Use Services
- ☑ Mental Health Evaluation & Treatment
- ☑ Mobile Treatment/ACT – 410-341-9696
- ☑ Older Adult/Aging Issues
- ☑ PAK (ages 18-29) – 443-736-7845
- ☑ Protection and Advocacy for Individuals with Disabilities
- ☑ Psychiatric Case Management
- ☑ Psychiatric Day Treatment
- ☑ Psychiatric Medication Services
- ☑ Psychiatric Mobile Response Teams
- ☑ Psychiatric Rehabilitation Program Off-site
- ☑ Psychiatric Rehabilitation Program On-site
- ☑ Residential Rehabilitation Program
- ☑ Residential Treatment Facilities
- ☑ Respite Care
- ☑ Senior Housing Information and Referral
- ☑ Substance Use Education/Prevention
- ☑ Substance Use Intervention Program
- ☑ Substance Use Inpatient Co-Occurring Capable (>30 days)
- ☑ Substance Use Outpatient
- ☑ Supported Employment
- ☑ Urgent Care Appointments
- ☑ Veterans
- ☑ Vocational Education
- ☑ Walk-in

Go-Getters is a community-based psychiatric rehabilitation program whose mission is to assist people recovering from severe mental illness in re-integrating their lives in the larger communities of Somerset, Wicomico, and Worcester counties. Day programs for adults and elderly people in Salisbury, Princess Anne, and Newark offer skills training for independent living, prevocational and vocational skills, food and nutrition training, breakfast, lunch, and snacks, socialization and recreation, a community of support and friendship, supported housing in all three counties, intensive 24-hour supervision, specialized housing for elderly and dually diagnosed people, crisis and respite care for psychiatric and other emergencies, 4 crisis beds, residential alternative to hospitalization, 3 respite beds available to the community for individual and caregiver needs. Lower Shore Clinic provides outpatient psychiatric treatment, ongoing clinical therapy, and primary care to a community caseload of 1000+ Lower Shore residents regardless of ability to pay, same day walk-in intakes for new clients, Assertive Community Treatment (ACT) team for people with greatest mental health difficulties in five counties, integrated health home, family psycho-education groups, 24 hour on-call back up for Go-Getters or Lower Shore Clinic staff working with clients in psychiatric distress, program-wide welcome and treatment for persons recovering from mental illness and substance-related disorders

Upper Bay Counseling & Support Services

Administration:	200 Booth Street Elkton, MD 21921	**Phone:**	410-996-5104 410-996-5197	**Website:** www.upperbay.org	**Hours of Operation:** Mon. – Thurs. 8am to 8am, Fri. 8 am to 3pm
Cecil:	1275-B W. Pulaski Hwy. Elkton, MD 21921	**Phone:**	410-620-7161 410-620-7168	**Email:** info@upperbay.org	**Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health, Medicare, Private Insurance
	251 South Bohemia Ave. Cecilton, MD 21913	**Phone:**	443-406-3427		

*** For a full listing of services, please see page 17 ***

Worcester County Health Department

Address:	9730 Healthway Drive Berlin, Maryland 21811	**Phone:** **Fax:**	410-629-0164 410-629-0185	**Website:** www.worcesterhealth.org

PRP provides an array of services to adults, youth, and families in Worcester County. PRP services are available to county residents who have a serious mental health diagnosis and are receiving behavioral health services. PRP services are intended to empower and assist individuals in developing appropriate social skills, enabling individuals to make positive life choices and become engaged in positive ways in domains of life including home, school, work, and community. Individuals receive assistance in developing skills and knowledge to utilize community resources and become active participants in their community. PRP staff helps arrange care with other behavioral health providers as necessary for your needs and established goals, and often attempt to get families involved as a means of making life easier for you.

*** For a full listing of services, please see page 19 ***

PEER SUPPORT GROUPS

Chesapeake Voyagers, Inc.

Main:	342-C North Aurora St. Easton, MD 21601	**Phone:** **Fax:**	410-822-1601 410-822-1621	**Hours of Operation:** Call for Open Times	**Website:** www.chesapeakevoyagers.org
Caroline:	Call for locations of support groups	**Phone:**	Call main #	**Caroline:** Call main # for information on support group	**Email:** dianelane@chesapeakevoyagers.org
Dorchester:	Call for locations of support groups	**Phone:**	Call main #	**Dorchester:** Call Main #	**Payment Types Accepted:** Free Services
Kent:	Call for locations of support groups	**Phone:**	Call main #	**Kent:** Call Main #	
Queen Anne's:	Call for locations of support groups	**Phone:**	Call main #	**Queen Anne's:** Call Main #	

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ N/A	☑ Crisis Intervention ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Protection and Advocacy for Individuals with Disabilities ☑ Substance Use Education/Prevention ☑ Walk-In ☑ Wellness Recovery Action Planning (WRAP)	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Mental Health Related Support Groups ☑ Peer Support ☑ Trauma Informed
Translator? No			

Chesapeake Voyagers Inc. (CVI) is a Peer Support Wellness & Recovery Center which is a place where adults having trouble with mental health and/or addiction can connect with others who have similar life experiences, learn about wellness and recovery, receive one on one and group peer support, and have fun – all for free! CVI serves residents in all five Mid-Shore counties at various locations. They offer a safe and comfortable environment where you can make friends who will become like family to you. They are open to EVERYONE! No referral, insurance or specific diagnosis is needed to attend. Stop by or call to learn more.

DRI-Dock Recovery and Wellness Center

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
524 Race St. Second Floor Cambridge MD 21613	410-228-3230 410-228-7086 www.dri-dock.org	Monday – Friday 8am to 6pm	Free Services

The Dorchester Recovery Initiative (DRI), in conjunction with Chesapeake Voyagers, Inc., promotes personal recovery for all, no matter what path one takes to recovery. They also help to strengthen the recovery community and the services and structures that help folks get and stay in recovery worldwide! We are here for those seeking help for mental health, co-occurring, and addictions concerns.

HALOS Support Group – Compass Regional Hospice

Address:	Phone: / Website:	Hours of Operation:	Payment Types Accepted:
255 Comet Drive Centreville, MD 21617	443-262-4109 or 410-643-7674 www.compassregionalhospice.org	2nd Wednesday of each month, 6:30 PM to 8:30 PM	Free Services

The HALOS (Healing After A Loved One's Suicide) Support Group is open to adults 18 and over. For more information, please contact Rhonda Knotts, 443-262-4109, rknotts@compassregionalhospice.org, or Wayne Larrimore, 443-262-4108, .

Maryland Coalition of Families

Address:	Phone: / Fax:	Website:	Payment Types Accepted:
9 S. Third Street Denton, MD 21629	410-730-8267 410-479-0018	www.mdcoalition.org	Free Services

Providers:	Services:	Conditions Served:
☑ N/A	☑ Family Peer Support	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Personality Disorders ☑ Physical Disabilities ☑ Gambling ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence
Translator?	**Treatment Modalities:**	
No	☑ Mental Health Related Support Groups ☑ Peer Support/Education	

Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers, youth, and other loved ones, we connect, support and empower Maryland's families. Our staff provide one-to-one support to parents and caregivers of young people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue.

To connect to MCF in your community, call 410-730-8267, press 1 or email referral@mdcoalition.org

Recovery in Motion – Kent County Health Department

Address:	Phone: / Website:	Hours of Operation:	Payment Types Accepted:
300 Scheeler Road Chestertown, MD 21620	410-778-5895 www.kenthd.org	Mon. and Fri. 9 am – 5 pm by appt only call Jennifer Wysong 410-778-5895	Free Services

1-on-1 peer support is available Monday and Friday by appointment only. Contact Brenna Fox 410-778-5894 to schedule an appointment. Walk-in 1-on-1 peer support is available Tuesday through Thursday.

Parents, Families, and Friends of Lesbian, Gay, and Transgender Communities (PFLAG) Chestertown & Mid-Shore

Address:	Phone: / Email:	Website:	Hours of Operation:
914 Gateway Drive Chestertown, MD 21620	301-938-0868 pflagchestertown@gmail.com	www.pflagchestertown.com	Meetings are the 1st and 3rd Thursdays of the month at 7:00PM, locations vary

Translator?	Services:	Conditions Served:	Treatment Modalities:

No	☑ LGBT Education, Support, and Advocacy ☑ Youth Development (Gay Straight Alliance)	☑ LGBT Family Support or Referrals	☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ Mental Health Related Support Groups

PFLAG promotes the health and well-being of lesbian, gay, bisexual, and transgender persons, their families, and friends through support, to cope with an adverse society; education, to enlighten an ill-informed public; and advocacy, to end discrimination and to secure equal civil rights. Parents, Families, and Friends of Lesbians and Gays provides opportunity for dialogue about sexual orientation and gender identity and acts to create a society that is healthy and respectful of human diversity.
We are a national support, education, and advocacy organization for lesbian, gay, bisexual, and transgender (LGBT) people, their families, friends, and allies. With 200,000 members and supporters, and local affiliates in more than 350 communities across the U.S. and abroad, PFLAG is the largest grassroots-based family organization of its kind. PFLAG is a non-profit organization and is not affiliated with any religious or political institutions.

CASE MANAGEMENT

Corsica River Mental Health Services

Dorchester:	403 High Street Cambridge, MD 21613	**Phone:** 443-225-5780 **Fax:** 443-225-5783	**Hours of Operation:** Admin/Billing: Mon. – Fri. 8:30am to 5pm Dorchester: Mon. – Thurs. 8:30am to 5pm, Fri. 8:30am to 4pm Queen Anne's: Mon - Thurs. 8:30am to 7pm, Fri. 8:30am to 4pm Talbot: Tue. 8am to 4:30pm, Wed. by appt. only Caroline: Tue. And Thurs. 8:30am-5pm	**Email:** CorsicaClinic@crmhsinc.com **Website:** www.crmhsinc.com **Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self-Pay, Public Behavioral Health, Medicare, Private Insurance
Queen Anne:	120 Banjo Lane Centreville, MD 21617	**Phone:** 410-758-2211 **Fax (main):** 410-758-0698		
Talbot:	933 S. Talbot Street St. Michaels, MD 21663	**Phone:** 410-745-8028 **Fax:** 410-745-0492		
Caroline:	322 N. Main Street Federalsbury, MD 21632	**Phone:** 410-479-0511 **Fax:** 410-754-6080		

*** For a full listing of services, please see page 10***

Hudson Health Services

Address:	1505 Emerson Avenue Salisbury, MD 21801	**Phone:** 410-219-9000 **Fax:** 410-742-7048 **Email:** info@hudson-health.org **Website:** www.hudson-health.org	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health, Private Insurance

*** For a full listing of services, please see page 38 ***

Upper Bay Counseling & Support Services

Administration:	200 Booth Street Elkton, MD 21921	**Phone:** 410-996-5104 410-996-5197	**Email:** info@upperbay.org **Website:** www.upperbay.org	**Hours of Operation:** Mon. – Thurs. 8am to 8am, Fri. 8 am to 3pm **Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health, Medicare, Private Insurance
Cecil:	1275-B W. Pulaski Hwy. Elkton, MD 21921	**Phone:** 410-620-7161 410-620-7168		
	251 South Bohemia Ave. Cecilton, MD 21913	443-406-3427		

*** For a full listing of services, please see page 17***

Wicomico Behavioral Health - Targeted Case Management Program

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
108 E. Main Street Salisbury, MD 21801	410-543-5179 410-543-6680 www.wicomicohealth.org	Monday – Friday 8am to 5pm	Grant Funds, Public Behavioral Health

Providers:	Services:	Conditions Served:	Translator?
☑ Case Managers	☑ Homeless Outreach ☑ Targeted Case Management	☑ Bipolar Disorder ☑ Co-Occurring ☑ Schizophrenia ☑ Chronic Mental Illness ☑ Depression ☑ Substance Use/Dependence	No

Worcester County Health Department

Main Office:	6040 Public Landing Road P.O. Box 249 Snow Hill, MD 21863	**Phone:** 410-632-1100 **Fax:** 410-632-5682	**Website:** www.worcesterhealth.org	**Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health, Medicare, Private
Berlin Health Department:	9730 Healthway Drive Berlin, MD 21811	**Phone:** 410-629-0164 **Fax:** 410-629-0185	**Hours of Operation:** Mon. – Fri. 8am to 5pm, Evenings and Saturdays by appointment only, Pocomoke Health Center closed on Fridays.	
Pocomoke Health Center:	400 Walnut Street Pocomoke City, MD 21851	**Phone:** 410-957-2005 **Fax:** 410-957-241		

*** For a full listing of services, please see page 19***

Wraparound Maryland

Address:	Phone: / Fax:	Website:
214 Civic Ave Salisbury, MD 21804	**Phone**: 410-369-3480 **Fax:** 866-582-2034	http://www.wraparoundmd.com/index.html

MOBILE TREATMENT TEAMS/ACT

Mobile Treatment Teams (MTT)

Cecil County:	Mid Shore:	Lower Shore:
Upper Bay Counseling & Support Services 200 Booth Street Elkton, MD 21921 410-996-5104 www.upperbay.org	Corsica River Mental Health Services, Inc. 120 Banjo Lane Centreville, MD 21617 443-480-8425 www.crmhsinc.com	Go-Getters, Inc. 106 Williamsport Circle Salisbury, MD 21801 410-341-9696 www.gogettersinc.org/Lower-Shore-Clinic.html

Mobile Treatment Services provide assertive outreach, treatment, and support to individuals with mental illness who may be homeless, or for whom more traditional forms of outpatient treatment have been ineffective. Service is provided by a multidisciplinary team, is mobile and is provided in the individual's natural environment (e.g., home, street, shelters). Mobile Treatment Services also are available for children, adolescents and their families who require more intensive intervention to clinically stabilize the child's or adolescent's psychiatric condition, to promote family preservation and/or to return functioning and quality of life to previously established levels as soon as possible. Services provided include psychiatric evaluation and treatment, clinical assessment, medication management/monitoring, interactive therapies, support with daily living skills, assistance with locating housing, and case management. The duration, frequency and intensity of services provided are determined by an individual's treatment plan. The goals are to connect consumers to treatment services in the community, avert hospitalizations, and remediate tenuous living situations.

Crisis Services

CRISIS RESIDENTIAL TREATMENT

Residential Crisis Services (RCS) are funded with state general funds and are short-term, intensive mental health and support services for children, adolescents, and adults in a community-based, non-hospital, residential setting rendered by a provider approved under Maryland Law (COMAR 10.21.26).

Go-Getters, Inc.
The Retreat

Address: 716 N. Division Street Salisbury, MD 21801	**Phone:** 410-749-2578 **Website:** www.gogettersinc.org **Email:** smobray@lowershoreclinic.org	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare

The Retreat offers a safe harbor and sanctuary for adults experiencing a psychiatric crisis. As a voluntary alternative to hospitalization, The Retreat provides short term Residential Crisis Services in a community-based setting 24 hours a day, 365 days of the year.

In addition to Residential Crisis Services, The Retreat offers crisis counseling.
The Retreat is appropriate as an alternative to psychiatric hospitalization or to shorten the length of a hospital admission. Anyone who is medically stable, under the care of a physician, awaiting admission to or stepping down from a psychiatric unit can be safely cared for at The Retreat.

Situated in a quiet community, The Retreat's trained crisis staff offer the comforts of a home-like setting augmented with counseling and therapeutic groups. The Retreat will assist you with meetings with physicians and therapists to further enhance your recovery. Our private accommodations support clients' need for calm and confidentiality.

*** For a full listing of services, please see page 51***

Harbour House

Harbour House

7731 West Drive
Glen Burnie, MD 21061
410-255-3539
Fax: 410-255-8583
Website: www.harbour-house.org

RESIDENTIAL CRISIS SERVICES
Serving Adults in Central Maryland

Formerly named Anne Arundel Crisis Beds, Harbour House, Inc. is a Maryland 501(c)3 that provides an alternative to hospitalization for adults experiencing a mental health crisis. Harbour House provides a psychiatric inpatient admission alternative for those experiencing a mental health crisis as evaluated by a physician or mental health professional. Without Residential Crisis Services, these individuals are at-risk for inpatient admission. Harbour House can also provide individuals who are being discharged from inpatient facilities a transitional location, as well as individuals needing temporary separation from their current living arrangements. Call 410-255-3539 or email contact@harbour-house.org for more information.

ACUTE PSYCHIATRIC HOSPITALS

Dover Behavioral Health Systems

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
725 Horsepond Road Dover, DE 19901	302-741-0140 / 855-609-9711 Fax: 302-741-8557 Website: www.doverbehavioral.com	24 hours a day, 7 days a week	Self Pay, Public Behavioral Health, Medicare, Private Insurance

*** For a full listing of services, please see page 11***

Peninsula Regional Medical Center

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
100 East Carroll Street Salisbury, MD 21801	410-543-6400 Fax: 410-543-7165 Website: www.peninsula.org	24 hours a day, 7 days a week	Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ MD ☑ Nurse	☑ Clinical Psychiatric Evaluation ☑ Detoxification ☑ Emergency Medical Care ☑ General Mental Health Info/Education ☑ Homeless Outreach ☑ Hotline ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation ☑ Psychiatric Emergency Room Care ☑ Psychiatric Hospitalization ☑ Walk-in	☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Developmental Disabilities ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Sexual Disorders ☑ Substance Use/Dependence	☑ Behavioral Treatment ☑ Group Counseling ☑ Mental Health Related Support Groups
Translator? Use language line			

Rockford Center

Address:	Phone:	Hours of Operation:	Payment Types Accepted:
100 Rockford Drive Newark, DE 19713	302-892-4205 Fax: 302-996-0269 Website: www.rockfordcenter.com	24 hours a day, 7 days a week	Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ LCPC ☑ PhD ☑ MD ☑ CRNP ☑ LCADC ☑ Nurse	☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ Detoxification ☑ General Mental Health Info/Education ☑ Geriatric Assessment ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Older Adult/Aging Issues ☑ Psychiatric Case Management ☑ Psychiatric Day Treatment ☑ Psychiatric Hospitalization ☑ Psychological Testing ☑ Substance Use Education/ Prevention ☑ Substance Use Intervention Program ☑ Substance Use Inpatient Co-Occurring Capable (<30 days) ☑ Substance Use Outpatient ☑ Walk-in	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Dementia ☑ Depression ☑ Personality Disorders ☑ Post Traumatic Stress Disorder ☑ Schizophrenia ☑ Self Injurious Behaviors ☑ Substance Use/Dependence	☑ Anger Management Counseling ☑ Art Therapy ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Death and Dying Counseling ☑ Family Counseling ☑ Gay/Lesbian/Bisexual/Transgender Issues ☑ General Counseling ☑ Geriatric Counseling ☑ Group Counseling ☑ Individual Counseling ☑ Marriage Counseling ☑ Mental Health Related Support Groups ☑ Pet Assisted Therapy ☑ Play Therapy ☑ Psycho Educational Groups ☑ Trauma Informed
Translator? Yes. Spanish			

Shore Behavioral Health

Address: 300 Byrn Street Cambridge, MD 21613	**Phone:** 410-228-5511 ext. 2112 **Fax:** 410-476-5105 **Website:** www.shorehealth.org	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Self Pay, Public Behavioral Health, Medicare, Private Insurance

*** For a full listing of services, please see page 16***

Union Hospital of Cecil County

Address: 106 Bow Street Elkton, MD 21921	**Phone:** 410-398-4000 **Fax:** 410-398-0698 **Website:** www.uhcc.com	**Hours of Operation:** 24 hours a day, 7 days a week	**Payment Types Accepted:** Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare, Private Insurance

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCPC ☑ PhD ☑ MD ☑ Nurse	☑ Adult Day Programs ☑ Clinical Psychiatric Evaluation ☑ Crisis Intervention ☑ Emergency Medical Care ☑ General Mental Health Info/Education ☑ Mental Health & Substance Use Services ☑ Mental Health Evaluation & Treatment ☑ Psychiatric Emergency Room Care ☑ Psychiatric Hospitalization ☑ Psychiatric Medication Services ☑ Psychological Testing ☑ Substance Use Inpatient Co-Occurring Capable (<30 days)	☑ ADHD ☑ Anxiety/Phobias ☑ Bipolar Disorder ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Personality Disorders ☑ Schizophrenia ☑ Self Injurious Behaviors	☑ Anger Management Counseling ☑ Behavioral Treatment ☑ Cognitive Behavioral Therapy (CBT) ☑ Dialectical Behavior Therapy (DBT) ☑ General Counseling ☑ Group Counseling ☑ Mental Health Related Support Groups ☑ Pet Assisted Therapy ☑ Psycho Educational Groups ☑ Trauma Informed

We understand how difficult it can be to realize there is a need for counseling and special care for a loved one. Behavioral health problems can be extremely challenging—particularly for family members. Our Behavioral Health team can help your loved one get the treatment and support for a safe transition back into everyday life through our inpatient or outpatient programs.

Our staff of specially trained psychiatric caregivers can provide intensive assessment and intervention to diagnose an illness or condition. After diagnosis, your loved one can become an inpatient or referred to outpatient treatment, depending on the program of care that is determined to be the best.

Our 15-bed inpatient unit is in Union Hospital on the fourth floor. Because patients are residents, they benefit from our full complement of medical services. Receiving treatment here eliminates the need for travel and contributes to a smoother transition. In this therapeutic environment patients learn techniques to cope with illness and the things that can trigger it. An individualized treatment plan is created for each patient—and includes daily activities and goal setting.

EMERGENCY DEPARTMENTS

University of Maryland Shore Medical Center at Dorchester

300 Byrn Street
Cambridge, MD 21613
410-228-5511
www.umshoreregional.org

University of Maryland Shore Medical Center at Easton

219 S. Washington Street
Easton, MD 21601
410-822-1000
www.umshoreregional.org

University of Maryland Shore Medical Center at Chestertown

100 Brown Street
Chestertown, MD 21620
410-778-3300
www.umshoreregional.org

University of Maryland Shore Emergency Center at Queenstown

115 Shoreway Drive
Queenstown, MD 21658
410-827-3900
www.umshoreregional.org

Peninsula Regional Medical Center

100 East Carroll Street
Salisbury, MD 21801
410-546-6400
www.peninsula.org

Union Hospital of Cecil County

106 Bow Street
Elkton, MD 21921
410-398-4000
www.uhcc.com

MOBILE CRISIS AND CRISIS RESPONSE

Affiliated Santé Group – Eastern Shore Crisis Response Services

Administrative: 408 Byrn Street, Cambridge, MD 21613

Fax: 443-225-5877
Website: www.thesantegroup.org
Phone: 888-407-8018

Hours of Operation: 7 days a week, 24-Hours a day

Payment Types Accepted: Grant Funds,

Providers:

- ☑ LCSW-C
- ☑ LCPC
- ☑ LMSW
- ☑ LSWA
- ☑ LGPC
- ☑ MSW interns

Translator?

Telephonic interpreter & translation services as needed

Services:

- ☑ Community Linkages
- ☑ Crisis Intervention/Stabilization (Free)
- ☑ ED and Incarceration Diversion
- ☑ Limited Transitional Support
- ☑ Mental Health Evaluation
- ☑ CISM/ Debriefings

SANTÉ
AFFILIATED SANTÉ GROUP
"Discover Your Options"

Conditions Served:

- ☑ ADHD
- ☑ Anxiety/Phobias
- ☑ Bipolar Disorder
- ☑ Brain Injuries
- ☑ Chronic Mental Illness
- ☑ Co-Occurring
- ☑ Crisis As Defined By Individual
- ☑ Dementia
- ☑ Depression
- ☑ Developmental Disabilities
- ☑ Eating Disorders
- ☑ Hoarding Behaviors
- ☑ Personality Disorders
- ☑ Post Traumatic Stress Disorder
- ☑ Schizophrenia
- ☑ Self Injurious Behaviors
- ☑ Sexual Disorders
- ☑ Substance Use

ESCRS is part of the Affiliated Sante' Group Family which is the largest provider of crisis services in Maryland. Mobile Crisis Teams services are dispatched vi the Eastern Shore Operations Center (ESOC) 888-407-8018. Mobile Crisis teams operate 24/7 serving Cecil, Kent, Queen Anne, Talbot, Caroline, Dorchester, Wicomico, and Somerset Counties. ESOC operates 24/7 and serves all 9 counties on the Eastern Shore. We offer services in person and by telehealth.

Worcester County Health Department – Crisis Response Team

Address: 9730 Healthway Drive Berlin, Maryland 21811	**Phone:** 410-629-0164 **Fax:** 410-629-0185	**Website:** www.worcesterhealth.org	**Payment Types Accepted:** Grant Funds, Free Services

The Worcester County Health Department's Crisis Response Team provides 24-hour coverage 365 days a year to residents and visitors of Worcester County. CRT is activated by Law Enforcement, Atlantic General Hospital, and various other agencies throughout the county. CRT provides an emergency mental health and addiction assessment on the scene and attempts to connect individuals to community resources as appropriate. Assessments are provided by masters' level mental health professionals.

RESPITE CARE

Respite Services are provided on a short-term basis in the consumer's home or in an approved community-based setting. Services are designed to support consumers remaining in their homes by providing temporary relief to the consumer's caregivers.

Children's Choice

Queen Anne: 1103 Butterworth's Court Stevensville, MD 21666	**Phone:** 410-643-9290 **Fax:** 410-643-9293	**Website:** www.childrenschoice.org	**Payment Types Accepted:** Grant Funds, Public Behavioral Health
Wicomico: 230 Florida Avenue Salisbury, MD 21801	**Phone:** 410-546-6106 **Fax:** 410-219-2640	**Hours of Operation:** Mon. – Fri. 8:30am to 4:30pm	

*** For a full listing of services, please see page 47***

Community Behavioral Health

Dorchester: 426 Dorchester Avenue Cambridge, MD 21613	**Phone:** 844-224-5264 **Fax:** 888-509-0010	**Hours of Operation:** Mon. – Thurs. 8am to 6pm, Fri. 8am to 5pm, Sat. please call	**Payment Types Accepted:** Grant Funds, Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare, Private Insurance
Queen Anne: 142 Coursevall Drive Centreville, MD 21617	**Phone:** 844-224-5264 **Fax:** 888-509-0010	**Email:** info@communitybehavioralhealth.net	**Website:** www.communitybehavioralhealth.net
Wicomico: 809 & 821 Eastern Shore Dr. Salisbury, MD 21804	**Phone:** 844-224-5264 **Fax:** 888-509-0010		

*** For a full listing of services, please see page 9***

Crossroads Community, Inc.

Dorchester: 404 LeCompte Street Cambridge, MD 21613	**Phone:** 410-221-7540 **Fax:** 410-221-7541	**Email:** cci@ccinconline.com	**Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health
Kent: 937 Gateway Drive Chestertown, MD 21620	**Phone:** 410-778-9200 **Fax:** 410-778-9622	**Website:** www.cccinconline.com	
Queen Anne's: 120 Banjo Lane Centreville, MD 21617	**Phone:** 410-758-3050 **Fax:** 410-758-1223	**Hours of Operation:** Mon.-Fri. 8am to 4pm	

*** For a full listing of services, please see page 50***

Go-Getters, Inc.						
Address:	716 N. Division Street Salisbury, MD 21801	**Phone:** **Fax:** **Website:** **Email:**	410-546-7754 410-334-3710 www.gogettersinc.org smobray@lowershoreclinic.org	**Hours of Operation:** Varies by program	**Payment Types Accepted:** Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare
*** For a full listing of services, please see page 50***					

MENTOR Maryland					
Talbot:	8133 Elliott Road, Suite 236 Easton, MD 21601	**Phone:** **Fax:**	410-820-4703 410-820-8459	**Website:** www.md-mentor.com	**Payment Types Accepted:** DHR
Wicomico:	220 Naylor Mill Road #A-F Salisbury, MD 21801	**Phone:** **Fax:**	410-548-5921 410-548-5983	**Hours of Operation:** Mon. – Fri. 9am to 5pm	

Providers:	Services:	Conditions Served:		Treatment
☑ LCSW-C	☑ Crisis Intervention ☑ Respite Care ☑ Therapeutic Foster Care	☑ ADHD ☑ Anxiety/Phobias ☑ Chronic Mental Illness ☑ Co-Occurring ☑ Depression ☑ Hoarding Behaviors	☑ Personality Disorders ☑ Sexual Disorders ☑ Self Injurious Behaviors ☑ Substance Use/Dependence	☑ Trauma Informed
Translator? No				

Housing

RESIDENTIAL REHABILITATION PROGRAMS

Residential Rehabilitation Programs (RRPs) for adults provides support in a residence outside of the individual's own home and provides needed resources and support not sufficiently available within the individual's own existing social support system. Residential Rehabilitation Programs (RRPs) provide services based upon the individual's needs in varying levels of support, both general and intensive, and are subject to additional admission/continued stay criteria.

*RRP Applications are processed through the Core Service Agency (CSA). Please contact your local CSA for placement, not the providers below. To obtain a full listing of Core Service Agencies in Maryland please visit *www.marylandbehavioralhealth.org.**

Channel Marker, Inc.					
Administrative Office:	8865 Glebe Park Drive Easton, MD 21601	**Phone:** **Fax:**	410-822-4619 410-822-0984	**Email:** cmarker@channelmarker.org	**Payments Accepted:** Grant Funds, Sliding Scale Fee, Self Pay, Public Behavioral Health
Caroline:	508 Kerr Avenue Denton, MD 21629	**Phone:** **Fax:**	410-479-2318 410-820-0124	**Website:** www.channelmarker.org	
Dorchester:	420 Dorchester Avenue Cambridge, MD 21613	**Phone:** **Fax:**	410-228-8330 410-221-6459	**Hours of Operation:** Monday – Friday 8am to 5pm	
Talbot:	222 Port Street Easton, MD 21601	**Phone:** **Fax:**	410-822-4611 410-822-6186		
*** For a full listing of services, please see page 48***					

Crossroads Community, Inc.

Dorchester:	404 LeCompte Street Cambridge, MD 21613	**Phone:** **Fax:**	410-221-7540 410-221-7541	**Email:** cci@ccinconline.com	**Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health
Kent:	937 Gateway Drive Chestertown, MD 21620	**Phone:** **Fax:**	410-778-9200 410-778-9622	**Website:** www.cccinconline.com	
Queen Anne:	120 Banjo Lane Centreville, MD 21617	**Phone:** **Fax:**	410-758-3050 410-758-1223	**Hours of Operation:** Mon.-Fri. 8am to 4pm	

*** For a full listing of services, please see page 50***

Go-Getters, Inc.

Address:	716 N. Division Street Salisbury, MD 21801	**Phone:** **Fax:** **Email:** **Website:**	410-546-03081 410-334-3710 www.gogettersinc.org smobray@lowershoreclinic.org	**Hours of Operation:** Varies by program	**Payment Types Accepted:** Sliding Scale Fee, Self Pay, Public Behavioral Health, Medicare

*** For a full listing of services, please see page 51***

Upper Bay Counseling & Support Services

Administration:	200 Booth Street Elkton, MD 21921	**Phone:**	410-996-5104 410-996-5197	**Email:** info@upperbay.org	**Hours of Operation:** Mon. – Thurs. 8am to 8am, Fri. 8 am to 3pm
Cecil:	1275-B W. Pulaski Hwy. Elkton, MD 21921	**Phone:**	410-620-7161 410-620-7168	**Website:** www.upperbay.org	**Payment Types Accepted:** Grant Funds, Self Pay, Public Behavioral Health, Medicare, Private Insurance
	251 South Bohemia Ave. Cecilton, MD 21913		443-406-3427		

*** For a full listing of services, please see page 17***

HOUSING PROGRAMS

Mid Shore Roundtable on Homelessness (Continuum of Care)

A Mid Shore collaboration of homeless service providers, community agencies, local governments, stakeholders, and consumers tasked with addressing the issue of homelessness in the Mid Shore region.

Mission: To provide leadership to improve the availability and delivery of both housing and supportive services to individuals and families who lack permanent, stable, and safe housing in the Mid Shore region. We continually work towards this mission with the following strategies:

1. To collaborate and continually build community partnerships among member organizations to provide a coordinated and seamless service delivery to homeless and unstably housed clients.
2. To identify needs, advocate for, and work towards a comprehensive continuum of care for persons and families without homes.
3. To reduce public stigma of homelessness through community awareness and education.
4. To do long and short-term planning, aligning our goals with our federal partners, to accomplish the mission.

For more information, please call Mid Shore Behavioral Health, Inc. 410-770-4801, Jeanine Beasley ext. 303. Check out our Shelter Bed Availability Sheet here.

Permanent Supportive Housing (Continuum of Care Housing Program and Supportive Housing)

Continuum of Care (CoC) Housing Programs are HUD funded rental subsidies for literally homeless person(s)/families with behavioral health disabilities. Eligibility is determined through an intake process by PATH Outreach, Case Management Staff, or CoC Housing Specialist. Program monitoring is provided through Supportive Services staff.

For CoC Housing information, please call Mid Shore Behavioral Health, Inc., 410-770-4801, Jeanine Beasley ext. 303, or Bernard Vervin ext. 319.

Homeless Management Information Systems (HMIS)

Database for local providers is known as Service Point. The system provides information and referral for licensed users, as well as tracking and reporting of homeless services used in the region. Serving Caroline, Dorchester, Kent, Queen Anne, and Talbot Counties.

For more information, please call Mid Shore Behavioral Health, Inc. 410-770-4801, Jeanine Beasley ext. 303.

Affordable Housing (Main Street Housing)

This program does not provide emergency housing. This is permanent affordable housing for tenants that are eligible for independent community living. Intake and placement require matching the tenant to the proper living situation based on available openings.

For more information, please call 410-540-9067 Gloria Bowen ext. 17.

PATH - Projects for Assistance in Transition from Homelessness (Homeless Outreach Case Management)

Priority population served includes persons with a mental health need who are homeless or at risk of becoming homeless. This program is designed to provide outreach and linkage assistance to street homeless for mental health services and housing.

For more information, please call Gloria Greene, Outreach Worker for Crossroads Community, Inc., at 410-490-3139.

SOAR Initiative (SSI/SSDI Outreach, Access, and Recovery)

SOAR is a national program designed to increase access to Social Security Insurance (SSI) / Social Security Disability Insurance (SSDI) for adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. Local agencies that have SOAR trained staff include Alliance, Inc., Chesapeake Voyagers, Inc., Crossroads Community, Inc., Community Behavioral Health, Mid Shore Behavioral Health, Inc., the Neighborhood Service Center, and St. James Zion Church.

Please contact SOAR lead Carole McCall for more information at 410-770-4801, ext. 311.

SHELTERS AND HOMELESSNESS SERVICES

The Salvation Army of the Mid Shore (Cambridge) 410-228-2442 Individuals and Families	**Ridgeway House (Easton) 410-822-5015** or **410-820-7013** 6 bed facility (serves 3 Men, 3 Women) Hours: Mon. – Fri., 4pm to 8am Sat. & Sun. open 24 hours Sheltering and Case Management	**Talbot Interfaith Shelter (Easton) 410-690-3120 www.talbotinterfaithshelter.org** Help Hotline: 410-253-5414 Individuals and Families	**Cecil County Men's Shelter (Elkton) 410-392-8066 www.meetingground.org** Men only	
Wayfarer's House (Elkton) 410-398-4381 www.meetingground.org Women and Children	**Christian Shelter, Inc. (Salisbury) 410-749-5673 www.christianshelter.org** Call for Information	**HALO (Salisbury) 410-742-9356 www.haloministry.org** Men, Women and Children	**The Samaritan Shelter (Pocomoke) 410-957-4310 www.thesamaritanshelter.org** Call for Information	**Diakonia Shelter (Ocean City) 410-213-0923 www.diakoniaoc.org** Call for Information
Delmarva Community Services (Cambridge) 410-901-2991 Men **Family Shelter (Hurlock)**	**Martin's House (Ridgely) 410-634-2537** Families			

Cold Weather Shelters

His Hope Ministries (Caroline County) (443) 448-7297 https://hishopeministries.org/emergency-crisis-shelter Open October through May Intake through Resource Center		**Dorchester Cold Weather Shelter (Dorchester County) 410-228-2442** Open December through mid-April
The Samaritan Group (Kent County) 443-480-3564 or **410-810-7600 www.samaritangroupkent.org** Open January through March	**Haven Ministries (Queen Anne's County) 410-739-7859 www.haven-ministries.org** Open December through mid-April	**Cold Weather Shelter (Lower Shore) 410-749-4357** Open January through March

Transitional Shelters

Wayfarer's House (Elkton) 410-398-4381 Women and Children	**Village of Hope (Salisbury) 410-860-4803** Women and Children

Day Shelter and Resource Centers

Mary Randall Center Day Program 401 North St Elkton, MD 21921 410-620-4701
www.meetingground.org

The Mary Randall Center is the first step for many on the path from shelter to home. It is a place where individuals currently experiencing homeless are able to shower, collect their mail, launder their clothing, and link with medical services and job seeking assistance. At the Mary Randall Center individuals find the means to new life, restored dreams, and opportunities to build personal and professional skills.

Hours of Operation: Monday – Friday, 8am to 11:30am
Monday, Wednesday, Friday, 1pm to 4pm

Haven Ministries

(Queen Anne's County)

St. Paul's Episcopal Church
301 South Liberty Street
Centreville, MD 21617
(410) 827-7194
www.haven-ministries.org

The Resource Center advances the missions of both Haven Ministries and St. Paul's Church by offering a place of referral and case management services to residents of Queen Anne's County. The Resource Center includes case management services, educational programs, job training, and use of computers and office equipment.

Hours of Operation:
Open December through mid-April
8:30am-4:30pm.

HALO Day Facility
119B South Boulevard
Salisbury, MD 21804
410-543-2003
www.haloministry.org

The Day Facility is a safe structured place where homeless individuals and families can come during the daytime hours. Our goal is to help rebuild the dignity of each person by providing services to meet not only the basic needs, but a Journey of Hope for Life Change. \ Services provided include Case Management, Showers, Restrooms, Voice Mail, Mail Services, Locked Storage Facility, and Class Opportunities including GED, Life Skills, and Bible Study.

Hours of Operation:
Monday – Friday, 8:45 AM to 4:30 PM

Friends Helping Friends Network, Inc.

443-477-3324

A non-profit, Christian-based organization that helps single moms and homeless families by providing temporary shelter, helping them set and reach goals, while working on a budget and a goal plan; teaching them to become independent by helping them to focus by taking away burdens that hold them back.

His Hope Ministries

(443) 448-7297
105 Gay Street
Denton, MD 21629
https://hishopeministries.org/emergency-crisis-shelter

His Hope Ministries helps families, individuals, youth, and elderly fight homelessness, hunger, and potential homelessness. We work towards a place where all people have access to quality housing, nutritious food, and opportunities to thrive.

