Behavioral Health System
Baltimore

FY 2018 Activities, Behavioral Health Indicators and System Utilization

February 2019

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Introduction

Behavioral Health System Baltimore (BHSB) is a nonprofit organization created in October of 2013 through the merger of Baltimore Mental Health Systems and Baltimore Substance Abuse Systems to form a single integrated behavioral health organization. BHSB provides leadership in advancing behavioral health and wellness and helps guide innovative approaches to prevention, early intervention, treatment and recovery. The goals of the organization are to build an efficient and responsive system that comprehensively addresses the needs of individuals, families and communities impacted by mental illness and substance use by expanding the reach and quality of the public behavioral health system, promoting the development of new and innovative services and addressing specific population and system-level needs.

BHSB serves as the local behavioral health authority for Baltimore City. In this role and in collaboration with the State of Maryland Department of Health (MDH) Behavioral Health Administration (BHA), the organization is tasked with overseeing the continuum of publicly funded behavioral health services in the city. The majority of public behavioral health system (PBHS) services are reimbursed through a statewide Medicaid fee-for-service system. In addition to overseeing these services, BHSB secures and directly awards public and private funds to support the development of innovative programs and the ongoing operations of behavioral health services not reimbursable by the fee-for-service system. In Fiscal Year (FY) 2018, BHSB awarded approximately $58 million in grants, with 332 contracts issued to 191 providers and consultants. Addendum A describes BHSB's contract monitoring procedures.

The continuum of services that BHSB oversees is broad. Services within the fee-for-service system include outpatient and intensive mental health and substance use disorder treatment, medication assisted treatment for substance use disorder, partial hospitalization, inpatient treatment, psychiatric and residential rehabilitation, residential substance use disorder treatment, respite care, residential crisis, mobile treatment, assertive community treatment, and supported employment. Grant-funded services include: assertive outreach, court-based assessments, mobile crisis response, methadone home delivery, housing supports, school-based services, wellness and recovery centers, peer support, prevention, overdose education and naloxone distribution outreach, early childhood services, and specialty services tailored to meet the unique needs of special populations such as older adults, people experiencing homelessness, women with children and individuals involved in the criminal justice system.

The public system of care available in the city is also quite large. While Baltimore City represents 11% of the state’s population, it represents over 26% of those utilizing public mental health services, and over 30% of those utilizing public substance use disorder (SUD) services.

In FY 2018, the fee-for-service system of care provided mental health services to more than 55,833 people, accounting for an annual expenditure of nearly $280 million. Substance use

disorder services were provided to 32,513 people, accounting for over $305 million in expenditures.

There was a significant increase in utilization of SUD services as compared to FY 2017. Total expenditures increased by 19%, and individuals served by 5%. Utilization of mental health services also increased, with a 7% increase in expenditures over FY 2017. As SUD services continue to be transitioned from grant funds to the fee-for-service system, it is expected that access will increase, and more people will be served. A more detailed analysis of the utilization of the public behavioral health system will be provided later in the document.

BHSB is required by the BHA to document annually the system of care for behavioral health services in Baltimore City, the core activities of the organization, and updated goals based both on progress made to-date and new opportunities. This document represents the fifth integrated report submitted by BHSB to the BHA and replaces what was previously referred to as the Annual Plan and Report for Mental Health, and the Grant Application and Local Drug and Alcohol Abuse Council Strategic Plan and Plan Update for substance use. The report includes the following areas as mandated by the BHA: a description of the structure of the organization and its vision, mission and values, description of the planning process, FY 2018 highlights of achievements and challenges in priority areas of work, an analysis of the utilization of public behavioral health services in Baltimore City as compared to the state for FY 2018, and a strategic plan for behavioral health for Baltimore City in FY 2019.

Organizational Structure

As an integrated agency and under the leadership of our Chief Executive Officer, the vision, mission and values of the organization guide the work of building an efficient and responsive system that comprehensively addresses behavioral health across the lifespan.

Vision Statement

We envision a city where people live and thrive in communities that promote and support behavioral health.

Mission Statement

BHSB's mission is to develop, implement and align resources, programs and policies that support the behavioral health and wellness of individuals, families and communities.

Statement of Values

BHSB embodies the following values in all of our work:

- Integrity

- Equity
- Innovation
- Collaboration
- Quality

BHSB employs approximately 80 individuals, including public health professionals, licensed behavioral health professionals and people with lived experience with mental illness and/or substance use disorders. BHSB is led by Crista M. Taylor, a clinical social worker and a leader in behavioral health in Maryland with more than 25 years of experience in this field. BHSB is overseen by a Board of Directors with the Baltimore City Health Commissioner serving as Chair. The Board of Directors serves in a governing role, guiding the strategic vision for the organization and, in addition, serves as the local mental health advisory council and the local drug and alcohol council as defined by the State of Maryland.

BHSB's organizational structure (Addendum B) supports a growing scope of work. It ensures responsiveness to the needs within the changing system and also establishes the organization as a leader in the new, integrated healthcare landscape. On the 432D form that BHSB submits to the BHA for each funding agreement, BHSB provides staffing information for each position, including name and title, that is funded or partially funded by that contract. Also attached (Addendum C) is a document that BHSB created for providers and the general public that describes the organizational structure and highlights opportunities to partner with BHSB. The six departments within the organization are:

President's Office

The President's Office is responsible for ensuring the organization is striving to meet its mission, aligning the work with the values of the organization and effectively and efficiently managing day-to-day programmatic, operational and fiscal activities. Coordination of Board of Director activities, medical consultation and support, human resources and procurement are also managed within the President's office, as well as oversight of select projects that cross all departments.

Policy and Communications

Policy and Communications uses advocacy and communications strategies to advance evidence-based practices, policy reforms, and mobilize community action. The department manages internal and external communications for BHSB, oversees government and community relations, and implements public education and advocacy campaigns to create positive change. BHSB participates on several coalitions and collaborates with a range of partners to advance policies that support behavioral health and wellness. The department has a dedicated provider relations contact to assist providers with getting information and support from BHSB.

Accountability

Accountability works collaboratively with behavioral health provider organizations to support high-quality behavioral health services in Baltimore City. This department provides support for providers in a variety of ways, including educating providers about the latest research, and encouraging and facilitating the coordination of care for consumers. Additionally, conducting site visits, and reviewing consumer quality reports are important aspects of effective monitoring and oversight. The team also manages provider complaints, investigations, and critical incidents.