Meal Service / Food Pantries

Caroline:	Martin's House and Barn 14376 Benedictine Lane, Ridgely, MD 21660	**Phone:**	410-634-1140	**Service:**	Food Pantry
Dorchester:	Delmarva Community Action Center 1000 Goodwill Road, Cambridge, MD 21613	**Phone:**	410-901-2991	**Service:**	Food Pantry
	Salvation Army 200 Washington Street, Cambridge, MD 21613	**Phone:**	410-228-2442	**Service:**	Food Pantry
Kent:	Community Food Pantry 401 High Street, Chestertown, MD 21620	**Phone:**	410-778-0550	**Service:**	Food Pantry
Queen Anne:	Haven Ministries 931 Love Point Road, Stevensville, MD 21666	**Phone:**	410-739-7859	**Service:**	Food Pantry
Talbot:	Neighborhood Service Center 126 Port Street, Easton, MD 21601	**Phone:**	410-822-5015	**Service:**	Food Pantry
	St. Vincent de Paul 29533 Canvasback Drive, Easton, MD 21601	**Phone:**	410-770-4505	**Service:**	Food Pantry
Wicomico:	Salvation Army 407 Oak Street, Salisbury, MD 21874	**Phone:**	410-749-3077	**Service:**	Food Pantry

	HALO Café 119B South Boulevard, Salisbury, MD 21804	**Phone:**	410-742-9356	**Service:**	Free Meal Service
Worcester:	Diakonia Shelter 12747 Old Bridge Road, Ocean City, MD 21842	**Phone:**	410-213-0923	**Service:**	Food Pantry

Thrift Stores

Caroline:	Martin's House and Barn 14376 Benedictine Lane, Ridgely, MD 21660	**Phone:**	410-634-1140	**Service:**	Thrift Store
	Samaritan House Thrift Shop 12 N. 5th Street, Denton, MD 21629	**Phone:**	410-479-1251	**Service:**	Thrift Store
Dorchester:	Anchor Point Family Thrift Store 714 Meadow Avenue, Cambridge, MD 21613	**Phone:**	410-330-0210	**Service:**	Thrift Store
	Salvation Army 200 Washington Street, Cambridge, MD 21613	**Phone:**	410-228-2442	**Service:**	Thrift Store
Kent:	Hidden Treasures – Kent Center 711 Washington Avenue, Chestertown, MD 21620	**Phone:**	410-778-1219	**Service:**	Thrift Store
	Women in Need 106 Philosophers Terrace, Chestertown, MD 21620	**Phone:**	410-778-5999	**Service:**	Thrift Store
Queen Anne:	Our Daily Thread 425 Thompson Creek Rd, Stevensville, MD 21666	**Phone:**	410-353-0455	**Service:**	Thrift Store
Talbot:	Friends Helping Friends 412 S. Harrison Street, Easton, MD 21601	**Phone:**	443-477-3324	**Service:**	Thrift Store
	Goodwill Industries of the Chesapeake 134 N. Washington, Street, Easton, MD 21601	**Phone:**	410-770-4458	**Service:**	Thrift Store
	St. Vincent de Paul 29533 Canvasback Drive, Easton, MD 21601	**Phone:**	410-770-4505	**Service:**	Thrift Store
Somerset:	Catholic Charities - Seton Center 30632 Hampden Avenue, Princess Anne, MD 21853	**Phone:**	410-651-9608	**Service:**	Thrift Store
Wicomico:	Goodwill Industries of the Chesapeake 700 S. Salisbury, Blvd. Salisbury, MD 21801	**Phone:**	410-219-9072	**Service:**	Thrift Store
	HALO Bargain Center 701 Snow Hill Road, Salisbury, MD 21804	**Phone:**	410-341-4256	**Service:**	Thrift Store
	Salvation Army 215 E Vine Street, Salisbury, MD 21874	**Phone:**	410-749-8146	**Service:**	Thrift Store
Worcester:	Coastal Hospice Thrift Shop 10445 Old Ocean City, Blvd., Berlin, MD 21811	**Phone:**	410-641-1132	**Service:**	Thrift Store
	Diakonia 'Used to be Mine' Thrift Store 12507 Sunset Avenue #13, Ocean City, MD 21842	**Phone:**	410-213-0923	**Service:**	Thrift Store

Chesapeake Caregivers, Inc.

Address:	839 Bestgate Road, STE 400 Annapolis. MD 21401	**Phone:** **Email:** **Website:**	443-694-4231 john@chesapeakecaregivers.com www.chesapeakecaregivers.com	**Hours of Operation:** 24 hours a day, 7 days a week	CHESAPEAKE CAREGIVERS INC.

Chesapeake Caregivers operates two assisted living homes in spacious community settings Annapolis. Whether the care needed is short-term (respite) or long-term, the trained staff at Chesapeake Caregivers are there to meet the needs of all the residents. Assisted living fees are based on the senior's specific needs and includes personal and professional care, 24-hour supervision, personal laundry service, 3 meals and snacks daily, medication management, and transportation for health care needs and social events.

With a team of Certified Nursing Assistants, Chesapeake Caregivers' Residential Services Agency can also visit a senior's home to provide services including companionship services such as escort to outside activities or appointments; personal services such as bathing, grooming, and medication management; and home services such as meal prep with cleanup, general housekeeping, laundry, and shopping/errands.

Senior Services

For a full list of senior services, contact Betsy Griffin, bgriffin@chespub.com, for a copy of the 2018 Senior Resource Guide for Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties.

Maryland Health Care Commission - Long Term Care

Consumer Guide to Long Term Care
http://mhcc.maryland.gov/consumerinfo/longtermcare/default.aspx

Long Term Care (LTC) refers to services that assist people who are aging, have disabilities, or have chronic care needs to maintain their independence in personal or health-related activities. Services can include activities such as shopping, taking medications, managing money, doing activities outside the home, and assistance with personal care such as bathing, dressing, and toileting. Services can be provided in a person's home, in the community, in alternate living facilities (assisted living, congregate housing or nursing homes). While most people who need LTC are 65 or older, a person can use LTC services at any age. An individual may use long term care services for a short period of time after an acute illness or hospitalization or over several months or years.

Many people prefer to receive LTC services in their home or community rather than an institution like a nursing home. You can use this web site to find LTC services in Maryland. The materials included on this site can be used by individuals planning for future needs or an immediate need for themselves or a loved one such as a parent, other relative or friend.

Maryland Access Point

Caroline, Kent, Talbot:	100 Schauber Road Frederick, MD 21702 Camp Springs, MD 21502 Chestertown, MD	**Phone:** 410-778-6000	**Website:** http://www.marylandaccesspoint.info/	
Dorchester, Somerset, Wicomico:	909 Progress Circle Salisbury, MD 21804	**Phone:** 410-742-0505, ex 109	Contact: Teja Rau: teja.rau@maryalnd.gov, 410-767-1266, Acting Chief, Long Term Services & Supports Eram Abbasi: eram.abbasi@maryland.gov, 410-767-1076, MAP I & A Manager	MARYLAND DEPARTMENT OF AGING
Queen Anne's:	104 Powell Street Centerville, MD 21617	**Phone:** 410-758-0848		

Aging and Disability Resource Centers (ADRC), known locally as Maryland Access Point (MAP), were established in 2003. MAPs are administered by the Maryland Department of Aging, in collaboration with the Maryland Departments of Health and Mental Hygiene, Disabilities, Human Resources and the Governor's Office for the Deaf and Hard of Hearing. The ADRC initiative is sponsored by the federal Administration for Community Living, the Centers for Medicare and Medicaid Services and the Department of Veterans Affairs, and involves a national network operating in 54 states and territories.

Maintaining Active Citizens (MAC), Inc.

Dorchester:	2540 Cambridge Beltway Cambridge, MD 21613	**Phone:** 410-221-1920	**Website:** www.macinc.org	MAC MAINTAINING ACTIVE CITIZENS Your area agency on aging
Wicomico:	909 Progress Circle Salisbury, MD 21804	**Phone:** 410-742-0505 **Fax:** 410-742-0525	**Email:** macmail@macinc.org	

MAC is the designated area agency on aging for Dorchester, Somerset, Wicomico, and Worcester counties. MAC is dedicated to the principle that older persons are entitled to lives of dignity, security, and physical, mental, and social well-being, as well as full participation in society. To achieve our purpose for all older persons, MAC, an equal opportunity employer and service provider, serves as a focal point from which to address social and economic needs identified by older persons, and to provide a full range of services. MAC is a private, non-profit organization and is proud to be a member agency of the United Way of the Lower Eastern Shore.

Maryland Department of Aging

301 West Preston Street, Suite 1007
Baltimore, Maryland 21201
410-767-1100 or 800-243-3425
Fax: 410-333-7943

The Maryland Department of Aging (MDoA) and the statewide network of 19 Area Agencies on Aging assist older Marylanders with a range of services and sources of information. MDoA administers state and federal programs, many of which are significantly lower in cost than nursing home placement. Programs include information, empowerment, community wellness and nutrition, long term services and supports, and elder rights protections.

Medicaid's Long-Term Care and Waiver Services

Community First Choice Waiver 1-877-463-3464	**Home and Community-Based Options Waiver** 1-844-627-5465
Services include: Personal Assistance Services, Personal Emergency Response Systems, Technology, Environmental Assessments, Accessibility Adaptations, Consumer Training, Supports Planning, Transition Services, Nurse Monitoring, and Home Delivered Meals.	Services include: Assisted Living, Medical Day Care, Family Training, Case Management, Senior Center Plus, Dietitian and Nutritionist Services, and Behavioral Consultation. Waiver participants are also eligible to receive Community First Choice Service.

Provides community services and supports to enable older adults and people with disabilities to live in their own homes. CFC and HCBO participants are also eligible to receive other Medicaid services which may include: Physician and Hospital Care, Pharmacy, Home Health, Laboratory Services, Mental Health Services, Disposable Medical Supplies, Durable Medical Equipment. Visit *http://mmcp.health.maryland.gov/longtermcare* for more information.

National Long-Term Care Ombudsman Resource Center

202-332-2275
Fax: 202-332-2949
www.ltcombudsman.org

The Long-Term Care Ombudsman Program resolves the problems of individuals in long-term care facilities, provides information and referral about facility selection and quality care, assists resident and family councils, promotes residents' rights, and represents residents' needs and interests to public officials. Nursing homes and board and care homes (including assisting living) are visited by long-term care ombudsmen. Ombudsmen are advocates for residents, working with them, and for them, to address complaints. Confidentiality is central to all ombudsman work.

Queen Anne's County Area Agency on Aging

Administrative Office:	104 Powell Street Centreville, MD 21617	**Phone:** **Fax:**	410-758-0848 410-758-4489	**Email:**	cwillis@qac.org	**Hours of Operation:**	Mon. – Fri. 8am to 4:30pm

The Area Agency on Aging offers programs and activities that support senior citizens in their effort to remain healthy, active, and independent, and to age in place. Services are provided through multi-purpose senior centers located in Grasonville, Kent Island, and Sudlersville; as well as the administrative offices in Centreville. The Queen Anne's County Area Agency on Aging is designated as a Maryland Access Point, whereby consumers and caregivers can access the availability of long-term care support services and programs. It is designed to be a single point of entry for disabled individuals between the ages of 18 and 59 and for any consumer age 60 and older. The Queen Anne's County Area Agency on Aging is an E.O.E. and does not discriminate based on race, color, religion, sex, age, national origin, or disability in the admission of, access to, or treatment in its programs or activities.

Upper Shore Aging

Main Office:	100 Schauber Road Chestertown, Maryland 21620	**Phone:** **Fax:**	410-778-6000 410-778-3562	**Hours of Operation:**		**Website:** www.uppershoreaging.org	
Amy Lynn Ferris Activity Center:	200 Schauber Road Chestertown, MD 21620	**Phone:** **Fax:**	410-778-2564 410-758-9994	Monday – Friday 8am to 3pm		**Email:** Gary Gunther, Executive Director ggunther@uppershoreaging.org	
Caroline County Senior Center:	403 S. 7th Street, Suite 127 Denton, MD 21629	**Phone:** **Fax:**	410-479-2535 410-479-1879	Monday – Friday 8am to 3pm			
Federalsburg Senior Center:	118 North Main Street Federalsburg, MD 21632	**Phone:** **Fax:**	410-754-9754 410-754-9262	Tuesday and Thursday 9am to 3pm			
Talbot County Senior Center:	400 Brookletts Ave. Easton, MD 21601	**Phone:** **Fax:**	410-822-2869 410-820-9563	Monday – Friday 8am to 3pm		"Ability is Ageless"	

Upper Shore Aging, Inc. is a nonprofit 501(c)(3) organization that is the designated Area Agency on Aging for Talbot, Caroline, and Kent counties, serving a potential market of nearly 22,000 persons over the age of sixty years. The organization develops and manages a coordinated program of services that work together with a goal of helping elders to remain, and live well, in the community if possible. Upper Shore Aging, Inc. works closely with the Maryland Department of Aging to serve the needs of its clients.

Veteran Services

Cambridge VA Outpatient Clinic

Address:	830 Chesapeake Drive Cambridge, MD 21613	**Phone:** **Fax:**	410-228-6243 410-901-4011	**Hours of Operation:** Mon. – Fri. 8am to 4:30pm	**Website:** www.maryland.va.gov

Healthcare services include: Audiology, Coumadin Clinic, Hearing Aid Fitting, Medication Management, Mental Health, Primary Care, Occupational Therapy, Optometry, Post Traumatic Stress, Pulmonary, Social Work, Telemental Health, Tele-retinal Imaging, Urology, Vet Center, Women's Health.

Department of Veterans Affairs and Hotline Numbers

U.S. Department of Veterans Affairs

Website: www.va.gov
Benefits:1-800-827-1000
Health Care: 1-877-222-VETS (8387)
VA Inspector General: 1-800-488-8244
Combat Call Center: 1-877-WAR-VETS (1-877-927-8387)
Homeless Veteran Services: 1-877-4AID-VET (1-877-424-3838)

Veterans Crisis Line
1-800-273-8255 PRESS 1

Maryland's Commitment to Veterans (MCV)

MCV is an outreach and referral initiative designed to serve those that have served our country. A live representative will connect veterans with a local Regional Resource Coordinator who will find the best services available to meet their needs and the needs of their family and ease the transition into civilian life.

Maryland's commitment to Veterans

For more information, please call 1-877-770-4801, visit the web: veterans.health.maryland.gov, or contact the Dina Karpf, Eastern Regional Resource Coordinator, at 410-725-9996 or dkarpf.mcv@gmail.com.

Perry Point VA Medical Center

Perry Point VA Medical Center
Perry Point, MD 21902
410-642-2411
Fax: 410-642-1161
Website: www.maryland.va.gov

The Perry Point VA Medical Center provides a broad range of inpatient, outpatient, and primary care services. As the largest inpatient facility in the VA Maryland Health Care System, the medical center provides inpatient medical, intermediate, and long-term care programs, including nursing home care, rehabilitation services, geriatric evaluation and management, respite care, chronic ventilator care, and hospice care.

The Perry Point VA Medical Center is a leader in providing comprehensive mental health care to Maryland's Veterans. The medical center offers long- and short-term inpatient and outpatient mental health care, including the following specialized treatment programs:

- **Mental Health Intensive Case Management**
- **Psychosocial Rehabilitation and Recovery Center**
- **Health Improvement Program**
- **Family Intervention Team**
- **Outpatient Trauma & Post Traumatic Stress Disorder Program**
- **Substance Use Residential Rehabilitation Treatment**
- **Domiciliary Residential Rehabilitation Treatment (for Homeless Veterans)**
- **Compensated Work Therapy – Transitional Residence**

Primary care and specialty outpatient services at the Perry Point VA Medical Center are provided in an outpatient facility that was designed and constructed to meet the needs of Veterans by offering the latest medical technology, ample clinical space and comfortable waiting areas and exam rooms.

Contact: Albert Pacitti, Outreach Social Worker - Healthcare for the Homeless Veterans, at Albert.Pacitti@va.gov for more information.

Salisbury Outstation - VA Vet Center

Address:	**Phone:**	**Hours of Operation:**	**Website:**
926 Snow Hill Road, #3 Salisbury, MD 21804	443-248-0362 or 877-927-8387	Mon. – Fri. 8am to 4:30pm	www.maryland.va.gov

In an effort to better serve the veteran and family members, upon request Vet Centers will provide services after normal work hours and/or on weekends.

Veterans Support Centers of America

Veterans Support Centers of America (VSCOA) is a nonprofit organization formed to serve the rural disabled and homeless Veteran community. Their PAWS (Partnering Animals with Soldiers) Program is dedicated to helping both homeless veterans and homeless animals. Visit www.vscoapaws.org or www.facebook.com/VSCOAPAWS for more information. The VSCOA also provides advocacy and limited shelter services. Their extensive network of service providers, knowledge of the Veterans Administration system and professional staff form a unique and successful program of services to support the needs of the rural veteran.

If you are a Veteran in need of shelter, please call: 410-873-2500 or 410-873-2550. For resource questions please call Mike Bargiband at 443-924-0872, mike.bargiband@vscoa.org. For general inquiries, please email: support@vscoa.org or visit the website at www.vscoa.org

Supportive Services for Veteran Families (SSVF) Programs

St James AME Zion Church – Zion House
521 Mack Avenue
Salisbury, MD 21801
410-742-1427
Hours of Operation: 10am to 4pm

St. James AME Zion Church – Zion House is a 501(c)(3) nonprofit organization that has served Marylanders since 2002. Each year St. James Zion House assists thousands of individuals through a variety of community- based services. St. James Zion House has worked collaboratively with and received grants from the Wicomico County Health Department, Healthy U, the American Psychological Association, and the Department of Health and Mental Hygiene. The non-profit also served as the Homeless Prevention and Rapid Re-housing vendor for the City of Salisbury utilizing funding obtained through the American Reinvestment and Recovery Act.

Homeless Prevention & Rehousing
There are many circumstances that can lead to homelessness. Some veterans become homeless due to a combination of housing shortages and high unemployment. Other veterans may be dealing with painful memories or health issues and have little access to health care or support from family and friends. SSVF provides direct services to veterans and their families to help homeless, or at-risk veteran families. SSVF provides a link to benefits and resources for family stability.
Homeless Veteran Re-integration Program (HRVP). We can assist qualified veterans with employment search, training, purchase of tools and work clothes, and job placement. We have two case managers and an employment development case manager.

Services
- Child Care
- Financial Planning
- Legal Services
- Moving Costs
- Rent/Utility Deposit
- Transportation

SSVF Temporary Assistance CANNOT be used for:
- Mortgage costs
- Property taxes
- Construction or renovations
- Credit card bills
- Car payments
- Insurance premiums
- Medical or dental care
- Gift/Food/Gas cards, or
- Furniture

Who is eligible?
Applicants must meet the following guidelines:
- At least one day of active military service
- Applicants must lack the financial resources and support networks needed to obtain housing or remain in existing housing
- Discharge other than dishonorable from active service
- Very low income: <50% of area median income

For more information, contact Lore Chambers at llchambers007@gmail.com

Alliance, Inc. - Veterans Housing Outreach and Assistance
7701 Wise Avenue
Baltimore, MD 21222
410-282-5900, ext. 3333
Website: www.allianceinc.org

Factors such as joblessness, limited income, disabilities, mental illness, substance use, poor credit, criminal histories, and traumatic events affect housing stability. Alliance's Supportive Services for Veteran Families (SSVF) program is designed to help Veteran families address these issues and secure permanent housing. SSVF provides a short, intensive period of case management to link families to benefits and provide temporary financial assistance with housing or moving expenses.

Temporary Financial Assistance
SSVF offers limited financial assistance that helps Veterans remain in or obtain permanent housing:

- Rent (not including mortgage payments, penalties, or fees)
- Utility fees
- Security or utility deposits
- Moving costs
- Childcare
- Transportation

Only participants receiving case management will be eligible for financial assistance payments. All payments made to third parties.

Case Management
Alliance case managers are experienced, trained, and educated professionals who truly care about helping others and who have a unique understanding of Veteran needs. They will:

- Assess your individual needs and situation.
- Develop a plan to help you achieve your housing goals.
- Link you with vital resources at the VA and in the community.
- Monitor progress towards your goals and refine as needed.
- Advocate on your behalf at the VA and in the community.

SSVF participants will receive a short (3-6 months) period of case management to assist them with obtaining permanent housing.
For program form, contact John Pomory at jpomory@allianceinc.org, 410-282-5900 ext. 3015.

Transportation

County Ride - Queen Anne's County

County Ride is the public transit system for Queen Anne's County and is operated under the Department of Aging. The County Ride team is committed to assisting and increasing the transportation and mobility options of our county residents. The staff is committed to providing quality transit service for the public and specialized services for seniors and persons with disabilities who are unable to use the fixed-route public system.

County Ride operates two deviated fixed routes, Route 1 and Route 2. Deviated-fixed routes operate on a time schedule. Drivers may deviate off the route for any rider if the deviation will not make the route late. Please call dispatch at 410-758-2361 or 410-758-2357 for more information about deviations.

County Ride also operates a demand response service which is open to everyone. Demand Response is a service for those not able to access Route 1 or Route 2. Please call dispatch at 410-758-2361 or 410-758-2357 to schedule a demand response ride or for more information about the service.

To contact County Ride for more information or to schedule a ride call 410-758-2357 Monday through Friday 8am to 4pm or via email at Transportation@qac.org

Bay Country Taxi

218 N. Washington Street,
Ste. 19 Easton, MD 21601
410-770-9030
Website: www.baycountrytaxi.com

Bay Country Taxi & Transportation Company is a locally-owned and operated company that has been serving the community for over 18 years. Provides fast and friendly pick-up and drop-off services at competitive prices. Get FREE ESTIMATES on all rides.

Delmarva Community Transit – One Stop

One Stops are located in Caroline (410-479-3867), Dorchester (410-221-1910), Kent (410-778-5187), and Talbot (410-822-4155) counties and provide one place for information and assistance about transportation solutions as well as information and assistance to access community agencies and people who may be able to help with other problems one might face. One Stops can make phone calls, assist with paperwork and locate resources, all under one roof. This service is free. Please ask to speak to "One Stop" for help. For Spanish line, dial 410-490-1696 for assistance.

Home Ports

P.O. Box 114
Chestertown, MD
21620 443-480-0940
Website: www.homeports.org

Home Ports is based in Kent County and provides services to its members, who are age 55 and over. There is a fee to be a member. Services include referrals to a vetted list of transportation providers for local and regional transportation needs. Limited volunteer-based transportation services available.

Key Lime Taxi of the Eastern Shore

222 South Bridge St Suite 1
Elkton, MD 21921
Cecil County: 410-996-4950
Kent/Talbot County: 855-996-4950 (Toll Free)
Website: www.elktontaxi.com

Highly experienced taxi drivers know their way around town and show up in a timely manner - enjoy a comfortable ride in one of our clean taxi cabs. Whether you're visiting our city or simply don't want to hassle with parking, let one of our cabs save you the stress of working out your transportation.

MTA Commuter Bus

800-543-9809
Toll Free: 1-866-RIDE-MTA (1-866-743-3682)

Hour of Operation:
MondayFriday, 6am to 7pm

Route 240/250 serves Kent Island of Queen Anne's County.

Maryland Upper Shore Transit (MUST)

1-866-330-MUST (6878)
Website: www.mustbus.org

A fixed route service. MUST is a collaborative effort between Delmarva Community Transit and Queen Anne's County, County Ride. Special services are available for persons unable to use the regional fixed routes. Contact your local transportation provider for trip availability.

Partners in Care

400 Brooklets Ave.
Easton, MD 21601
410-822-1803
Website: www.partnersincare.org/upper-shore

Partners in Care based in Talbot County offers a volunteer-based 'time bank" transportation program to its members, who are age 60 and over. Contact: Pam O'Brien, Site Coordinator, pamo'brien@partnersincare.org

Shore Transit

443-260-2300
Website: www.shoretransit.org

Shore Transit, a division of the Tri-County Council for the Lower Eastern Shore of Maryland, is the public transit agency for the Maryland lower eastern shore counties of Somerset, Wicomico, and Worcester. Shore Transit offers public transportation via fixed route and origin-to-destination services.

Upper Shore Take A Ride (USTAR)

USTAR (Upper Shore Take-A-Ride) is a rural transportation program operated by Upper Shore Aging, Inc., serving Kent, Talbot and Caroline counties, Maryland. It is the only multi-jurisdictional transportation enterprise operated in Maryland. USTAR supports the various programs of Upper Shore Aging, and directly provides for the transportation needs of the elderly and disabled persons of the service area, as well as the public. The program also provides for the transportation needs of Medical Assistance clients, and coordinates services with other social service agencies. Due to the rural nature of the service area, USTAR is a Demand-Response transportation program: clients call a dispatcher and arrange to be picked up from their door. Service is subject to advance scheduling (at least 48 hours' notice). Contact Cary Malkus, Director of General Services, 410-758-6500, for special transportation projects/trips.

USTAR Fares: *Senior Citizens/Disabled Persons:* $.50 per day, if within the county; $2.50 per day, if outside the county (up to 50 miles round trip); $10.00 per day, outside the county and over 50 miles round trip. *General Public:* $1.00 per day, if within the county, $5.00 per day, if outside the county (up to 50 miles round trip), $20.00 per day, outside the county and over 50 miles round trip.

Local Numbers: Caroline County: 410-479-3867; Kent County: 410-778-5187; Talbot County: 410-822-4155

Disability Programs

Bay Area Center for Independent Living

Wicomico (physical address): 909 Progress Circle, Suite 300 Salisbury, MD 21804	**Phone:** 443-260-0822 **Fax:** 443-260-0833	**Email:** **Website:** www.bayareacil.org	**Hours of Operation:** Mon. – Fri. 8:00am to 4:30pm **Payment Types Accepted:** DORS, Medicaid

Services:

- ☑ Advocacy Services
- ☑ Assistive Technology Evaluations and Loans
- ☑ Benefits Counseling
- ☑ Information and Referral
- ☑ Independent Living Skills
- ☑ Independent Living Communities for Older Adults
- ☑ Job Search/Placement
- ☑ Peer Mentoring
- ☑ Transition Services
- ☑ Vocational Education
- ☑ Youth Development

Translator?

ASL

Conditions Served:

- ☑ ADHD
- ☑ Anxiety/Phobias
- ☑ Bipolar Disorder
- ☑ Brain Injuries
- ☑ Chronic Mental Illness
- ☑ Co-Occurring
- ☑ Dementia
- ☑ Depression
- ☑ Developmental Disabilities
- ☑ Personality Disorders
- ☑ Physical Disabilities
- ☑ Post Traumatic Stress Disorder
- ☑ Schizophrenia
- ☑ Developmental Disabilities

An independent living center is a consumer controlled, community-based, cross disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities. Independent living services maximize the ability to live independently in the environment of their own choosing. Bay Area Center for Independent Living (Bay Area CIL) offers five core services mandated by the Rehabilitation Act of 1973, as amended, Title VII, Chapter 1, and reauthorized by the Workforce Innovations and Opportunities Act of 2014. Bay Area CIL is a private nonprofit organization established in 1974 to serve citizens with disabilities of the 9 counties of Maryland's Eastern Shore.

The Benedictine School

14299 Benedictine Lane
Ridgely, MD 21660
410-634-2112
Fax: 410-634-2640
Website: www.benschool.org

Benedictine Programs and Services: Educational, residential and day services for children and adults with developmental disabilities, ages 5 through 60. School programs include functional academics; speech therapy; psychological, psychiatric, social work, counseling, and case management; assistive technology; physical and occupational therapy; vocational and transitional services; and intensive collaborative programs designed for students within the Autism Spectrum. The Open Community Program operates state-licensed group homes for adults in Maryland. Benedictine is a fully approved, non-sectarian service provider caring for individuals with special needs without regard to racial, ethnic, or religious background, on Maryland's Eastern Shore.

Caroline Center, Inc.

12061 School Street
P.O. Box 460
Ridgely, MD 21660
800-863-2102 or 410-643-2103
Fax: 410-634-2653
Website: www.carolinecenterinc.org

Caroline Center inspires program participants to make healthy choices with regards to where, and with whom, they live, learn, work, and socialize; and to share in the responsibilities attributing to their quality of life. The Caroline Center offers a Life Enrichment Program, available to adults and transitional-aged youth (18 years of age and older) with intellectual and developmental disabilities; a Residential Program, designed to allow individuals to have access to the services and supports, within the agency and the community, they need to live their lives in the way that they choose; and Support Services, including Community Supported Living Assistance (CSLA) and Family & Individual Supported Services (FISS). These services are available to eligible children and adults with intellectual and developmental disabilities so that they may remain in their own homes. Individuals receive guidance related to daily living skills, meal preparation, transportation, employment opportunities and participation in life enriching activities. FISS services are flexible and responsive to the needs of the individuals and/or families who live within a household. These services enable families to receive emotional, physical, and financial support by providing financial assistance, transportation and in-home care for individuals.

Chesapeake Center, Inc.

Address:	Phone: / Fax: / Website: / Email:	Hours of Operation:	Payment Types Accepted:
713 Dover Road P.O. Box 1906 Easton, MD 21601	410-822-4122 410-822-4184 www.chesapeakecenter.org info@chesapeakecenter.org	Vocational: Mon. – Fri. 8:30am to 2:30pm, Office open until 4:30pm	Grant Funds, Sliding Scale Fee, Public Behavioral Health, DDA Funding & DORS

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ Nurse **Translator?** No	☑ Community Support for Adults w/Developmental Disabilities ☑ Job Search/Placement ☑ Residential Rehabilitation Program ☑ Respite Care ☑ Supported Employment ☑ Vocational Education	☑ Developmental Disabilities ☑ Intellectual Disabilities	☑ None

Chesapeake Center is a community non-profit agency, serving the needs of those with primarily developmental disabilities. They offer vocational training, job training, supported employment and habilitation services. They provide supervised residential settings for adults with DD that target independent living skills training. They can also offer community supports to adults with DD who live on their own and need help with errands, banking, budgeting, community integration, appointments, and securing/retaining benefits.

Chesterwye Center, Inc.

Address:	Phone: / Fax: / Website:	Hours of Operation:	Payment Types Accepted:
110 Chesterwye Lane P.O. Box 96 Grasonville, MD 21638	410-827-7048 410-827-6457 www.chesterwye.com	Monday – Friday 9am to 4pm	Grant Funds, Sliding Scale Fee, Self Pay, Medicare, Private Insurance, DDA Funding

Providers:	Services:	Conditions Served:	Treatment Modalities:
☑ LCSW-C ☑ Nurse **Translator?** Yes, Spanish and Hearing Impaired	☑ Job Search/Placement ☑ Older Adults/Aging Issues ☑ Program Transportation ☑ Residential Services for Adults with Intellectual Disabilities ☑ Respite Care ☑ Supported Employment ☑ Vocational Education	☑ Anxiety/Phobias ☑ Autism ☑ Bipolar Disorder ☑ Brain Injuries ☑ Chronic Mental Illness ☑ Dementia ☑ Depression ☑ Developmental Disabilities ☑ Eating Disorders ☑ Hoarding Behaviors ☑ Intellectual Disabilities ☑ Personality Disorders ☑ Physical Disabilities ☑ Self Injurious Behaviors ☑ Sexual Disorders	☑ Behavioral Treatment ☑ General Counseling ☑ Individual Counseling ☑ Mental Health Related Support Groups

Delmarva Community Services, Inc.

2450 Cambridge Beltway
Cambridge, MD 21613
410-221-1900
Fax: 410-221-1917
Website: https://www.dcsdct.org/services-for-individuals-with-disabilities.html

Residential services are available to persons with developmental disabilities via a referral service in conjunction with the Dorchester County Health Department's Office of Developmental Disabilities. Based on this referral process, a plan is developed to secure appropriate funding and decide on the level of care needed to meet the individual's/service plan. Services range from drop-in supervision to 24-hour supervision. Individuals may live in single dwellings or in homes having three to five bedrooms. Staff members receive special training to work in these settings. Everyone is assigned a coordinator who monitors their care and supervision and makes certain their outcomes and goals are addressed. Call 410-221-1900, ext. 137, for more information.

The Vocational Program is a multi-faceted approach that offers many opportunities for individuals with developmental disabilities. Several avenues of training and work are available based on the McCarron Dial Basic Vocational Evaluations, and the goals and desires of the individual. Call 410-221-1900, ext. 120, for more information.

Respite is a program that helps caregivers get a break from the care they provide a loved one. This allows caregivers to be able to continue to do what they do, caring for a loved one. They can use the respite hours for vacation, appointments they have, shopping, etc. Caregivers are reimbursed. There are five respite care programs administered by Delmarva Community Services. All programs require an application. Please contact the respite office to see if you or your loved one qualifies for one of our programs.

Kent Center

Address:	**Phone:**	**Hours of Operation:**	**Payment Types Accepted:**
215 Scheeler Road Chestertown, MD 21620	410-778-7303 **Fax:** 410-778-7305 **Website:** www.kentcenter.org	24/7	Grant Funds, Self Pay, Medicare, DDA Funding

Providers:	**Services:**	**Conditions Served:**	**Treatment Modalities:**
☑ Nurse	☑ Adult Day Programs ☑ In Home Supportive Services ☑ Job Search/Placement ☑ Program Transportation ☑ Residential Services for Adults with Intellectual Disabilities ☑ Respite Care ☑ Supported Employment ☑ Vocational Education	☑ Autism ☑ Developmental Disabilities ☑ Intellectual Disabilities ☑ Physical Disabilities	☑ Vocational Rehabilitation
Translator?			
Yes, Spanish and French			

Kent Center, Inc. is a not-for-profit organization, that provides highly personalized 24-hour a day services for adults who have a broad spectrum of developmental disabilities, such as intellectual disabilities, autism, cerebral palsy, and/or physical disabilities. Since 1970, the mission of Kent Center has been to ensure the safety and wellbeing of each individual family member, treat them with respect and dignity and provide enriching opportunities and choices which will enable them to independently live, work and contribute positively to our community to the greatest extent of their abilities.

Kent Center is the primary provider in Kent and northern Queen Anne's Counties, of daytime, vocational, PSS (CSLA), respite, supported employment, and/or residential services for 80 adults. Kent Center's services are tailored to meet the specific needs of each person we have the privilege of working with and focus on enhancing their lives as well as the lives of the families that love them. Kent Center core focus is to enhance all lives by Creating hometown connections.

Kent Center's retail thrift store, Hidden Treasures and Kent House Kitchen provides clients interested in working in a controlled environment within Chestertown a sheltered workshop where they can work with group or one-to-one job coaching so they may complete their jobs and experience the pride and satisfaction that come with a job well done. Hidden Treasures is located at the Kent Plaza Shopping Center on Washington Avenue in Chestertown.

Kinera Foundation

115 Sallitt Dr., Suite C
Stevensville, MD 21666
443-249-3126
Website: www.kinera.org
Email: info@kinera.org

Kinera Connect allows an opportunity for parents of children with special needs to come together, in a supportive setting, to gain information for assisting their children and families, further educate themselves on aspects of special needs areas, gain a support network, and share ideas from family to family. Kinera provides quality childcare for the duration of the meetings, and offers a variety of guest presenters relevant to your child's need and location.

Kent Island Kinera Connect
Meets the 3rd Wednesday of each month from 6:30pm-8:30pm
Busy Bodies Bay Area Gym – Stevensville
For more information contact: Julie Vallecillo, Julie@kinera.org

Salisbury Kinera Connect
Meets the second Wednesday of each month from 6:00pm-8:00pm
Emmanuel Wesleyan Church - Salisbury
For more information contact: Anna Haberkorn, Anna@Kinera.org

Kinera Foundation Eastern Shore Regional Hub: Kinera Foundation is committed to ensuring that families raising children with special needs have equitable access to therapies and treatments, within the Region the family resides. Services provided within the Hub are geared toward children with special healthcare needs, and are Patient/ Family Centered, coordinated, and centralized. Their therapists and specialists have years of training and experience in the pediatric field, and are focused on providing Family Centered Care. As depicted in the floor plan, Kinera forgoes the traditional waiting area for a Family Lounge, which allows for families to interact in a more natural environment, is aimed at easing anxiety for children waiting, and is equipped with resource computers allowing access to information pertaining to your child's need. We also understand that new spaces and the anxiety of upcoming appointments can be too much for children to endure. To ensure a successful appointment for children with sensory needs, we have a Sensory Friendly Wait Room, equipped with low lighting, sensory toys, and Yogibo (c) chairs. In addition to direct services, the Kinera Foundation Regional Hub aims to provide families with a space to seek information and resources, network with other families, and establish an avenue for the greater community to learn how to create inclusive and community programs for children with special health care needs.

Pathfinders for Autism

303 International Circle, Suite 110
Hunt Valley, MD 21030
443-330-5370
Toll Free Helpline: 443-330-5341
Fax: 443-330-5361
Website: www.pathfindersforautism.org

Pathfinders, Inc. was established as a 501(c)3 nonprofit organization in February 2000 by parents of children with autism, including Baltimore Orioles Hall of Famer William "B.J." Surhoff and his wife Polly Winde Surhoff. After 18 months of development, Pathfinders for Autism launched the Pathfinders for Autism Resource Center – offering knowledgeable staff and a searchable online database to help families in Maryland find critical service providers quickly and efficiently.

Since then, Pathfinders for Autism has grown into the State's largest autism organization dedicated to helping individuals, parents, and professionals find resources, supports, and training while working to increase the awareness of autism spectrum disorders and advocating for the needs of individuals with autism and their families. Open Monday – Friday, 9:00am to 3:00pm by appointment; call in advance.

Legal Services

Legal Aid

MARYLAND LEGAL AID

Upper Eastern Shore
(Caroline, Kent, Queen Anne's, and Talbot)
106 N. Washington Street, Suite 101
Easton, MD 21601
410-763-9676
Fax: 410-763-8752
Website: www.mdlab.org

Lower Eastern Shore
(Dorchester, Somerset, Wicomico, and Worcester)
111 High Street
Salisbury, MD 21801
410-546-5511
Fax: 410-860-2148
Website: www.mdlab.org

Disability Rights Maryland

40 YEARS Disability Rights Maryland Empowerment. Integration. Equality.

1500 Union Ave, STE 2000
Baltimore, MD 21201
410-727-6352 or 800-233-7201
Fax: 410-727-6387
Website: www.disabilityrightsmd.org

A private non-profit organization staffed by attorneys and paralegals. The protection and advocacy organization for Maryland.

Maryland Volunteer Lawyer Services

1 North Charles Street, Suite 222
Baltimore, MD 21201
1-800-510-0050
Website: www.mvlslaw.org

Legal assistance for people in need. MVLS provides free or reduced fee representation to low-income individuals and non-profit organizations that have civil legal issues throughout Maryland.

Mediation Services

Mid-Shore Community Mediation Center
300 Talbot Street, Suite 206
Easton, Maryland 21601
410-820-5553
mscmc@goeaston.net
Website: www.midshoremediation.org

MID SHORE MEDIATION

Mid Shore Community Mediation Center provides mediation and conflict resolution services for all types of disputes and situations, please contact us if you have questions about how mediation may be suitable for your conflict. In addition to mediation, we offer group meeting facilitation and conflict management workshops.

Community Mediation Upper Shore, Inc.
P.O. Box 692
Chestertown, MD 21620
410-810-9188

info@cmusmediation.org
Website: www.cmusmediation.org

CMUS

The mission of Community Mediation Upper Shore is to provide accessible conflict resolution services through mediation, education, and training to promote respectful resolution of conflicts and disputes throughout Queen Anne's, Kent, and Cecil counties in Maryland.

Mid-Shore Pro Bono, Inc.

The Eastern Shore's Legal Assistance Network
MIDSHORE PRO BONO

8 S. West Street
Easton, MD 21601
410-690-8128
Fax: 443-385-0210
Website: www.midshoreprobono.org

Mid-Shore Pro Bono is a legal services provider for Kent, Queen Anne's, Caroline, Talbot, and Dorchester counties. They offer several programs to residents with civil legal issues only. Mid- Shore Pro Bono is committed to ensuring equal access to civil justice y connecting low-income individuals and families in need of civil legal help with volunteer attorneys and community resources.

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Recovery Supports and Other Resources

American Red Cross

100 West 10th Street
Wilmington, DE 19801
320-656-6620

Website: www.redcross.org

Americans with Disabilities Act Hotline

1-800-514-0301

This service permits businesses, State and local governments, or others to call and ask questions about general or specific ADA requirements including questions about the ADA Standards for Accessible Design. ADA specialists are available Monday through Friday from 9:30am to 5:30pm except on Thursdays, hours are 12:30pm to 5:30pm.

Behavioral Health Integration in Pediatric Practice (B-HIPP) Salisbury

B-HIPP provides in-house behavioral health consultant service to local pediatric providers and the families they serve. Master of Social Work (M.S.W.) interns serve as a resource to local agencies seeking a pipeline for information to and from the pediatric primary care offices. Daily roles of B-HIPP interns include advocate, case manager, therapist, behavioral interventionist, navigator, family worker, educator, and crisis manager. Intervention targeting includes parenting skills training, stress management, communication and targeted mood management, assessment and behavioral management, and motivational interviewing. Additional services include outreach to local agencies, resource fairs, and continuing education.

B-HIPP also provides phone consultations for pediatric primary care providers throughout the State of Maryland with questions surrounding mental health concerns. Medical providers may contact 1-855-MD-BHIPP or mcrosby@jhsph.edu for a free enrollment form.

B-HIPP is supported by funding from the Maryland Department of Health and Mental Hygiene and Maryland State Department of Education and is conducted through a partnership among the University of Maryland School of Medicine/Department of Psychiatry, the Johns Hopkins University School of Public Health, and Salisbury University Social Work Department.

For more information, please contact Amy Habeger, LCSW-C, B-HIPP Salisbury Program Coordinator by calling 410-251-9162 or by emailing adhabeger@salisbury.edu

The Center for Eating Disorders at Shepard Pratt

Address:	Physicians Pavilion North, Suite 300 6535 North Charles Street Baltimore, Maryland 21204	**Phone:** **Fax:** **Website:** **Email:**	410-938-5252 410-938-5250 www.eatingdisorder.org EatingDisorderInfo@sheppardpratt.org

The Center combines a behavioral program to assist in the management of eating disorder impulses with an evidence-based, multi-modal therapy program. Individual and group therapies include cognitive-behavioral therapy, dialectic behavior therapy, interpersonal therapy, body image therapy, art therapy, occupational therapy, nutritional counseling and mindfulness approaches including gentle yoga, breath work and creative visualization. Family therapy at The Center is guided by a Family-Based Treatment approach (Maudsley model) and family systems theory. The Center for Eating Disorders provides state-of-the-art treatment for females and males of all ages and ethnicities affected by eating disorders.

The program provides a full-continuum of evidence-based and individualized care for people struggling with the following disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Compulsive Overeating, Eating Disorder Not Otherwise Specified (EDNOS), Avoidant/Restrictive Food Intake Disorder (ARFID), Body Dysmorphic Disorder (BDD), and other issues in feeding and eating.

Chase Brexton Health Care

Address:	8221 Teal Drive, Suite 202 Easton, MD 21601	**Phone:** 866-260-0412 x4350 **Fax:** 410-822-6721 **Website:** www.chasebrexton.org	**Hours of Operation:** Mon-Fri 8:30am – 500pm Closed daily 12:00pm-1:00pm	**Payment Types Accepted:** Sliding Scale Fee, Self Pay, Medicare, Medicaid, and Most Insurances

Chase Brexton Health Care
Because everyone's health matters.

Mission: to provide compassionate, quality health care that honors diversity, inspires wellness, and improves our communities.

Services: Chase Brexton Easton Center offers primary care, specialty care for HIV and Hepatitis C, case management, in house lab and access to the Chase Brexton Pharmacy in Baltimore which has financial assistance for reduced cost medications for those patients who are uninsured. We look forward to adding our own in-house Pharmacy in Early 2019.

Chase Brexton sites on the Western Shore provide medical, dental, behavioral care including substance abuse treatment. Those sites include Columbia, Glenn Burnie, Randallstown, and our Mount Vernon Center in Baltimore. Each of our sites on the western shore includes a pharmacy. Find out more at our website. chasebrexton.org

Chesapeake HELPS! – Chesapeake College

Chesapeake HELPS 1-866-722-HLPS
Local Needs? ... Local Resources!

P.O. Box 8
Wye Mills, MD 21679
1-866-722-4HLPS (4577)
Fax: 410-827-7121
Website: www.chespeakehelps.org

Connections to resources for Queen Anne's County, Maryland.

Free and confidential services, here to help!

Choptank Community Health System, Inc.

CHOPTANK community health see how healthy you can be!	**CHS Billing Offices** 301 Randolph Street Denton, MD 21629 410-479-4306	**Hours of Operation:** Monday – Friday 8:00am to 4:30pm	In addition to the corporate offices, departments at this location include Billing, Human Resources, Information Technology and Facilities Maintenance. An annex at the same location houses the School Based Wellness and Migrant Health programs.
Caroline:	**Denton Medical Center** 609 Daffin Lane Denton, MD 21629 410-479-2650	**Hours of Operation:** Mon. 7:30am to 6:45pm, Tues- Fri 7:00am to 5:00pm	The Denton Medical Center provides Family Practice, Women's Health (one days per week), and Pediatric services for central Caroline County.
	Goldsboro Medical & Dental Center 316 Railroad Ave. Goldsboro, MD 21636 410-634-2380 (Medical) 410-482-2224 (Dental)	**Hours of Operation:** Monday – Thursday 7:30am to 4:30pm Friday 7:30am-4:00pm	The Goldsboro Medical Center provides Family Practice and General Dentistry services for northern Caroline County.
	Federalsburg Medical & Dental Center 215 Bloomingdale Ave. Federalsburg, MD 21632 410-754-9021 (Medical) 410-754-7583 (Dental)	**Hours of Operation:** Mon & Wed 7:00am – 6:45pm Tues & Thurs 7:00am- 5:00pm Friday 7:00am- 4:30pm	The Federalsburg Medical and Dental Centers offer complete Family Practice and General Dentistry services to the town of Federalsburg and lower Caroline County.
Dorchester:	**Fassett Magee Health Center** 503 A Muir Street Cambridge, MD 21613 410-228-4045	**Hours of Operation:** Monday – Friday 7:30am to 5:00pm	The Fassett Magee Health Center offers complete Family Practice to the city of Cambridge and Dorchester County, as well as Women's Health.
	Cambridge Dental Center 503 A Muir Street Cambridge, MD 21613 410-228-9381	**Hours of Operation:** Monday – Thursday 7:30am to 6:30pm Friday 8:00am-4:30pm	The Cambridge Dental Center offers Pediatric Dental services to the city of Cambridge and surrounding lower Dorchester County.

Talbot:	**Bay Hundred Health Center** 933 South Talbot Street, Unit 4 St. Michaels, MD 21663 410-745-0200	**Hours of Operation:** Monday – Thursday 8:00am to 4:30pm Friday 7:30am to 4:00pm	Bay Hundred Health Center offers Family Practice services to the town of St. Michaels and surrounding lower Talbot County.
	Easton Pediatrics 522 Cynwood Drive, Suite 100 Easton, MD 21601 410-770-8910	**Hours of Operation:** Monday-Friday 7:30am- 5:00pm	The Easton Pediatric Center offers complete Pediatric services.

Compass Regional Hospice, Inc.

255 Comet Drive
Centreville, MD 21617
443-262-4100
Fax: 410-758-5471
Website: www.compassregionalhospice.org

For more than 30 years, Compass Regional Hospice has been dedicated to supporting and helping people through the difficult and challenging time of living with a serious illness. What began as an all-volunteer organization has since developed into a visionary, state-of-the-art organization recognized locally, regionally, and statewide for its excellence. We serve the communities of Queen Anne's, Kent, and Caroline counties, wherever you call home, including private residences and assisted living and skilled nursing facilities. We will meet you wherever you are on your journey.

In addition to our home hospice and bereavement care programs, we offer Bridges, a nonmedical supportive care program for individuals who are transitioning to the next level of care or are not yet ready for hospice. When care at home is no longer an option, our residential hospice centers in Centreville and Chestertown offer a clinically supportive environment with around-the-clock care in a home-like setting.

We also are a Level 4 partner of the We Honor Veterans program and offer veteran-centric care to our military men, women, and families. Our staff can provide additional information and tools to our patient families surrounding veteran end-of-life experiences, benefits provided to them and other ongoing projects to recognize the dedication of their loved one.

Compass Regional Hospice is a fully licensed, independent, community-based nonprofit organization certified by Medicare and the state of Maryland and accredited by the Joint Commission. It is affiliated with the National Hospice and Palliative Care Network and the Hospice Network of Maryland.

Deaf Independent Living Association, Inc. (DILA)

806 Snow Hill Road
Salisbury, MD 21804
410-754-5052
Fax: 410-543-4874
Videophone: 443-365-2645
Website: www.dila.org
Hours: Mon.-Fri. 9am to 5pm

The mission of Deaf Independent Living Association, Inc. (DILA) is independence of people who are deaf or hard of hearing through communication, connection, and community support.

Department of Health

Caroline:	403 S. 7th Street, Denton, MD 21629	Phone:	410-479-8030	Fax:	410-479-0554
Dorchester:	3 Cedar Street, Cambridge, MD 21613	Phone:	410-228-3223	Fax:	410-228-9319
Kent:	125 Lynchburg Street, Chestertown, MD 21620	Phone:	410-778-1350	Fax:	410-778-6119
Queen Anne's:	206 N. Commerce Street, Centreville, MD 21617	Phone:	410-758-0720	Fax:	410-758-2838
Talbot:	100 S. Hanson Street, Easton, MD 21601	Phone:	410-819-5600	Fax:	410-819-5690

Maryland Department of Health

MARYLAND Department of Health

201 W. Preston Street
Baltimore, MD 21201
410-767-6500 or 1-877-463-3464
Website: www.health.maryland.gov

MDH works together to promote and improve the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement.

Department of Juvenile Services (DJS)

Caroline:	317 Carter Avenue, Suite 105, Denton, MD 21629	Phone:	410-819-6556	Fax:	410-819-6559
Dorchester:	310 Gay Street, Cambridge, MD 21613	Phone:	410-228-6452	Fax:	410-228-3342
Kent:	315 High Street, Suite 202, Chestertown, MD 21620	Phone:	410-778-6103	Fax:	410-778-6307
Queen Anne's:	120 Broadway, Suite 9, Centreville, MD 21617	Phone:	410-819-4180	Fax:	410-819-4190
Talbot:	600 Dover Road, Suite 104, Easton, MD 21601	Phone:	410-822-5010	Fax:	410-822-5550

Department of Social Services (DSS)

Caroline:	207 S. Third Street, Denton, MD 21629	Phone:	410-819-4500	Fax:	410-819-4504
Dorchester:	627 Race Street, Cambridge, MD 21613	Phone:	410-901-4100	Fax:	410-901-2705
Kent:	350 High Street, P.O. Box 670, Chestertown, MD 21620	Phone:	410-810-7600	Fax:	410-778-1497
Queen Anne's:	125 Comet Drive, Centreville, MD 21617	Phone:	410-758-8000	Fax:	410-758-8110
Talbot:	301 Bay Street – Unit 5, Easton, MD 21601	Phone:	410-770-4848	Fax:	410-820-7117

Eastern Shore Area Health Education Center (AHEC)

Eastern Shore AHEC

814 Chesapeake Dr
Cambridge, Maryland
410-221-2600
Website: www.esahec.org

The Eastern Shore Area Health Education Center (AHEC) is a private, non-profit, 501(C) 3 organization, which became operational in 1997. Governed by a 16-person Board of Directors, AHEC services the nine counties comprising Maryland's Eastern Shore. AHEC's goal is to increase the number of health care providers who provide services in rural and underserved areas and eliminate health disparities among diverse populations of the Eastern Shore by providing and coordinating programs that improve the health status of all. In the face of rapidly changing demographics in the region, AHEC leverages federal, state, and local resources to support health careers promotion, health professions student rotations in underserved rural communities, continuing education, and community health promotion activities.

Forensic Mental Health Services

MSBH Forensic Mental Health Program

28578 Mary's Ct., Suite 1, Easton, MD 21601
410-770-4665/Fax 410-770-4809
Website: www.midshorebehavioralhealth.org
Forensic Mental Health Program Manager: Belinda Frankel, LCSW-C (bfrankel@midshorebehavioralhealth.org)
Forensic Mental Health Case Specialist: Akima Copper (acopper@midshorebehavioralhealth.org)

The Forensic Mental Health Program focuses on the intersection between the criminal justice and mental health systems. This program works to evaluate and connect criminal defendants and probationers to the limited community mental health resources available on the mid-shore. The FMHP staff works closely with Judges, Masters, Parole and Probation Agents and local detention centers to assist in cases where the defendant has mental health and/or co-occurring issues. The FMHP staff can provide mental health evaluations, jail diversion plans, referral and resource connection, mental health treatment monitoring and advocacy. Case management services are provided for diversion and monitoring cases.
The staff consists of a mental health coordinator who is a licensed mental health professional with experience in forensics and a case manager with knowledge of Mid Shore resources.

Maryland Community Criminal Justice Treatment Program

The Maryland Community Criminal Justice Treatment Program (MCCJTP) is a State funded jail based mental health program that targets individuals 18 and older who have a serious mental illness, such as schizophrenia, major affective disorder, organic mental disorder, and other psychotic disorders. MCCJTP more commonly referred to as the "jail program" is administered in all five counties of the Mid Shore region, as well as 18 additional jurisdictions in the State. Common goals among participating jurisdictions include:

- Identify individuals in the criminal justice system who have severe and persistent mental illness or who are at risk for re-hospitalization at a psychiatric facility.
- Deliver clinically appropriate mental health services to identified individuals.
    - Health services are delivered in cooperation with the medical/psychiatric staff of the detention center.
    - Health services are delivered by a licensed, Master's level clinician who is responsible for providing bio-psycho-educational treatment in individual and/or group sessions.
- Case management services conducted by an individual with a minimum degree of baccalaureate who provides coordination of services while the consumer is incarcerated as well as development of an aftercare plan with the consumer in making community referrals, advocating "mainstream" services, and establishing communication for monitoring the receipt of treatment upon re-entry to the community.
- Educate detention center staff members, community mental health providers, and appropriate stakeholders regarding the needs of this population.
- Maintain communication with courts, parole and probation, and community-based providers to provide information about MCCJTP.

Caroline County Detention Center	**410-479-4117**	**Queen Anne's County Detention Center**	**410-758-3817 option 5**
Dorchester County Detention Center	**410-228-8101**	**Talbot County Detention Center**	**410-770-8136**
Kent County Detention Center	**410-810-2266**		

Trauma, Addictions, Mental Health and Recovery (TAMAR)

TAMAR is a State funded program offered to women who are detained in Caroline and Dorchester detention centers. These women have been identified, or self-identified, as having a history of physical and/or sexual abuse and a recent treatment history for a mental health condition, as well as a drug use/abuse disorder. Individuals eligible to participate are encouraged to voluntarily join the program with the knowledge that participation does not in itself reduce jail time.

- Program services are delivered by a licensed, Master's level clinician who is responsible for providing bio-psycho-educational treatment in accordance with the TAMAR program manual.
- Case management services are to be conducted by an individual with a minimum degree of baccalaureate and provide coordination of services while the consumer is incarcerated, as well as development of an aftercare plan with the consumer in making community referrals, advocating "mainstream" services, and establishing communication for monitoring the receipt of treatment upon re-entry to the community.
- Ensure the education of detention center staff members, community mental health providers, and appropriate stakeholders about the needs of trauma survivors.
- Maintain communication with courts, parole and probation, and community-based providers to provide information about TAMAR.

For Community Referrals, please contact Alisha Saulsbury, TAMAR Supervisor, For All Seasons, Inc., at 410-476-4441.

Family Support Centers

Caroline:	100 N. 6th Street, Denton, MD 21629	Phone:	410-479-3298	Fax:	410-479-3789
Kent:	125 Lynchburg Street, Chestertown, MD 21620	Phone:	410-778-1350	Fax:	410-778-6119
Queen Anne's:	103 N. Linden Street, P.O. Box 201, Sudlersville, MD 21668	Phone:	410-438-3182	Fax:	410-438-3806
Talbot:	215 Bay Street, Suite 1, Easton, MD 21601	Phone:	410-820-6940	Fax:	410-820-6958

Futures for Families, LLC

29466 Pintail Drive,
Suite 10 Easton, MD
21601 410-
924-1032
Website: www.mdcourts.gov/clerks/talbot/family.html

Provides supervised visitation (parent-child time) for families in Talbot County, Dorchester County and Caroline County when the court determines a needed for guided contact with one of the parents, or it is necessary to establish or reestablish a parent/child relationship. A court order must be entered to utilize Parent-Child Time. Both parents must contact the Futures for Families Center and complete an intake before visits may occur. Contact Program Director Brenda Ramage, Futures4Families.brenda@gmail.com.

Harriet's House

Phone: 443-786-1843
www.harrietshouse.org

Harriett's House
Setting Captives Free

We offer a safe place for women to receive resources and referrals, emergency food pantry, toiletries, clothes, computer access, and skill development classes. We screen for human trafficking and exploitation and offer case management for those with indicators or such. We connect women to residential programs for those interested and encourage counseling. We connect women to other resources in the community to help where we cannot.
Open Monday, Tuesday, Wednesday, Friday – 10 am – 2 pm Thursday 6 pm – 8 pm Closed Saturday & Sunday

Healthy Talbot

Healthy Talbot is a project of the Talbot Family Network. We believe that healthy communities are made up of healthy families. As a result, we seek to link local families and individuals to information and resources that can help them lead healthier, happier lives.

On our site: www.healthytalbot.org you will find some great information on various topics under the categories of Health, Home, School, Work and Play. You will also find numerous local Resources listed that can help with anything from parenting or daycare needs to mental health to hunger and nutrition-related needs. Feel free to click around and see if there is something that could benefit your family.

Local events and featured articles are also highlighted.

The Johns Hopkins Eating Disorders Program

Department of Psychiatry and Behavioral Science
The Johns Hopkins Hospital
600 North Wolfe Street, Meyer 101
Baltimore, Maryland 21287
Inpatient Admissions: 410-502-5467
Outpatient or Consultation: 410-955-3863
Hopkins Access Line: 800-765-JHHS

The Johns Hopkins Eating Disorders Program is a nationally recognized treatment center for anorexia nervosa, bulimia, and other eating disorders. They offer comprehensive evaluations, treatment planning, and ongoing care for patients with eating disorders. Led by a psychiatrist, their interdisciplinary team includes nurses, social workers, occupational therapists, dieticians, and other specialists. Consultations are available, as needed, from gastroenterology, allergy, cardiology, internal medicine, neurology, and other medical specialties at Johns Hopkins. Medical and nutritional interventions are integrated with physical and psychological therapies to develop a comprehensive individualized treatment plan for each patient. Our primary goals are to restore the functional capacity, to normalize the eating patterns, and to improve the quality of life of our patients.

Judy Centers

Caroline:	323 S. University Avenue, Federalsburg, MD 21632	Phone: 410-754-2467	Fax: 410-754-7091
Dorchester:	1405 Glasgow Street, Cambridge, MD 21613	Phone: 410-221-5268	Fax: 410-228-0534
Kent:	Henry Highland Garnett Elementary School 320 Calvert Street, Chestertown, MD 21620	Phone: 410-810-3903	Fax: 410-778-5707
Queen Anne's:	Sudlersville Elementary, 300 S. Church Street, Sudlersville, MD 21668	Phone: 410-438-3887	Fax: 410-438-3551
Talbot:	215 Bay Street, Suite 1, Easton, MD 21601	Phone: 410-820-6940	Fax: 410-820-6958

Mission is to provide comprehensive, integrated, full-day, full-year services that promote school readiness for children from birth through age five.

Legislative Advocacy

Behavioral Health Coalition of the Mid Shore

Website: www.midshorebehavioralhealth.org/advocacy

The Behavioral Health Coalition seeks to bring together community leaders to address the behavioral health needs of individuals, families, and providers in the mid shore region with our local legislators. Coalition efforts are focused on improving access and service delivery, destigmatization, and increasing awareness. Each year, the Behavioral Health Coalition hosts an annual Legislative Forum for Behavioral Health, inviting local government officials and Delegation from the 36th and 37th Districts to attend.

Coalition partners include: Maryland Coalition of Families, Chesapeake Voyagers, Inc., For All Seasons, Inc., Channel Marker, Inc., Crossroads Community, Inc. / Corsica River Mental Health, Affiliated Santé Group's Eastern Shore Crisis Response, Eastern Shore Psychological Services, Recovery for Shore, and Local Health Departments.

Maryland Behavioral Health Coalition

Website: www.mhamd.org

The Maryland Behavioral Health Coalition brings together 100+ mental health and substance-related disorder organizations representing consumers, advocates, family members, service providers and behavioral health professionals. We are united in our mission to improve behavioral health access and service delivery for all Marylanders.

Since its inception in 1993, the Coalition has achieved numerous legislative and policy victories in behavioral health. These include passage of the Maryland Mental Health Parity Law, the establishment of an integrated, performance-based public behavioral health system, and the protection and expansion of funding for mental health and substance-related disorder services.

For more information, contact Dan Martin, Director of Public Policy, 443-901-1550, ext. 208, or via email dmartin@mhamd.org.

Local Management Boards (LMB)

Caroline:	Caroline County Human Services Council 317 Carter Ave Suite 101 Denton Maryland 21629	Phone: 410-479-4446 Fax: 410-479-4617
Dorchester:	Dorchester County Office of Child & Family Services 501 Court Lane, Room 103, P.O. Box 26, Cambridge, MD 21613	Phone: 410-221-0281 Fax: 410-228-9642 Website: www.docogonet.com
Kent:	Kent County Local Management Board 400 High St., Second Floor, Chestertown MD 21620	Phone: 410-810-2673 Fax: 410-810-2674 Website: www.kentcounty.com/residents
Queen Anne's:	QAC Community Partnership for Children 104 Powell Street, Centreville, MD 21617	Phone: 410-758-6677 Fax: 410-758-6904 Website: www.communitypartnerships.info
Talbot:	Talbot Family Network c/o County Manager's Office South Wing–Courthouse, 11 N. Washington Street, Easton, MD 21601	Phone: 410-770-6869 Website: www.talbotcountymd.gov

Maryland Access Point (MAP)

MARYLAND ACCESS POINT
YOUR LINK TO HEALTH & SUPPORT SERVICES
www.marylandaccesspoint.info

Upper Shore Aging, Inc.
200 Schauber Road
Chestertown, MD 21620
410-778-2564
Toll Free: 1-877-MAP-LINK

Queen Anne's Dept. of Community Services
104 Powell Street
Centreville, MD 21613
410-758-1040
Toll Free: 1-877-MAP-LINK

Aging and Disability Resource Centers (ADRC), known locally as Maryland Access Point (MAP), were established as the single-entry point for individuals seeking long term support services. Maryland's 20 local MAP sites provide individual, person centered counseling to consumers seeking information, referral, and program support for long term services. The MAP program also provides an online, searchable resource directory to serve the public and professionals in identifying, connecting, and accessing private and public resources: www.MarylandAccessPoint.info. Individuals can use the website to directly find and contact service providers or they can find an appropriate agency in their local area to contact for counseling and assistance.

Maryland State AIDS Hotline

1-800-638-6252
Hearing Impaired: 1-800-553-3140
Hispanic AIDS Hotline: (301) 949-0945
Baltimore only TTY area: (410) 333-2437

Monday-Friday, 9am to 5pm (Except Holidays).
Information on testing and other referrals.

Maryland Health Connection

maryland health connection

P.O. Box 857
Lanham, MD 20703
1-855-642-8572
Website: www.marylandhealthconnection.gov

A one-stop health insurance marketplace where individuals and families can shop, compare, and select the health plan that's right for you, making health insurance for Marylanders more accessible.

Medication Drop Boxes

Caroline:	Denton Police Department	100 N 3rd Street, Denton, MD 21629
Dorchester:	Cambridge Police Department	3 Washington Street, Cambridge, MD
	21613 Hurlock Police Department	200 Nealson Street, Hurlock, MD 21643
	Dorchester County Sheriff's Office	829 Fieldcrest Road, Cambridge, MD
	21613	
Kent:	Kent County Sheriff's Department	104 Vickers Dr., Unit B, Chestertown, MD 21620
Queen Anne's:	Queen Anne's County Office of the Sheriff	505 Railroad Avenue, Centreville, MD
	21617 Maryland State Police Barracks "S"	311 Safety Drive, Centreville, MD 21617
Talbot:	Talbot County Public Safety Center	115 W. Dover Street, Easton, MD 21601
	St. Michaels Police Department	100 South Freemont Street, St. Michaels, MD

Mentoring Services

Talbot Mentors, Inc.
108 Maryland Ave, Suite 102
Easton, MD 21601
410-770-5999
Fax: 410-770-5991
Website: www.talbotmentors.org

Founded in 1997, Talbot Mentors is a 501(c)3 nonprofit organization. We provide our services to local kids at no cost thanks to the financial support of many individuals, area churches, service clubs and business and with grants from local, regional and national foundations. Our mission is to match young people in Talbot County with volunteer mentors in order to support those children in the challenges and opportunities of adolescence through friendship, guidance, and education.

Big Brothers Big Sisters
200 W. Main Street, 3rd Floor
Salisbury, MD 21801
410-543-2447
Fax: 410-543-8032
Website: www.biglittle.org

For more than 60 years, BBBS of the Greater Chesapeake has operated under the belief that inherent in every child is the ability to succeed and thrive in life. As MD's largest donor and volunteer supported mentoring network, we make meaningful, monitored matches between adult volunteers ("Bigs") and children ("Littles"), ages 6 through 18, in your local community. We develop positive relationships that have a direct and lasting effect on the lives of young people.

Mid-Shore Council on Family Violence

8626 Brooks Drive, Suite 102
Easton, MD 21601
410-690-3222
Fax: 410-690-3271
Hotline: 800-927-4673
Website: www.mscfv.org

MSCFV is a comprehensive domestic violence program which provides support and the following services to victims in crisis and through their transition to self-sufficiency and independence: Crisis shelter, 24-hour hotline (800-927-4673), individual counseling, advocacy, legal advocacy and accompaniment to court proceedings, attorneys to represent victims in Final Protective Order hearings and divorce and custody cases, economic empowerment services, Transitional Program (including a Transitional House), therapeutic mental health counseling, crisis response and emergency food and clothing and all services are provided in Spanish through a Bilingual Advocate.

Multi-Cultural Resource Center

20 Bay Street
P.O. Box 1990
Easton, MD 21601
443-786-1120
Website: www.chesmrc.org

The Chesapeake Multicultural Resource Center empowers people from different cultures to become successful and engaged members of the community by coordinating services and informational programs.

MyFamilyNeeds

Database of community information for Caroline County. Funded by a grant from Caroline County Human Services Council and sponsored by
Caroline County Libraries.

Network of Care

A web-based internet tool and mental health resource for everyone, including a provider service network, a medical library, resource/ veterans' links, and support/advocacy group contacts. Sponsored by: Department of Health and Mental Hygiene; Transformation Project, and Mid Shore Behavioral Health, Inc.
Visit www.networkofcare.org

The Parents' Place of Maryland

801 Cromwell Park Drive, Suite 103
Glen Burnie, MD 21061
410-768-9100
Fax: 410-768-0830
Website: www.ppmd.org

If you have a child with a disability or want to help parents who do, give them a call. The Parents' Place of Maryland is committed to improving the lives of children with disabilities and special health care needs.

NAMI | Kent & Queen Anne's County

For information:
Address: PO Box 966
Email: namikentandqueenannes@gmail.com
Phone: 443-480-0565

NAMI (National Alliance on Mental Illness) Kent & Queen Anne's is an affiliate of NAMI Maryland and NAMI national. Our mission is to educate, support and advocate for those with mental illness and their families. Information and programs are available to educate about mental illnesses to reduce stigma and help people seek help early.

Queen Anne's County Safety Net

Mission: To make Queen Anne's County citizens knowledgeable and help them recognize indicators of suicidal thinking and link residents in need with prevention and intervention services with emphasis on stigma related events, public service announcements, and education/intervention.

Meets the 3rd Wednesday of every month at 1:15pm at the QAC Board of Education. For more information, please contact Matt Evans, Pupil Personnel Worker at Queen Anne's County Public Schools, 410-758-2403 x154 or via email at Starke.Evans@qacps.org

The Renfrew Center for Eating Disorders

The Renfrew Center of Baltimore
1122 Kenilworth Drive, Suite 105
Towson, MD 21204
1-800-RENFREW (736-3739)
Fax: 443-519-5601

The Renfrew Center of Bethesda
4719 Hampden Lane, Suite 100
Bethesda, MD 20814
1-800-RENFREW (736-3739)
Fax: 301-656-4601

The Renfrew Center specializes in the treatment of anorexia, bulimia, binge eating disorder and related mental illnesses. Programming consists of a comprehensive range of services, including day treatment, intensive outpatient, and group therapy.

Rural Assistance Center (RAC)

1-800-270-1898
https://www.ruralhealthinfo.org/

RAC helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents.

Talbot Hospice

Address: 586 Cynwood Drive, Easton, MD 21601	**Phone:** 410-822-6681	**Website:** www.talbothospice.org	Talbot Hospice

Talbot Hospice is a model for community based hospice care at the end of life. Since 1981 they have cared for patients and their families with dignity and respect. They offer comprehensive hospice care in your home, in nursing facilities and at Hospice House. They provide nurses, spiritual support, a bereavement center, family services and compassionate well trained volunteers. *"We Celebrate Life Every Day."*

Turn Around, Inc.

401 Washington Avenue, Suite 300
Towson, MD 21204
410-377-8111

1800 N. Charles Street, Suite 404
Baltimore, MD 21201
410-837-7000

9100 Franklin Square Drive, Room 317
Baltimore, MD 21237
410-391-2396

24-Hour Hotline 443-279-0379
Website: www.turnaroundinc.org

Turn Around's mission is to build a community free of violence by working with adults and children affected by intimate partner and sexual violence to address their needs and prevent further violence through advocacy and education.

FOR ADDITIONAL RESOURCES, VISIT:

http://www.midshorebehavioralhealth.org/

INFORMATION ON ENTITLEMENTS

INCOME SUPPORTS

Federal Level:

1. **Supplemental Security Income (SSI-Title XVI):** This federal government income supplement is for those who meet the Social Security Administration's (SSA) requirements for financial need due to disability, blindness, or age, and have no substantial history of employment. If you are found eligible for SSI, you are automatically eligible for Medical Assistance.

2. **Social Security Disability Insurance (SSDI-Title II):** This federal government income support is also for those who have met eligibility requirements for disability, but is based on the amount and recency of one's past earnings. Benefits from a spouse's record can be granted to a disabled widow over age 50, even if the widow has never been employed. Individuals who are disabled prior to age 18 may be able to draw on a disabled, deceased or retired parent's claim indefinitely.

For both of these entitlements, there is a complex application process and several eligibility requirements that must be met. The application process begins by contacting the local Social Security Office located at 828 Airpax Road Suite 500, Cambridge, Maryland 21613; website: www.ssa.gov/ssi; 410-228-8811 or 1-800-772-1213; to request full information as well as forms to be mailed to you, and to schedule an appointment.

Information that you will need to submit:

- Original social security card and proof-of-age documents (no copies accepted).
- Full medical information including name, address and phone numbers of all physicians, hospitals, clinics, etc. that have provided treatment. This is needed to document your disability.
- Summary of employers and type of work performed during the previous 15 years.
- Copy of the previous year's W-2 form from any employment.
- Proof of marriage, if the spouse is applying.

It is recommended that the completed application and all accompanying and subsequent documentation be HAND DELIVERED to the Social Security office rather than mailed. You should request a receipt or some documentation from SSA.

If you are applying for SSI, you will also need full information regarding financial assets (bank accounts, stocks, bonds, trust accounts and burial accounts or trusts, etc.). If you are living with family who helps to support you, the monetary award will be less. Families are often contacted regarding how much support they provide. If a recipient of SSI obtains employment, Social Security must be notified immediately.

Social Security considers many factors in making awards, including ability to work and diagnosis. Some diagnoses qualify a person automatically; others require substantial documentation and may require a physical examination by a physician under contract with the Social Security Administration.

The process of determining your disability is the same for SSI and SSDI. The process takes approximately 120 days and will include consideration of your ability to work in jobs other than the kind you may have done prior to becoming disabled.

SOAR is a program developed by the Substance Abuse and Mental Health Services Administration to address the critical need to help those who are homeless; as well as those who are at risk of homelessness and/or are returning to the community from institutions. This program also assist those who are experiencing mental illness, substance use issues, and co-occurring disorders.

There are five steps that are required to become SOAR eligible:

1. Individual is experiencing homelessness or at risk of homelessness.
2. Individual is diagnosed with a mental illness by a psychiatrist or psychologist.
3. Individual is at least 18 years old.
4. Individual is currently exhibiting symptoms of mental illness or has periods with worsening of symptoms that prevents sustainable employment.
5. Individual exhibits functional impairments in three out of the following four areas: Understand, remember, or apply information. Interact with others, Concentrate, persist, or maintain pace and adapt or manage oneself.

The SOAR Case Specialist will meet with the client to evaluate if they are eligible and begin to work with the individual, to fill out appropriate paperwork to file with the Social Security Administration. We do this by interviewing the client about their past/current homelessness, medical and mental disabilities. Then obtain medical records and other documents needed to complete the application. Once the application is completed, it is submitted to the Social Security Administration for their review to determine if they are appropriate to receive SSI/SSDI benefits. If you have any questions about SOAR or the program please contact Yvette Hynson, SOAR Case Specialist at 410-770-4801, ext 312 or send an email to: yhynson@midshorebehavioralhealth.org

MARYLAND MEDICAL CARE PROGRAMS

Medicare - Medicare is an insurance program that pays medical bills for people who are at least 65 years old, or who are disabled. It is available to people who receive Social Security benefits regardless of how much money they have. It pays medical bills with money from the Social Security Trust Fund, which most people pay into while they work. Retired and disabled people pay a monthly insurance premium for Medicare Part B. This is usually taken out of their Social Security check before they get the check.

If you are elderly and only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your LDSS for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. To receive an application, call your LDSS or the area Agency on Aging (AAA). For more information, you may call MDH's Recipient Relations Hotline at 1-800-492-5231 or (410) 767-5800.

Medicaid (Medical Assistance) Program – The Maryland Department of Health (MDH) provides Medical Assistance, also called Medicaid, coverage to individuals determined to be categorically eligible or medically needy. Medicaid coverage is automatically given to individuals receiving certain other public assistance, such as Supplemental Security Income (SSI), Temporary Cash Assistance (TCA), or Foster Care. Effective January 1, 2014, Medicaid covers more adults ages 19 to 64, whether they have children or not.

- A single person can make up to $16,243 per year and qualify for Medicaid.
- A family of three can make up to $27,724 per year and qualify for Medicaid.

To qualify for Medicaid coverage through Maryland Health Connection, you must be under age 65, be a U.S. citizen or a qualified alien who has lived in the U.S. for five or more years, and be a resident of the state of Maryland. Medicaid is also expanding to cover former foster children under age 26 who left the foster care system on their 18th birthday. Former foster care children do not have to meet income limits, they qualify because of their status as former foster care children.

To apply for Medical Assistance, you can apply through Maryland Health Connection by calling 1-855-MHC-8572 (1-855-642-8572). You can also go to your Local Health Department, Local Department of Social Services (LDSS), or Connector Entity.

Employed Individuals with Disabilities (EID) - Want to work and still keep your benefits? Employed Individuals with Disabilities provides Medical Assistance for people with disabilities who work. You pay a monthly premium based on your income. It may be $0-$55 per month. Income can be as high as $71,052 a year for a single person and $95,388 a year for a married couple. For more details: Call Toll Free: 1.800.637.4113, TTY/Voice: 443.514.5034 or 410.767.3360, email: eid@mdod.state.md.us, or visit the website http://mdod.maryland.gov/employment/Pages/eid-program.aspx.

State Level:

1. **Public Assistance for Adults:** Designated for needy adults without children who reside in Residential Rehabilitation Programs (RRPs) funded by the Public Behavioral Health System. Yearly re-application is necessary. Apply through local Department of Social Services.

2. **TEMHA - Transitional Emergency Medical and Housing Assistance:** Provides essential medical, housing, and other services to low-income disabled adults who are ineligible for other categories of assistance. Apply through Local Department of Social Services.

3. **TCA - Temporary Cash Assistance for Families with Dependent Children:** This income support program is administered by the state through the Department of Social Services. This time-limited program provides temporary cash assistance to needy families with dependent children. To be eligible, families must cooperate with child support, participate in work activities, and comply with substance-related provisions.

4. **Energy Assistance, SNAP (Supplemental Nutrition Assistance Program), and the WIC (Women, Infants and Children) Program:** These programs offer specific, limited support with varying eligibility requirements. Information regarding Energy Assistance and Food Stamps can be obtained through the Department of Social Services. The WIC program provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breast feeding, and non-breast feeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. This program can be accessed through your local Health Department.

To view all Maryland Medical Care Programs visit https://mmcp.health.maryland.gov/Pages/home.aspx .

OPTUM | Maryland

Optum Maryland

Optum Maryland gives care to people served by the Maryland Department of Health (MDH), Behavioral Health Administration (BHA). We invite you to look through this site to see the many ways we can serve you. If you are a person or a family member seeing an MDH/BHA provider, you can access relevant information with the touch of a finger:

Services: Find out more about the many recovery-oriented services that MDH/BHA funds through local mental health centers!

About Us: Learn more about the MDH/BHA and Optum Maryland partnership. Find out what that means for you!

News and Events: Stay up to date on the upcoming Maryland mental health news and training and events. MDH/BHA and Optum Maryland offer education and community events.

The Web site has sections for participants and families as well as providers of mental health services. Click on either the "Participants and Families" or the "Providers" tab to see the information that applies to you. Check the web site often as it continues to grow to better serve you!

Visit Optum Maryland: https://maryland.optum.com/content/ops-maryland/maryland/en.html
Download Optum Provider Manual: https://maryland.optum.com/content/dam/ops-maryland/documents/provider/Provider%20Manual.pdf

Participant Questions Call Toll-Free:
(800) 888-1965, TTY 711
Monday - Friday: 8:00 AM to 6:00 PM EST

Participant Help to Find a Provider:
Maryland 2-1-1

Provider Questions Call Toll-Free:
(800) 888-1965, TTY 711
Monday - Friday: 8:00 AM to 6:00 PM EST

Maryland Crisis Hotline 2-1-1

Optum Public Toll-Free Help Line:
(866) 342-6892

2021 RESOURCE GUIDE

PUBLIC BEHAVIORAL HEALTH SERVICES IN CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S & TALBOT COUNTIES OF MARYLAND

MID SHORE BEHAVIORAL HEALTH

RESOURCES, GUIDANCE, WHOLENESS, & HOPE

WWW.MIDSHOREBEHAVIORALHEALTH.ORG

DIRECTIONS FOR COMPLETING THE FY2020 LOCAL SYSTEMS MANAGEMENT INTEGRATION SELF-ASSESSMENT TOOL (*Due to BHA by October 30, 2020*)

This tool is for Local Authorities (LBHA, CSA, LAA) responsible for managing the local public behavioral health system to assess their current level of integration of systems manager functions in seven key domains:

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

Steps to Complete the Self-Assessment:

1. **Collaborate**. One self-assessment should be done for each local jurisdiction (or region for MidShore), to be filled out by the Local Behavioral Health Authority (LBHA), or the Core Service Agency (CSA) and Local Addictions Authority (LAA) together.
2. **Check one box in each domain**. Discuss the options, consider the local evidence upon which your team is basing the decision, and check the ONE box that mostly closely reflects the current level of integration (Level 1, 2 or 3) in your local jurisdiction.
3. **Answer the questions** under each domain. Questions #1, #2 and #3 must be answered; question #4 is optional. For question #1, list the evidence used – there is no need to attach documents. Examples offered (pg. 11) are meant to help, but your list may differ.
4. **By October 30, 2020, email completed self-assessment to the Behavioral Health Administration (BHA):** Tsegereda Assebe (tsegereda.assebe@maryland.gov), Angela Onime (angela.onime1@maryland.gov) and Diane Stollenwerk (diane@stollenwerks.com)
   - *NOTE: based on your completed self-assessment, BHA will meet with the local authority(-ies) in your local jurisdiction to discuss the status of integrating systems management in the seven domains and the actions needed to achieve integration per BHA expectations.*

The information in each completed self-assessment will be used for several purposes, including:

1. Compare to the self-assessment responses, submitted to BHA in Oct. 2018 and in Oct. 2019, to assess local progress toward integrated system manager functions over time, specific to each local jurisdiction and overall;
2. Inform planning for Learning Community sessions and other support of local efforts to integrate local systems manager functions;
3. Become the basis for the virtual site visit that BHA will have with each LBHA, or CSA and LAA, in Spring of 2021 to discuss the status of local systems management integration and specifically what is needed to achieve integration per BHA expectations; and,
4. Identify issues that require attention from BHA or others to support local progress in integrating systems manager functions.

Levels of Integration Self-Assessment Tool

PURPOSE: This tool is for local authorities[1] to assess the integration level of systems manager functions for the local behavioral health system. The results should inform local plans to improve coordination and integration of their system oversight functions.