Strategy

Strategy seeks to instill an equity lens into all facets of BHSB's internal and external work. The department supports this in a variety of ways, including synthesizing and analyzing data to inform decision making, broadening public health efforts to reduce substance use, implementing community prevention activities based on analysis of data trends, amplifying the voices of people who have lived experience using drugs, expanding harm reduction knowledge and capacity, conducting street outreach to educate the public in preventing and responding to opioid overdoses, expanding knowledge about the science of toxic stress and resilience and supporting providers in implementing policies and practices informed by this science.

Programs

Programs works to develop and manage a range of early intervention, treatment and recovery services for individuals and families with mental illness and/or substance use disorders. The department oversees services within the larger Medicaid fee-for-service system, as well as those directly funded by BHSB through private and public grants, including child and family services, peer support services, medication-assisted treatment, criminal justice diversion, and crisis services for youth and adults. The team collaborates with providers, city and state agencies, and other system partners to implement best practice programming and new or innovative pilots.

Finance and Administration

Finance and Operations manages the fiscal, contracting and administrative operations of the organization. The department provides oversight of private and public grant or funding awards, contracts issued to sub-vendors, grants accounting, and administrative support for organizational-wide work. Activities include oversight of procurements, issuance of letters of awards, monitoring of budgets and budget modifications, tracking of contract deliverables, and assurance that all funds are properly utilized and expended.

FY 2017-2018 Highlights, Achievements and Challenges

Summary of FY 2018 Highlights

- 55,833 people received mental health services, 26.2% of the total people served in Maryland.
- 34,747 people received substance use disorder services, 30.7% of the total people served in Maryland.
- 42,990 people called the Crisis, Information and Referral line for assistance.
- 11 of 12 hospitals in Baltimore City (all but the Veterans Administration Hospital), provide SBIRT in their emergency department.
- 9,112 people were trained on overdose prevention and how to administer naloxone, and 8,779 naloxone kits were distributed.
- 9,707 children and youth received individual treatment services through the Expanded School Mental Health program.
- 924 children received early childhood mental health services within Head Start centers in Baltimore City.
- BHSB is co-leading the Collaborative Planning and Implementation Committee (CPIC) to meet the behavioral health requirements of the Consent Decree between Baltimore City, the Baltimore Police Department and the Department of Justice.

The last several years have been a time of considerable change for behavioral health in Baltimore City, the State of Maryland and the country as a whole. As the health care financing landscape continues to shift, the behavioral health system will need to continue to adapt. BHSB recognizes that an integrated system with well-connected and coordinated access points to services is essential to ensuring the highest quality care for people with substance use and mental health disorders. It is also critical that the system continues to develop its capacity to use data to inform decision making and evaluate the impact of resource allocation in promoting behavioral health and wellness of individuals, families and communities.

While challenges in each of the priority areas of work are described below, there are two systemic challenges to behavioral health and wellness that should be highlighted. Racism and other forms of discrimination and oppression perpetuate behavioral health inequities. As a society, we generally perceive individuals and communities to be solely responsible for their conditions. A deeper understanding of how racism is experienced at the individual, interpersonal, institutional and systemic levels demonstrates that external systems create the internal realities that many people experience daily. As the local behavioral health authority, it is our responsibility to work collaboratively with other system partners to do the work of analyzing institutional power in order to create a society in which people thrive in communities that promote behavioral health and wellness for all.

Stigma also continues to be a barrier that impacts every aspect of work in the behavioral health system. It impacts people receiving services, family members supporting loved ones, behavioral health practitioners, and personnel within other systems where individuals with behavioral health disorders present. Reducing stigma is essential to developing a more accessible, quality-driven system of care that is responsive to the individuals, families and communities in need of behavioral health support. Ongoing, assertive public education is critical to helping individuals and communities understand that mental illness and substance use disorders are treatable, chronic health conditions and that people recover.

1. SYSTEM MANAGEMENT AND INTEGRATION AT THE LOCAL LEVEL

The Role of the Local Behavioral Health Authority

BHSB is the local behavioral health authority (LBHA) for Baltimore City. It was created in 2013 through the merger of the city's Core Service Agency (CSA) and Local Addictions Authority (LAA). While the merger allowed BHSB to leverage resources to more fully engage in promoting quality and advancing public education, advocacy and data analysis, integration has been an ongoing process.

At the state level, behavioral health system integration is a policy imperative set by the General Assembly in the 2017 Maryland state budget. Across the state, local jurisdictions are in various stages of integration, and the BHA's goal is to develop infrastructure and processes to support continued integration, using a framework of shared accountability between the BHA and local jurisdictions.

During the fall of 2018, local jurisdictions were required to complete a self-assessment tool to assess the current level of integration across seven key system management domains:

- Leadership and Governance
- Budgeting and Operations
- Planning and Data-Driven Decision Making
- Quality
- Public Outreach, Individual and Family Education
- Stakeholder Collaboration
- Workforce

The tool required jurisdictions to rate themselves for each domain: level 1 (Coordinated Communication), level 2 (Formal Collaboration) or level 3 (Integrated). Based on the criteria in the tool, BHSB assessed itself at level 3 for each domain, with the exception of the stakeholder collaboration domain.

The expectation of local jurisdictions is that each creates and implements a local plan to increase systems management integration. To provide support, the BHA, in partnership with the Maryland Association of Behavioral Health Authorities (MABHA), launched a Learning Community in July 2018 to provide technical assistance, tools, resources, and peer-to-peer learning. BHSB is actively participating and is incorporating the tools into its planning processes.

The integration process has expanded the role of the LBHA by adding authority at the local level to investigate complaints of both substance use disorder and mental health providers. This has supported BHSB in having a more active presence in promoting quality service delivery. In partnership with the BHA, Office of Health Care Quality and the Administrative Services Organization (ASO), BHSB conducts site visits, oversees performance improvement plans, and documents approval of providers entering the system. BHSB has staff focused solely on complaint investigation and compliance and has integrated staff functions so that each team member works with both mental health and substance use providers.

System Partnership

BHSB works to strengthen the continuum of behavioral health services and ensure access to these services through collaborative partnerships. BHSB partners closely with the Maryland Department of Health (MDH), other state and city agencies, and a range of nonprofit organizations and providers, as well as the community. These partnerships focus on systems where at-risk populations can be identified. Key partners include: Department of Juvenile Services, Department of Public Safety and Correctional Systems, Baltimore City Department of Social Services, Baltimore City Public Schools, Baltimore Police and Fire Departments, the District and Circuit Courts of Baltimore City, the Mayor's Office, the Baltimore City Health Department, and the Maryland Hospital Association. It is through these and other partnerships that BHSB will continue to expand access to and increase quality of care for residents of Baltimore City by creating opportunities for individuals across the lifespan regardless of which door they enter for services.