VALUE: This self assessment tool should be used by local authorities, the Behavioral Health Administration (BHA) and others to:

- Consider the impact on person-centered experience of care created at each level of systems management integration
- Understand the seven key domains that need to be addressed when integrating systems manager functions for behavioral health
- Visualize ways to increase integration, moving from basic (*approaching*) to mid (*capable*) to integrated (*enhanced ability*)[2]
- Highlight local accomplishments and milestones achieved in the journey toward integrated systems management
- Identify domains and activities on which local authorities choose to focus to increase integration of systems management
- Offer feedback about domains in which local integration is challenging, to signal where the Learning Community can offer lessons from others who have overcome those difficulties and/or identify issues that need further attention from BHA or others

HOW TO USE THIS TOOL:

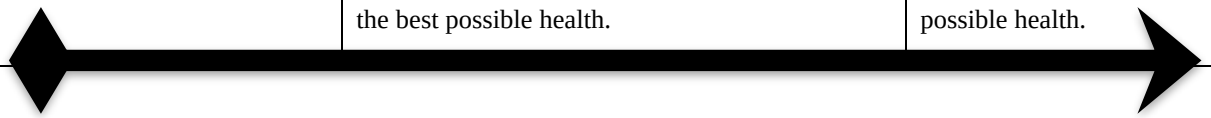
1) Building on the self-assessments completed in FY2019 and FY2020, each year the LBHA (or CSA and LAA together) in each local jurisdiction will complete <u>one</u> self-assessment for that local jurisdiction.
2) For each of the seven domains starting on page three:
   a) Select ONE level of integration (Level 1, Level 2 or Level 3) that most closely describes the degree of integration of systems manager functions currently in place within the local jurisdiction, then check the box next to that level.
   b) Provide brief answers to the three questions, and add other comments if desired.
3) No later than October 30, 2020, email your completed Self-Assessment to the BHA (see page 1 for three email addresses to use).

Note: Physical proximity (co-located, shared workspace) does <u>not</u> indicate integration as systems management teams in the same location might not collaborate and, conversely, teams in different locations might engage in integrated activities.

[1] Local Behavioral Health Authority (LBHA), or Core Service Agency (CSA) and Local Addictions Authority (LAA), plus other local stakeholders as appropriate
[2] The matrix in this tool was modeled after SAMHSA's *Six Levels for Collaboration / Integration, 2013*

FOCUS ON THE OUTCOME: Taking an integrated approach to managing and oversight of the local behavioral health (BH) system is to ensure **high quality, person-centered experiences for individuals and families across the local community**. All behavioral health systems management activities should be conducted in ways that are consistent with the *Principles for Integration*.

***PERSON-CENTERED EXPERIENCE**: Across the seven domains, moving to Level 3 of integration increases the likelihood that the local behavioral health system produces the best possible health outcomes for individuals and families in all communities.*		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
Basic collaboration and communication on an informal basis	Collaboration with some formal structure that may include shared functions	Merged, integrated or tightly coordinated functions, with little or no duplicated effort
Stakeholders view local MH and SU/A[3] oversight and systems of care as separate. Individuals and families receive MH and/or SU/A services through separate providers. Referrals are made, yet services feel siloed for most people. Help to access needed services and supports is hard to find, so people do it on their own. They must repeat the same information to various providers, whether in BH[4], somatic[5] care and/or community services[6]. There are known gaps in prevention, treatment, recovery and support services in the local BH system and quality is inconsistent. Overall result: limited ability for many people to achieve the best possible health.	Stakeholders see some connections between local MH and SU/A oversight and systems of care. Many individuals and families receive MH and/or SU/A services via separate providers, but some receive integrated BH intake and assessment. Referrals may be made via formal connections among providers, but services seem disconnected to many people. To access services and supports, some people are on their own to find providers and connect among BH, somatic care, and community services. Quality is often good and reflects cultural and linguistic competency, yet there may be gaps in the local BH network. Overall result: many people are able to achieve the best possible health.	Both the oversight and the system of care for local MH and SU/A are integrated or tightly coordinated. No matter where a person starts in the system, they have timely access to quality BH care – often with somatic care and/or community services – that is culturally and linguistically appropriate. System gaps are identified and addressed via collaboration. Individuals and families receive BH services (plus specialized MH and/or SU/A) from providers who share information and develop treatment plans on co-occurring disorders using an integrated approach. All providers are encouraged to use integrated BH intake and assessments. Overall result: nearly all people are able to achieve the best possible health.



[3] Mental Health (MH), Substance Use and/or Addiction, including gambling (SU/A)
[4] Behavioral Health, which includes mental health, substance use and addictions (prevention, treatment and recovery)
[5] Primary, specialty and tertiary treatment and care for health needs that are not behavioral health
[6] Examples include but are not limited to housing, food support, transportation, education and legal or justice services

DOMAIN #1: LEADERSHIP AND GOVERNANCE (vision, community engagement, management, policy advocacy, innovation)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated or tightly coordinated functions, with little or no duplicated effort
☐ LAA and CSA[7] have separate: governing bodies; visions to drive local systems management; community advisory councils[8]; and, hiring and management. Interaction between CSA and LAA is routinely or as needed, yet no formal structure connects the LAA and CSA leaders. Community advisors mostly focus on oversight of either MH or SU/A.	☐ LAA and CSA, or LBHA[9], address MH and SU/A separately, yet leaders have a formal structure to collaborate on some activities via integrated meetings of senior management and leaders, joint meetings of advisory councils, joint work on strategic planning, policy advocacy and innovation, etc. Leaders see systems management integration as important for the local BH system and have begun bringing key functions together.	☐ LBHA leaders and senior management are accountable for outcomes of the local BH system, and formally drive the vision and strategic direction of all local systems management functions. The joint community advisory committee[10] takes a comprehensive view of and offers guidance for the local BH system.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- Working on statute analysis with MABHA subcommittee and local advisory groups; MSBH and QAC LAA are represented on the subcommittee reviewing Statute language.
- RBHAC Leadership: Maggie Thomas; Co-Chair Started July 1, 2020
- Organized the Mid-Shore Counties Local Systems Management Integration Workgroup: Group composition of Mid-Shore Health Officers, LAA Directors, and CSA Leadership and team members.
- Election and endorsement of a name to the mid-shore local authorities' partners: Mid Shore Planning Collaborative (MSPC)
- FY2021 Mid Shore Planning Collaborative Community Behavioral Health Plan

2) If you selected Level 1 or Level 2:

[7] Local Addictions Authority (LAA) and Core Service Agency (CSA)
[8] Local Drug and Alcohol Abuse Council and Local Mental Health Advisory Committee
[9] Local Behavioral Health Authority (LBHA)
[10] Joint Mental Health and Substance-Related Committee

Which specific aspects are you working on to move to the next level of integration?

- Integrated Provider Meetings in the following counties: Caroline, Dorchester, Kent, and Queen Anne's counties. Meetings are co-facilitated by LAA and MSBH.
- All mid-shore local authority leadership participate in MABHA and the State-Level Integration Meetings
- MSBH manages a five county, regional behavioral health advisory committee that satisfies the mental health advisory council statue requirements: Regional Behavioral Health Advisory Committee (RBHAC)
- MSBH is active and has membership on all five mid-shore Local Drug and Alcohol Abuse Councils. MSBH is contracted with Caroline County to formally support the administration and management of the LDAAC; Drug Free Caroline since 2015.
- Regional advocacy activities through the Eastern Shore/Mid-shore Behavioral Health Coalition to support engagement with local delegation and government leaders for legislative advocacy, communication regarding behavioral health trends and gaps, and partnership for support.
- MSBH organized the Integration Workgroup, initially in FY14 with integration related to providers of MH/SRD preparation for fee-for service transition, and most recently has reformatted the workgroup to focus on integration activities with local authority entities in an effort to partner and increase relationships and partnerships as we work on local integration planning.
- MSBH Board of Directors is representative of an integrated Board; leadership from all counties representing integrated services, law enforcement, healthcare, local hospital, fiscal, school based, quality, legal, peer leadership and providers represented.
- MSBH has county agreements with all five mid-shore counties to serve as the CSA, specific MOU arrangements currently with Dorchester County to support LAA System Management, and Caroline County for LDAAC management.

a) What challenges do you perceive regarding achieving the next level of integration?

- Subjective nature of the word "formal" as it relates to defining our progress of integration.
- Collaboration on the expectation of leadership and integrated governance across five counties.
- Challenge of integrating leadership over five counties and six organizations.
- Sensitivity of State Statues to recognize the RBHAC as well as the five LDAAC as an integral part of the mid-shore region. Opportunity for mid-shore to support the development of a regional structure that would be respective of the autonomy of these advisory groups.
- Governance body definition that would support the non-profit structure of MSBH and be respective to the health departments.
- Endorsement of the three-five-year planning for mid-shore counties integration plan; BHA and local governance.
- COVID-19 impact with shifting priorities with responsiveness to the pandemic.

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- FY21 Community Behavioral Health Plan completion and accountability activities.
- Local Systems Managers working to evaluate the Advisory Council Statues for the State of Maryland
- Expanded reach with the Mid-Shore Behavioral Health Coalition to include LAA Leadership in the mid-shore.
- COVID-19 collaborative response to behavioral health community.

4) Provide additional comments, if desired.

- COVID-19 Impact to focus and planning with local integration. Integration meetings and activities resumed formally 8/11/2020.

DOMAIN #2: BUDGETING AND OPERATIONS (financing and billing, technology infrastructure, resource and expense sharing)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated or tightly coordinated functions, with little or no duplicated effort
☐ Plans for programs, budgets and staffing for the CSA and the LAA are separately developed and submitted to the BHA,[11] which grants separate awards to each. Generally, LAA and CSA interact independently with the ASO and providers on budget or operations issues. Whether the LAA and CSA communicate with each other routinely or as needed, there is no formal structure to coordinate on budgeting or operations.	☐ LAA and CSA, or LBHA, have a formal structure to coordinate across MH and SU/A on aspects of development and submission to BHA of program plans, budgets and staffing. Coordinated interaction with ASO and providers on MH and SU/A issues is routine. Some shared BH staff, or SU/A and MH staff work together. Sub-vendor contracts may be structured with joint funding for delivery of integrated services or support.	☐ LBHA uses a formal structure to develop and submit to BHA a plan for BH programs, budget and staffing, with combined funding where possible, with little or no duplication of administrative functions. Interaction with ASO and providers on BH is routine. Shared staff focus on BH, and all SU/A or MH staff work together. Sub-vendor contracts are structured with joint funding for delivery of integrated services or support, when appropriate.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- Enhanced collaboration on grant activities this year: MDRN, OOCC, MH FedBlock and S.O.R. initiatives.
- Mid Shore Planning Collaborative: Financial information sharing over the course of FY20 and Finance Plan for FY2021 collectively submitted (separate documents, submitted together).
- MDRN: Universal forms and process/management process for mid-shore counties for MDRN non-housing recovery support funds. MSBH formal grant management and disbursement of funds for Caroline, Kent, Queen Anne's counties. Integrated oversight confirmed in July, 2020.

2) If you selected Level 1 or Level 2:

a) Which specific aspects are you working on to move to the next level of integration?

- Assessing and orienting to separate funding streams processes, amount of funding by county, and management.
- Separate reporting on our funding streams
- Rollover budgets planning initiatives include both mental health and substance related programming activities.

[11] Behavioral Health Authority within the Maryland Department of Health (MDH)

- Funding from BHA is procured and managed separately. The funding that comes to BHA is received in a non-integrated fashion which makes local planning for integrated budgeting that much more challenging.

b) What challenges do you perceive regarding achieving the next level of integration?

- Funding with integration translates to risk exposure and concerns regarding "wholeness" of entities.
- Financial clarity and role responsibility. Continued work to address inherent conflict of interest issues.
- Variances in procurement; Health Department vs. Non-profit
- Financial planning presents as the most complex domain to move through for regional integration. This domain requires increased time for planning, stakeholder collaboration, technical assistance, and expanded administrative dollars/resources to support.

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- Agreement to enhance collaboration on FY2022 Finance Plans by jurisdiction.

4) Provide additional comments, if desired.

- ASO/Optum: Financial Impact with mid-shore provider network.
- Local Mechanisms are mirroring how funding at the State Level is managed. The transition of funding to the Department of Health (Prevention Dollars example) is complicating our planning process.
- Award delays, COA, Annual Notification of Funding delayed for finance planning is inhibitive of the processes for planning for integration.
- Goal for FY21 Integrated Rollover Planning (Fall 2021)

DOMAIN #3: PLANNING AND DATA-DRIVEN DECISION MAKING (data analysis, community needs assessment, network adequacy, program outcomes)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated or tightly coordinated functions, with little or no duplicated effort
☐ LAA and CSA engage in a separate Community Behavioral Health Planning processes, aligned with the State Behavioral Health Plan, and each plan is endorsed by separate governing bodies and advisory councils and submitted separately to the BHA. CSA and LAA coordinate informally on some aspects of planning, data analysis, and/or assessing and improving network adequacy and program outcomes.	☐ CSA and LAA, or LBHA, have a formal structure for the Community Behavioral Health Planning process to address MH and SU/A, aligned with the State Behavioral Health Plan. Involvement of governing bodies, advisory councils, community and staff may be coordinated, but SU/A and MH plans are mostly separate. Formal structure exists to coordinate on aspects of planning, data analysis, and/or assessing and improving network adequacy and program outcomes.	☐ LBHA uses a formal structure for the Community Behavioral Health Planning process, aligned with the State Behavioral Health Plan, and submits one plan using integrated approaches whenever possible. Formal structure exists for integrated or tightly coordinated BH planning, data analysis, and assessing and improving network adequacy and program outcomes, with little or no duplication of these systems management activities.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- Integrated Annual Plan developed, submitted, and accountability planning for FY2021.
- Collaboration for Integration Self-Assessment response; joint response process has been productive and continues to support relationship building.
- For FY21 Annual Plan: Development of the first integrated mid-shore Substance Abuse Data Set for analysis and interpretation in for planning purposes.

2) If you selected Level 1 or Level 2:

a) Which specific aspects are you working on to move to the next level of integration?

- Through the work of the mid-shore Local Systems Integration Workgroup, there is an awareness and acknowledgement that combining planning processes will benefit the group. Agreement of Strategic Planning and Annual Planning as a group through the integration process.
- Goal of integrated planning will enhance our ability to have more resources afforded to support the needs of the region.

- Mid Shore Planning Collaborative: For the FY21 Annual Plan development and submission process, the six entities represented in the Mid Shore Planning Collaborative met for at a minimum, 15 times for work sessions and co-facilitated a regional local governance presentation for the endorsement of the Annual Plan on 2/4/2020 (Five LDAACS, RBHAC)

b) What challenges do you perceive regarding achieving the next level of integration?

- Data Access Across Local Authorities: The data for CSA and LAA continues to be firewalled despite integrated planning.
- Use of the "formal" Structure language in the domain description.
- Data for FY2022 Annual Planning is limited due to ASO transition.

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- Successful completion of FY2021 Annual Plan; significant BHA endorsement for the FY21 Plan and CLC Strategic Plan.
- Accountability scheduling and monitoring for FY21 Goals, Objectives, and Strategies.
- Preparing for FY22 Annual Plan

4) Provide additional comments, if desired.

- BHA support of data-driven decision making; specifically related to the Cultural and Linguistic Competency
- Regional Needs Assessment in partnership with LAA counterparts in FY2022
- MSBH Workgroups Expansion: Peers, Recovery Housing
- Formalized Performance Measure and Program Specific data analysis.

DOMAIN #4: QUALITY (provider training, client experience, complaints, performance improvement, licensing and credentialing)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated or tightly coordinated functions, with little or no duplicated effort
☐ CSA and LAA engage in separate quality oversight and improvement activities. Generally, each interact with the ASO and providers separately on quality issues, including cultural and linguistic competency, though there may be informal coordination between the LAA and CSA on some aspects of quality oversight, provider training and education, assessment of client experience, handling complaints, or ensuring compliance with provider or program improvement plans.	☐ CSA and LAA, or LBHA, engage in some formally coordinated quality oversight and improvement for BH. Interactions with the ASO and providers on quality issues, including cultural and linguistic competency, are conducted jointly or coordinated as possible. A structure is in place to ensure coordination on aspects of BH quality oversight, provider training and education, assessment of client experience, handling complaints, or ensuring compliance with provider or program improvement plans.	☐ LBHA has a formal structure for BH quality oversight and improvement activities. Interactions with the ASO and providers are routine and focused on BH quality, including cultural and linguistic competency. All aspects of quality oversight, provider training and education, assessment of client experience, handling complaints, or ensuring compliance with provider or program improvement plans, address BH whenever possible with little or no administrative duplication.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- Cross sharing of contract monitoring tools, complaint investigation processes, and site visits.
- Development of MDRN forms for the mid-shore region.

2) If you selected Level 1 or Level 2:

- **Which specific aspects are you working on to move to the next level of integration?**
- More intentional communication, more mindful inclusion on creating a collaborative approach to quality management.
- MSBH has expertise and experience with Complaint Management. MSBH has support revitalized Complaint and Critical Incident management process and guidelines with BHA; we are a resource to our LAA counterparts.
- Quality issues are addressed regardless of the provider-type across local authorities.
- Training offered through the agency are integrated, and sensitive to the spectrum of healthcare needs of the region.
- Work with assisting providers in the accreditation process for both MH and SRD provider-types.
- Audits: Integrated participation for provider-types. Transition to Optum Audits: Monitoring and support for integrated provider audits.

- MSBH practices an integrated mindset with responsiveness to help calls and consumer support: provider, consumer, natural supports, community, consumer supports, help calls are processed equally regardless of the priority diagnosis.
- Behavioral Health Services Network for the mid-shore and surrounding county involvement and participation is an integrated model. Providers and resources from the entire healthcare spectrum, specifically MH and SRD are invited to present and engage. Representation from delegation and providers is strong.
- Enhanced collaboration with provider meetings.
- COVID-19 Impact on increased partnership and collaboration.
- Nine county Provider Network Meetings and cross-region support to integrated providers. MSBH is the primary facilitator and administrator of this activity. Optum and BHA representation on each call. (Initiated in March 2020)
- Mid-shore Diversity and Inclusion Workgroup: Application of FY21 CBHP strategies and CLC Strategic Planning: Implementation of the first mid-shore workgroup focused on addressing health-equity, inclusion, and addressing systematic racism in the community and most specifically, with behavioral health and human service partners and community members.

a) What challenges do you perceive regarding achieving the next level of integration?

- Definition of "formal" structure in domain
- Licensing and credentialing Boards
- ASO rate study planning for integrated health model- development and stakeholder input
- Regulations in general- acknowledgement of the need to increase integrated regulations.
- Partner education regarding current quality activities and outcomes.
- ASO Transition

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- MSBH has offered our contract monitoring tools with LAA counterparts.
- Warm Hand-Off Initiative
- Provider Meetings
- Additional complaint investigation
- Data Waiver Training: November 6, 2019
- Buprenorphine Training
- Cultural and Linguistic Trainings
- ACES, Resilience, Angst, Liked, Upstanders (Fall 2020)

4) Provide additional comments, if desired.

- In person and virtual site visits: Agreement to Cooperate and Licensure for Avenues Recovery in Cambridge, MD. Complex licensure application process. MSBH and DCHD collaboration.

DOMAIN #5: PUBLIC OUTREACH, INDIVIDUAL & FAMILY EDUCATION (messaging, communication, feedback)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated or tightly coordinated functions, with little or no duplicated effort
☐ LAA and CSA generally develop separate messaging and materials for MH and SU/A and engage in independent, culturally and linguistically appropriate communications with individuals, families and the public. Client or public feedback must be sent to the CSA or to the LAA, although the organizations may share feedback received. CSA and LAA coordination of outreach and communication efforts is informal.	☐ CSA and LAA, or LBHA, use a formal process to coordinate messaging and materials across MH and SU/A, and engage in coordinated, culturally and linguistically appropriate communication and outreach with individuals, families and the public about BH when possible. Feedback from clients or the public is regularly compiled and shared with MH, SU/A and shared staff, if any.	☐ LBHA is formally structured to ensure that messaging, materials and outreach take an integrated, culturally and linguistically appropriate approach to BH issues. Individuals, families and the public receive consistent messaging and information via newsletters, public awareness activities, social media, etc. Feedback from clients or the public is routinely compiled and shared with staff. Such efforts are tightly coordinated to avoid administrative duplication.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- Support cross-county and cross population type educational initiatives, collaboration with the regional audience as a target population regardless of county. Mutual-aid approach to training needs. Application for FY20 Rollover funds for mid-shore trainings- cross application process CSA and LAA applications.

2) If you selected Level 1 or Level 2:

a) Which specific aspects are you working on to move to the next level of integration?

- MSBH Integrated Resource Guide is representative of all five mid-shore counties and MSBH maintains an integrated website, and Facebook and Twitter account.
- "Going purple" regionally.
- Regional advocacy activities through the Eastern Shore Behavioral Health Coalition
- Duplication of services and trainings: division of workload and meetings while keeping each other abreast of information.

b) What challenges do you perceive regarding achieving the next level of integration?

- Continued work to "formalize" this domain.

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- Integrated Resources Information, Educational literature
- Weekly Newsletter with focus on integrated activities
- Warm hand-off Provider Tool Kit development and distribution
- Going Purple Together: September 25, 2020- Regional virtual event.
- Expanded engagement of providers and community stakeholders: Provider Network Meetings, Shore Regional Strategic Planning- Enriching Access to Behavioral Health Meeting March 11, 2020 and continued collaboration. Anticipated partner meeting December 2020.

4) Provide additional comments, if desired.

- Plans for increased intentionality with use of the Weekly Newsletter as a tool for integrated messaging.
- Invitation to LAAs for participation in Programs/Collaboration for announcements and newsletter content.

DOMAIN #6: STAKEHOLDER COLLABORATION (with providers of BH, somatic care, community services, and other partners)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ CSA and LAA focus on interacting either with MH or SU/A providers, respectively. Each engage in some collaboration with providers of somatic care and/or community services and supports to encourage effective coordination of culturally and linguistically appropriate services. The LAA and CSA informally work together on aspects of their interaction and collaboration with providers that impact the health of individuals and families involved in the behavioral health system.	☐ LAA and CSA, or LBHA, have a formal structure to coordinate interactions with MH and SU/A providers to reduce duplicated efforts, potential knowledge gaps or confusion due to differences in expectations and to support the provision of culturally and linguistically appropriate services. Collaboration on care coordination with somatic and community service providers, who impact the health of individuals and families involved in the local behavioral health system, is often done from an integrated BH perspective.	☐ LBHA is structured so interactions with BH, MH and SU/A providers are integrated or tightly coordinated to ensure consistency and clear points of contact, avoid duplication and confusion, and support the provision of culturally and linguistically appropriate services. Collaboration with somatic and community service providers is done from an integrated perspective to improve coordination among providers who impact the health of individuals and families involved in the behavioral health system.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- Provider Capacity and Operations Google Doc (COVID-19 Response)
- CoC and Shelter Occupancy Google Doc (Online access COVID-19 Response)
- Mid-shore counties Integrated Resource Guide
- Integrated Mid-Shore Provider Network Listserv for Correspondence (COVID-19 Response) (estimated 400 providers represented)

2) If you selected Level 1 or Level 2:

a) Which specific aspects are you working on to move to the next level of integration?

- Working to operate from an integrated behavioral health perspective with all planning and gaps assessments.
- Engaging partners from an integrated health perspective; MH/SRD/Somatic/Criminal Justice.
- Integrated Crisis Response Systems development and planning for the region, which is an integrated, co-occurring enhanced service.

b) What challenges do you perceive regarding achieving the next level of integration?

- Increased planning and communication with LAA partners to ensure that there is minimal duplication of efforts, and to assist with joining in the planning process.

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- We are working enhance stakeholder support towards an integrated behavioral health information, advisement, and oversight program. 2019-2020 has presented a challenge with COVID-19 that was turned in to an opportunity to enhance our integrated activities. The MSPC has turned the curve with funding for integrated grants opportunities, workforce hiring practices and a more streamline assessment which will provide better outcomes for all consumers in the jurisdiction.

4) Provide additional comments, if desired.

- Warm hand-off Provider Tool Kit development and distribution
- Safe Station Coalition of the Eastern Shore
- RBHAC
- Behavioral Health Coalition
- Problem Solving Courts
- Crisis Response, CIT Training with increase training focus on substance use
- GOCCAP: Lead Initiative
- Harm Reduction Training
- SIM (Sequential Intercept Model Mapping: Regional)
- Handle With Care Initiative
- OOCC Director Schuh Presentation: Regional Behavioral Health Systems Management: February 21, 2020
- START Initiative: Participation on Advisory Committees (2 of 5 counties)
- Data Waiver 2000 Training
- COVID-19 Collaboration: messaging, information sharing, Provider Network Meetings.
- Recovery House Workgroup

DOMAIN #7: WORKFORCE (recruitment, training and development, retention)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated or tightly coordinated functions, with little or no duplicated effort
☐ LAA focuses on SU/A workforce capacity, licensing and credentialing issues and meeting training needs for providers and systems management staff. CSA does the same for MH. Some coordination of activities occurs between the CSA and LAA on an informal basis.	☐ CSA and LAA, or LBHA, approach MH and SU/A separately when addressing workforce capacity, licensing and credentialing issues and training for providers and systems management staff. However, formal structure is used to coordinate across SU/A and MH on certain activities, including intentionally promoting and supporting integration of BH services for individuals and families. Cross-training of staff is prioritized, along with efforts to hire shared BH staff.	☐ LBHA tightly coordinates or is structured to ensure that workforce capacity, licensing and credentialing, and training for providers and systems management staff reflect an integrated approach to BH systems management, with priority on integration of BH services for individuals and families. Systems management staff use integrated approaches to BH to avoid duplication of effort, and are cross-trained on MH and SU/A terminology, treatment philosophy and approaches.

1) What documentation or other concrete information was the evidence used to select the level of integration above? (See attachment for examples)

- MSPC commitment and experience in behavioral health service oversight and systems management. MSPC investment with the recruitment, development, and sustainability of an integrated behavioral health workforce in the mid-shore region.

2) If you selected Level 1 or Level 2:

a) Which specific aspects are you working on to move to the next level of integration?

- MSBH Posting integrated job opportunities in weekly email distribution.
- Psychiatry crisis response has been organized from an integrated perspective; how is it impacting providers across types.
- Scholarship for peers: Integrated for peers for MH/SRD/Forensic training and certification.
- Eastern Shore Behavioral Health Coalition for Advocacy for integrated providers, capacity, and credentialing issues
- Collaboration with local FQHC for behavioral health needs and planning for expansion of provider accessibility and collaboration by way of warm hand off for patients with behavioral health diagnoses and needs.
- Recruitment and retention of Regional Youth Outreach Coordinator: September 2020

b) What challenges do you perceive regarding achieving the next level of integration?

- Growing and sustained rural impact of workforce shortage.
- Parity and Credentialing
- Licensure and leadership at the local authority level that are representative of integrated workforce. Increased collaboration and support across disciplines.

3) Describe any substantive changes in your integration activities since completing your local integration Self-Assessment in October 2019.

- MSPC acknowledgement that this Domain is the next closest to movement and advancement to Level 3.
- Peer Support Specialist Scholarship
- S.O.R. Grant: Peers Support Specialist Staff
- Crisis Response: MCT onboarding of Peer Workforce
- UMD Child and Adolescent Psychiatry Fellows: Recruitment outcomes
- Data Waiver 2000 Training in partnership with TCHD and DCHD
- Post local positions in weekly email/newsletter for integrated workforce
- Crisis Response, CIT Training with increase training focus on substance use

4) Provide additional comments, if desired.

- Integrated Weekly Newsletter: LAA input with content and open positions. Example: Impact of COVID-19 on A.F. Whitsitt Center staffing.
- Adolescent Clubhouses Initiatives: Expanded and creative staffing models

ATTACHMENT: EXAMPLES OF EVIDENCE THAT REFLECTS PROGRESS TOWARD INTEGRATION

DOMAIN 1: Leadership and Governance

- ☐ Local organizational chart that demonstrates a clear means for decision-making that ensures integrated system management
- ☐ Local vision and strategic priorities that are focused on integrated system planning and management
- ☐ Local leaders have education, knowledge, demonstrated interest and experience in integrated behavioral health
- ☐ Individuals attending state meetings (e.g., with MDH, BHA, MABHA) have responsibility and authority to make needed changes in and integration decisions for behavioral health at the local level
- ☐ There is a local mechanism to measure and document progress toward system management integration and improvement
- ☐ Ways in which the leadership and government structure has led to positive change in the local behavioral health system

DOMAIN 2: Budgeting and Operations

- ☐ Local streamlined and efficient system for budgeting and operations. Examples include merging budgeting and operations functions into an integrated unit contained within one local entity, establishing a strong and collaborative working agreement that maximizes the strengths and resources of more than one entity while reducing duplication, combining resources from more than one local authority, and drawing on local resources in these areas to maximize efficiency and reduce costs
- ☐ A local mechanism that is efficient with clear lines of authority and responsibility specifically for budget, staffing and administrative functions
- ☐ A local mechanism for reviewing budgeting and operations for opportunities to further integrate and maximize efficiencies
- ☐ Descriptions of ways that local operations have been streamlined or budget efficiencies achieved as a result of integration efforts

DOMAIN 3: Planning and Data-driven Decision Making

- ☐ Local integrated behavioral health plan for the local jurisdiction
- ☐ A single integrated behavioral health plan submitted by the local authority(-ies) to the state
- ☐ A local mechanism that is strong and efficient for reviewing and using data to improve network adequacy, address system gaps and achieve better behavioral health outcomes within the local jurisdiction
- ☐ Behavioral health planning and data-driven decision making at the local level is focused on system planning and management
- ☐ Description of specific ways in which integrated planning and data-driven decision making have improved the local behavioral health system

DOMAIN 4: Quality

- ☐ An established forum for regular meetings with providers
- ☐ Demonstration, using data, that all local complaints receive a response in a timely manner consistent with BHA standards
- ☐ A reliable process has been established for responding to complaints in a timely manner consistent with BHA standards
- ☐ Regular provision or facilitation of provider training and education in best practices and other areas of interest to providers
- ☐ Regular interaction with individuals who receive services and organizations representing individuals and families
- ☐ A mechanism to routinely seek and get feedback from individuals who receive services and organizations that represent them
- ☐ Demonstration, using data, that the local authority does timely follow-up on Program Improvement Plans per BHA standards
- ☐ Demonstration that the local authority interacts with all public and private agencies with an interest in behavioral health
- ☐ Description of specific ways in which the local integrated approach to quality has improved the local behavioral health system

DOMAIN 5: Public Outreach, Individual and Family Education

- ☐ An integrated local communication plan and process for educating individuals, families, specific groups and the general public
- ☐ A mechanism to ensure that public messaging on behavioral health is coordinated for greatest impact and best use of resources
- ☐ Use of a standardized logo and single point of contact, when appropriate, for all public messaging regarding behavioral health
- ☐ A way to seek and get input from individuals, family members, agencies, and the public about the local behavioral health system
- ☐ Demonstration that all feedback received is used to adjust and target local behavioral health communication strategies
- ☐ Documents that show integrated behavioral health messaging used in communication with individuals, families, and the public

DOMAIN 6: Stakeholder Collaboration

- ☐ A mechanism in place for collaborating with entities that can either benefit from a strong local behavioral health system and/or can contribute to strengthening the local behavioral health system
- ☐ Demonstration that leaders and staff are expected to work with stakeholders and trained in best practices to create partnerships
- ☐ Descriptions of examples of behavioral health collaboration that is effectively happening within the local jurisdiction
- ☐ Demonstration of ways your integrated approach to stakeholder collaboration has improved the local behavioral health system

DOMAIN 7: Workforce

- ☐ Local leaders and employees have education, knowledge, demonstrated interest and/or experience in behavioral health
- ☐ Employee satisfaction survey results demonstrate progress in increasing inclusion and a more integrated culture
- ☐ Position descriptions include cross-training expectations for all individuals in the local behavioral health system
- ☐ All employees, including leaders, are trained in integrated system planning and management expectations
- ☐ All employees, including leaders, can articulate their specific role within the local approach to integrated systems management

Representing County	Mid Shore Behavioral Health, Inc. Board of Directors	
Caroline	Doncella Wilson (T1 exp.10/1/2024) Kent County Local Management Board 400 High Street Chestertown, MD (W) (410) 810-2673 dwilson@kentgov.org	Trish Todd (T2 exp. 6/30/22) Maryland Coalition of Families 9 South Third Street Denton MD 21629 (W) 410-479-1146 (C) 443-537-5219 ttodd@mdcoalition.org
Dorchester	Mary June McGinnis (T2 exp. 10/31/21) Marshy Hope Family Services 813-1 Chesapeake Drive Cambridge, MD 21613 (W) 410-221-2266 marshyhope@marshyhope.com	Valerie Davis (T2 exp. 10/31/23) Dorchester County Health Department Healthy Families 3 Cedar Street Cambridge, MD 21613 (W) 410-228-3223 valerie@dcsdct.org
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Queen Anne's	Roger Harrell (T2 exp. 10/31/22) Dorchester Co. Health Department 3 Cedar Street Cambridge, MD 21613 (W) 410-228-3223 (C) 443-521-0851 roger.harrell@maryland.gov	Stirling Ward (T2 exp. 12/31/22) Queen Anne's County Board of Ed 202 Chesterfield Avenue Centreville, MD 21617 (W) 410-758-2403 ext. 179 stirling.ward@qacps.org
Talbot	Deputy Tim Connors (T1 exp. 12/1/2023) Talbot County Sherriff's Department 115 West Dover Street Easton, MD 21601 tconnors@talbgov.org	Joan Brooks (T1 exp. 4/1/2023) P.O. Box 1172 Easton, MD 21601 (C) 410-924-0792 docgirl12@verizon.net
At-Large (max 5 members)	Arlene Lee (T1 exp. 10/1/2022) 100 Crestview Court Chestertown, MD 21620 (C) 410-299-4539 Aflee12345@yahoo.com	Susan Johnson (T1 exp. 12/1/21) Choptank Community Health 301 Randolph Street Denton, MD 21629 (W) 410-479-4306 x5009 smjohnson@choptankhealth.org
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Slate of Officers		
Ben Kohl	Vice-President	Stirling Ward
Susan Johnson	Secretary	Trish Todd

Board Sub-Committees	
Executive Committee/Personnel Committee Ben Kohl – Chair Stirling Ward Susan Johnson Trish Todd	**Finance Committee** Susan Johnson – Chair Ben Kohl Stirling Ward Trish Todd
Program Services Committee Valerie Davis – Chair Trish Todd Stirling Ward	**Nominating Committee** Eboni Taylor- Tue – Chair Trish Todd Mary June McGinnis

January 11, 2021 KGD

MSBH Emergency Communications
As of February 2021

MSBH Emergency Cellphone:
410-714-5400

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Administrative Specialist

410-924-1274

Kathryn Dilley
Executive Director

202-999-2630

Yvette Hynson
SOAR Case Specialist

410-533-6028

Carole McCall
Behavioral Health Coordinator

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Audra Cherbonnier
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410-490-6373

Pat Doyle
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410-212-9385

Sarah Baynard
Accounts Payable

410-490-8593

Belinda Frankel
Forensic MHP Manager

410-200-5483

Akima Copper
Forensic MH Case Specialist

410-924-3250

Jazzmine Davis
CoC Program Specialist

443-362-1743

Additional contacts to be made in the event of an office closure:
Cleaning Services
Accounting Services
Scheduled Meeting Participants
Landlord (when necessary)

When necessary, group text using WhatsApp messenger will be utilized in place of phone calls.
All employees will be required to respond with confirmation of receipt of the text.

Emergency Operations Plan

Created: 4/12/17
Updated: 02/12/2020

I. PURPOSE:

Mid Shore Behavioral Health, Inc. (MSBH), the local behavioral health authority for Caroline, Dorchester, Kent, Queen Anne's and Talbot counties, is responsible for planning, monitoring, evaluating, and funding all public behavioral health services in the mid-shore region. MSBH is a partner agency, in conjunction with local health departments, for mobilization, coordination, and delivery of disaster behavioral health services during an emergency. *See the State of Maryland - Department of Health and Mental Hygiene - Behavioral Health Administration - All Hazards Plan and CSA Disaster Mental Health Plan.*

The purpose of this plan is to establish a comprehensive, integrated and coordinated behavioral health plan to respond to environmental and man-made disasters in the mid-shore region. It aims to minimize the adverse affects of stressful situations and/ or traumatic events affecting citizens in the workplace and community. This plan enables MSBH to maximize the use of personnel, facilities, and other resources in providing behavioral health assistance to disaster victims, emergency response personnel, and the community at large.

The disaster plan includes provisions for the services MSBH will deliver, coordinate and/or procure, as well as when, how, and by whom these services will be provided. Backup MSBH staff and community resources are also a part of the plan, in the event the first behavioral health responders are not available or are immobilized by the disaster.

This plan was developed by MSBH in cooperation with the Support Agencies that would assist should the plan need to be implemented.

II. SITUATION

The mid-shore region of the Eastern Shore of Maryland is comprised of five counties; three share a border with the state of Delaware. The area is primarily rural in character. Tourism, farming, and small businesses drive much of the economic climate. Major business centers are the towns of Chestertown, Centreville, Easton, Denton, and Cambridge.

There are four hospitals/emergency rooms in the area, with two counties having no hospital facilities. Choptank Community Health Systems, Inc., a federally funded agency providing services for underserved areas, has eight federally qualified health centers in three of the five counties.

Based on the 2019 County census estimates, the population covered by Mid Shore Behavioral Health is 172,319. The area has a higher than Maryland average of citizens over the age of 65, with an average of 25.2%. Kent County is highest at 38% and Queen Anne's lowest at 18%. According to 2019 Census data (www.census.gov) poverty rates on the mid-shore range from the lowest in Queen Anne's County of 5.7% and the highest in Dorchester County of 15.8%, with a five-county average of 10.2%.

As in most rural areas, the primary hazards in the mid-shore area are major fires, flooding, hazardous material incidents, severe winter weather, power failures, essential resource shortages, and transportation accidents.

Located midway on the Delmarva Peninsula between the Chesapeake Bay and the Atlantic Ocean, hurricanes are also of great concern to this area. Routes 404, 50, and 301 are major highways traveling through the area, all part of hurricane evacuation routes. In the last 2 years, tornadoes have touched down on the mid-shore, adding to the list of potential disasters.

Toxic Release Inventory facilities are in all five counties of the mid-shore. Most of the area is also included within the 50-mile plume area of the Calvert Cliffs Nuclear Plant, with parts of Dorchester County being part of the initial response. In today's environment, there is also a real threat of the terrorist use of biological agents in addition to the "usual" disasters of weather, transportation incidents, radiological, and hazardous materials.

The area is, of course, subject to the kinds of wide-spread or localized Public Health emergencies that can occur anywhere, such as epidemics or other outbreaks. Large area gatherings include the Waterfowl Festival, Chesapeake Balloon Festival, and the Chestertown Tea Party.

III. ASSUMPTIONS

- The Mid Shore area is subject to a naturally occurring infectious disease emergency or a covert terrorist attack (BT event), as well as natural disasters, which may cause injuries to a considerable number of people, produce physical and/or biological health hazards throughout the affected area, and create a widespread need for behavioral health care. Special behavioral health needs can emerge that include the “worried well”. It has been estimated that in a terrorist attack, the "worried well" may outnumber the injured by as much as 20 to 1.

- Mid Shore Behavioral Health (MSBH) will assume primary oversight responsibility for disaster behavioral health services in the five-county area for which it is responsible and will assist local health departments in coordinating a regional response to meet the behavioral health needs.

- Disaster behavioral health response will be coordinated through each county’s Emergency Operations Centers (EOC).

- There may not be an adequate number of behavioral health personnel available to support the response.

- All partnering agencies are responsible for the development of agency-specific standard operating procedures that dictate their roles and responsibilities in responding to the behavioral health needs of the community, including their own staff, during an emergency.