BHSB also works closely with system partners to advance policies that support the behavioral health and wellness of Baltimore City residents. This is accomplished through legislative advocacy and the active participation in state-wide committees including, but not limited to: the Forensic Services workgroup, the Baltimore City Substance Abuse Directorate, Buprenorphine Expansion workgroup, Maryland Behavioral Health Coalition, Maryland Alliance for the Poor, Maryland Association for the Treatment of Opioid Dependence (MATOD), Mental Health Association of Maryland (MHAMD) Mental Health and Criminal Justice Partnership, Maryland Parity @10 Coalition, Maryland State Council on Child Abuse and Neglect, Justice Reinvestment Act Advisory Council, Transition of Funds work group, Behavioral Health Advisory Council and sub-committees, and Maryland Association of Behavioral Health Authorities (MABHA), in which a BHSB staff member serves as co-facilitator. MABHA meets

monthly with the BHA leadership and provides feedback to the Behavioral Health Advisory Council.

System Promotion

BHSB staff works closely with the Baltimore City Council and the Baltimore City state delegation to reform the behavioral health system and support behavioral health and wellness in Baltimore City. BHSB developed 2018 Policy Priorities (Addendum D), which outline the policy efforts for which BHSB will be advocating in the coming year.

BHSB announced 2018 Policy Priorities during the Behavioral Health Leadership Network meeting which was held in January 2018. This is a new forum BHSB launched to bring together leaders and decision makers and is described in more detail below in the *Provider and Stakeholder Relations* section. Quarterly meetings will be held, with agendas focusing on different topics related to system change and special initiatives. The January meeting featured a presentation from a budget analyst with the Department of Legislative Services on what to expect in the state's FY 2019 budget for behavioral health. It offered an opportunity for stakeholders to better understand the state's budgeting process and engage in discussion about budget priorities.

In the 2018 Maryland General Assembly legislative session, BHSB worked with the Maryland Behavioral Health Coalition to advance the Keep the Door Open advocacy efforts by ensuring the state's FY 2019 budget included a reimbursement rate increase for behavioral health services. BHSB also partnered with stakeholders to pass legislation that establishes a Behavioral Health Crisis Response Grant Program, which allocates $12 million over three years to assist local jurisdictions in establishing or expanding community behavioral health crisis response systems.

State Financing and Regulatory Structure Change

BHSB recognizes that its work has and will continue to undergo significant change and that changes in the financing and regulatory structures will promote integration, increase access, and improve outcomes. BHSB supports the sustainability of the provider system through ongoing technical assistance and change management support to help prepare providers for a successful future in a changing health care environment.

As will be discussed in more detail in the *Quality* section of *Highlights, Achievements and Challenges*, effective April 1, 2018, state regulatory changes required most behavioral health programs to be accredited and licensed under COMAR 10.63 to continue operations. BHSB supports providers in fulfilling accreditation and licensing requirements, one of which is to complete an Agreement to Cooperate. BHSB also partnered with the BHA to manage grant funds that were allocated to reimburse for one-time accreditation assistance.

In preparation for residential substance use disorder (SUD) services to be managed by the Administrative Services Organization (ASO) instead of through grants at the local level, BHSB restructured the contractual and payment process for providers in FY 2017 and FY 2018. Specifically, residential providers moved from a slot-based, cost reimbursement structure to payment based on bed days and actual utilization. This change prepared providers to manage their budgets in a fee-for-service environment and allowed for a more effective use of funding, with transparent and real-time access to data on bed day utilization available for both providers and BHSB staff.

Provider and Other Stakeholder Relations

BHSB's Provider Relations Manager serves as the main point of contact for providers and assists with addressing questions, troubleshooting concerns and responding to stakeholder issues that arise. More specifically, BHSB helps coordinate services, identify resources, provide information, provide technical assistance and coordinate meetings between providers, stakeholders, community organizations and other agencies. BHSB also manages provider closures in collaboration with the BHA, providers, stakeholders and the ASO, including the transition of consumers. Other functions include answering questions about accreditation, licensure and Code of Maryland Regulations (COMAR) and completing Agreements to Cooperate. BHSB facilitates orientation sessions to welcome new and prospective providers into the system, introduce them to BHSB and begin building collaborative relationships.

In 2018 BHSB created the position of Associate Director, Policy and Community Engagement, to proactively and systemically address the growing need to promote positive relationships between providers and communities. BHSB meets with community members, their elected representatives and providers to facilitate constructive conversations and establish good neighborhood agreements.

BHSB launched the Behavioral Health Leadership Network in January 2018, bringing together leaders and decision makers, including providers, funders, system partners and advocates. Quarterly meetings are held, with agendas focusing on different topics related to system change and special initiatives.

Individual service line meetings are held with the following groupings of providers: Psychiatric Rehabilitation Programs (PRP), Residential Rehabilitation Programs (RRP), mobile treatment and Assertive Community Treatment (ACT), Targeted Case Management (TCM), residential SUD, buprenorphine, school-based, supported employment, Capitation Project, housing first, outpatient clinics, and veteran-serving providers. Meetings are generally held quarterly to educate providers on happenings within the system and engage them in dialogue about how to best support and enhance service delivery, including ways to promote behavioral health integration.

In addition to meetings hosted by the organization, BHSB regularly attends the Baltimore City Substance Abuse Directorate, a coalition of providers formed to collectively advocate for policy and programmatic changes to better serve individuals with substance use disorders. BHSB has worked with the leadership of the Directorate to provide guidance and support in reaching out to and integrating with mental health providers, as well as being a regular source of information concerning systemic changes. BHSB also attends Provider Council and Behavioral Health Advisory Council meetings and participates with the Association of Baltimore Area Grantmakers (ABAG), attending meetings regularly, participating in discussions regarding system needs and helping ABAG plan for educational opportunities for the Health Funders committee to ensure that the voice of behavioral health and the importance of integration is incorporated into its work.

Integration at the Provider Level

A comprehensive, integrated crisis response system functions as the foundation of a high-quality behavioral health system. For this reason, a large focus of BHSB's integration activities at the provider level has been within this system. Key components of Baltimore's system offer integrated mental health and substance use disorder services, including the Crisis, Information, and Referral (CI&R) Line; mobile crisis teams; residential crisis beds and withdrawal management services. BHSB is also finalizing a plan for system improvement of the behavioral health crisis response system, which is described in more detail in the *Access* section of *Highlights, Achievements and Challenges*. A key principle in the plan is that the crisis response system in Baltimore should be fully accessible to individuals with mental illness and substance use disorder.

To address the criminalization of individuals with behavioral health disorders and increase access points to services, BHSB collaborated with the Baltimore Police Department and other partners to implement two initiatives, the Crisis Response Team (CRT) and Law Enforcement Assisted Diversion (LEAD), both of which provide integrated services. These initiatives will be discussed in more detail in the *Access* section of *Highlights, Achievements and Challenges.*

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a practice that works to integrate behavioral health into the somatic health care system. BHSB was the first jurisdiction to systemically implement SBIRT and now serves as the project lead for what has become a state-wide project with multiple sources of federal, state and private funding. Through Substance Abuse and Mental Health Services Administration (SAMHSA) funding alone, the SBIRT initiative screened approximately 299,650 individuals from April 2015 to June 2018.

SBIRT provides prevention and early intervention through the use of validated screening tools and evidence-based interventions to identify individuals at risk of substance use disorders and those in need of behavioral health services and to refer them to treatment. BHSB's efforts, through multiple SBIRT funding sources, have expanded over time to include 45 organizations with 121 sites in 17 Maryland counties:

- Ten Federally Qualified Health Center (FQHC) organizations with 39 sites
- Two non-FQHC primary health care organizations with two sites
- Ten hospital affiliated primary care centers with 27 sites
- 11 hospital emergency departments
- One hospital obstetrics unit with two sites
- Seven hospital-affiliated obstetrics/gynecology practice sites
- Four family planning clinics with seven sites
- Three large pediatric practices with five sites
- Four county school systems with 15 schools
- Two college/universities with 2 sites
- One mental health/family support organization with 3 sites
- One county detention center

Behavioral Health Disaster Plan

BHSB coordinates with the Baltimore City Health Department (BCHD) and the City of Baltimore in the event of a public emergency. In this role, BHSB is responsible for the following functions:

1. Before emergency situations, BHSB:
    a. Reviews and updates the Baltimore City Behavioral Health Disaster Preparedness Plan.
    b. Identifies and trains BHSB's response team.
2. During emergency situations, BHSB:
    a. Coordinates with BCHD to assess the emergency, determine the types of behavioral health resources required, ensure adequate behavioral health services are available, and ensure accurate information on mental health resources is disseminated to the public.
    b. Assigns and oversees teams of behavioral health professionals at the Baltimore City Command Center, identified crisis centers, emergency shelters, and other locations as needed.
3. After emergency situations, BHSB:
    a. Assesses community needs for ongoing/long-term disaster recovery services and identifies resources to provide those services.
    b. Conducts debriefing sessions with emergency responders.
    c. Completes a report of the emergency response, including number of people served, types of services provided, etc., and recommendations for improving planning, response, and recovery activities in the future.

In November 2018, BHSB updated the 2016 plan. A copy of the updated plan is not attached to this document due to it being large. It can be provided if needed.

Challenges

While BHSB rated itself at the highest level for six of the seven systems management domains according to the criteria specified in the BHA's *Integration Self-Assessment Tool*, significant

challenges remain, particularly with making the impact of integration tangible at the consumer level. In addition, BHSB has identified the need for the development of an advisory council to ensure the voices of people with lived experience, family members and communities are incorporated into planning and decision making.

At the system level, to maximize progress in local planning and management, the LBHA must have the stature and authority to perform those functions. The role that the LBHA plays in the system of care is not always clear to stakeholders. Continued work to develop clarity around roles and authority within the behavioral health system would support the LBHA getting to and being successful at the table with hospitals and physical health care organizations for decision making that impacts people living with mental illness or substance use. BHSB is working to build better relationships with the 12 hospitals in the city. However, this is challenging given the sheer number of hospitals and the size and complexity of each health care system. Collaboration between hospitals, health care organizations, behavioral health providers and other system partners is essential in order for people to experience effective, high quality, culturally appropriate services accessed through a "no wrong door" model. Because LBHAs hold relationships with the provider network and other system partners, such as the Departments of Social Services and Juvenile Services, judiciary, police, fire, etc., they are well-situated to facilitate cross-system collaboration.

The all-payor model of reimbursement for hospitals is complicated. Support in increasing understanding of the model, as well as support in devising meaningful partnership strategies between hospitals and community-based providers is welcomed. As the health care financing landscape shifts to a value-based payment system, providers will need substantial resources, training and support to develop capacity to adjust to these changes.

Also at the system level, BHSB is challenged with securing the resources needed to sustain and expand system-integration practices and projects such as CRT, LEAD and SBIRT as well as implementing a 24/7 fully accessible and accountable crisis response system. BHSB is working to develop capacity to sustain and continue to expand these projects.

At the service delivery level, the payment structure for the PBHS does not support integration. Providers are forced to choose the mental health or substance use disorder rate structure. While new, integrated regulations have been promulgated, the system continues to reimburse for individual services that cannot happen on the same day, rather than an enhanced rate for integrated care. Until an integrated reimbursement model is established, providers are not fully incentivized to move forward in the integration process.

The last, and probably most crucial challenge is in recruiting and retaining direct service, clinical, administrative and system management staff. Hospitals and large managed care entities often have compensation packages that community organizations cannot match. In addition, in order to reduce stigma and integrate services, creative approaches to advocacy and public policy

will be needed because of differing public views of mental illness and substance use. It is critical that the behavioral health field prepares leaders to address the change management needed to successfully facilitate integration at the staff, provider, community and system levels. Overall, the behavioral health workforce is too few, inadequately supported and trained, and facing significant changes that impact practice, credentialing, funding, and ability to keep up with changes in practice models driven by changing science, technologies and systems.

2. ACCESS

A comprehensive, integrated crisis response system is the backbone of any successful behavioral health system; it connects individuals to the right care while reducing harm and overall system cost. One of the main goals of a well-functioning behavioral health crisis response system is to support people in the least restrictive settings by intervening as early as possible to prevent some of the negative outcomes associated with behavioral health crises, such as arrest, unnecessary hospitalization, homelessness, overdose, suicide, and other poor health outcomes.

Crisis, Information and Referral

Baltimore City has one number, the Crisis, Information and Referral (CI&R) line, to call for crisis intervention, mental health and substance use disorder services and recovery supports. Services also include general resource information, telephone outreach to individuals for whom an intake appointment was scheduled, and assistance with obtaining health insurance if needed. The CI&R line is jointly staffed by Baltimore Crisis Response, Inc. (BCRI), which has the infrastructure to answer calls 24/7 and staff qualified to respond to a crisis or suicidal emergency, and HealthCare Access Maryland, Inc. (HCAM), which connects individuals not in need of crisis response but in need of ongoing behavioral health services to the resources they need.