- Response to a health emergency may be exclusively dependent upon local/regional resources for the duration of the health event.

IV. LEGAL AUTHORITIES

MSBH is a local Core Service Agency (CSA), under contract with the Behavioral Health Administration (BHA), Department of Health (DH).

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707, requires that states plan for the provision of disaster behavioral health services. It authorizes financial assistance for state/local agencies

or private organizations to provide crisis counseling, outreach, education, referrals, and other short-term interventions to survivors of major disasters. Section 416 of this act specifically addresses the behavioral health function.

Legal authority of Maryland Department of Health concerning disasters derives from Maryland Health General Articles 18-901 to 18-908. Disaster Mental Health is particularly referenced in Maryland Policy 1043(SYS) 08-1, Disaster and Terrorism Preparedness. The Maryland Department of Health (MDH), state hospitals and training centers, and behavioral health authorities are expected to do the following: respond and coordinate with other state agencies to provide crisis-counseling programs and other mental health response initiatives, prepare grants to secure federal emergency response funding, and ensure the provision of accurate, timely, and instructive information to the public during a disaster. These responsibilities will be fulfilled in accordance with § 416 of the Stafford Act.

The extent and limits of emergency authority of the Governor and the Secretary of Health are defined in Senate Bill 234, Catastrophic Health Emergencies. Where necessary, support agencies listed in this plan will sign a Memorandum of Understanding with MSBH to define the coordination of mental health services within the five-county area in the event of a health emergency. Each support agency will be responsible for the tracking and reporting of resources and other financial records related to the health emergency.

V. PARTNERS

Supporting Agencies and Organizations

MD Responds: Maryland Medical Reserve Corp

Working under the Office of Preparedness and Response (OP&R) in the Maryland Department of Health (DH), the Maryland Volunteer Corps consists of health care and community professionals ready to assist with disaster and emergency recovery during an emergency. MD Responds is a Medical Reserve Corps (MRC) administered by the Department of Health. The MRC program coordinates the skills of practicing and retired physicians, nurses, other health professionals, and citizens who are eager to address their community's ongoing public health needs and to help during large-scale emergency situations. A MD Responds registrant is provided with liability protection and has the option of choosing where he or she wishes to work geographically.

Only the Health Officer and the MD Responds unit administrative contact within local Health Department (usually the public health emergency planner in the county where MD Responds registrants reside) have direct access to those names, and request for volunteers through the MD Responds must be conducted through the local Health Department. Furthermore, MD Responds registrants can only be activated as MD Responds members (and thus covered by state-provided liability protection) by the DH Office of Preparedness and Response. They can, of course, have individual or employer-based liability coverage.

Mid Shore Behavioral Health promotes recruitment of volunteers who are urged to register with MD Responds. Those working specifically with County Health Departments serve as a local all-hazards resource, augmenting and supporting the existing local public health system. Many of these volunteers are being trained in Psychological First Aid and/or Mental Health First Aid to support the community’s behavioral health needs, as well as self-care training to help them maintain their own psychological well-being.

Maryland Department of Health

The Maryland Department of Health (MDH) includes the state system for public behavioral health (including mental health and substance use) and intellectual disabilities. During an emergency, MDH will address the associated public health ramifications, including the continuity of public health functions and the delivery of public health services, and act as the overall lead agency for Emergency Support Function 8 Health and Medical Services. In this capacity, MDH will coordinate the provision of emergency response (e.g., pre-hospital, hospital, and other) at the state level. MDH may engage in the roles and responsibilities associated with the Four Phases of Emergency Management (mitigation, preparedness, response and recovery).

All public health related requests are generated at the local level first. If the local health department cannot fill the request, it is then forwarded to the Local Emergency Management Agency Emergency Support Function 8 (Health). In the event the local EMA cannot locate or does not have access to the resources needed, then the request is forwarded to the state EOC or the state Department of Health EOC or the MDH Office of Preparedness and Response, depending on the level of state-wide activation.

American Red Cross, Delmarva

The American Red Cross (ARC) helps people prevent, prepare for, and respond to emergencies. All Red Cross DMH personnel are licensed mental health professionals. Acceptable licensures include: 1) School Counselor; 2) School Psychologist; 3) National Certified School Psychologist; 4) Licensed School Psychologist; 5) Licensed Clinical Psychologist; 6) Licensed Professional Counselor; 7) Marriage and Family Therapist; 8) Licensed Substance Abuse Treatment Practitioner (not Substance Abuse Counselor); 9) Licensed Clinical Social Worker (not Licensed Social Worker); 10) Registered Nurse, Clinical Nurse Specialist or Nurse Practitioner with psychiatric nursing experience and training beyond the normal RN rotation; 11) Doctor of Medicine or Doctor of Osteopathic Medicine specializing in psychiatry. In addition to licensure, Red Cross DMH volunteers must pass a background screening process and complete two training courses: *Foundations of Disaster Mental Health* and *Disaster Services: An Overview*. DMH volunteers are encouraged to take additional Red Cross disaster training. The Delmarva Regional Office, as a part of the National disaster system of the American Red Cross, facilitates resource sharing throughout the region to increase disaster response capabilities.

Other Resources

Mobile Crisis Teams (MCT)

Four regional Mobile Crisis Teams (MCT) cover eight (8) counties of the Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot and Wicomico. Mobile Crisis Team members intervene with callers referred from the Eastern Shore Operations Center who are experiencing a behavioral health emergency. Mobile Crisis Teams assist law enforcement and emergency responders, providing behavioral health crisis consultation and intervention to stabilize the consumer in the least restrictive environment through a range of services including assessment, crisis intervention, supportive counseling, information and referrals, linkage with appropriate community based behavioral health services for ongoing treatment, and follow up.

Critical Incident Stress Management (CISM) Teams

Local CISM Teams are coordinated through local Emergency Services and Fire Departments. Caroline, Dorchester, and Talbot County EMS have a Tri-County CISM team. Kent and Queen Anne's County Rescue Squad through the fire departments also have a CISM team. CISM teams are dispatched through the EOC.

U.S. Public Health Service Commissioned Corps Behavioral Health Team
The Behavioral Health Team (BHT) consists of mental health and substance use experts who assess behavioral health risks within the affected population, manage responder stress, and provide therapy, counseling, and crisis intervention. The BHT may be requested through the State EOC and can deploy within 36 hours of notification.

MDH Office of Preparedness and Response (OP&R) website
The OP&R website (https://preparedness.health.maryland.gov/Pages/Home.aspx) lists information and web hyperlinks for resources to help address the needs of those family or community members experiencing crisis due to an emergency event. In the event of an actual public health and/or medical emergency or other traumatic event, information regarding behavioral health teams and how to contact such personnel will be made available both on the MDH OP&R web site and via media outlets.

Faith Based Organizations
Members of several faith-based organizations in the Region have received specialized training in self-care and "psychological first aid" for others. They are best utilized as a resource when faith-based support is sought.

Citizens Emergency Response Team (CERT)
A part of the Talbot County Citizen Corps under the auspices Talbot County Emergency Management, these volunteers have had at least 20 hours of specialized emergency-related training, and some have been organized into town-based teams. Their particular emphasis is on community outreach and preparation and mitigation.

Local Behavioral Health Provider Network
MSBH maintains an accurate and up-to-date resource guide of behavioral health providers and partners with the regions. Providers are licensed and regulated by the Office of Health Care Quality ensuring professional licensure and required training standards are met.

County Schools Critical Incident Response Teams
Some County School Systems have a Critical Incident Response Team (CIRTs) activated when incidents occur in the school system. These teams are a potential behavioral health resource, especially within the school system, during disasters.

Behavioral Health Response Team at University of Maryland Shore Regional Health
The Behavioral Health Response Team is a group of licensed mental health professionals at UM Shore Medical Centers at Chestertown, Cambridge, and Easton with educational backgrounds in nursing, psychology, and social work. Their job is to perform mental health and substance abuse evaluations and referrals to consumers in our hospitals, 24 hours a day, seven days a week. This includes emergency room assessments, medical floor consultations, debriefing medical staff, crisis counseling, and bereavement counseling. In addition, the team answers call from individuals in the community about emergency services and outpatient and inpatient resources.

Hotlines

Eastern Shore Operations Center (ESOC), 1-888-407-8018
Serves as the behavioral health emergent, urgent, and information and referral call center for all nine counties of the Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot,

Wicomico, and Worcester counties. The ESOC is available 24 hours a day, 7 days a week to assess and respond to calls from consumers, family members, community members, businesses, and human services agencies. ESOC staff provides linkage to community resources through referral to all appropriate and existing behavioral health and human services.

Maryland Crisis Hotline, 1-800-422-0009
Provides counseling for victims of domestic violence or sexual assault, suicide prevention, support groups, emergency shelter, shelter referral, medical care, and assistance with the process of prosecution. The Life Crisis Center answers 2-1-1 calls made from all nine counties on the Eastern Shore.

Life Crisis Center (Maryland 2-1-1)
Administered by Life Crisis Center and sponsored by the Maryland Department of Social Services, this statewide hotline network provides residents with suicide prevention, crisis intervention, emotional support, and information and referrals for health and human services on Maryland's Eastern Shore. The network is available 24/7 and can be accessed from within or outside Maryland.

Mid-Shore Council on Family Violence, 1-800-927-4673
Provides direct services for victims of family violence including a 24-hour hotline, crisis intervention, counseling, support groups, emergency shelter, client advocacy, children's program, court accompaniment, information, and referral.

VI. OPERATIONS

Federal, state, and local governments recognize there is a role for local behavioral health authorities in disaster planning and response. Each county within MSBH's jurisdiction will have their own specific Emergency Operation Plans (EOP). MSBH will work with each county's Health Department to assure they have a departmental EOP that includes behavioral health planning and response and will maintain a copy of that plan.

These plans will:

- Ensure that appropriate behavioral health services are available for disaster victims, survivors, bystanders, responders and their families, and other community caregivers during response and recovery. Services may include crisis counseling, critical incident stress debriefings, information and referral to other resources, and education about normal, predictable reactions to a disaster experience and how to cope with them. There should be a capacity to provide specialized assistance for those affected by a traumatic event or who become traumatized by cumulative stress related to the disaster experience.
- Provide outreach to identify and serve those in need of behavioral health support.
- Provide needs assessments/information gathering annually to update plan.
- Ensures quality training for the behavioral health community.

The MSBH shall assist the Health Officer in each of the five counties to maintain clear communications with the State Behavioral Health Administration and serve as coordinator to the State Mental Health Emergency and Disaster Preparedness and Response Plan.

Specifically, the MSBH Director will:

- Coordinate the State and County Plans;

- Develop and coordinate with the State and County Critical Incident Stress Management (CISM) team organizations;
- Assure that all levels of behavioral health personnel are trained and ready; and
- Plan for continuing education and practice drills.

In general, MSBH will base its operations on the Federal Emergency Support Function (ESF) model. Under such a model, the local Health Department will serve as lead agency for ESF-8 (Public Health and Medical), of which behavioral health is a part. If the local Health Department does not staff the behavioral health function itself, MSBH will function under ESF and will staff the behavioral health function in three possible ways depending on the nature of the situation in the counties it serves. (1) If able, they will provide staff to the local EOC. (2) If Public Health as ESF 8 is not in the EOC, MSBH will co-locate with ESF 8 if required. (3) MSBH will designate a staff liaison for each county. This latter option will also make it easier for the liaison to coordinate with persons serving as liaisons to other jurisdictions. Depending on the type of incident, MSBH may provide support to one or more emergency support functions, including, ESF-5 (Emergency Management), and ESF-6 (Mass Care), among others.

If serving as the behavioral health lead in a county:
- The MSBH Director (or designee) will oversee all requests for behavioral health resources and will be the main point of contact for coordination and delivery of behavioral health services.
- MSBH will be responsible for mobilizing qualified behavioral health personnel and directing a response to the behavioral health needs of residents and response personnel.

For all counties:
- MSBH will coordinate with DHMH and other partnering agencies to ensure that the appropriate level of behavioral health services is available.
- In coordination with local, state, and federal agencies, MSBH will plan for follow-up services to ensure long-term recovery, such as additional community interventions, individual or family counseling, or community education.

Pre-Emergency Period (two phases)

Normal Preparation Phase

Emergency Support Function assigns to Health Departments the responsibility for the provision of behavioral health services. MSBH will develop policies and procedures as necessary to define the behavioral health and special needs services.

Current internal personnel notification rosters, external communication routes with other CSAs, notification rosters of behavioral health agencies, disaster trained behavioral health professionals, and crisis technicians, and standard operating procedures will be maintained. There are also special preparations needed to be addressed for terrorist activities.

Readiness at the community level means having in place not only a preparedness plan that meets pre-determined criteria, but also a workforce that can demonstrate an understanding of preparedness and the behavioral health clinician's role in that plan. MSBH will assure that quality training is provided for individuals who may work in the disaster behavioral health function. It will be responsible for an annual training needs assessment to identify areas of interest by behavioral health professionals and will work with Local Health Departments to identify natural helpers/community responders. Behavioral health trainings will be annually offered. Both the identification of qualified individuals and the provision of training may be coordinated by the Maryland Professional Volunteer Corps/MD Responds.

MSBH will encourage participation of behavioral health providers in Disaster Behavioral Health education through such topics as the American Red Cross Disaster Health Class, Critical Incident Stress Management training, NOVA training, Mental Health First Aid training, Psychological First Aid training, Bioterrorism Symposia, Incident Command Instruction, Emergency Management drills and classes, and the treatment of trauma. This will be in addition to the training presented by UMBC for the Maryland Disaster Volunteer Corps.

Mid Shore Behavioral Health staff will receive assignments regarding their roles during a disaster and will have the opportunity to attend educational seminars. All staff will receive training in Incident Management, CPR, First Aid, and Mental Health First Aid.

Those agencies receiving funding from MSBH will be responsible for the development of their individual disaster plan, including procedures for evacuation and sheltering in place for residential facilities. MSBH will provide guidance.

Increased Readiness Phase

This phase will begin upon the receipt of a credible prediction of an event that may require the activation of Emergency Operations Centers. Standard Operating Procedures and checklists detailing the disposition of public and private mental health resources will be reviewed, resource listings will be updated, and communication will be made with the five health department contacts. Business continuity plans and redundancy communication plans will be addressed.

Emergency Period

The primary goal during the response phase is to ensure that there is an appropriate behavioral health response to the immediate and ongoing needs of affected people in the Mid Shore Counties and response personnel. During this phase, Mental Health First Aid, Psychological First Aid (PFA), and crisis counseling services will be provided as necessary. If it appears that the behavioral health needs precipitated by the incident require a response greater than the capability of local resources, additional resources will be sought first from neighboring jurisdictions and then from the state and/or federal levels.

During this period, it is the responsibility of MSBH to coordinate behavioral health resources not already dedicated to a health department's initial response. This includes overseeing the Eastern Shore Crisis Response Helpline (1-888-407-8018), assisting the Local Health Departments in acquiring volunteers from Maryland Responds, and recruiting and assigning behavioral health professionals from the local provider network. Assistance with the special needs' populations served by MSBH programs will also be coordinated. MSBH has five (5) Emergency Operations Center (EOC) liaisons; one for each of the five mid-shore counties. This person will serve as the point of contact in, or for, the Emergency Operations Center of that county alongside the Health Officer in the event of a disaster or public health emergency.

Upon notification of a public health emergency, the Director will initiate the staff call down list and coordinate county needs with each EOC liaison. Appropriate information for the disaster will be pulled from the plan and received from the five counties. It will then be copied and distributed to each EOC liaison. Calls will be made to trained behavioral health professionals and crisis technicians and assignments will be made as requested from the five counties through the State DHMH EOP and/or the Maryland Volunteer Corps/MD Responds.

Mid Shore Behavioral Health will either directly do the following or ensure these activities are conducted:

- Serve as the lead for Disaster Mental Health working within ESF-8.

- Assess the behavioral health needs of emergency workers and victims following an emergency, considering both the immediate and cumulative stress resulting from the emergency.
- Coordinate behavioral health activities among response agencies.
- Provide outreach to serve identified behavioral health needs.
- Coordinate behavioral health support for workers and families, as appropriate.
- Provide advice to the community for dealing with the event.
- Coordinate the dissemination of public education on critical incident stress and stress management techniques through the County PIO or a Joint Information Center.
- Arrange for state-licensed medical and behavioral health support personnel, as requested.
- Arrange for counseling and crisis intervention to emergency victims in mass care settings.
- Coordinate increased staffing of telephone hotlines, as necessary, to field incoming calls.
- Assess and communicate the needs of the Department's residential populations.

Immediate and Intermediate Actions

Upon notification of a potential or evolving incident, each Health Department will activate according to its Emergency Operations Plan (EOP). If the incident requires a behavioral health response, the Health Department will notify MSBH who will then activate under guidance from the ESF 8 lead. The MSBH Director (or designee) will oversee all requests to the EOC for behavioral health resources and will be the main point of contact for coordination of behavioral health services during the response.

Health Departments will coordinate with MSBH to identify the nature, scope, and severity of the incident, as well as to conduct a disaster behavioral health needs assessment. Information gathered should include:

- Extent of physical damage and/or other types of impact on individuals and the community
- Location of different types of impact
- Number of individuals likely to have immediate disaster behavioral health needs
- Diverse populations, special needs, priority groups for intervention
- Response sites being set up and services planned by other agencies/organizations
- Assistance expected or requested by other agencies/organizations
- Availability of behavioral health staff and volunteer responders in the impacted areas
- Availability of staff and resources in non-impacted areas

In coordination with the EOC, MSBH will be responsible for determining the settings where behavioral health needs should be addressed. Locations may include:

- Site where the incident occurred
- Locations where impacted individuals are gathering
- Shelters and feeding sites
- Family assistance centers
- Medical settings including points of dispensing (PODs)
- First responder respite sites
- Locations of routine assembly (such as churches and schools)

Community Behavioral Health

Once the appropriate service settings have been identified, MSBH will mobilize and deploy qualified behavioral health personnel to respond to the behavioral health needs of the community. The range of behavioral health services to be provided includes outreach, Mental Health First Aid, Psychological First Aid,

triage, assessment, crisis counseling, and referrals. Services will be carried out in accordance with MSBH emergency response plans.

The primary objective of behavioral health interventions immediately following an incident will be to facilitate emotional stabilization. Once an individual has achieved some degree of emotional stability and can verbalize and process limited information, interventions will aim to alleviate distress and help with problem-solving and recovery.

As required and depending on the scope of the emergency, the Emergency Support Function 8 will activate MMPH volunteers through the state EOC, the DHMH EOC, or directly through the DHMH OP&R to support behavioral health response in the community. These volunteers might be directed to, for example:

- Greet individuals who arrive at PODs, shelters, health care sites, hospitals, feeding sites, first responder respite sites, or other locations, as necessary
- "Float" in these locations to help, answer questions, and observe individuals for stress or other problems
- Provide MHFA & PFA as necessary and appropriate
- Refer individuals who exhibit extreme signs of distress to the Behavioral Health Supervisor in charge
- Distribute behavioral health information throughout the community (e.g., flyers or brochures)
- Staff a telephone hotline

As requested by the EOC, the Red Cross will mobilize their Disaster Mental Health (DMH) volunteers to support the response. DMH personnel can provide interventions such as crisis counseling, MHFA, FA, psychological triage and referral, condolence visits, and psychoeducation to responders and the community in accordance with established guidance (see ARC *Disaster Mental Health Handbook*). Assistance can be provided on scene, by telephone, or through follow-up interviews. If a shelter is opened, the Red Cross will ensure that a licensed behavioral health professional is always on site. If the number of Red Cross DMH personnel is insufficient to support the response, regional resources may be utilized.

In conjunction with their role in Emergency Support Function 8, MSBH will communicate and coordinate with (but have no direct operation authority with) the Talbot County Schools Critical Incident Response Team (CIRT), local professional volunteer organizations, charitable groups, and faith-based teams to provide short and long-term interventions for specific populations as needed.

Communication

Each county has a designated Public Information Officer (PIO) through which information should be relayed to the media. In addition to MSBH, other sources may release information, but it is imperative, to reduce panic and confusion within the community, that releases be coordinated among the agencies, preferably at the Incident Command Center. MSBH will provide examples of public health information messages regarding behavioral health matters when requested by the PIOs. MSBH will coordinate with the county PIO to disseminate behavioral health information and guidance to affected residents, response personnel, and the general public, including:

- Stress symptom identification
- How to cope with emotional reactions to the incident
- Where and how to access behavioral health services
- Issues related to children, their families, and teachers
- Issues related to special needs
- Dispelling rumors

Radio and television stations, websites, computer aided dispatch, Emergency Alert System cable interrupt, etc., will be utilized by the Local Health Department to disseminate information to the public.

In addition to English, the main languages spoken in the mid-shore area are Spanish, Haitian Creole, Vietnamese, Mandarin, and Russian. A list of persons in the community who speak foreign languages, as well as those who know sign language, can be accessed through several services including the Network of Care's Statewide Interpreter listings, Language Link, the Deaf Independent Living Association (DILA), and the Cultural Resource Information System (CRIS).

Media briefing will be conducted as necessary at the Incident Command Center with alternate sites at the service provision locations.

If needed, the county can set up a hotline to answer questions and provide information on local behavioral health services. The county may also rely on hotlines (identified earlier) to provide residents with additional information and referrals for behavioral health services in the area.

The Executive Director is the Public Information Officer for MSBH, with the Deputy Director the secondary PIO.

Death Notification

Health Department and MSBH staff/volunteers typically do not deliver information regarding deaths, but they may participate on teams that accompany the person responsible for this notification. Behavioral health responders may provide support to the family receiving the news and, at times, to those persons conducting the notifications. In some cases, MSBH staff/volunteers may be able to provide information on specific cultural or ethnic customs regarding the expression of grief and rituals surrounding death and burial.

Responder Behavioral Health

Personal stress management is a key mechanism in preserving responders' abilities to perform and function effectively. During an incident, response personnel will be encouraged to self-monitor for symptoms of stress and fatigue using a self-monitoring checklist and to take actions to maintain their psychological well being. Supervisors should be attentive to stress responses among their staff.

As described above, Critical Incident Stress Management (CISM) teams and/or the Mobile Crisis Teams (MCT) may be activated to provide support to responders, including post-incident stress defusing, demobilization, and debriefing, to first responder units (e.g., Fire, EMS, Police). Health Department personnel who are involved in response or who are affected by the incident may also receive behavioral health support from these teams. The Maryland Department of Health and Mental Hygiene will activate CISM members, if needed, in response to notification from Fire/Police dispatch or at the request of the EOC.

MSBH and MPVC volunteers who need behavioral health support will be encouraged to access the behavioral health services and resources available to the wider community. Formal psychological debriefing (or the use of techniques that include trauma remembrance) will not be part of the standard behavioral health response.

Red Cross DMH personnel will provide behavioral health exit interviews to Red Cross relief workers during their out-processing.

On-Site Incidents

Several possible incidents (e.g., natural disaster, fire, explosion, workplace violence, threats, and medical emergencies) may occur at Health Department or other agency locations and many of these incidents have

the potential to raise levels of stress and anxiety among staff, volunteers, and clients. MSBH may provide behavioral health guidance for on-site incidents.

Special Needs Populations

The following are potentially vulnerable populations that may require additional support:

- Age groups (children and seniors)
- Cultural and ethnic groups (recent immigrants, non-English speakers, undocumented residents, etc.)
- Low-visibility groups (homeless, unemployed, cognitively impaired, etc.)
- Individuals with persistent mental illness or substance abuse disorders
- Group residential facilities (hospitals, nursing homes, and correctional facilities)
- Human service, healthcare, and disaster relief workers

Hospitals, nursing homes, group homes, ambulatory care centers, schools, religious centers, and other facilities that provide behavioral health care to special needs populations may be damaged or destroyed or may be overwhelmed in dealing with the response to the incident. These facilities are expected to maintain plans to ensure continuity of behavioral health services for the populations they serve.

Continuity of Operations

In addition to meeting behavioral health and broader public health needs that may emerge in the community following a disaster, Mid Shore Behavioral Health must ensure that its essential other services are maintained. MSBH has a Continuity of Operations Plan (COOP) that addresses these issues, whether a disaster or emergency impacts their agency directly or impacts the services it can provide. The COOP prioritizes services provided by the agency and describes processes for maintaining their critical functions during an incident, including prioritizing the services it supports with other agencies.

Post-Emergency Period (Recovery)

Priorities during this period will be focused on continuing to provide essential behavioral health care and aid in the restoration of the area's behavioral health care delivery capacity. Disaster behavioral health services may need to continue beyond the immediate and intermediate phases of the response for weeks, months, and even years, depending on the nature of the incident. MSBH will continue to act in a coordinating role with behavioral health, private sector, and other government and partnering agencies when addressing the long-term needs of the community.

The methods utilized will depend on the incident; however, recovery actions should include:

- Ensuring that normal functions are restored as quickly as possible to provide needed services to the community.
- Providing extensive and continued public education regarding the behavioral health impact/risks of the event and the community resources available to help individuals cope.
- Continuing to support the staffing of family assistance centers (if established) so that behavioral health professionals may provide ongoing counseling to residents and response personnel.
- Supporting ongoing hotline staffing to provide support and appropriate referrals.
- Renewing outreach and resilience efforts that were in place prior to the incident.
- Assisting, if needed, in community memorial and commemoration activities.
- Evaluating the disaster response and developing recommendations to improve planning, response, and recovery.

If it is a nationally declared emergency, MSBH will assist with the application process for federal assistance and will be involved locally with the administration of the FEMA funded disaster crisis counseling and training grants and/or monitoring the grant programs and financial expenditures as well as preparing the mandated reports for the federal government will be implemented.

Reporting

In addition to reports that may be required by DHMH, MSBH will coordinate to provide regular behavioral health situation reports to the EOC during the incident.

Operational Records

The operational records generated during a behavioral health response will be collected and filed in an orderly manner by ESF-8. A record of events is kept in order to determine the possible recovery of emergency operation expenses, to document response costs, to assess the effectiveness of operations, and to update emergency plans and procedures. Administrative records will be kept in accordance with established practices.

Clinical Records

Clinical records will not be created or maintained for individuals receiving mental health first aid, psychological first aid, crisis counseling, etc. during the response. Instead, MSBH will track individual and group encounters using SAMHSA-developed data collection tools. The full manual and toolkit are available at http://www.samhsa.gov/dtac.

Documentation of Costs

Response costs and expenditures will be documented in accordance with established practices and forwarded to the appropriate ESF Group Supervisor during the incident. Expenses incurred in carrying out behavioral health services for certain hazards may be recoverable through FEMA or a third party. Hence, all agencies should maintain records and/or substantiating documentation of personnel time expended, equipment used, and supplies consumed during the response.

Grant Funding

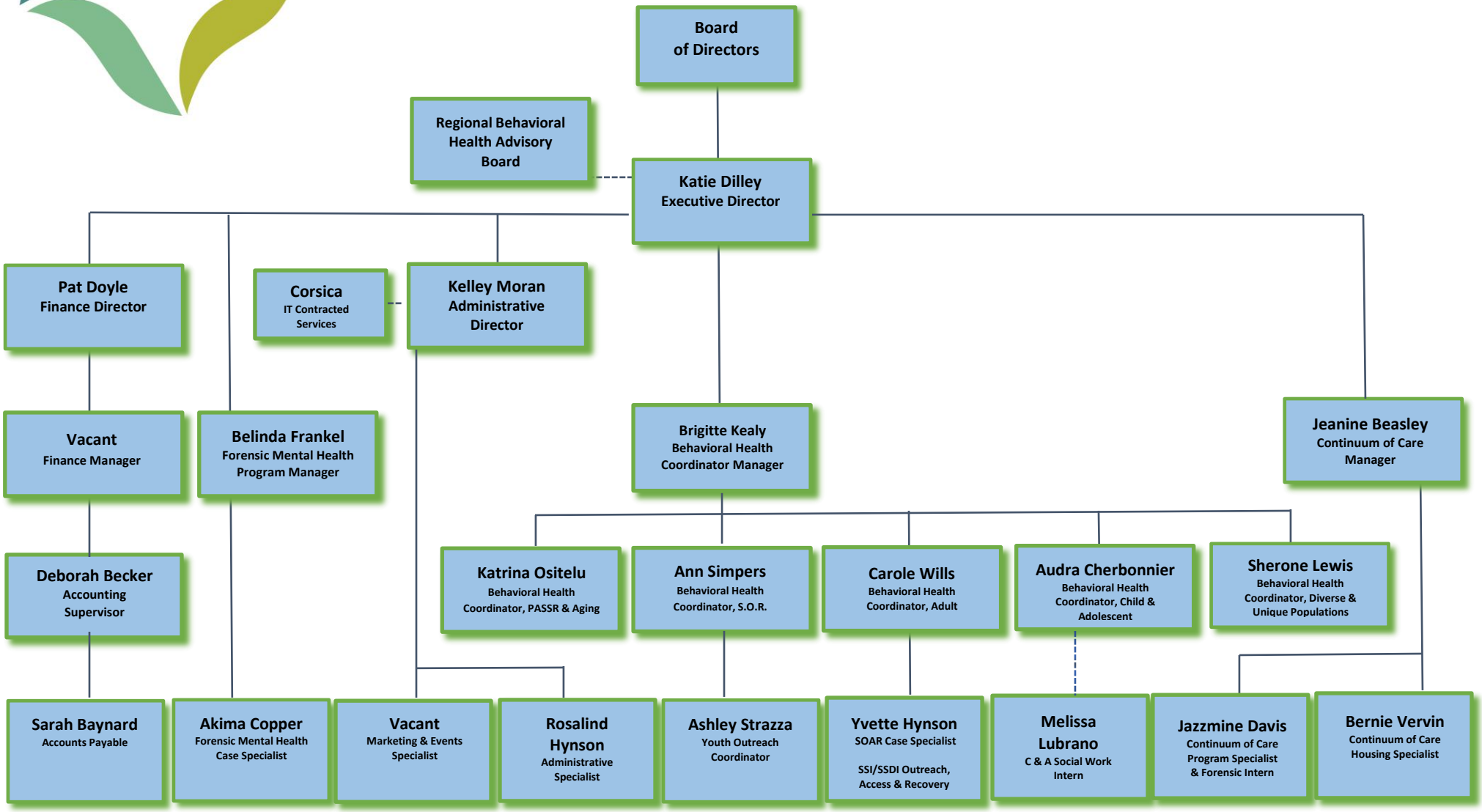
In the event of a presidentially declared disaster, federal funding may be available for crisis counseling and education through the FEMA Crisis Counseling Assistance and Training Program (CCP). SAMHSA Emergency Response Grant (SERG) funds may also be available and do not require a presidential disaster declaration. MSBH, in concert with the Office of Emergency Management, will be responsible for coordinating any documentation required by the State to receive grant funds.

VII. PLAN REVIEW

This plan will be reviewed annually by Mid Shore Behavioral Health in January. MSBH will take the lead in training, exercising, and planning maintenance efforts for this plan.

MID SHORE BEHAVIORAL HEALTH, INC.

ORGANIZATIONAL CHART



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Regional Behavioral Health Advisory Committee

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DORCHESTER **Jennifer Berkman** Eastern Shore Area Health Education Center 814 Chesapeake Drive, Cambridge, Maryland 21613 (W) 410-221-2600, Ext. 108 jberkman@esahec.org Hospital Representative T1 Exp. 6/30/23	DORCHESTER **Omeaka Jackson** Harvesting Hope, Inc. 204 Cedar Street, Suite 102 Cambridge, MD 21613 (W) 443-351-4846 harvestinghopeinthecommunity@gmail.com Mental Health Professional T2 Exp. 6/30/22	KENT **Alice Barkley** A.F. Whitsitt Center 300 Scheeler Rd Chestertown MD 21620 (W) 410-810-7654 Alice.Barkley@maryland.gov Addictions Professional T2 Exp. 6/30/22	KENT **Maggie Thomas** QAC Local Addictions Authority 205 N. Liberty St Centreville, MD 21617 (W) 410-758-1306 maggie.terzaghi@maryland.gov T1 Exp. 6/30/22
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Chair	Maggie Thomas – 1st Term Exp. 6/30/2022	Vice-Chair	Brooks Robinson- 1st Term Exp. 6/30/22

Sub-Committee Members

Nominating Committee
Brooks Robinson
Wilber Levengood
John Plaskon

UPDATED 8/13/20

REGIONAL BEHAVIORAL HEALTH ADVISORY COMMITTEE REPORT – 2020-2021

Pursuant to the Annotated Code of Maryland, Health General, Title 10, Subtitle 308 - Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties have established a local mental health advisory committee, for the purpose of advising and assisting in the planning and evaluation of publicly funded mental health and substance-related disorder services. The Regional Behavioral Health Advisory Committee (RBHAC) serves that purpose and thus meets the requirement. The committee is closely aligned with and receives outstanding support and guidance from the Board of Directors and staff of, Mid Shore Behavioral Health, Inc. (MSBH). The RBHAC desires to support and encourage MSBH and the Mid Shore Planning Collaborative as they work to implement the FY2022 Community Behavioral Health Plan for the mid-shore of Maryland.

The chair and members of RBHAC appreciate the tremendous amount of effort that has been put forth to make behavioral health integration successful on the mid-shore. While the population of the area covered is relatively small, the task is large. The reach includes five counties, five health officers, five Local Drug and Alcohol Abuse Councils, the five Local Addiction Authorities, a Core Service Agency with staff and a board and a large RHBAC. Each entity comes with customers, consumers, constituents, and providers. While regionally close and with some similar underlying concerns (e.g., lack of behavioral health resources, opioid crisis, etc.), the region's presenting problems are often varied, and locally preferred solutions are even more different. This past year, the emergency response and community and provider support the was needed to address the impact of COVID-19 strengthened the partnerships and collaboration across the five counties. If one thinks about it, the task of bringing the five jurisdictions together to unite two very different health systems across five varied counties with unique needs is a feat that would seem impossible.

The mid-shore's behavioral health community is fortunate to have intelligent hard-working leaders who are able to maintain focus on what will be best for the consumers and the region. They make serving the consumer and positive health outcomes, either related to mental health or addictions, the target. The RHBAC appreciates the hard work of Mid Shore Behavioral Health's Board and staff, the Health Officers, Local Addiction Authority Directors, and the members of all the Boards and staff who did this work and made sacrifices. We appreciate what they have done and are hopeful that this resolve will continue as we all work to implement the Fiscal Year 2022 Community Behavioral Health Plan.

The RHBAC fully supports the Fiscal Year 2022 Community Behavioral Health Plan. We recognized the enormity of what this year's plan represents and are proud to be a part of the work. Substance abuse and mental health efforts were brought together in an intentional effort to make the citizens of this region healthier with improved opportunities for well-being. The ultimate result of this historic unification should be increased resources for the mid-shore resulting in better outcomes. RBHAC stands behind the five MSPC goals for FY2022 and plans to follow developments closely to help ensure the progress continues and that desired results occur.

The RBHAC continues to be aware of the seven system integration management domains that serve as the FY2022 goals as presented by the Behavioral Health Administration of the Maryland Department of Health and plans to do their best to maintain a focus within those domains as behavioral health integration efforts continue. The RBHAC is especially well suited to work within domains numbered four, five and six which represent quality, public outreach, and stakeholder collaboration respectively. Additionally, domain one, Governance, and it's relevance with the role of the Advisory Committee in the supportive role as guiding and supporting MSBH and MSPC.

The Regional Behavioral Health Advisory Committee convened six times in from 2020-early 2021. Two special meetings were convened specific to for reviewing of nominating committee, and the other was an orientation meeting for new members. Each meeting was robust with discussion, reports, and updates. Each meeting agenda began with welcome and introductions and ended with roundtable updates from all committee members.

<u>The group received presentations and held discussions around the following topics:</u>

- Local and State Behavioral Health Systems Updates: Behavioral Health Coalition, Regional Hospital Focus Group, COVID-19 Behavioral Health Response
- Mid Shore Planning Collaborative FY21 Annual Plan Implementation
- FY21 Community Behavioral Health Plan Implementation and CLC Workgroup Discussion
- RBHAC Membership: New Membership Recruitment May 2020: Special Nominating Meeting and July 2020: New Member Special Orientation Meeting
- MSBH Award Updates and Funding Discussion FY21
- Mid Shore Planning Collaborative Updates
- CLC Workgroup: Diversity and Inclusion Priorities
- Addressing Systematic Racism
- New Continuum of Care Awards/Resources Homeless Services
- Going Purple Together
- State Behavioral Health Systems Updates
- State Opioid Response Grant Part II and Opioid Operational Command Center Grants
- Youth Outreach Coordinator and Programs Update
- Special Presentation: Corsica River Mental Health: Caring Connections Program
- State Behavioral Health Systems / Advisory Councils Integration Efforts
- FY22 Annual Community Behavioral Health Plan Goals & Objectives Review
- FY20/FY21 RBHAC Year- in - Review Highlights

On December 21, 2020, the RBHAC met for a scheduled meeting with a special focus on highlights for the year. The following are highlights for the RBHAC for FY20-FY21:

1. FY21 Combined Community Behavioral Health Plan Presentation: February 4, 2020
2. RBHAC Membership

3. COVID-19: Addressing the impact of the pandemic on the behavioral health community and needs of our constituents. In addition, the success of the committee to remain active and engaged with virtual meetings.
4. Adapting to the need to rapidly pivot and address unique provider needs as a result of the pandemic impact. For example, the PPE distribution initiative in the mid-shore region.
5. Addressing unrest in our nation and prioritizing our commitment to addressing disparities and discrimination in our communities.
6. Shelter and Homeless population concerns: Shelter expansion and resource supports with COVID-19. Addressing "policing of homelessness" and advocating for this to be addressed.
7. Governance: Transition of Chair Role July 1, 2020: Endorsement of leadership role to Maggie Thomas, Director of Addiction and Prevention Services Local Addictions Authority Queen Anne's County Department of Health
8. Ongoing collaboration and strategic planning to address the need for workforce and psychiatric recruitment in the mid-shore/Eastern Shore region of Maryland.

<u>The RBHAC has endorsed the three-to-five-year goals of MSPC for FY22:</u>

1. Community- Enhance the health and wellness of our mid-shore community.
2. Social Determinants-Strategically address the impact of social determinants across the lifespan.
3. Services-Build and support a regional behavioral health system of care.
4. Integration-Implement an integrated systems management structure.
5. Workforce-Collaborate to expand and sustain a dynamic rural workforce.

A key component of the Behavioral Health Advisory committees across the State of Maryland is to help move the field towards "a culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members." The Regional Behavioral Health Advisory Committee of the mid-shore is welcoming this priority for another year and is sensitive to the urgency to make this work a priority in the communities that we represent.

With gratitude, hope for future opportunities to collaborate, the RBHAC said goodbye to a long-standing member and Chair, Mike Clark. Mike's term expired this year. Mike is an active and passionate member of the committee and engaged in the mid-shore community in his role as Chief of Housing & Family Services QAC Department of Community Services – Division of Housing & Local Management Board. The RBHAC is very grateful for Mike's leadership and service and ongoing advocacy for mental health both in the local community and at the State level.