BHSB promoted the CI&R line throughout the year. Posters and cards were developed and distributed widely at community events, conferences and trainings, and posters were hung in public areas of settings frequented by individuals with behavioral health needs. In addition, BHSB promoted the hotline regularly through social media, including Facebook, Twitter, and Instagram. BHSB also continued to advertise the hotline through transit ads in certain areas of Baltimore City. BHSB promoted the crisis line for consumers who have limited English proficiency by making posters and cards available in Spanish.

Over the ten years that the hotline has been in operation, there has been a 60% increase in calls, from a total of 26,833 calls in FY 2006 to 42,990 in FY 2018.

Crisis Services for Children and Families

Baltimore Child and Adolescent Response System (BCARS) is the youth crisis services provider for Baltimore City. BCARS' youth community stabilization program offers urgent care appointments and six or two-week in-home/community/school stabilization services to youth and

families. It also provides limited mobile crisis response services to the public school system and youth in foster care. BCARS currently operates Monday - Friday from 8:30 am to 7:00 pm. However, 24/7 telephonic supports for youth and families in crisis is supported through a partnership between BCARS and BCRI, utilizing the CI&R Line. BCARS' larger parent company, Associated Catholic Charities (ACC), has also worked to support Baltimore City's youth crisis response system through the provision of respite care services in Baltimore City.

BHSB worked with BCARS to assist in diverting youth from unnecessary hospital-based care through the Pediatric Diversion program in partnership with John Hopkins Hospital and University of Maryland Hospital's Emergency Departments. The Pediatric Diversion program is not adequately funded. For the last few years, the budget gap has been met through the use of rollover funds. Unfortunately, an Over the Allocation Request submitted by BHSB to secure ongoing funding to retain this valuable service was declined and Pediatric Diversion program services were discontinued at the end of FY 2017.

In FY 2018, BCARS responded to 1,863 CI&R Line calls. Of those calls, 539 youth received triage services and linkage to community resources, 275 received a formal assessment and 229 were admitted to individualized BCARS services.

Crisis Services for Adults

BCRI operates the CI&R hotline 24-hours-per-day, 7-days-per-week; mobile crisis services from 7 am to midnight; a 21-bed residential crisis program; targeted case management services and a 13-bed residential withdrawal management program for adults in Baltimore City.

In FY 2018, BCRI:

- Responded to 42,990 hotline calls.
- Provided mobile crisis response to 2,599 individuals.
- Successfully diverted 1,034 of 1,461 (71%) emergency department referrals from inpatient hospitalization.
- Completed 724 admissions to residential crisis services, with 71% of those served having a co-occurring substance use disorder.
- Maintained an occupancy rate of 91% for the residential crisis beds.
- Completed 679 admissions to residential withdrawal management (level 3.7D), with 47% of those served having a co-occurring mental health disorder.

Maryland Crisis Stabilization Center

The Maryland Crisis Stabilization Center ("Center") provides safe, short-term sobering services for individuals who are under the influence of drugs and/or alcohol or who were recently revived from an overdose. The Center's innovative model supports recovery in communities, as it helps to link people with substance use disorders to treatment and recovery support services that will help them in overcoming their addiction.

The Center is specifically designed to serve adults under the influence of substances (or recently revived) in Baltimore City who meet medical criteria for safe transport to the Center and who can be safely served in a community setting. BHSB worked closely with the Baltimore City Fire Department (BCFD), Baltimore City Health Department (BCHD) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) in developing the medical criteria for Center eligibility.

The Center is located at Tuerk House, 730 N. Ashburton Street, Baltimore, MD, and services began on April 2nd, 2018. The Center operates 24 hours a day, 7 days a week, 365 days a year, and is staffed by Tuerk House with a combination of a nurse practitioner, licensed practical nurse, and peer recovery specialists at any given time. A licensed social worker is on-site during normal business hours, and staff from BCRI conduct follow-ups with individuals admitted to the Center for up to 30 days.

Currently, BCFD Emergency Medical Services (EMS) and BCRI mobile crisis teams serve as the two transporters of eligible individuals to the Center. BCFD EMS Advanced Life Support providers will identify individuals during their regular work routine as they respond to 911 calls for emergency services. The Center is currently not accepting walk-in appointments. When individuals are ready to leave the Center, staff assists them in connecting with transportation to return to their home, treatment services, or another destination.

An eleven-member Advisory Board for the Center was established to ensure proper project oversight, accountability of all project partners, and develop a financial sustainability plan. The Advisory Board is chaired by the Behavioral Health Administration's Deputy Secretary and the Baltimore City Health Commissioner, and board members were nominated by the State of Maryland Governor.

BHSB will utilize an action research paradigm to learn from experiences during both the development and implementation phases of this project to ensure high quality sobering and crisis stabilization services. A self-adjusting evaluation model will be used to assess the effectiveness of the proposed interventions. Both process and outcome data will be collected throughout the pilot project. The data derived from this effort will be used to achieve the following outcomes:

- Decrease drug and alcohol-related emergency department visits;
- Increase the number of individuals discharged from the Center who are linked to community-based behavioral health services and recovery supports upon discharge or within 30 days.

Significantly, this project creates a non-traditional access point within the crisis services continuum for individuals with behavioral health disorders who engage in high-risk substance use and related behaviors. Traditionally, crisis services are accessed by calling the 24/7 CI&R Line. This mode of access is dependent upon the individual, concerned family member or other community member calling the hotline for help, and the individual in crisis agreeing to be visited

by the team. Sometimes in the middle of a crisis, an individual may not see the need to call a hotline for behavioral health support and instead ends up in contact with police and/or EMS. The incorporation of direct referral protocol and training for EMS and police supports the integration of emergency personnel into the behavioral health crisis response system.

24/7 Urgent Opioid Use Disorder Crisis Services

In September 2017, BHSB received grant funding through the Maryland Opioid Rapid Response initiative to fund a new service that will provide 24/7 crisis services operated within a residential substance use disorder setting. These services are available on a walk-in basis for adults with an opioid use disorder. The project began operations on November 13, 2017 and has 12 beds that can serve individuals for up to 96 hours before transitioning to another level of care. Walk-in intake and assessment is available seven days a week, 24 hours a day.

A consumer experiencing an opioid-related crisis may walk in or be referred by a hospital emergency department, family members, service providers, or emergency personnel such as EMS and police. A multidisciplinary team develops a client-centered care plan with each consumer served in the crisis unit. Care plans address the individual's medical and behavioral health needs to determine the course of treatment while on the unit and an establish an appropriate discharge plan to community services. Peer support specialists and care coordinators work in collaboration with the consumer and treatment team to facilitate linkage to the agreed-upon services upon discharge and assure a warm handoff to the next level of care. The services provided at the Opioid Crisis Center are listed below.

- Urgent/walk-in screening and referral crisis services 24 hours a day.
- A nursing/medical assessment for medical clearance by a licensed nurse on site upon arrival. The Opioid Crisis Center staff monitors each consumer's medical needs throughout the stay.
- Evaluation for medication assisted treatment (MAT) and either induction of buprenorphine or linkage to an opioid treatment program (OTP) for methadone maintenance.
- A comprehensive biopsychosocial assessment to determine treatment needs.
- An American Society of Addiction Medicine (ASAM) assessment by a licensed addiction counselor to determine the appropriate level of care.
- Linkage with a peer support specialist.
- Impatient stay for up to 96 hours with referral to another level of care as appropriate based on medical necessity.
- Clinical crisis stabilization services, such as counseling, de-escalation, treatment and safety planning.
- Care coordination to assist with linkage for ongoing care and warm handoff to the next level of care.

During FY 2018, 556 consumers were referred to the Opioid Crisis Center, of whom 524 consumers met criteria by testing positive for opioids during intake and were admitted to the Opioid Crisis Center. Of consumers admitted, 321 (61%) were linked to another level of care upon discharge, 133 (25%) left before completing services, 33 (6%) completed services with no further treatment needed, 17 (3%) were medically discharged and linked to an area hospital, 12 (2%) were still enrolled at the end of FY 2018, six were discharged for violent behavior, one was referred to supportive housing, and one consumer died.

Law Enforcement and Behavioral Health

Public safety officials often find themselves on the front lines of responding to behavioral health crises but have few resources available to address the needs of people with serious behavioral health conditions. Meanwhile, people with behavioral health conditions are over-represented in jails and prisons: 65% of inmates meet the criteria for a substance use disorder, and more than half have a mental illness.[1]

BHSB works closely with BPD to provide leadership and oversight of specific projects, as well as to more generally inform and coordinate efforts within each other's systems. To address the criminalization of individuals with behavioral health disorders and increase access points within the system, Baltimore City has implemented several initiatives.

BHSB, the Baltimore Police Department (BPD), National Alliance on Mental Illness Metropolitan Baltimore (NAMI Metro) and the city's two crisis providers, BCRI and BCARS partnered in 2004 to create a program to train patrol officers to better respond to behavioral health crises. The five partners have maintained a strong collaboration that has supported changes to the approach over time to integrate ongoing learning and quality improvement.

These five partners work collaboratively to sustain the Crisis Intervention Team (CIT) program, which is a nationally recognized model for community policing that has proven to keep individuals experiencing mental illness out of jails and improve public safety. CIT helps to improve officers' ability to identify and address behavioral health crises and ensure safety of officers, individuals in crisis and bystanders. The collaboration between officers and behavioral health providers allows for the identification of resources, provides assistance to those experiencing the crisis and their families and ensures officers get the training and support needed to respond. BHSB employs a full-time coordinator for the project who is a clinician and works out of the police training academy. The coordinator works to fully integrate the training into the police department, facilitate improved provider and police relationships and implement components of the CIT model.

[1] The National Center on Addiction and Substance Abuse at Columbia University, Behind Bars II: Substance Abuse and America's Prison Population (February 2010).

The CIT program provides all new city officers with 16 hours of CIT training, and experienced officers with 40 hours. CIT training results in officers having the knowledge and ability to:

- Reduce stigmatization of persons with mental illness
- Prevent unnecessary restraint, incarceration, and hospitalization
- Help prevent injury to officers, family members, and individuals in crisis
- Link individuals with mental illness to treatment and resources in the community

In FY 2018, ten training classes were held, with 138 new patrol officers and 169 experienced officers, patrol supervisors, Sheriff's deputies, and parole and probation agents trained. The CIT Sub-Group of the larger Collaborative Planning and Implementation Committee (CPIC), an element of the national CIT model, met regularly to oversee the implementation of the project and plan for enhancements.

After completing a pilot phase, the CIT program continued the Crisis Response Team (CRT), which is a behavioral health unit within the BPD. It consists of a CIT officer-clinician team in BPD's Central District that responds to 911 and other dispatch calls believed to be related to behavioral health crises occurring in the Central District of downtown Baltimore City. The team also responds to calls and provides support in other districts as needed. In addition, the CRT provides some outreach and follow-up support to individuals who have had prior contact with the police department and/or the behavioral health unit.

Another year of funding to support the CRT past the pilot phase was secured from the Morton K. and Jane Blaustein and the Leonard and Helen R. Stulman Foundations, and BPD is committed to finding sustainable funding. A preliminary analysis completed by the Johns Hopkins School of Public Health concluded that "CIT was responsible for a 37.6% reduction in use of force in Central district compared to the other districts, a significant result ($p = 0.015$)," and "CIT was responsible for a 9.2% reduction in citizen complaints against officers in Central district compared to the other districts." Ongoing data collection continues to indicate a higher usage of de-escalation techniques and diversion to community-based resources by the team when compared to other behavioral health calls for service in the Central District. In addition, surveys and focus groups that were conducted reflected an increased level of confidence among officers in responding to behavioral health calls and an overall positive impact on the culture and attitudes toward behavioral health.

Another initiative that addresses the criminalization of individuals with behavioral health disorders is Law Enforcement Assisted Diversion (LEAD). LEAD is a diversionary pilot program that was launched on February 21, 2017. It provides public safety officials with an alternative to incarceration by diverting people with low-level drug offenses to treatment and support services. Care is provided through intensive interventions such as assertive community treatment, residential substance use disorder services, comprehensive case management, medication assisted treatment and other support services. LEAD has demonstrated that treatment

and recovery support services improve health and reduce recidivism. Through the end of FY 2018, LEAD received 204 referrals and served 79 participants.

LEAD was first implemented in Seattle, WA in 2011. A 2015 study found the following positive outcomes:

- Participants are 58% less likely to be arrested than individuals arrested for similar offenses but not enrolled in LEAD.
- Participants have lower recidivism rates than individuals in the normal criminal justice system, including those in therapeutic or problem-solving courts.
- Criminal justice costs declined by $2,100 for participants, while control group participants' costs increased by $5,961.

In addition, an unplanned, but welcomed, effect of LEAD in other states has been the reconciliation and healing brought to police-community relations. LEAD has helped facilitate positive relationships between police officers and residents and strong alliances between police and the behavioral health provider community. Baltimore City has experienced a similar effect within the pilot zone where LEAD is operating.