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DRUG & ALCOHOL ABUSE COUNCIL

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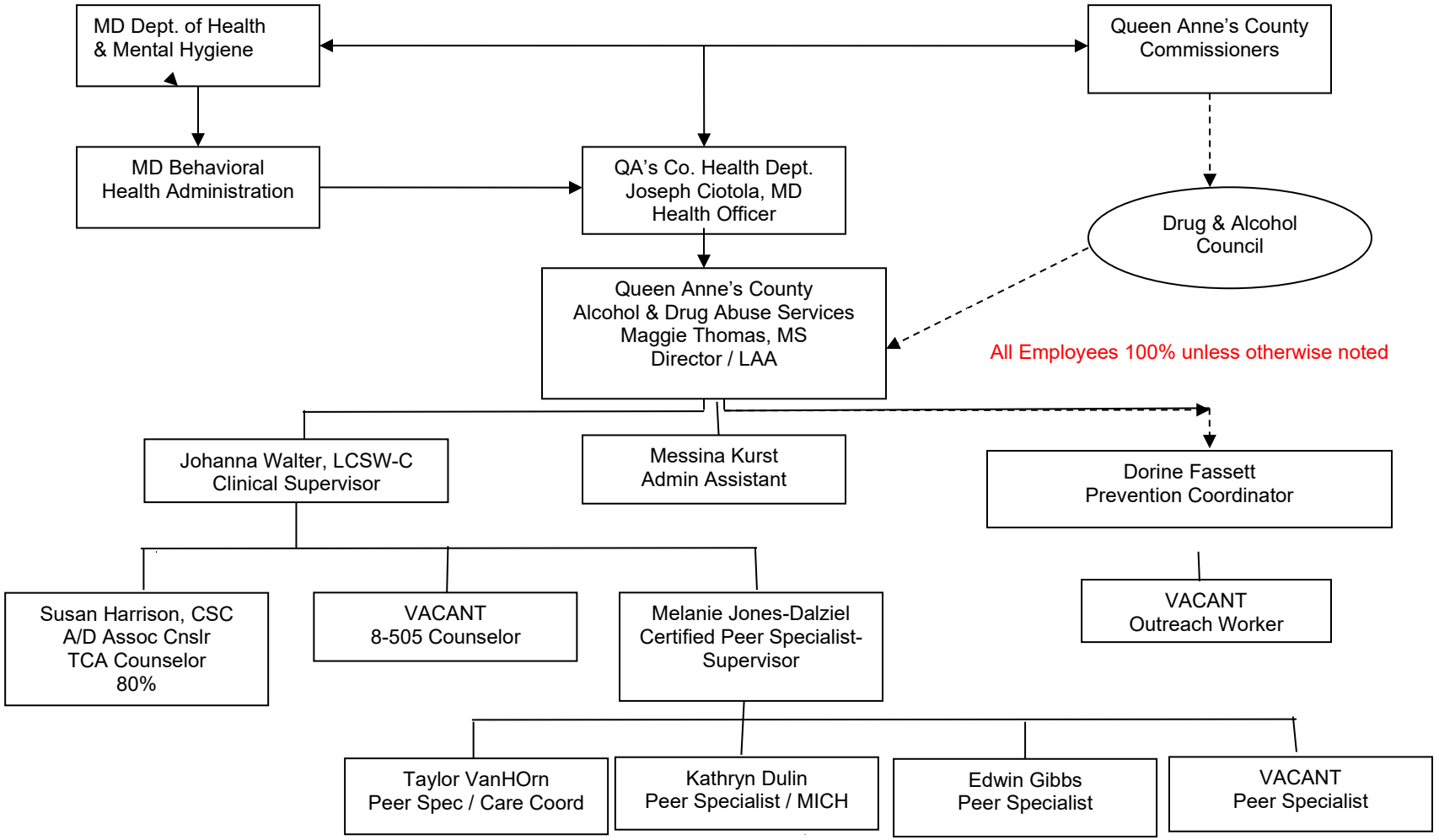
ORGANIZATIONAL CHART

QUEEN ANNE'S COUNTY ALCOHOL & DRUG ABUSE SERVICES

January, 2021



QAC LDAAC / Org structure blurb

Queen Anne's County is the hub for information, treatment services and support for all residents. The agency supports walk-in clients, although during COVID restrictions, the buildings are temporarily closed to the public, outside of necessary appointments. Phones are answered during normal business hours and staff are able to perform duties remotely. Clinicians and peer support staff are available to assist with referrals to all levels of treatment, 8-505s, TCA, Recovery housing, transportation, Care Coordination, and MAT program information and case management. Referrals for treatment are based on the needs of the client, level of care that is deemed appropriate, and client choice.

The peer specialist presence in Queen Anne's County has increased exponentially and positively impacted the care and services residents receive. The peers are involved in all local leadership committees and councils, providing their lived experience to ensure that the services and experiences are meaningful and well received.

The focus of services for SUD in Queen Anne's County is on the person as a whole, meaning that the public health crisis of both somatic and behavioral health matter when supporting clients towards a life in recovery. With the move to tele-support for peer based support groups, the need for additional groups arose. A support group focused on MAT recipients was created, which provides a space for those in recovery, who are not comfortable in a traditional 12 step group.

The peer overdose response has been successful in offering overdose survivors support and treatment options. While each survivors path to recovery may look different, the peers support specialists provide knowledge of the treatment system and other available wrap around services, to support the person achieve their goals. While COVID has prevented the peer support specialists from meeting face to face with the survivors, both telephonic and following up after they are released from the ED continues to ensure that services are accessible.

The peers are vetted through Shore Regional Health System as 'volunteers' and are allowed to enter the emergency department as a part of the 'care team'. This encompasses three locations: Chestertown, Queenstown ED, and Easton. As our county is located directly across from Anne Arundel Medical Center and is a different system than Shore Regional, our Mobile Integrated Community Health (MICH) team is able to reach out to those who are transported to that site for follow up and service assessment and provision.

Harm reduction efforts in Queen Anne's County began in the past two years through Naloxone distribution and the availability of Fentanyl Test Strips. Due to COVID and the anticipation of increased substance use. The peers partnered up with a local agency hosting food drive through events, and offered Naloxone and CPR training – distributing approximately 500 doses in three months. In addition, safe disposal items, such as Deterra bags, along with educational materials were also provided to the public.

Queen Anne's County's Department of Health serves as the Local Addiction Authority. The responsibilities are for systems management for the county. Planning, overseeing programs both internal, and at partner provider sites, along with monitoring publicly funded SUD services in the county.

In addition, investigation of complaints, participation in audit reviews and exceptions for needs requests that are for those who are uninsured are duties that are included.

The strategic plan for the county is created through the receipt of date from local councils and boards, as well as data from partner agencies. Planning together with partner agencies, councils, and committees form the outline for service provision. This plans is also adopted by the combination Local Drug and Alcohol Abuse / Opioid Intervention Team meeting as well. Entities that contribute to the information obtained for this plan is the local Drug Free Coalition, the Liquor Board, the Regional Behavioral Health Advisory Council, the Board of Education and special committees that focus on needs identification, Wellness Coalition, the Judiciary system, Law Enforcement, Medical and Behavioral Health Providers, Emergency Services, OMPP, Addictions Consortium of the Eastern Shore, Child Fatality Team, and Department of Social Services.

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Joe Gamble, Vice Chair
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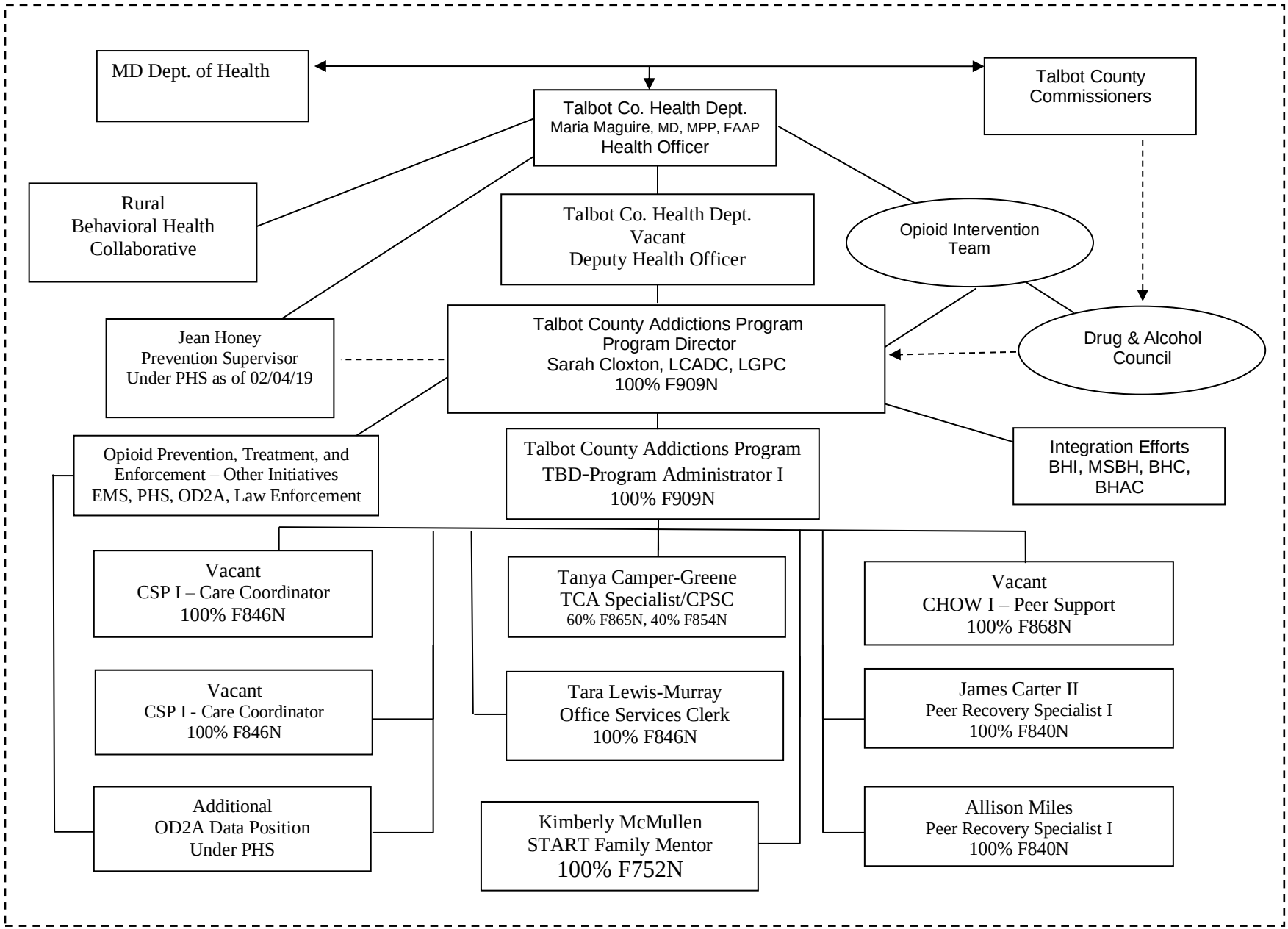
TALBOT COUNTY ALCOHOL & DRUG ABUSE SERVICES
ORGANIZATIONAL CHART FY2021
February 10, 2021



Talbot County Health Department Emergency Response

The Talbot County Health Department Programs and Services follow the Comprehensive Emergency Management Plan, Emergency Support Function #8 – Public Health.

The Emergency Management Division is responsible for the planning, assignment, and coordination of all available resources in an integrated program of mitigation, preparedness, response and recovery for all emergencies and disasters whether from a terrorist attack, man-made, or natural disaster.

The Emergency Management staff is also responsible for staffing, training and operating the Emergency Operations Center (EOC). The EOC is the facility from which the County or other governmental organizations' emergency response is controlled, coordinated, and directed.

TCHD employees serve on the Local Emergency Planning Committee (LEPC) who is responsible for preparing a regional hazardous materials emergency response plan, serves as a repository for regional hazardous materials information, and performs outreach functions to increase hazardous materials awareness.

The following are ways Talbot DES will communicate with the public for pending or existing emergency situations.

- Press Releases issued through local newspapers, radio, television, and social media
- Situational Awareness Advisories to key groups and organizations who relay messages to the community
- Emergency Alert System - The is a National System that allows for the preemption of radio and television
- Everbridge Citizen Alerting System – To activate all land line telephones and to send voice, text, and email messages to those who sign up for the free service Everbridge
- Community Alert Sirens – These are the same sirens used by the Volunteer Fire Companies to alert them for Fire and Rescue calls. When activated to alert the Community there is a different signal emitted.

In addition to providing backup communications after a disaster, the Radio Amateur Civil Emergency Service (RACES) is also used for less-than-catastrophic emergencies when additional communications bandwidth may be required. For example: If Red Cross Shelters are opened during a winter storm or flood, RACES would provide radio communications between the Emergency Operations Center (EOC) and the shelters in order to leave the public safety radio system's bandwidth available for first responders. It is also common for cell and landline phones to be overwhelmed and inoperable during certain incidents and subsequent media frenzy. Amateur frequencies are always available for emergency communications.

Talbot County
Comprehensive Emergency Management Plan
ESF# 8 – Public Health

Primary Agency: Talbot County Health Department

Support Agencies:
Medical Examiner's Office
Maryland Institute for Emergency Medical Services Systems
Department of Emergency Services
Law Enforcement
Talbot County Public Schools
Talbot County Roads
Fire Service
Department of Social Services
Red Cross
PIO

I. PURPOSE

This ESF discusses the overall coordination of emergency health and medical services from local agencies.

II. SITUATIONS AND ASSUMPTIONS

Talbot County is vulnerable to both natural and man-made disasters, which may not only have the potential for mass casualties, but may also lead to an increase in health hazards, i.e., disease, sewage and waste disposal, and vermin and vector control.

Most local medical systems have the capabilities necessary to respond to the health and medical needs associated with emergency situations. However, when an emergency is of such magnitude as to exceed local capabilities, assistance will be needed from State and federal agencies.

III. CONCEPT OF OPERATIONS

A. Possible Threat

Depending on the type of threat, the actions taken during this phase will range from monitoring the situation to partial mobilization. As appropriate, the following actions should be taken at both the State and local levels:

1. Notify the appropriate response agencies including health and medical facilities.

2. Alert the Director of the Talbot County Department of Emergency Services if the Talbot County Health Department receives the initial notification of the incident.

3. Review the plans and procedures.

4. Check readiness of emergency health services facilities, supplies, and equipment.

5. Brief County Officials on the nature of the possible health threat.

6. Coordinate the release of information and advisories with the local PIO.

B. Imminent Threat

As appropriate, local organizations will:

1. Initiate actions listed under "Possible Threat" if not previously accomplished.

2. Activate emergency plans and mobilize emergency health personnel.

3. If there is a defined risk area, position monitors or observers with the appropriate equipment.

4. Provide emergency health information.

5. Notify the Director of the Maryland Emergency Management Agency (MEMA)

C. Emergency Situation

1. Initiate actions listed above.

2. The County Health Officer will determine the need for additional resources.

3. The County Health Officer may direct health protection measures including evacuation and/or quarantine, but will consult with the President of the Talbot County Council and the Director of Emergency Services before issuing such orders.

4. The County Health Officer may issue any orders he/she deems necessary to protect the health and safety of the public.

5. If the Talbot County Health Department determines that the health and medical needs exceed local capabilities, assistance from State agencies may be requested through the Talbot County Director of Emergency Services.

6. Reduce the patient population in hospitals, nursing homes and other health care facilities if evacuation is necessary and continue medical care for those that cannot be removed.

7. When mass casualties are involved:

   a. Fire and rescue services responding first to the incident will determine the number of casualties, request additional assistance, establish staging areas and initiate triage procedures.

   b. The Maryland State Police (MSP) will assist local police and/or the Talbot County Sheriff in control of the disaster scene, and administer first aid to the injured until additional EMS personnel arrive at the scene.

   c. The County Medical Examiner will activate and supervise temporary or permanent morgues. A Forensic Investigator will act in the absence of the County Medical Examiner.

   d. The County Medical Examiner will take charge of all bodies or parts of bodies and provide for the identification and disposition of the deceased. A Forensic Investigator will act in the absence of the County Medical Examiner.

   e. The Talbot County Health Department will coordinate with the local PIO to provide information to friends and relatives of the injured.

   f. The Talbot County Health Department will obtain information concerning the medical facilities to which the injured were taken, lists of the dead and descriptions of the unidentified dead.

   g. MSP will assist local police in notification of the next of kin. Should the deceased be a resident of another state, MSP will forward the information to the State Police of the appropriate state.

8. When the emergency involves significant health hazards, the Talbot County Health Department will, as appropriate, carry out the following activities:

   a. Initiate epidemic control measures, i.e. quarantines and mass immunizations.

   b. Sample, test and control food, water, milk, livestock feed, waste and refuse disposal, and provide vermin and vector control.

   c. Identify disaster areas where access should be restricted.

D. Recovery

The following actions will be taken at the local level:

1. Determine if a continuing health problem exists requiring an on-going commitment of resources, or if there is a potential for new problems to develop, controls may be continued or new ones imposed.

2. Determine impact of damage on providing health and medical services. Damage assessment information should be provided as soon as possible to Emergency Services and forwarded to MEMA.

3. If the emergency involved mass casualties activate ESF 9 and:

   a. The Talbot County Health Department, in cooperation with Mid Shore Mental Health Systems Inc., will implement crisis counseling for disaster workers or victims.

   b. The County Medical Examiner will provide guidance for determining suitable sites for temporary cemeteries, if necessary. A Forensic Investigator will act in the absence of the County Medical Examiner.

4. If the emergency involved a health hazard, the following actions will be taken to protect the health of the public:

   a. Determine suitable sites and acceptable procedures for the disposal of hazardous materials.

b. The Talbot County Health Department will coordinate the monitoring of those exposed to health hazards for long-term health problems.

c. The Talbot County Health Department will provide public health awareness information.

IV. ORGANIZATIONAL RESPONSIBILITES

A. General

The Talbot County Department of Emergency Services is responsible for coordinating the County response to an emergency or disaster. Within that coordination:

1. The County Health Officer is responsible for the overall direction and control of health related personnel and resources committed to the emergency health and medical service efforts.

2. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) is responsible for supporting local Emergency Medical Services and coordinating emergency medical care for the critically ill or injured throughout the state.

B. Responsibilities

1. County Health Officer

a. Assist EMS providers in triage and casualty management.

b. Provide mobile emergency medical teams in cooperation with the local hospitals and local fire/rescue organizations.

c. Control distribution of medical supplies, equipment and pharmaceuticals as necessary.

d. Establish a medical/health section in the Emergency Operations Center (EOC).

e. Provide first aid and other medical needs at mass care and reception centers.

f. Supervise all environmental health activities to assure the safety of the citizens and the protection of the environment.

g. Assess the emergency medical or health protection needs and survey the damage to water systems, wastewater systems and health facilities.

h. In cooperation with Mid-Shore Mental Health Systems, Inc., provide crisis counseling for disaster workers and victims.

i. Request assistance from the State in providing services essential to disaster operations, including medical supplies, personnel, hospitals, mortuary services, refrigerator trucks, and so forth.

j. Determine the emergency capabilities of hospitals, nursing homes and other medical facilities.

k. Coordinate a system of victim tracking and release of information with the local PIO, County Medical Examiner (or Forensic Investigator), hospitals and EMS providers.

2. Medical Examiner's Office (or Forensic Investigator)

a. Coordinate with the Talbot County Health Department in designating and supervising permanent and temporary morgues, supervise the collection, identification, release and/or interment of the dead.

b. Provide the County Health Officer with a listing of the identified dead and descriptions of the unidentified dead.

c. Insure that the supplies, equipment and resources necessary to deal with the deceased are available.

3. Maryland Institute for Emergency Medical Services Systems (MIEMSS)

a. Upon request of the County Health Officer, assist and augment the local emergency medical services system.

b. Coordinate the provision of additional EMS support to the critically ill and injured patients as directed when local resources request assistance.

4. Law Enforcement (Sheriff, Local Police, and MSP)

   a. Provide security and law enforcement at disaster scene.

   b. Provide traffic control at disaster scene and shelter sites as necessary.

   c. Conduct such activities as blood runs, physician transports and communications backup as necessary.

   d. Provide helicopter and medical support.

5. Fire and Rescue Service

   a. Maintain fire suppression and prevention activities.

   b. Provide basic life support trained personnel as needed.

   c. Conduct rescue operations as necessary.

6. Talbot Co. Public Schools

   a. Provide buses for medical evacuation of uninjured or slightly injured disaster victims.

   b. Provide school facilities for use as secondary or tertiary triage areas.

7. Talbot County Roads

   Upon request, assist Fire and Rescue Services with special equipment and crews needed in rescue operations.

8. Maryland Department of Agriculture

   Upon request:

   a. Provide vector and vermin control, provide mosquito control to coastal or swampy areas.

   b. Provide technical assistance to the Talbot County Health Department and to the Department of Natural Resources in the identification of dangerous chemicals and pesticides.

c. Assist the Talbot County Health Department in sampling and controlling food, water, milk and livestock feed which may have become contaminated.

10. U.S. Department of Health and Human Services

a. Alcohol, Drug Abuse and Mental Health Administration

Assist State and local agencies and private mental health organizations in applying for assistance in the event of a major disaster. Provide services either directly, or through financial assistance, including professional counseling services to victims of a major disaster and training of disaster workers to provide these counseling services.

b. Health Facilities Damage Assessment Team

Provide health and safety teams to determine the extent of damage to health facilities in the disaster area and advise on the administrative, operational and staffing requirements needed to return the damaged facility to operation during the emergency.

11. U.S. Department of Agriculture

a. Provide emergency control or eradication of disease, pests and biological or chemical agents to protect livestock and poultry.

b. Provide for the protection of crops and plant products from disease, pests and biological or chemical agents.

c. Provide, through the Cooperative Extension Agency, information on the mitigation, preparation, response and the recovery from disaster such as floods, hurricanes, winter storms, etc. The Disaster Handbook for extension agents provides information on such emergency health related needs as sanitary precautions, insect, snake and rodent control, sewage and garbage disposal, etc.

d. Provide inspections to assure the wholesomeness of meat and meat products and poultry and poultry products.

12. Ministerial Association

a. Provide chaplain services at the disaster site.

b. Organize use of church facilities for possible triage sites.

13. Talbot County Department of Social Services

Provide trained staff to open and operate public shelters, if necessary.

14. Red Cross

Assist Social Services in public shelter operations, if necessary.

15. Maryland State Funeral Directors Association

a. Provide guidance and assistance in establishing temporary or permanent morgues.

b. Provide embalming services at temporary or permanent morgues.

c. Maintain lists of resources for supplies and equipment necessary to deal with a mass fatality situation.

V. ADMINISTRATION AND LOGISTICS

A. Medical supplies and equipment

1. The Talbot County Health Department will contract for bulk supplies of medicines and other supplies as necessary.

2. Materials, equipment and funds provided through federal/State cooperative disease programs will be coordinated with the U.S. Public Health Service, Region III, by the Talbot County Health Department.

B. Reports and Records

1. Vital statistics will continue to be collected by the Talbot County Health Department.

2. Data concerning outbreaks of disease or epidemics will be collected by the Talbot County Health Department and forwarded to the appropriate State and federal officials.

3. Lists of casualties, triage tags, etc., will be collected by the Talbot County Health Department.

4. Damage Assessment reports will be forwarded to the MEMA through the Director of Talbot County Department of Emergency Services.

5. Records pertaining to costs of aid or resources provided by State and local agencies will be collected by the respective agency and forwarded to appropriate State or federal officials.

6. When there has been a Presidential Declaration, portions of the costs incurred may be eligible for federal reimbursement.

   a. Costs incurred by local health departments should be reported to the Director of the Talbot County Department of Emergency Services and the Maryland Department of Health and Mental Hygiene.

   b. Costs incurred by the State Health Department should be reported to the Director of MEMA.

VI. PLAN DEVELOPMENT AND MAINTENANCE

The agencies identified in this ESF are responsible for working with the Talbot County Emergency Services Director in the development and maintenance of this ESF.

Mid Shore Planning Collaborative

Agenda

March 31, 2020

- BHA Approval Call-April 21st
- Finance Plan follow up — Katie/Pat
- FY21 Goal Point persons — Sherone
- Goal Tracking sheet — Jazzmine
- FY21 CBHP Timeline (mthly/qtrly) — Sherone
- CLC Strategic Plan implementation
- FY21 launch event, Wednesday, July 1st?

Action Items:

Zoom link: https://zoom.us/j/877263358

Next mtg--May 29th?

Mid Shore Planning Collaborative

Agenda

April 14, 2020

- BHA Approval Call-April 21st
- FY21 Goal Point persons — Sherone
- Goal Tracking sheet review — Jazzmine
- FY21 CBHP Timeline (bi-monthly) — Sherone
- CLC Strategic Plan-workgroup ideas — Sherone
- FY21 (virtual) launch event, Wednesday, July 1st-

Action Items:

Zoom link:

Next mtg—April 24th

Mid Shore Planning Collaborative

Agenda

May 12, 2020

CLC Strategic Plan-implementation and workgroup ideas

Open Discussion: implementing the FY21 plan amid COVID

Monthly Challenges/Awareness events

FY21 virtual *launch event*, July 1st (any ideas)

Next mtg—May 26th

FY21 Mid Shore Planning Collaborative Update

August 11, 2020

Agenda

A. Introductions

B. Meeting Purpose: **Share status of the FY21 CBHP and recommit to the Integration planning process.**

C. MSPC Progress since January 6th meeting:
- March 31st, two meetings in the months of April, May, and June
- July 6th-10th, FY21 Goal meetings
- Implementation amidst COVID restrictions
- FY21 Cultural and Linguistic Strategic Plan (Workgroup)

D. Integration (Goal 4)
- Local Systems Integration Workgroup-Strategy 1A
- Strategy 1B-Behavioral Health Regional Needs Assessment
- Objective 2-RBHAC, LDAAC's, MD's Local Advisory Council Subcommittee, integrated Board of Directors
- Objective 3-Financial Planning-who are the key persons from each agency?
- Objective 4-Program planning, utilizing data, coordinating with the ASO, formalized contract monitoring, quality assurance practices with accreditation and licensure, complaint management
- Draft Timeline for 3-5 year Integration process

E. LAA Director Report out

F. Local Systems Management Integration Self-Assessment-October

G. FY21 CBHP implementation meetings (quarterly-September, January, April, June)

H. FY22 Planning process (usually November, when BHA sends the Guidelines)

Save the Date:

Tuesday, August 25th (11am-12:30pm)-Cultural and Linguistic/Diversity/Inclusion Workgroup

“Diversity & Inclusion” Workgroup

“Sometimes, we don’t know what we don’t know”.

August 25, 2020

Mid Shore Planning Collaborative

Welcome

- What is the Mid Shore Planning Collaborative?

- **Intended impact:** "To educate and to raise awareness among community stakeholders and service providers. To provide services-increasing CLC provided to consumers throughout the region. Encourage participation of consumers."

- Insert the logos here.

FY21 Community Behavioral Health Plan

- The Behavioral Health Administration requires that we create a yearly plan that holds mental health and local addiction authorities accountable to the communities they serve. The annual Community Behavioral Health Plan (CBHP) is usually done separately by those local authority agencies (core service or Health Department). The FY21 CBHP was created jointly by the Mid Shore Planning Collaborative: MSBH, Caroline, Dorchester, Kent, Queen Anne's and Talbot County Local Addiction Authorities (LAA).
- **BHA Plan Guidelines**
- **FY21 CBHP Goals, Objectives and Strategies**
- **CLC Strategic Plan**

MSPC FY21 Community Behavioral Health Plan

Goals:

1. **Enhance the health and wellness of our mid-shore community.**
2. **Strategically address the impact of social determinants across the lifespan.**
3. **Build and support a regional behavioral health system of care.**
4. **Implement an integrated systems management structure.**
5. **Collaborate to expand and sustain a dynamic rural workforce.**

Important terms:

- ***Culture*:** Shared, patterned history of reproduced symbols and practices that facilitate *meaningful human existence*. Ex Deaf, Millennials, LGBTQ, Veterans, minorities
- ***Linguistic Competence*:** "the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate and individuals with disabilities" (Goode and Jones, 2004)
- ***Race*:** Arbitrary category of a group of people, based on observable physical differences (skin tone, eye shape, bone structure, hair texture); social construct; 5 identified in the U.S.
- ***Structural Racism*:** "systems and structures that have procedures or processes that disadvantages African Americans." Derek Johnson, NAACP President
- **Privilege:** something that is not earned or necessarily deserved but is granted.

Social Determinants of Health

- "The conditions in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality of life outcomes and risks."
- Examples:
  - Adverse Childhood Experiences and other Trauma
  - Racism and racial discrimination
  - Alcoholism

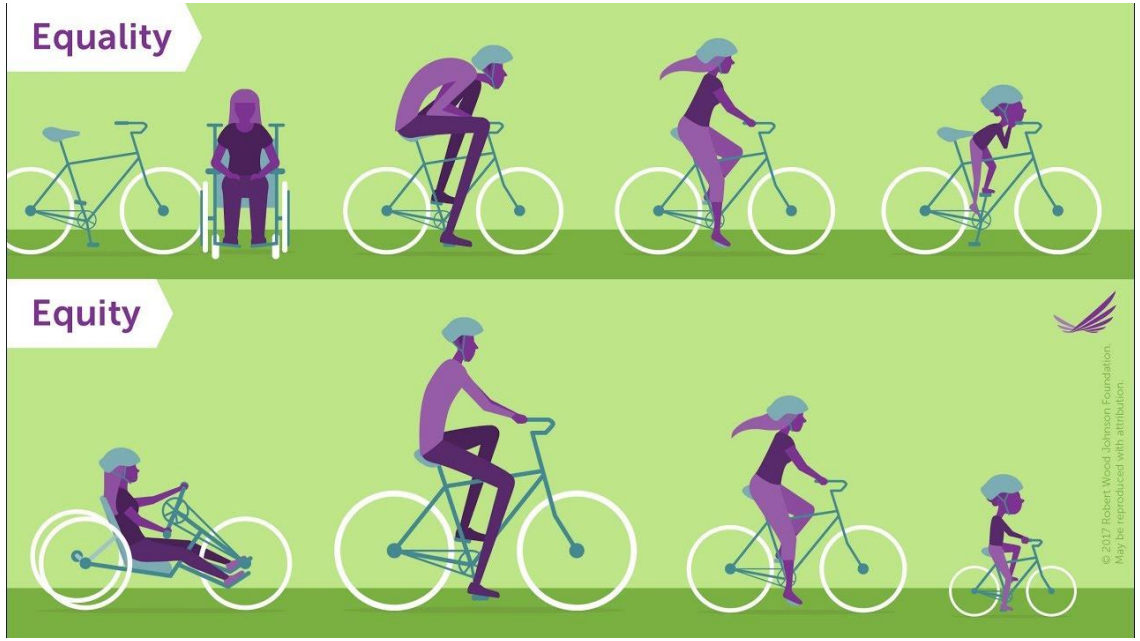
- Health equity: social justice in health, no one is denied possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged.

- Health inequities: avoidable inequalities in health between groups of people…arise from inequalities within and between societies.

- Health disparities: the differences in health status between people that are related to social or demographic factors (race, gender, income).

**Information from the Opioid Operational Command Center, Webinar February 27, 2019

Equity: "The quality of being fair and impartial."



Equality

The assumption is that **everyone benefits from the same supports**. This is equal treatment.

Equity

Everyone gets the supports they need (this is the concept of "affirmative action"), thus producing equity.

Justice

All 3 can see the game without supports or accommodations because **the cause(s) of the inequity was addressed**. The systemic barrier has been removed.

The Cultural Competence Continuum

- Racism/Ethnocentrism
- Incapacity
- Blindness
- Awareness
- Sensitivity
- Reciprocity
- Competence

- I treat people who are different than me in dehumanizing manner on purpose.
- It is hard for me to work with people from other cultures.
- Everyone is the same-there are no differences. I do not see color, I just see a person.**
- I know others have cultures and some cultural practices are different than my own.
- I am committed to using appropriate responses to cultural differences. However, I still need to learn more.
- I respect cultural differences and am continuously expanding cultural knowledge and resources. I engage in self-reflection.
- I highly regard cultural differences, I collaborate with others on developing procedures and policies that allow us to provide effective services to a variety of cultural and linguistic groups.

Adapted from Cross, Bazron, Dennis, Isaacs, 1989

National CLAS Standards

What is CLAS?
Culturally and Linguistically Appropriate Services (CLAS) - a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity.

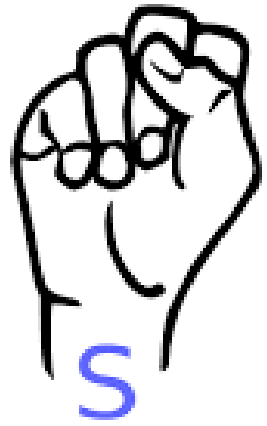
CLAS is about respect and responsiveness: Respect the whole individual and Respond to the individual's health needs and preferences.
Health inequities in our nation are well documented.

The provision of health services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients can help close the gap in health outcomes

*Thinkculturalhealth.org

Diverse and Unique Cultures

- **Military**
- **LGBT+**
- **People of Color**
- **Deaf or Hard of Hearing**



Workgroup Roundtable

- What has/is your agency doing to be more culturally and linguistically inclusive?
- How was your agency/community addressed systemic racism or social injustices?
- What would you like to gain from this workgroup (presenters, information/training)?

Next steps:

- Name the Workgroup…
- Workgroup Schedule (quarterly)
- Purpose/Mission/Vision Statement?

- Any outstanding?...

Action Items:

- …

FY22 Community Behavioral Health Plan

MID SHORE PLANNING COLLABORATIVE (MSPC)

FY22 CBHP Meeting Agenda

- Introductions and housekeeping

Please type your name and the agency you represent in the chatbox. Meeting will be recorded.

- Mid Shore Planning Collaborative
- Strategic Planning: New Developments & Challenges
- FY22 CBHP Goals and Objectives
- Data and Planning
- Cultural and Linguistic Competency Strategic Plan
- FY20 Highlights and Achievements
- Q & A
- Vote to approve CBHP and the approval process

Mid Shore Planning Collaborative

- History
- Local integration
- The FY22 Annual Plan Process
- Future of The Plan

Mid-shore Local Authority Directors

CAROLINE COUNTY-TERRI ROSS, LCSW-C

DORCHESTER COUNTY-DONALD HALL, MHS LCADC

KENT COUNTY-BRENNA FOX, RPS, CPRS

MSBH-KATIE DILLEY, LCSW-C

QUEEN ANNE COUNTY-MAGGIE THOMAS, MS

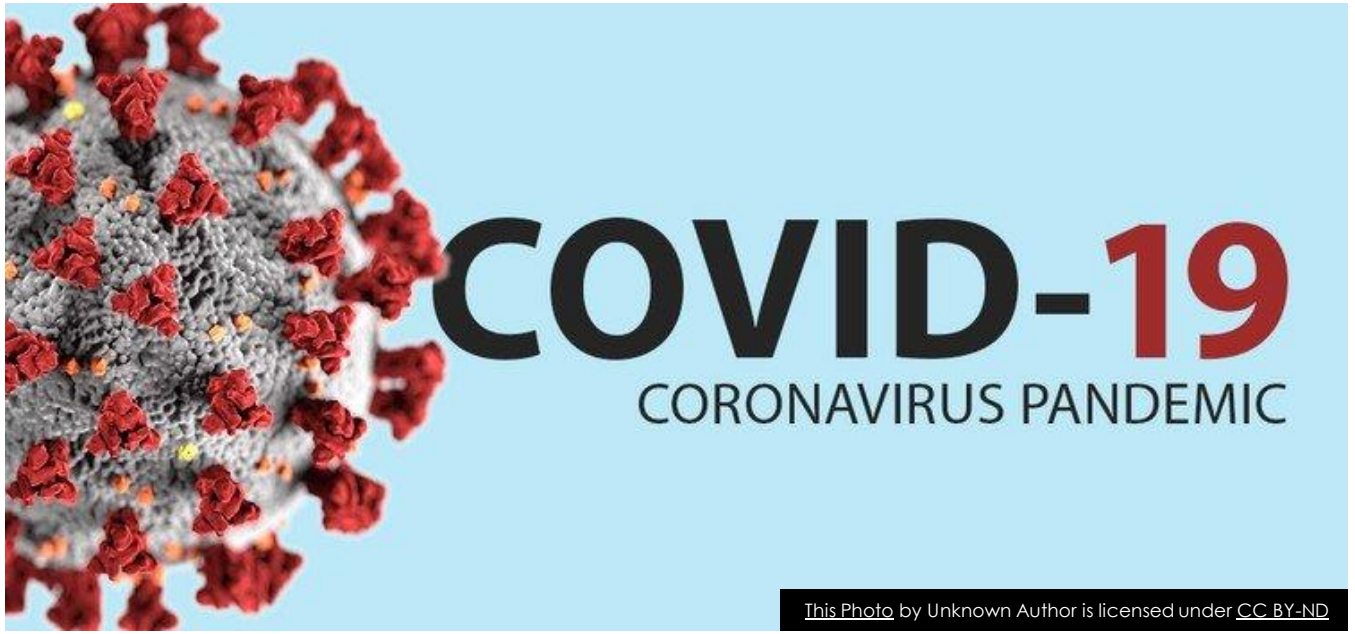
TALBOT COUNTY-SARAH CLOXTON, LGPC, LCADC

Acknowledgements

- MSBH Board of Directors
- Regional Behavioral Health Advisory Council
- Health Officers
- Drug Free Caroline
- Dorchester County Criminal Justice Treatment Network/LDAAC
- Kent County LDAAC
- Queen Anne's LDAAC/OIT
- Talbot County LDAAC

Strategic Planning in COVID

- **New Developments and Challenges**

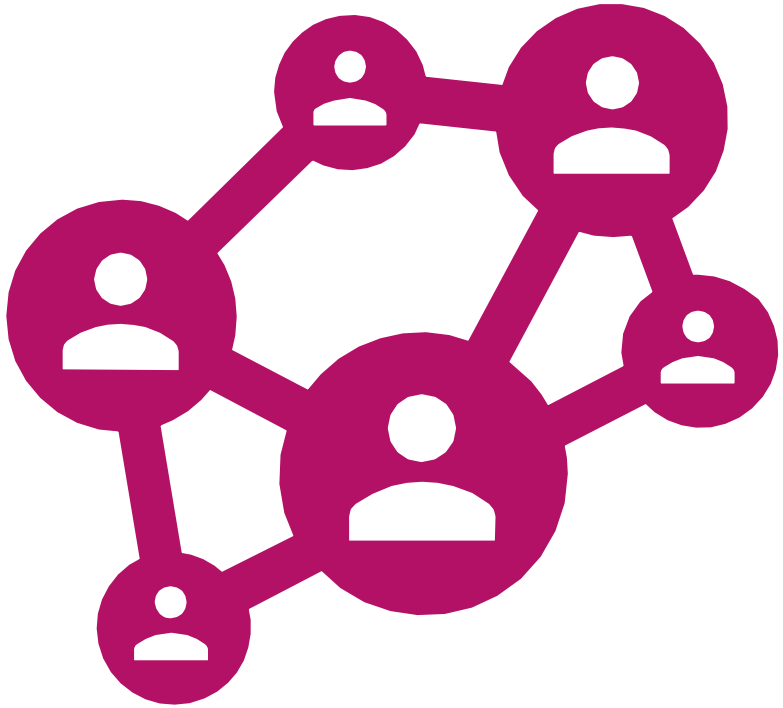


FY22 Mid Shore Planning Collaborative Goals

Community	**Enhance the health and wellness of our mid-shore community.**
Social Determinants	**Strategically address the impact of social determinants across the lifespan.**
Services	**Build and support a regional behavioral health system of care.**
Integration	**Implement an integrated systems management structure.**
Workforce	**Collaborate to expand and sustain a dynamic rural workforce.**

Goal 1: Community

- **Objectives**
  - **Objective 1:** In partnership with consumers, their natural support systems, providers, and the community at large, promote awareness and understanding of behavioral health.
  - **Objective 2:** Collaborate with key stakeholders to expand knowledge of behavioral health among professionals and the community, promoting integrated care and working towards health literacy
  - **Objective 3**: Identify and address the culture of stigma associated with behavioral health in the mid-shore.
  - **Objective 4**: Actively involve members of the mid-shore community in behavioral health systems management.



Goal 2: Social Determinants of Health

- **Objectives**
  - **Objective 1:** Recognize the role of systemic social injustice and racial inequity and how in inhibits wellness in the mid-shore community.
  - **Objective 2:** Address the issue of homelessness in the mid-shore.
  - **Objective 3:** Address the needs of individuals who are impacted by the criminal justice system.
  - **Objective 4:** Work collaboratively with the mid-shore community to promote a Trauma-informed system of care.
  - **Objective 5:** Continue to work collaboratively with local partners to improve the provision of transportation resources.
  - **Objective 6:** Partner in the development of opportunities to support gainful employment of community members in the mid-shore.
  - **Objective 7:** Enhance our relationship with private and public school systems.