Initial funding was secured from Open Society Institute; Governor's Office of Crime, Control and Prevention; Abell Foundation; and Morton K. and Jane Blaustein Foundation. Baltimore City has committed to one additional year of funding thourgh FY 2019, and legislation was passed in the most recent General Assembly session that includes provisions for two additional years of funding to continue support of the project.

Crisis Response System Planning

During FY 2018 BHSB continued work on a planning process to identify and prioritize recommendations to strengthen the behavioral health crisis response system in Baltimore City. The goals included:

1. Outline existing behavioral health crisis services,
2. Identify known service gaps and access barriers, and
3. Make recommendations to improve the behavioral health crisis response system.

BHSB researched best and emerging practices at the national level, synthesized relevant data at the state and local levels and developed a first draft of the plan. In May 2018, BHSB hosted a session to seek stakeholder feedback. The feedback was reviewed and incorporated into a second draft.

The next step will be to seek public feedback, after which BHSB will release a final plan and work to implement the recommendations. While the original timeline had been to publicly

release the second draft during September 2018, this step was placed on hold to give priority to the Gap Analysis described in the next section, which will potentially move this work forward.

Public Behavioral Health System Gap Analysis

BHSB is working closely with the City of Baltimore, the Baltimore Police Department (BPD), the U.S. Department of Justice (DOJ), and the Baltimore Police Department Monitoring Team (MT) to complete the requirements related to behavioral health in Baltimore City's 2017 Consent Decree with the U.S. Department of Justice[2].

The Consent Decree includes several specific requirements related to BPD's response to and interactions with people with behavioral health disorders or people experiencing a behavioral health crisis. One of those requirements is to complete a comprehensive assessment of the behavioral health service system. The goal of the *Public Behavioral Health System Gap Analysis (Gap Analysis)* is to analyze existing public behavioral health service systems to identify: unmet need, service gaps, barriers to accessing care, opportunities for better collaboration, and other recommended system improvements, particularly as they pertain to decreasing or improving interactions with police. BHSB and its partners will use the results of this Gap Analysis to implement the recommendations.

In June 2018, BHSB released a *Request for Proposals* seeking a qualified vendor to conduct a thorough Gap Analysis or needs assessment process for Baltimore City's PBHS. Through a competitive process, Human Services Research Institute (HSRI) was selected to lead this work, which will result in a final report and implementation plan by June 30, 2019.

A second requirement in the Consent Decree is that a Collaborative Planning and Implementation Committee (CPIC) comprised of a wide variety of stakeholders, including behavioral health service users, community members, service providers, behavioral health advocates, and other city and state partners be assembled to advise on the implementation of the behavioral health requirements in the Consent Decree. CPIC was originally formed to guide the implementation of the Crisis Intervention Team (described in *Law Enforcement and Behavioral Health*) and has been restructured so that it provides broad, integrated oversight to all joint behavioral health projects with a larger scope of stakeholders participating.

The first restructured CPIC meeting occurred in April 2018, and meetings have continued on a monthly basis. Several sub-committees have formed to work on specific areas of the Consent Decree, one of which is to advise on and guide all of the activities related to the Gap Analysis process.

[2] https://consentdecree.baltimorecity.gov/

Outpatient Civil Commitment

There are some Baltimore City residents with serious mental illness that the PBHS has not engaged well in treatment. These individuals may end up involuntarily hospitalized or unnecessarily involved in the criminal justice system, resulting in poor overall health outcomes.

1) BHSB received federal funding from SAMHSA to implement a pilot Outpatient Civil Commitment (OCC) program in Baltimore City and secured funding through the Behavioral Health Administration to continue the pilot once federal funding ended. The OCC program serves Baltimore City residents with a mental illness who are currently civilly committed to an inpatient psychiatric unit and have been civilly committed to an inpatient psychiatric hospital at least one other time over the past 12 months,
2) have a demonstrated history of not engaging in available community treatment, and
3) are unlikely to seek and/or participate in community treatment upon discharge.

Legislation was passed during the 2017 legislative session to support implementation of the project and regulations that grant the legal authority to operate the program were promulgated October 27, 2017.

The program offers intensive outreach and engagement by peer specialists, with the goal of building trusting relationships and connecting people to ongoing treatment to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarceration and interaction with the criminal justice system, while improving the health and social outcomes of individuals with a serious mental illness. The pilot is being implemented in partnership with the BHA, National Alliance on Mental Illness (NAMI), MHAMD and other partners.

BHSB selected Bon Secours Baltimore Health System through a competitive procurement process to provide peer outreach and engagement to individuals referred to the OCC program. Peer specialists work with the individual, family members, hospital treatment team and a community treatment provider of the individual's choice to develop client-centered service plans based on the individual's wants and needs. Individuals receive help connecting to behavioral health services, primary and/or specialty care providers, housing support, employment services, entitlements and benefits.

BHSB is responsible for the full implementation of the OCC project, including reviewing all referrals to ensure that the eligibility criteria are documented sufficiently and that providers are serving individuals in a client-centered manner. The Consumer Quality Team at the MHAMD is conducting regular qualitative interviews with participants and relaying important feedback to project partners. A stakeholder group is overseeing project design and implementation, monitoring project impact, and gathering lessons learned to inform how the pilot might best be expanded statewide in the future.

To date there have been 14 referrals and seven enrolled participants. There are three active participants in the project. OCC staff continues to build relationships with local hospitals that can refer individuals to the project.

State Hospitals

BHSB partners with an Assertive Community Treatment (ACT) team to support people who are homeless to acquire and maintain housing. The team provides in-reach, engagement, and transition planning services to individuals residing in state psychiatric hospitals with complex mental health and other secondary diagnoses who require additional support for discharge readiness. Funding is available for subsidies to help make housing affordable, and the ACT team provides follow-up services after discharge from the hospital. This project was successful in transitioning one consumer from a state hospital and assisting four consumers who transitioned from state hospitals in previous years in maintaining housing in the community throughout FY 2018.

BHSB also partners with a Forensic Assertive Community Treatment Team (FACTT) to serve individuals with serious and persistent mental illness who are involved with the criminal justice system. Thirteen individuals were assisted in transitioning out of state hospitals during FY 2018.

Housing First is another project that provides increased support to individuals in Baltimore City, Prince George's County and Montgomery County who are homeless. During FY 2018, two consumers were assisted in transitioning from a state hospital into independent community housing. Ten consumers who transitioned from state hospitals through the project in previous years maintained independent housing in the community throughout FY 2018.

Residential Rehabilitation Program (RRP) programs in Baltimore City have a total of 357 beds serving city residents. There are seven RRP providers located throughout Baltimore City. In addition to RRP programs, there are two providers that participate in the Capitation Project, which has a total of 354 slots that serve city residents and those willing to reside in Baltimore City. For both service lines, BHSB serves as the point of contact for all referrals, which originate from state hospitals or from the community. State hospital referrals are prioritized.