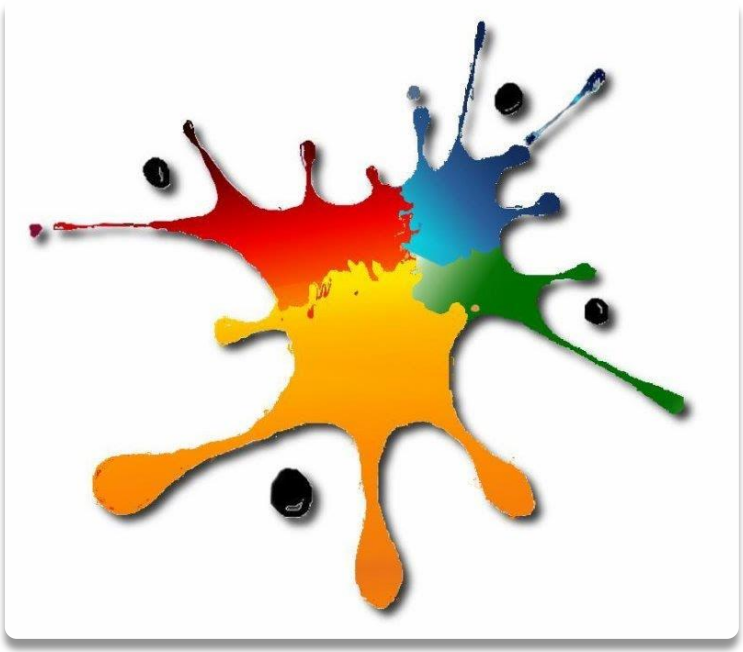
Goal 3: Services

Objectives

- **Objective 1: Promote a "No wrong door" culture across multiple community access points.**
- **Objective 2: MSPC will promote and monitor the development, access and sustainability for the provision of services for the following target populations:**
  - **Maternal Health and Early Childhood**
  - **Transitional-Aged Youth**
  - **Adults**
  - **Aging Population**

Goal 4: Integration

- **Objectives**
  - **Objective 1:** Mid-shore counties local behavioral health managers, will continue to work collaboratively toward regional system integration.
  - **Objective 2:** MSPC will work with system partners to develop and integrated leadership and governance model in the mid-shore
  - **Objective 3:** MSPC will assess, develop and plan for an integrated budget and operational structure.
  - **Objective 4:** MSPC will practice coordinated quality management of our regional behavioral health system.

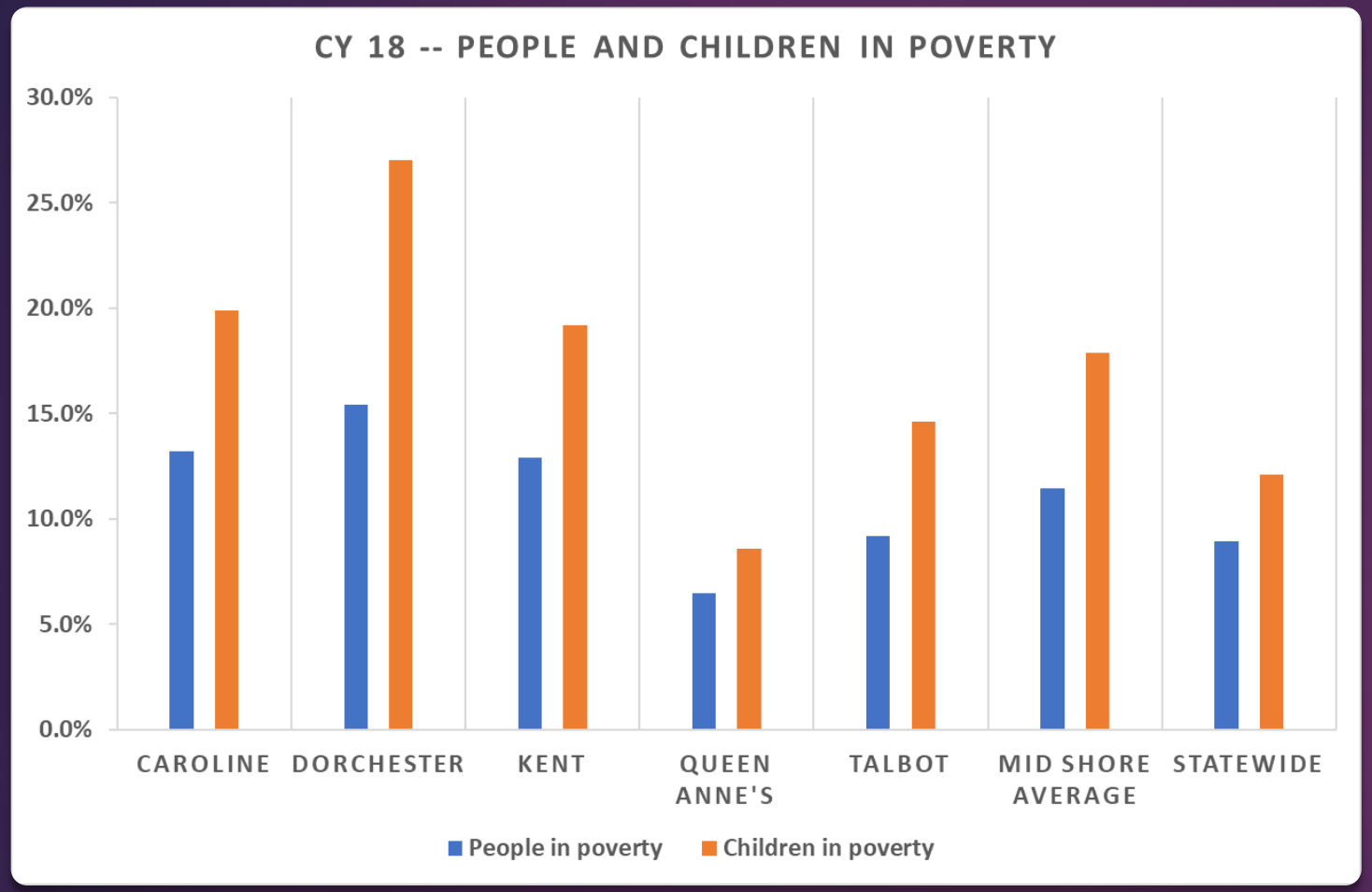


Goal 5: Workforce

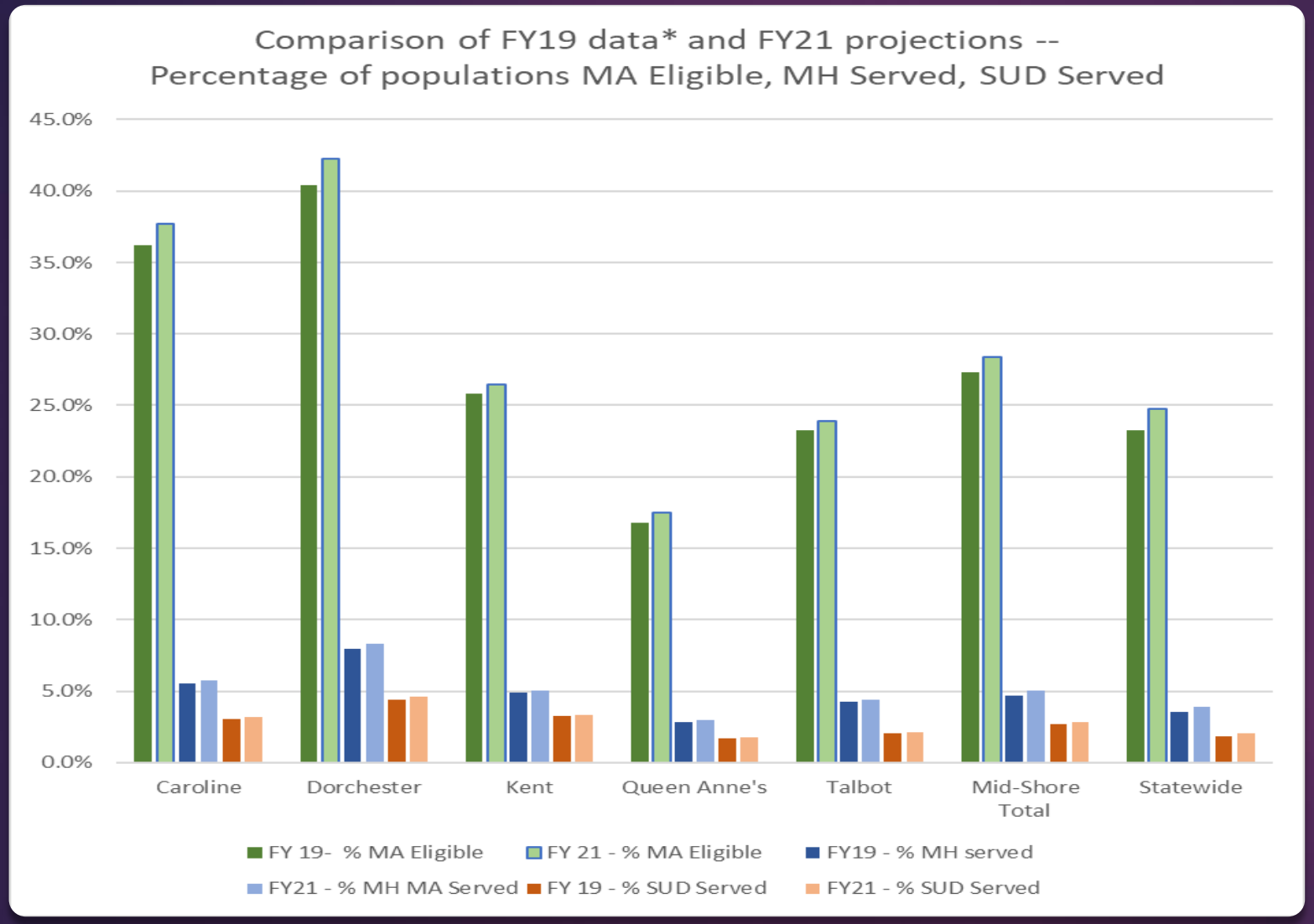
- **Objectives**
  - **Objective 1:** Identify and implement strategies to address the inadequate workforce in our rural region.
  - **Objective 2:** Enhance and sustain our current community workforce.

Data Analysis

- Data collection process-new for FY2022
- Target areas:
  - Health and Behavioral Health Disparities Response
  - Crisis Response & Prevention
  - Overdose Events

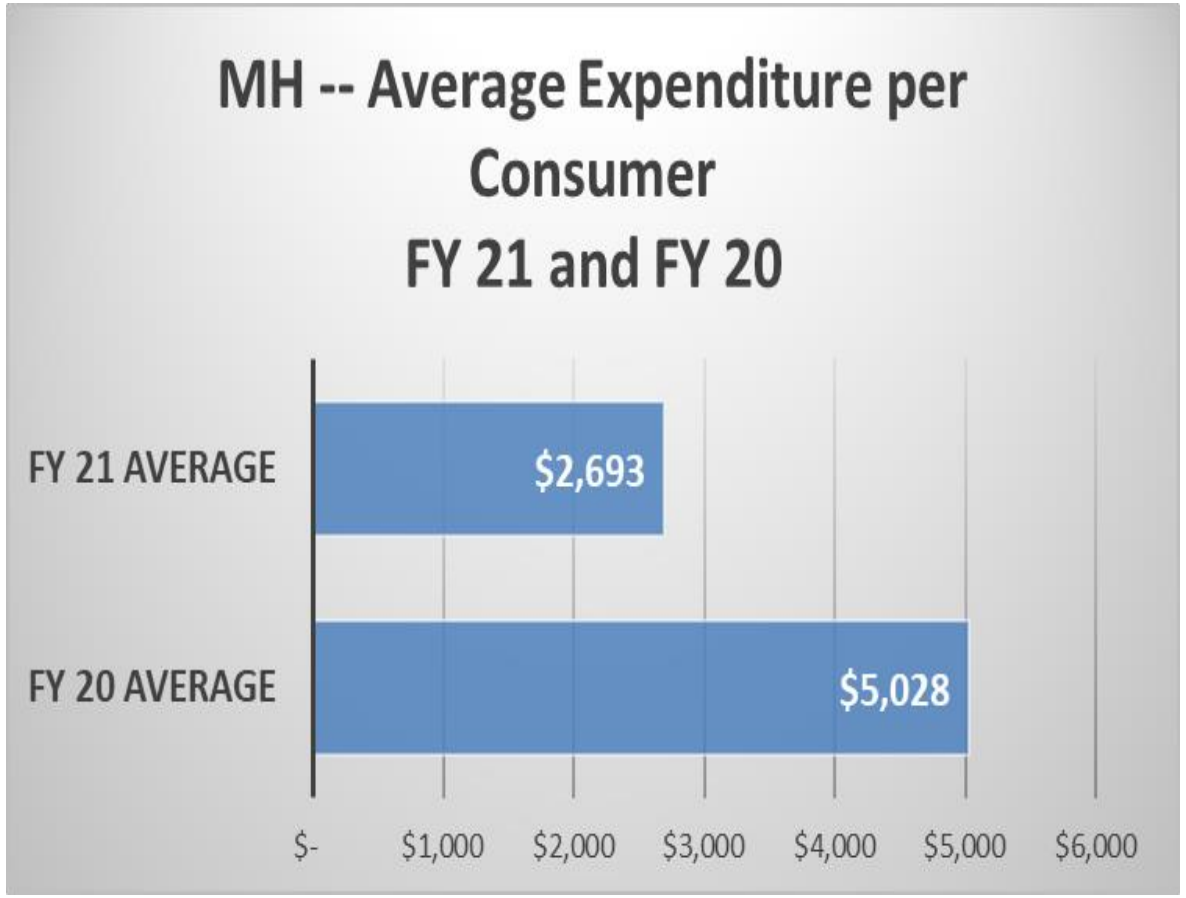


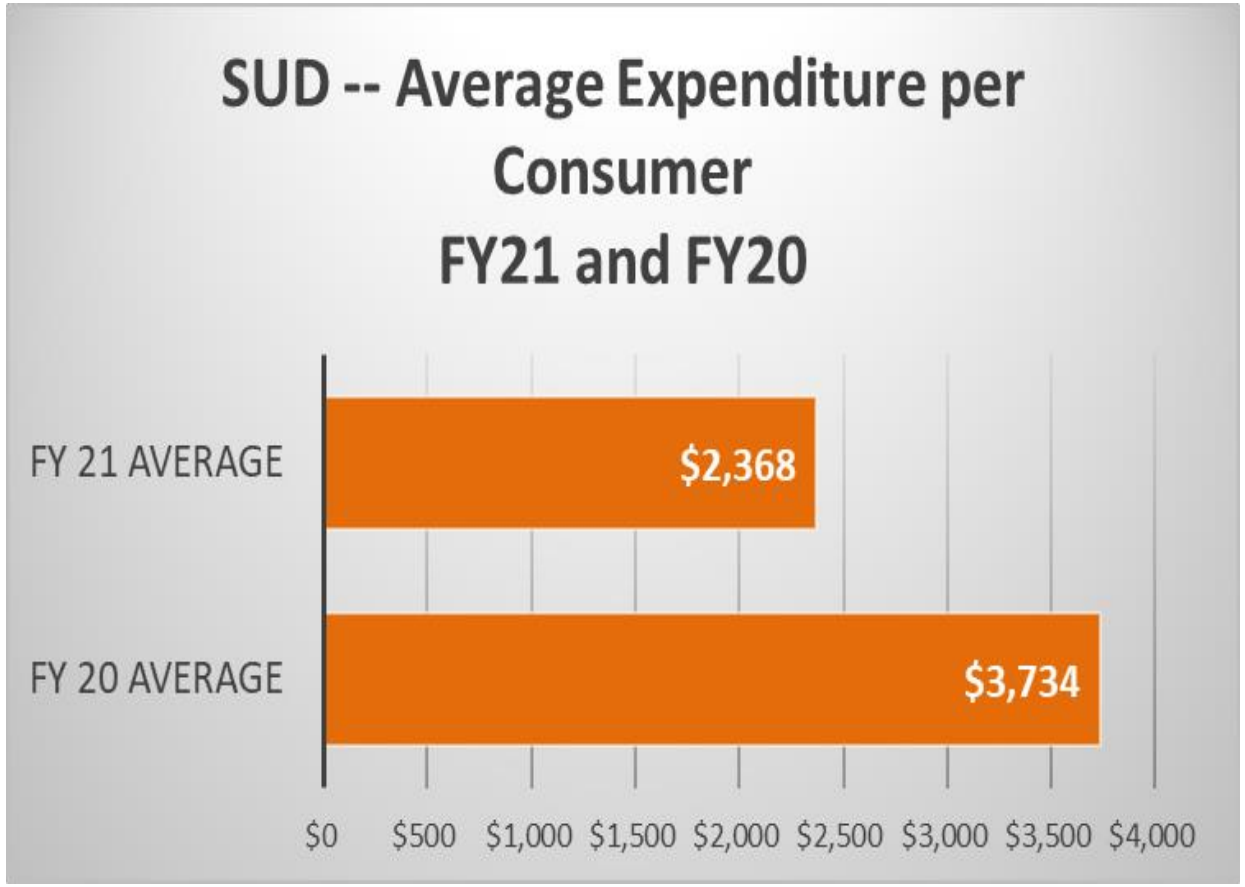
Mid-shore landscape

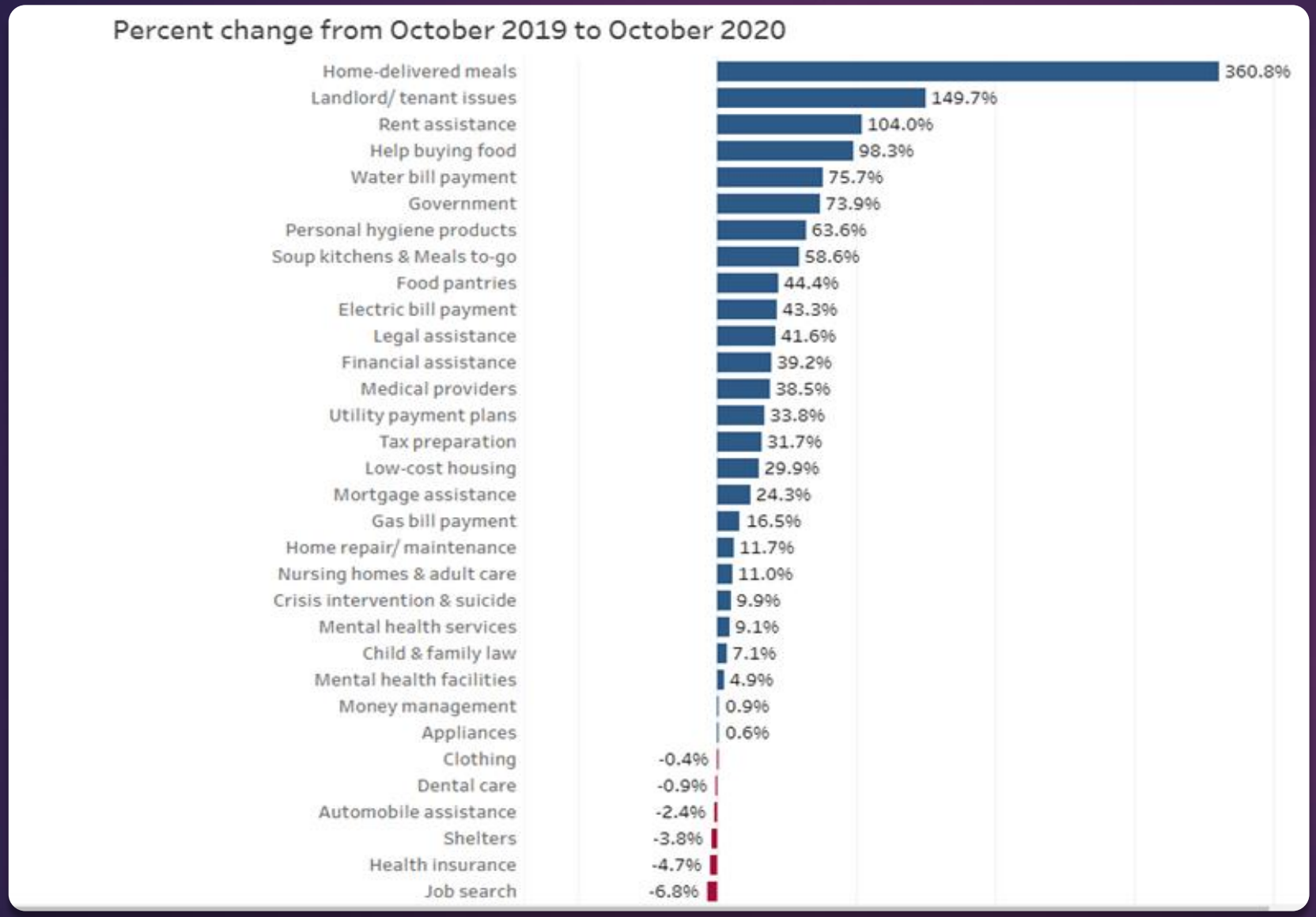


Medicaid: eligible and served

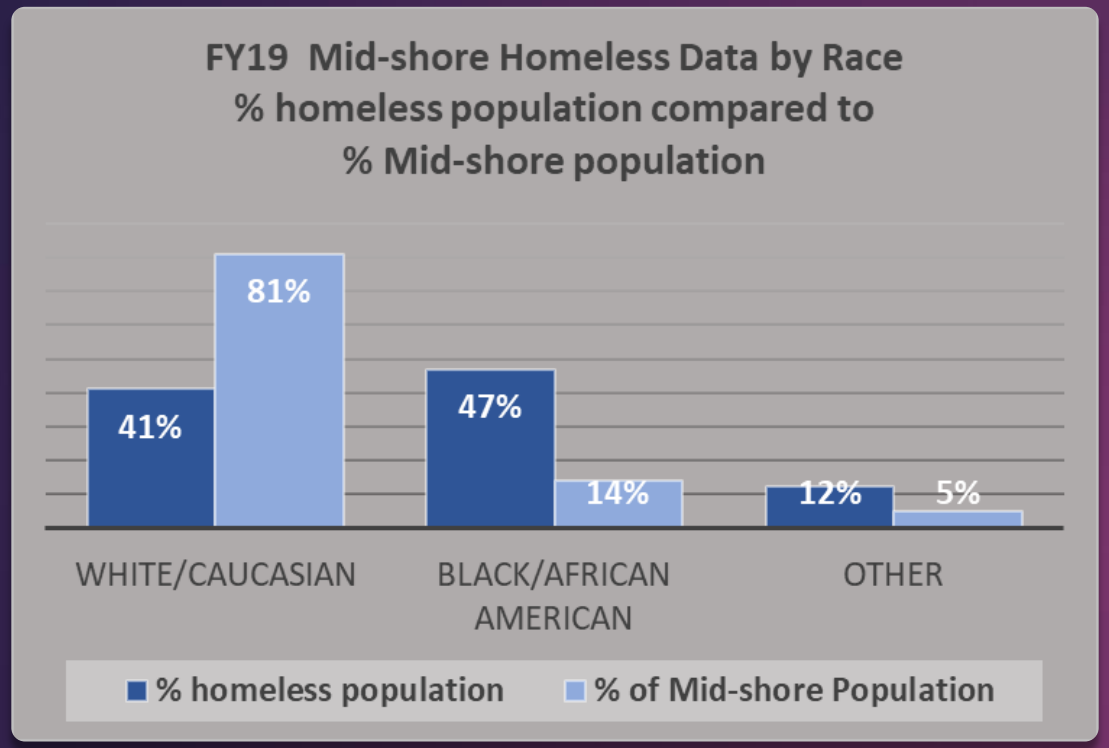
Maryland: expenditure per consumer

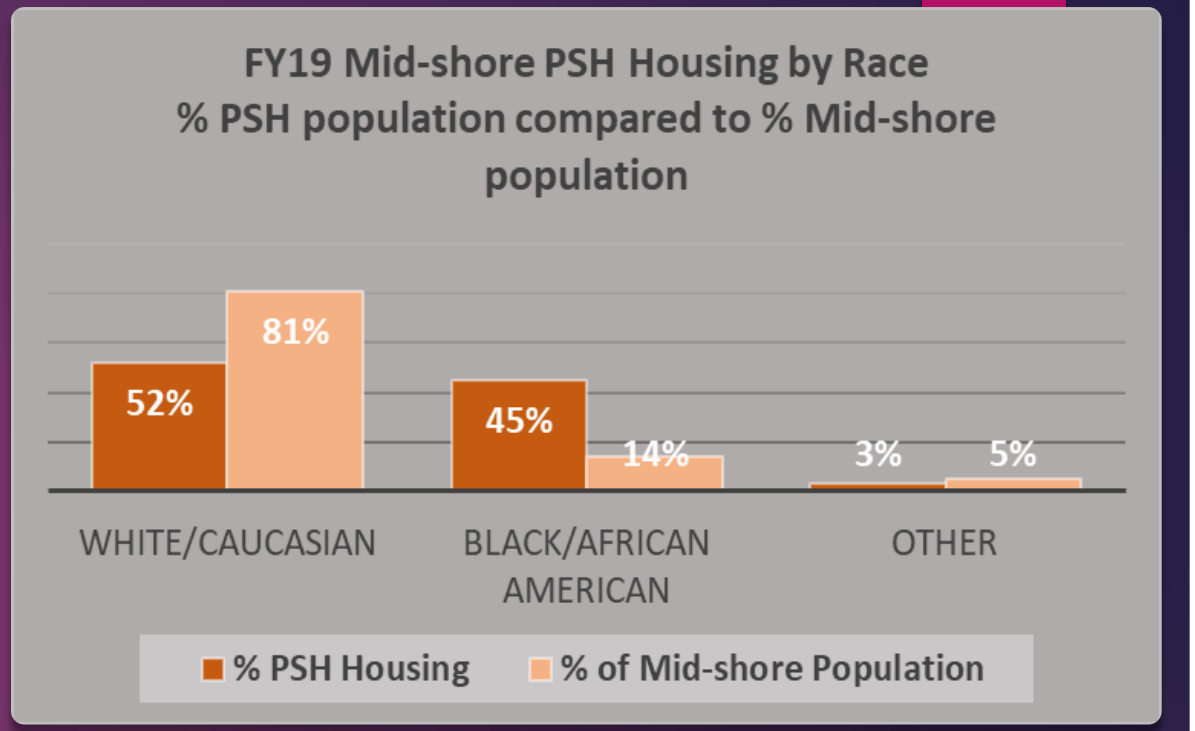






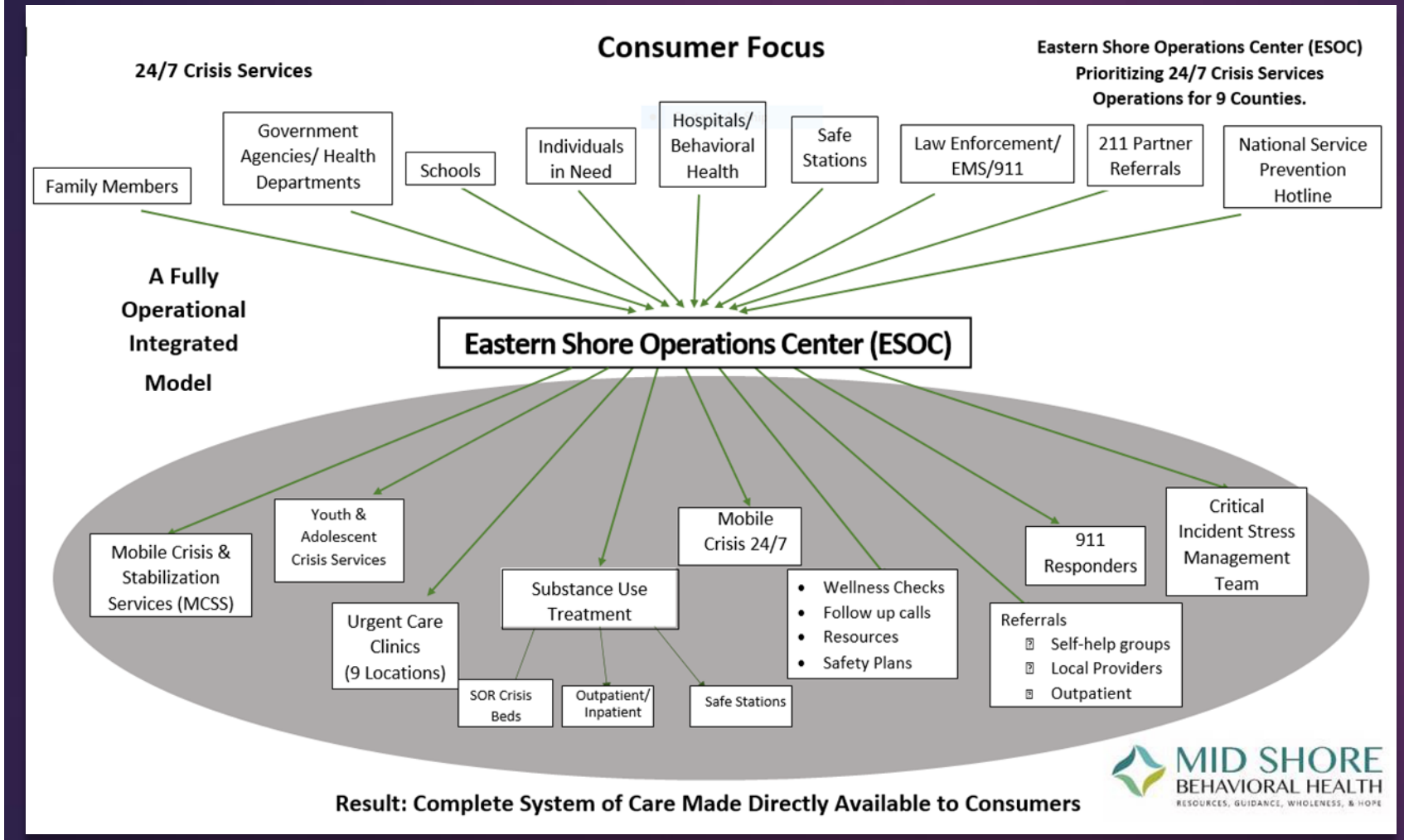
Health Disparities



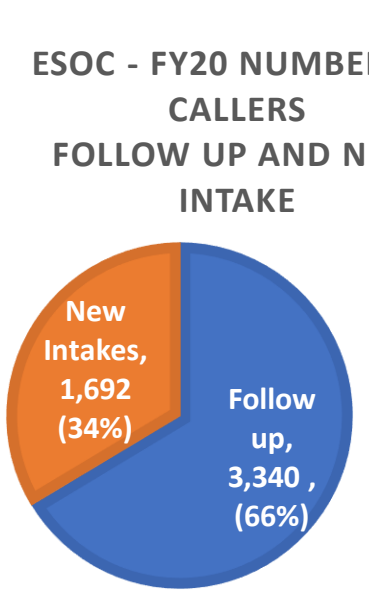


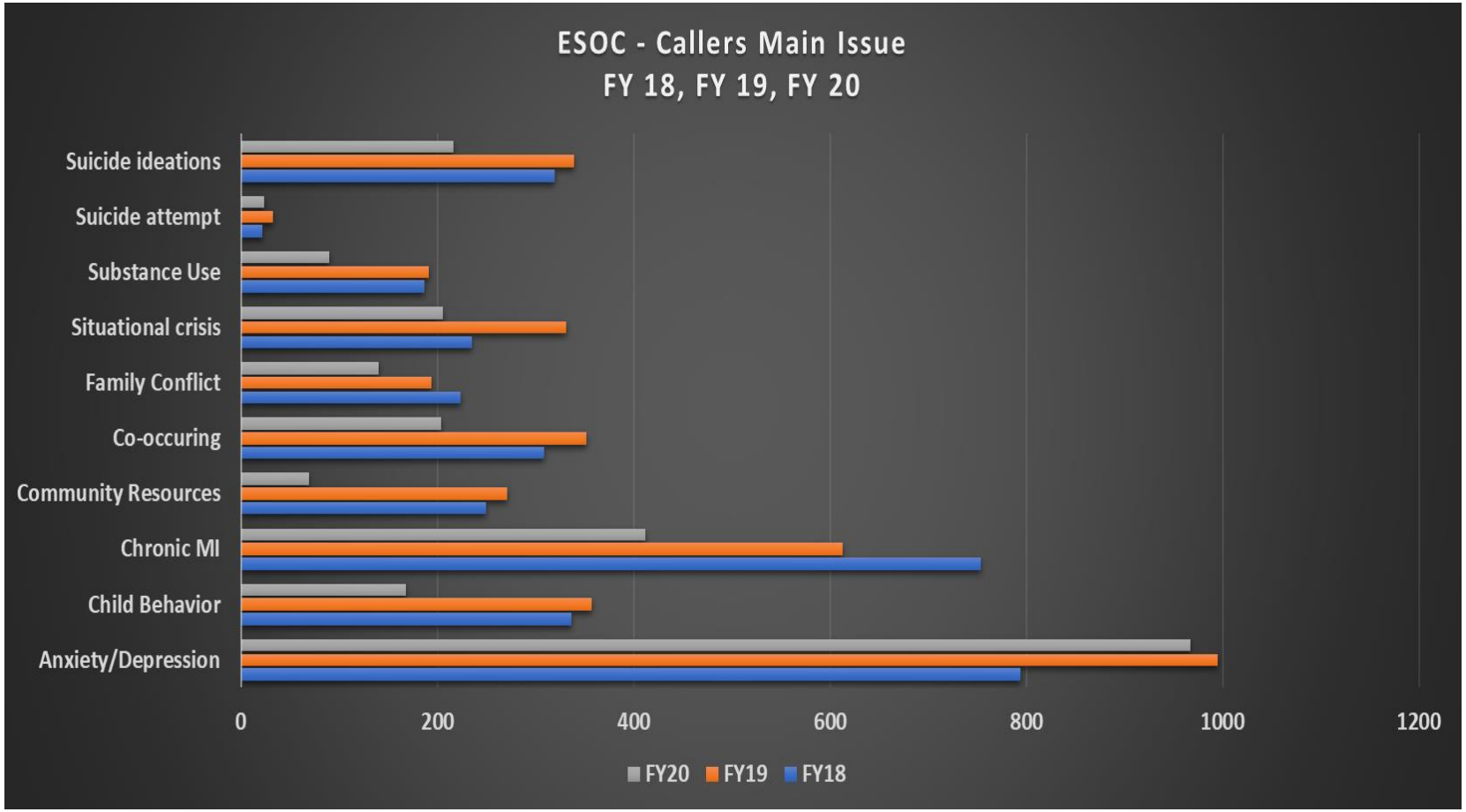
Health Disparities

Crisis Prevention & Response- ESOC

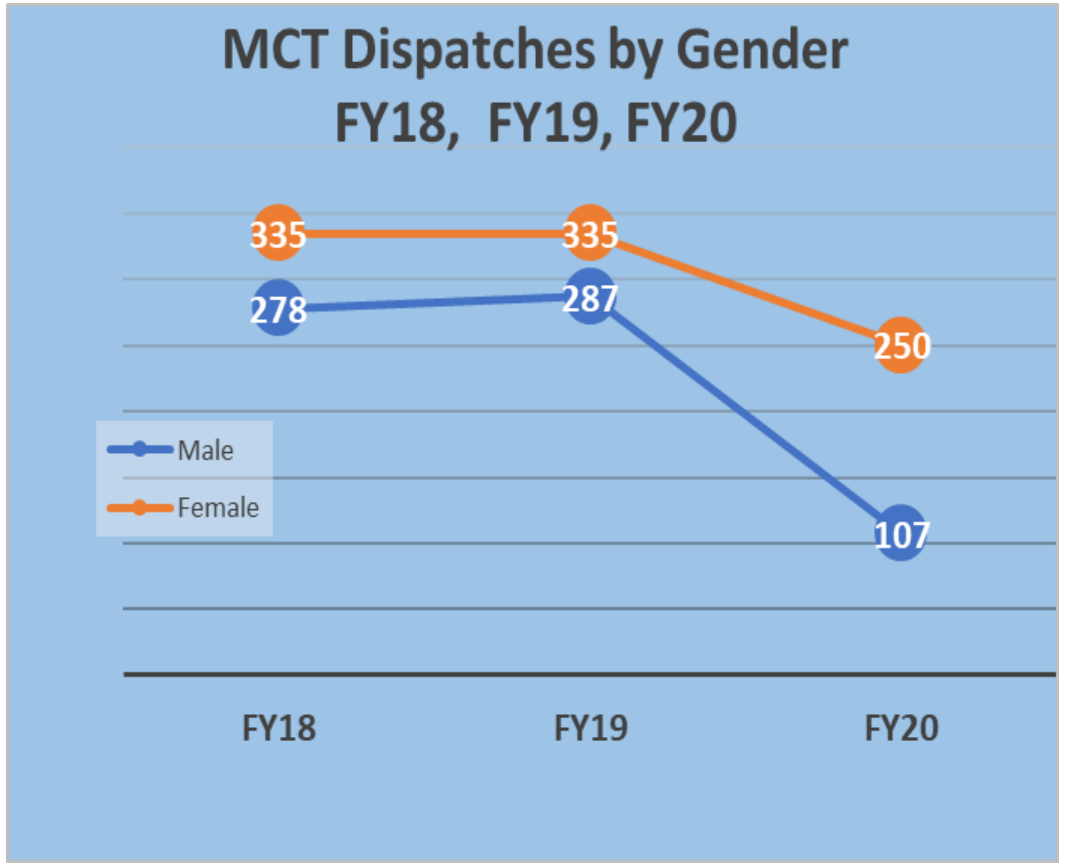


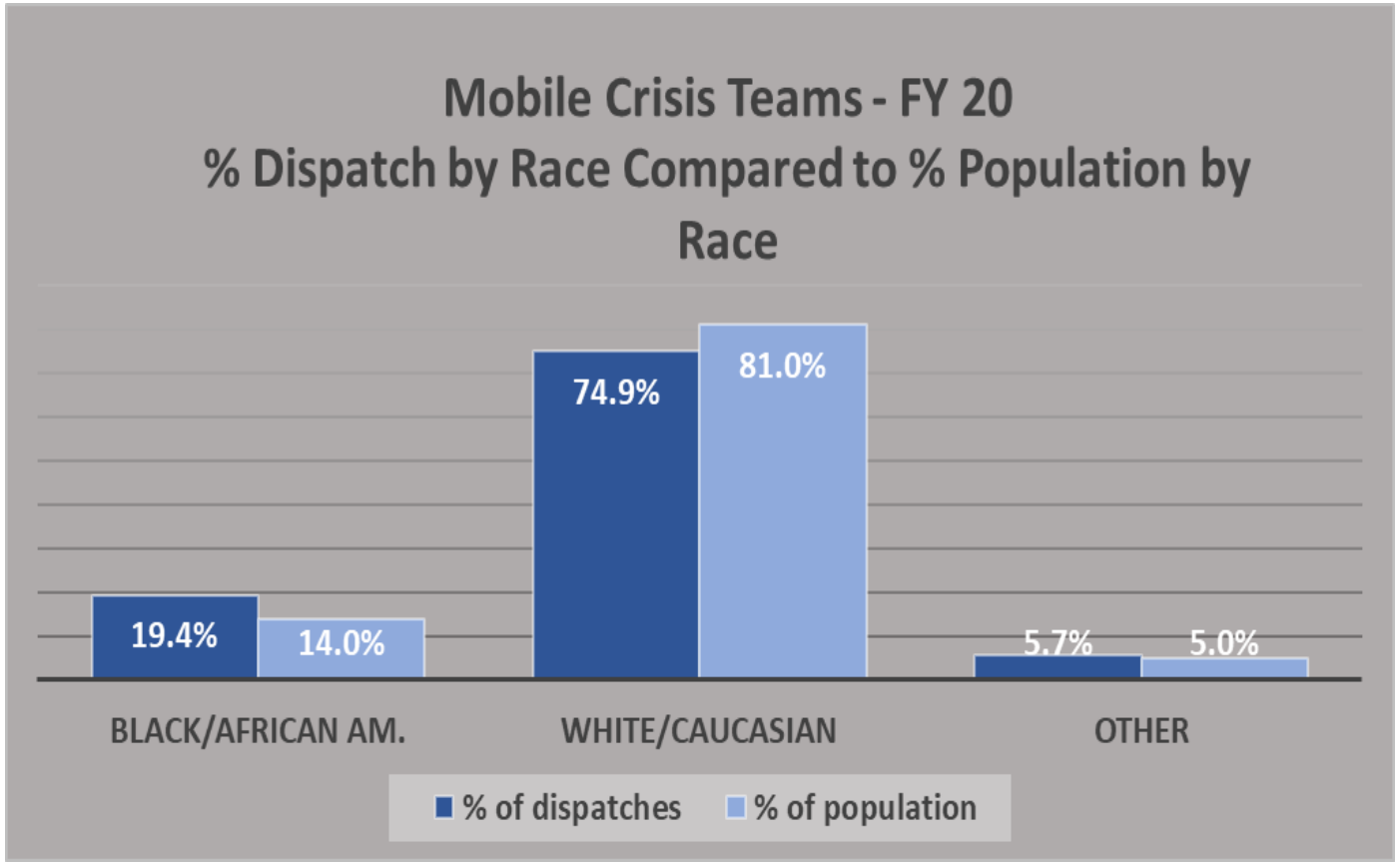
Crisis Response





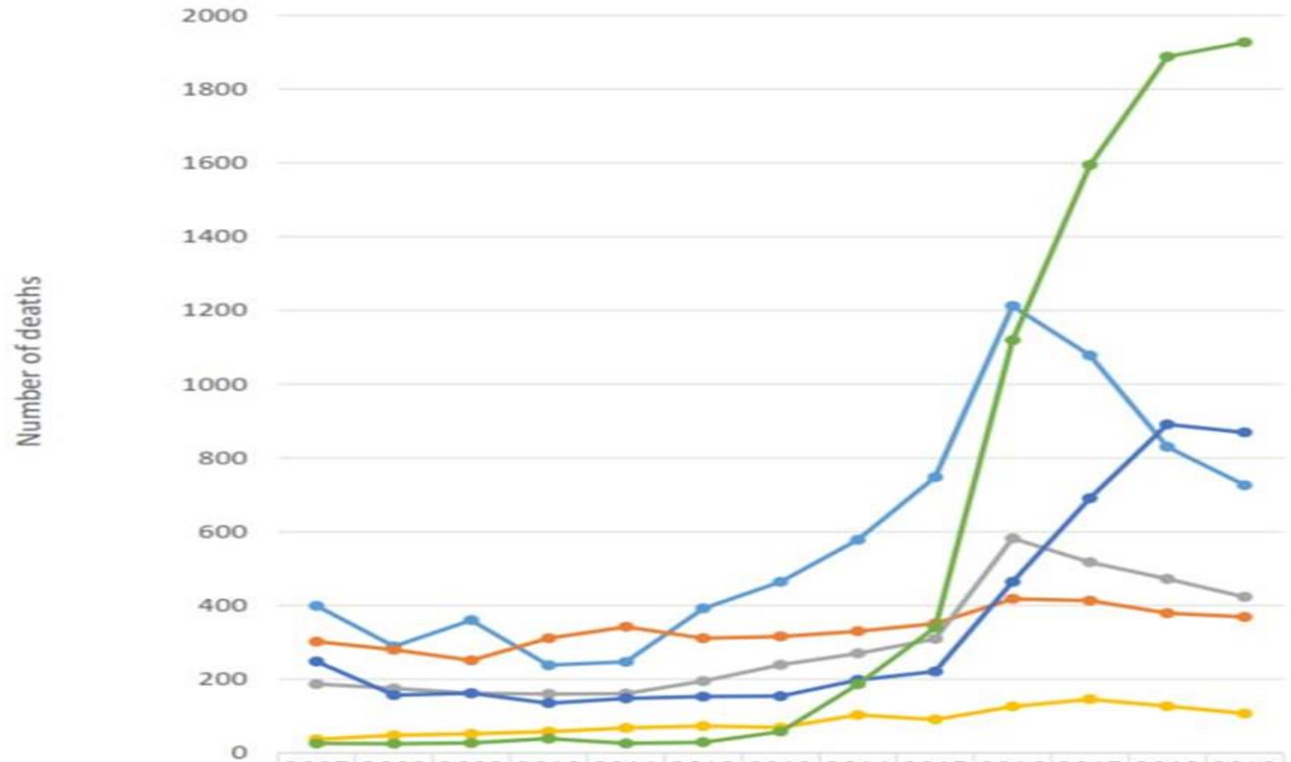
Mobile Crisis Teams dispatches- Race & Gender





Overdose Events

Number of Unintentional Drug- and Alcohol-Related Intoxication Deaths by Selected Substances*, Maryland, 2007-2019.

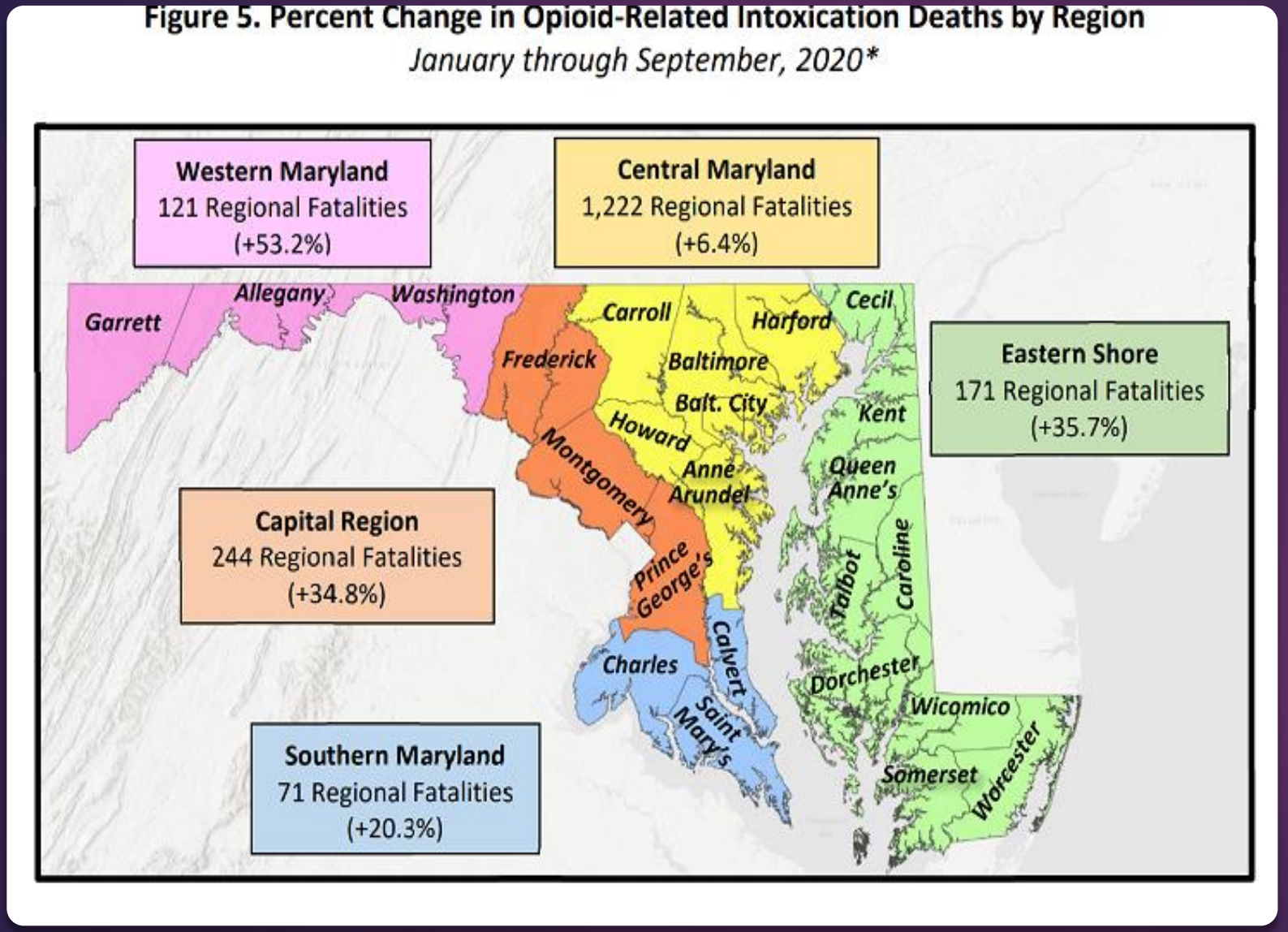


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Heroin	399	289	360	238	247	392	464	578	748	1212	1078	830	726
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413	379	369
Alcohol	187	175	162	160	161	195	239	270	309	582	517	472	423
Benzodiazepines**	37	48	52	58	68	73	69	103	91	126	146	127	107
Cocaine	248	157	162	135	148	153	154	198	221	464	691	891	869
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594	1888	1927

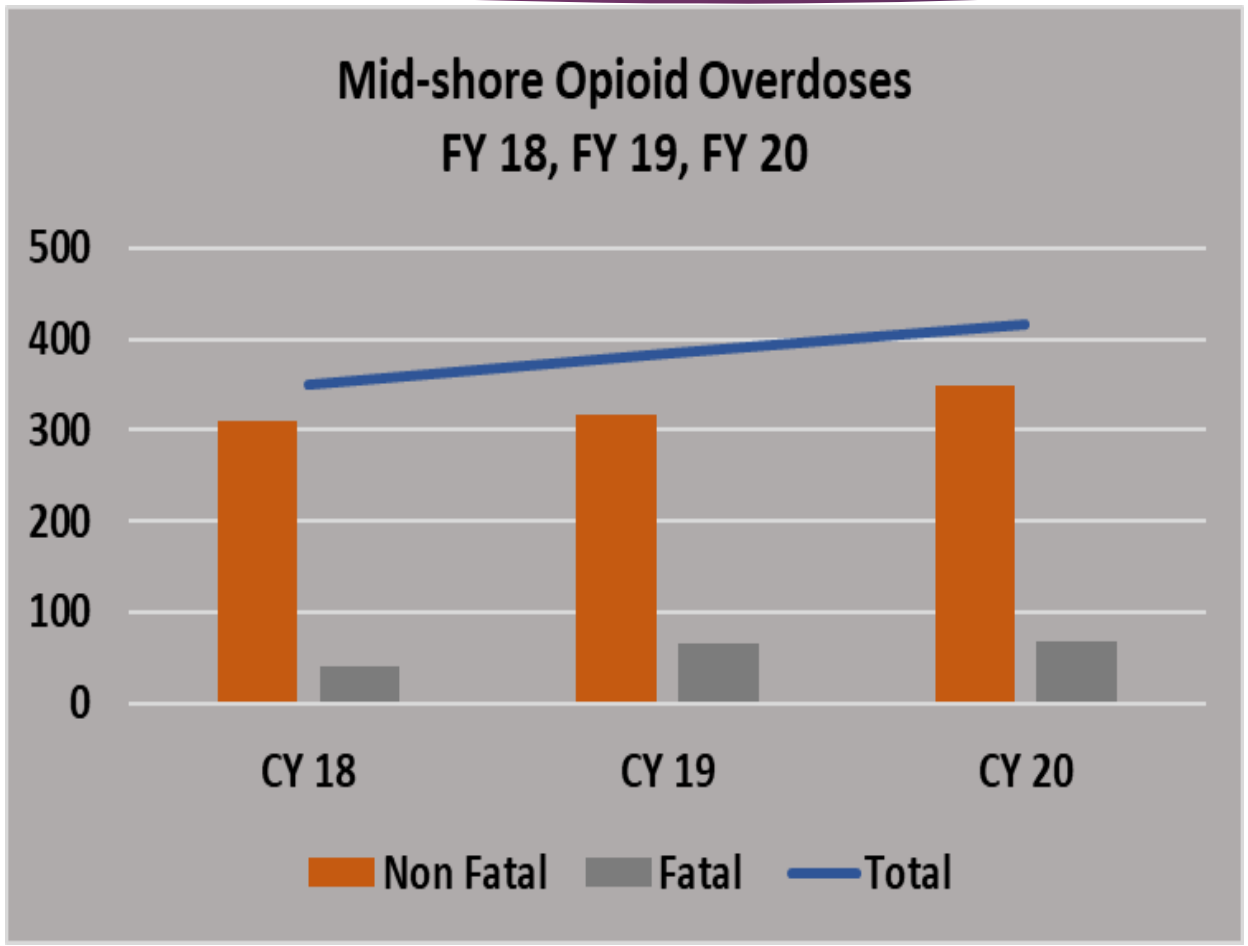
*Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.

**Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

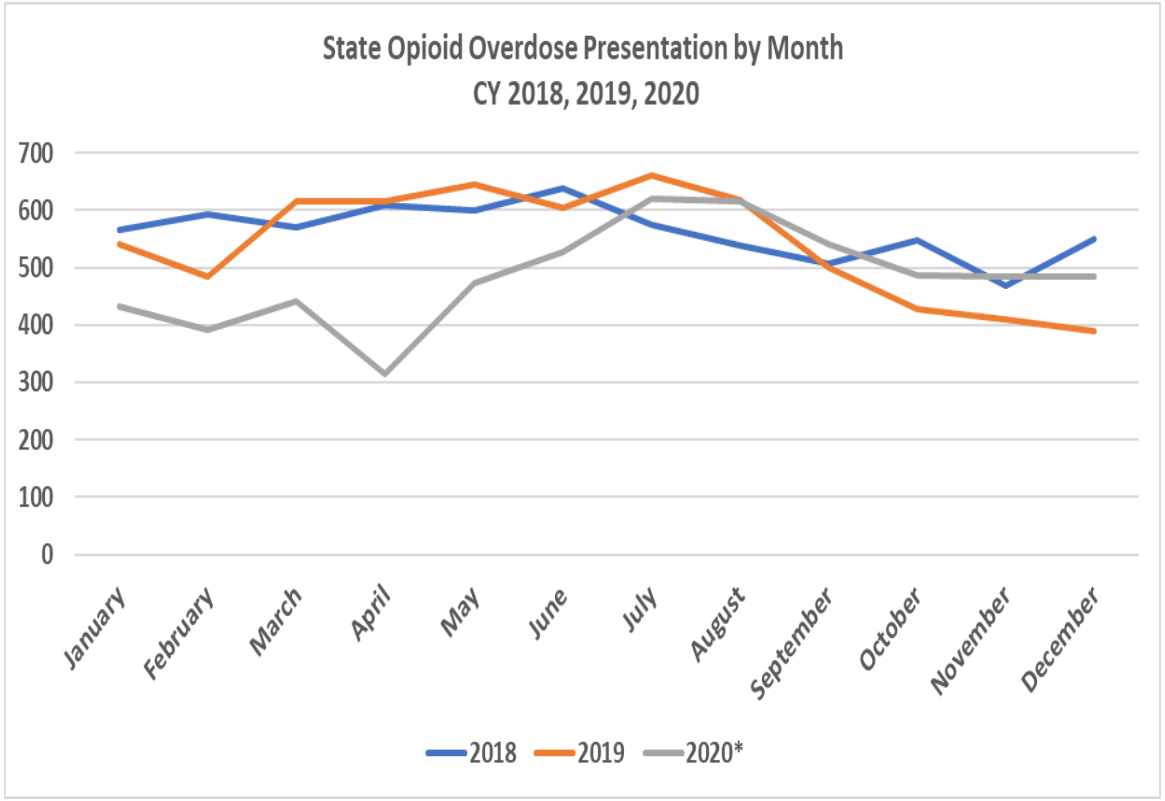
Opioid related Deaths by Region

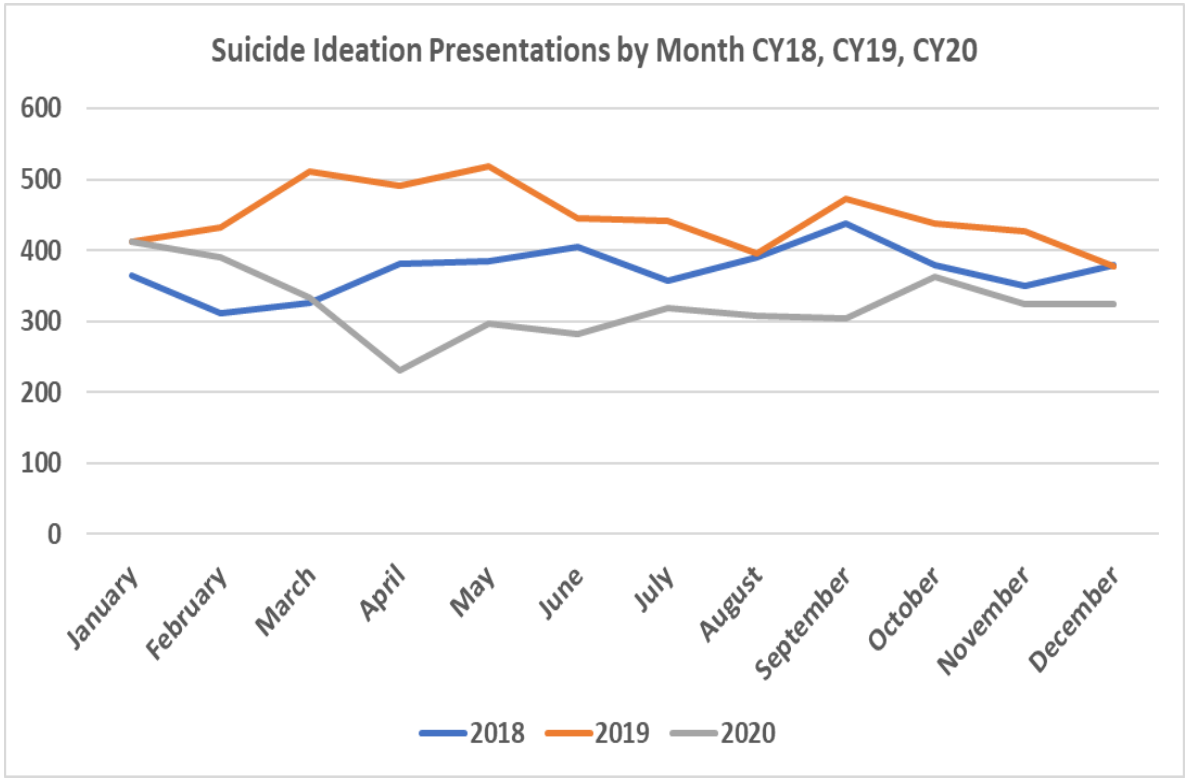


Mid-shore Opioid Overdoses



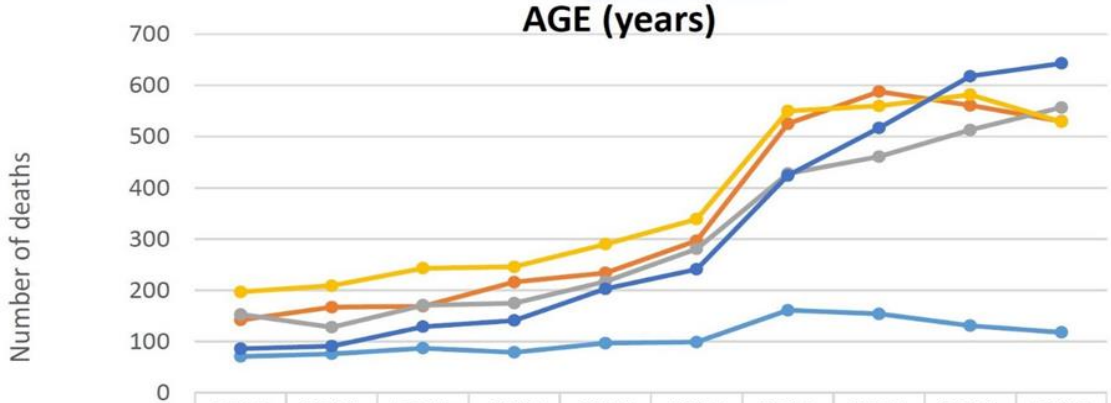
OD and suicide ideation by month





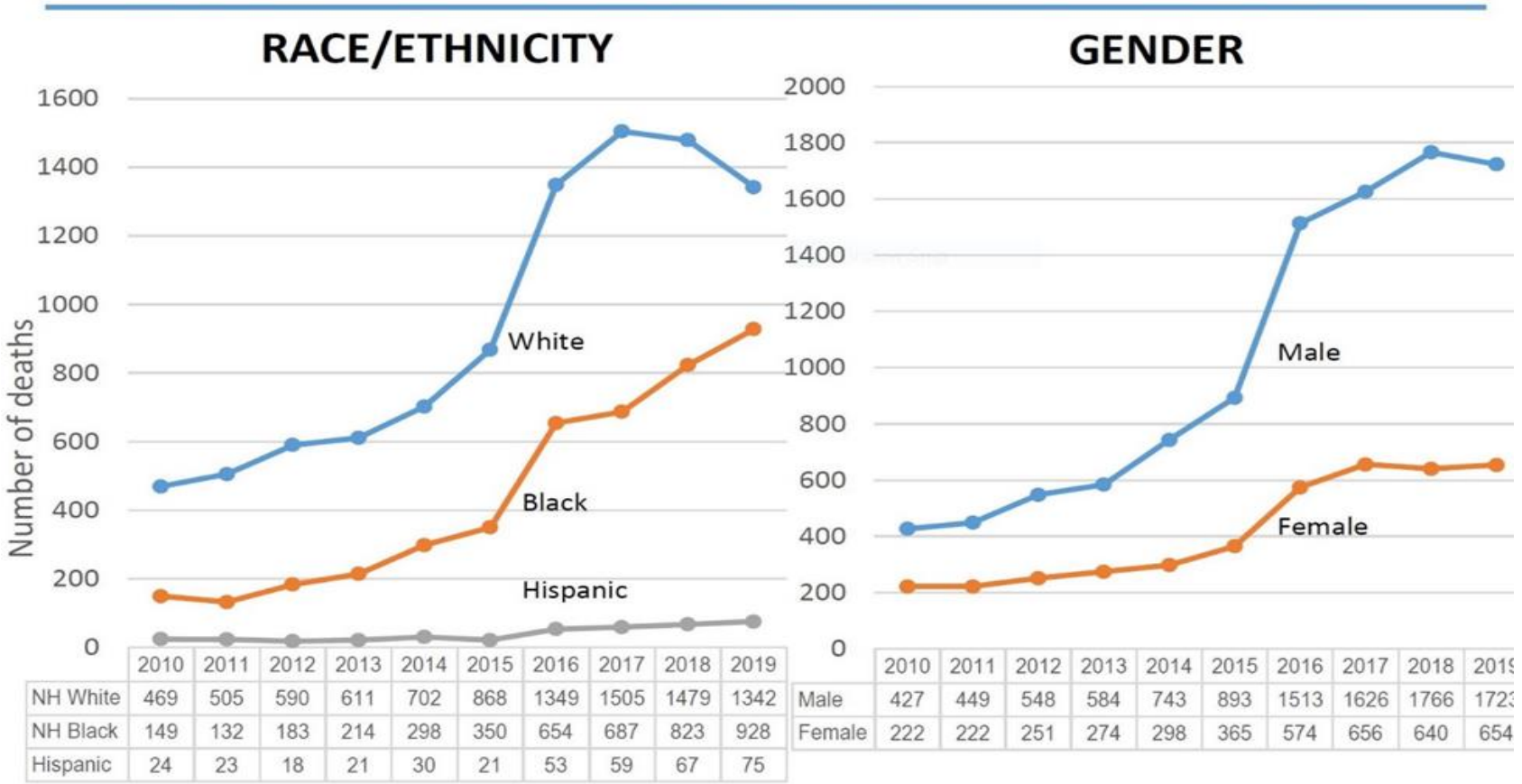
MD drug and alcohol deaths by age

Figure 3. Total Number of Drug- and Alcohol-Related Intoxication Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2010-2019.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<25 years	71	76	87	79	97	99	161	154	131	118
25-34 years	142	167	169	216	234	297	525	588	561	530
35-44 years	153	128	171	175	217	281	428	461	513	557
45-54 years	197	209	243	246	290	339	550	560	582	529
55+ years	86	91	129	141	203	241	424	517	618	643

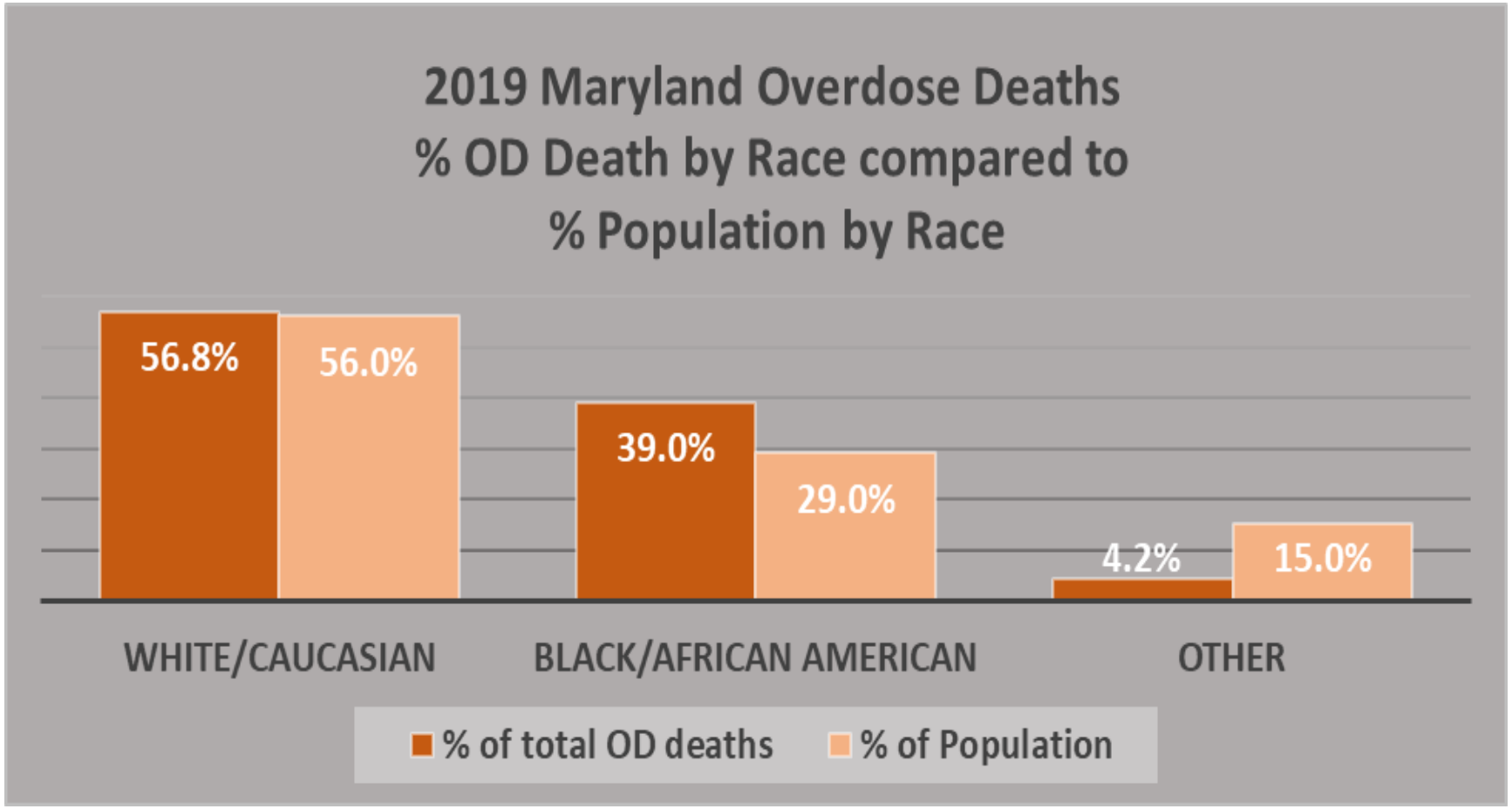
MD drug and alcohol deaths by race/gender



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
NH White	469	505	590	611	702	868	1349	1505	1479	1342
NH Black	149	132	183	214	298	350	654	687	823	928
Hispanic	24	23	18	21	30	21	53	59	67	75

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Male	427	449	548	584	743	893	1513	1626	1766	1723
Female	222	222	251	274	298	365	574	656	640	654

MD Overdose deaths by race

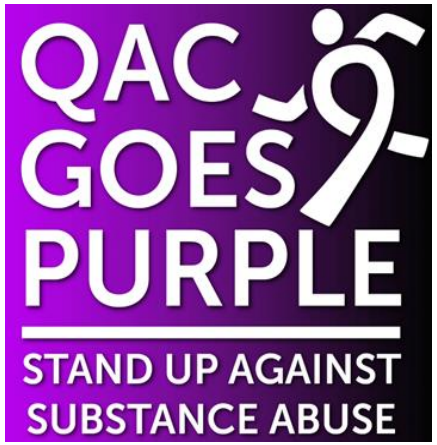


FY22 Cultural and Linguistic Strategic Plan

- Diversity and Inclusion Workgroup: overview (August), Grassroots/LMB Racial Equity (October), LGBT+ Resources (December), Rural Mental Health Initiative (2/5)…Linguistic Competency (April)
- MSPC presentation of FY21 CLC Strategic Plan (November 2020)
- MSPC combined CLAS Assessment
- FY22 CLC Strategic will address same CLAS Standards

Highlights & Achievements

MSPC-Going Purple Together




Q
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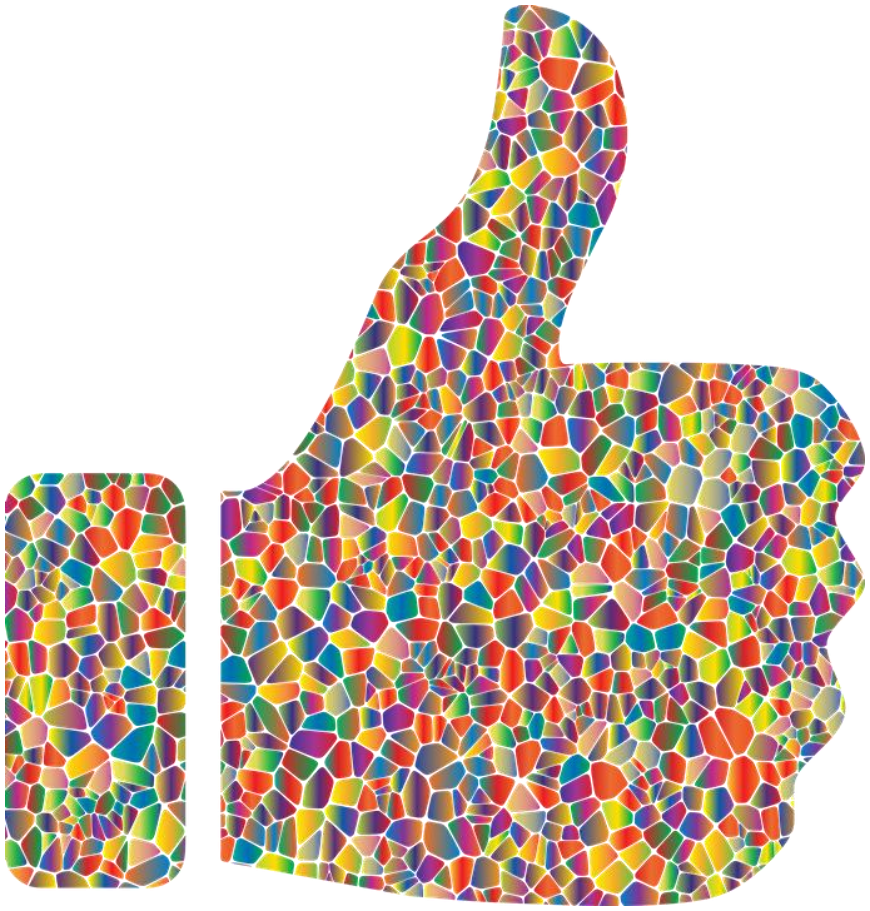
A



Next steps of the approval process.

Caroline

Mid Shore Planning Collaborative

Local Drug and Alcohol Advisory Council
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

LDAAC MEMBER	County	EMAIL ADDRESS	SIGNATURE
Terri Ross			
Denae Spiering			
Vicki Rahenkamp			
Trish Todd			
Roger Hall			
Laura Patrick			

Dorchester

Mid Shore Planning Collaborative

Local Drug and Alcohol Advisory Council
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

LDAAC MEMBER	County	EMAIL ADDRESS	SIGNATURE
Donald Hall			
Vicki Rabenkamp			
Angela Grove			
Clare Spillane			
Roger Hall			
Megan Salisbury			
Evdokia Dozia Rahilly			
Kirk Howie			
Teresa Health			
Alicia Myers			

Kent

Mid Shore Planning Collaborative

Local Drug and Alcohol Advisory Council
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

LDAAC MEMBER	County	EMAIL ADDRESS	SIGNATURE
Brenna Fox			
Jennifer McCready			
Heather Baginski			
Amelie Dickey			
Joe Jones			
Chrissy Chisolm			
Bill Webb			
Patrick Maffiy			
Lindy Schrader			

Mid Shore Planning Collaborative

BOARD OF DIRECTORS
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

BOARD MEMBER	PHONE #	EMAIL ADDRESS	SIGNATURE
Dorcella Wilson			
Ben Kuo Kohl			
Stirling Ward			
Robert Roca			
Joan Brooks			
Valerie Davis			
Kathleen McGrath			
Trish Todd			
Roger Hall			

Mid Shore Behavioral Health, Inc.

STAFF
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

STAFF	SIGNATURE
Brigitte Kealy	
Sherone Lewis	
Katie Dilley	
Pat Doyle	
Ann Simpers	
Audra Cherbonnier	
Carole Wills	
Kelley Moran	
Jeanine Beasley	
Jazzmine Davis	
Melissa Lubrano	
Sarah Baynard	
Yvette Hynson	
Katrina Ositelu	
AKima Copper	
Deborah Becker	
Ashley Strazza	
Rosalind Hynson	

Queen Anne

Mid Shore Planning Collaborative

Local Drug and Alcohol Advisory Council
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

LDAAC MEMBER	County	EMAIL ADDRESS	SIGNATURE
Maggie Thomas			
Holly Ireland			
Warren Wright			
Patrick Mettix			
Scott Hacs			

Mid Shore Planning Collaborative

REGIONAL BEHAVIORAL HEALTH ADVISORY COMMITTEE
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

RBHAC MEMBER	PHONE #	EMAIL ADDRESS	SIGNATURE
Brooks Robinson			
Diane Lane			
Maria Daniels			
Lindy Lewis			
John Plaskin			
Megan Pinder			
Jennifer Berkman			
Sharon Dundon			
Wilbur Levengood			
Katie Dilley			
Maggie Thomas			

Other

Mid Shore Planning Collaborative

SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

Name	PHONE #	EMAIL ADDRESS	SIGNATURE
Patrick Mattix			
Dave Bromwell			
Megan Saulsbury			
Senator Addie Eckardt			

Talbot

Mid Shore Planning Collaborative

Local Drug and Alcohol Advisory Council
SIGN IN SHEET

Community Behavioral Health Plan FY22
February 9, 2021

LDAAC MEMBER	County	EMAIL ADDRESS	SIGNATURE
Sara Claxton			
Greg Fries			
Vicki Rahenkamp			
Sharon Dundon			

February 12, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
Dix Building, 55 Wade Avenue
Catonsville, MD 21228

RE: Community Behavioral Health Plan FY2022

Dear Dr. Jones:

At a February 9, 2021 meeting, the Mid Shore Planning Collaborative (comprised of the Caroline, Dorchester, Queen Anne, Kent and Talbot Local Addiction Authorities and of the local mental health authority, Mid Shore Behavioral Health Inc.) presented and requested approval of the FY22 Community Behavioral Health Plan. Present were the Mid Shore Behavioral Health Inc., Board of Directors (with the required quorum), the MSBH Regional Behavioral Health Advisory Committee and leadership from the five Local Drug and Alcohol Abuse Council (LDAACs). The plan was reviewed and all representation and governing bodies expressed their support for the Community Behavioral Health Plan FY2022.

Thank you for your attention to this matter. If further information in needed, please contact Laura Patrick.

Sincerely,

Brandy James

Brandy James, Chairperson
Caroline County LDAAC

Dorchester County Department of Health

"Working for Healthier People"

3 Cedar Street
Cambridge, MD 21613
www.dorchesterhealth.org
Tel# (410) 228-3223
FAX# (410) 228-9319

Roger L. Harrell, MHA, Health Officer

February 12, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
Dix Building, 55 Wade Avenue
Catonsville, MD 21228

RE: Community Behavioral Health Plan FY2022

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Sincerely,

Roger L. Harrell

Roger L. Harrell, MHA
Health Officer
Dorchester County LDAAC

KENT COUNTY
HEALTH DEPARTMENT

COUNTY OF KENT

WILLIAM WEBB, HEALTH OFFICER
125 S. LYNCHBURG STREET, CHESTERTOWN, MARYLAND 21620 • PHONE: 410-778-1350

STATE OF MARYLAND

February 12, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
Dix Building, 55 Wade Avenue
Catonsville, MD 21228

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Thank you for your attention to this matter. If further information in needed, please contact insert Health Officer name

Sincerely,

William Webb, Kent County Health Officer
Kent County LDAAC

MID SHORE
BEHAVIORAL HEALTH
RESOURCES, GUIDANCE, WHOLENESS, & HOPE

28578 Mary's Court, Suite 1
Easton, MD 21601
410-770-4801

February 12, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
Dix Building, 55 Wade Avenue
Catonsville, MD 21228

RE: Community Behavioral Health Plan FY2022

Dear Dr. Jones:

At a February 9, 2021 meeting, the Mid Shore Planning Collaborative (comprised of the Caroline, Dorchester, Queen Anne, Kent and Talbot Local Addiction Authorities and of the local mental health authority, Mid Shore Behavioral Health Inc.) presented and requested approval of the FY22 Community Behavioral Health Plan. Present were the Mid Shore Behavioral Health Inc., Board of Directors (with the required quorum), the MSBH Regional Behavioral Health Advisory Committee and leadership from the five Local Drug and Alcohol Abuse Council (LDAACs). The plan was reviewed and all representation and governing bodies expressed their support for the Community Behavioral Health Plan FY2022.

Thank you for your attention to this matter. If further information in needed, please contact Kathryn Dilley, LCSW-C.

Sincerely,

BGKohlJr

Dr. Benjamin Kohl Jr.
MSBH Board President

Queen Anne's County Department of Emergency Services
100 Communications Drive ♦ Centreville, Maryland 21617
Phone 410.758.4500 ♦ Fax 410.758.2086
9-1-1 Communications ♦ Animal Control ♦ EMS ♦ Emergency Management
Fire Marshal ♦ Support Services

February 16, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
Dix Building, 55 Wade Avenue
Catonsville, MD 21228

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Thank you for your attention to this matter. If further information is needed, please contact Dr. Joseph Ciotola.

Sincerely,

Scott A. Haas
Queen Anne's County LDAAC/OIT

February 12, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
Dix Building, 55 Wade Avenue
Catonsville, MD 21228

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Thank you for your attention to this matter. If further information in needed, please contact Kathryn Dilley, LCSW-C.

Sincerely,
Maggie Thomas

Maggie Thomas/Brooks Robinson
RBHAC Chair and Co-Chair

February 12, 2021

Aliyah Jones, M.D., MBA
Deputy Secretary, Behavioral Health Administration
Maryland Department of Health
Spring Grove Hospital Center
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Thank you for your attention to this matter. If further information in needed, please contact Dr. Maria McGuire.

Sincerely,

Clay Stamp, Chairperson
Talbot County LDAAC