For RRP referrals, BHSB's clinical staff determines the applicant's eligibility and identifies the appropriate level of care (Intensive or General). When there are no RRP vacancies, the applicant is assigned to a waiting list. The waiting list is maintained and reviewed on a regular basis to ensure system capacity is fully utilized. Referrals are forwarded to programs when a vacancy becomes available. BHSB clinical staff ensures that individuals who are on the RRP waiting list are connected with other resources.

During FY 2018, over 1,000 individuals were served in RRP beds in Baltimore City, and 340 individuals were severed in the Capitation Project.

BHSB continues to work to streamline and structure the referral processes to increase efficiency and support quality of care transitions. An additional goal is to track demographic data, assist in increasing capacity, and provide an understanding of the needs of the population served while also identifying gaps in services.

Early Childhood Services

Early Childhood Mental Health (ECMH) services supported by BHSB were provided in four of the five Head Start centers in Baltimore City, serving 924 children during FY 2018. ECMH ensures that children who are enrolled in Head Start Centers and their families have access to high-quality mental health services that promote optimal social-emotional health and academic success. To be effective, behavioral health service providers in early childhood centers collaborate with teachers, administrators, families and clinicians to employ sound behavioral health service integration that leads to academic success and is essential to overall health. A special emphasis is placed on ensuring support for children and families during the critical transition from pre-school settings to school settings.

Behavioral Health Services in Schools

Mental illness and substance use among youth are important behavioral health issues that significantly impact youth, families, and communities. Behavioral health conditions experienced by youth contribute to significant problems found in schools, such as chronic absence, low achievement, disruptive behavior, and dropping out. Schools can provide stability, important educational and social supports, and the opportunity to link to behavioral health services to which many youths might not otherwise have access.

BHSB partners with Baltimore City Public Schools (City Schools) to ensure that youth have access to high-quality behavioral health care that promotes social-emotional health and academic success. BHSB plays a critical role in funding, coordinating and overseeing a range of behavioral health services for youth and families through the schools.

The Expanded School Mental Health (ESMH) program provided prevention and mental health treatment services in 126 out of 177 (71%) schools to 9,707 youth during school year 2017-2018. Annual funding of $2.7 million for the ESMH program is provided through a long-standing collaboration between BHSB, City Schools, and several private foundations. This funding supports licensed mental health professionals who provide a range of services, including screenings and evaluations, parent and teacher consultations, individual and group treatment, and prevention services to youth at schools. Costs of some mental health treatment services are covered by Medicaid.

The prevention services model for 6th graders that is embedded within the ESMH program is LifeSkills Training (LST), which is provided by ESMH clinicians in 35 schools, targeting sixth graders who are at risk of dropping out based on a set of specific criteria, including academic

performance in math and reading, attendance, and behavior. LST is a research-validated SUD prevention program proven to reduce violence and the risks of alcohol, tobacco, and drug use by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations. Rather than just teaching about the dangers of drug use, LST promotes healthy alternatives to risky behaviors through activities designed to:

- Teach students the necessary skills to resist social (peer) pressure to smoke, drink and use drugs,
- Help students develop greater self-esteem and self-confidence,
- Enable students to effectively cope with anxiety,
- Increase students' knowledge of the immediate consequences of substance use and
- Encourage cognitive and behavioral competency to reduce and prevent a variety of health risk behaviors.

SUD prevention, early intervention and treatment services were provided to students in 15 schools and two school-based sites in Baltimore City. BHSB provides $525,000 annually to support licensed behavioral health professionals with skills in the area of addictions treatment who provide a range of services, including screenings and evaluations, individual treatment and early intervention services, parent and teacher consultations, and group prevention activities for youth and families. Licensed behavioral health professionals also coordinate closely with School-Based Health Centers and health suites to address students' health care needs and refer for HIV or TB testing.

Transition Age Youth (TAY)

BHSB oversees three funding resources specific to Transition Age Youth (TAY). This funding supports enhancement of Residential Rehabilitation Program (RRP) services for TAY in two Baltimore City RRPs and embeds a clinician in a Baltimore City housing program to support behavioral health assessment and linkage to services for TAY. During FY 2019, BHSB is transitioning this work from BHSB's Adult Services team to the Child and Family team to mirror the transition of state oversight occurring at the BHA. BHSB is also working to implement a process to evaluate the quality of TAY RRP enhancements and ensure alignment with best practices and state expectations.

To support the system of care in being responsive to the unique needs of TAY, BHSB provides outreach and education to the provider network, in addition to ensuring that TAY are identified as a special population. BHSB anticipates expanding knowledge and focus in this area given the increase in the number of TAY in Baltimore City during the past year.

Peer Delivered Services

Peer Recovery Specialists ("peers") use their personal experience of recovery from trauma, substance use, or mental illness to help others make their own journey to recovery. Peers' personal experience makes them uniquely capable of authentically engaging with people, building trust, and instilling a sense of hope that treatment works and recovery is possible. State-credentialed "Certified Peer Recovery Specialists" have received training and passed an exam on ethics, advocacy, self-care, mentoring and other topics.

BHSB's partner providers employ peers in various roles and settings, including:

- Overdose education and naloxone distribution
- Street outreach/overdose outreach
- Anti-stigma trainings and group support around mental health disorders, substance use, and medication assisted treatment
- Recovery coaching in outpatient treatment settings
- Case management support for clients in the Law Enforcement Assisted Diversion and Outpatient Civil Commitment programs
- Emergency Department SBIRT (Screening, Brief Intervention, and Referral to Treatment)

Baltimore's seven Wellness and Recovery Centers provide consumer-centered peer support services, such as anti-stigma workshops, Wellness Recovery Action Planning (WRAP), educational sessions such as parenting and GED classes, one-on-one peer counseling, peer-led group support (e.g. SMART Recovery®, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA), acupuncture, tai chi, and other activities that reduce isolation and promote family and social support. One of these centers focuses on LGBTQ persons. Two of the centers provide nearly 24/7 availability of drop-in recovery support, which helps bridge the time when traditional services are not available.

Two centers are unique in following the Clubhouse International model. One serves adolescents ages 13-17 who are at risk for behavioral health issues, and the other serves adults with a serious mental illness. The Adolescent Clubhouse, run by Progressive Life Center, receives an average of 297 visits per month and provides a culturally-centered and spiritually-based Afrocentric therapeutic approach called NTU, with a focus on harm reduction and reducing high-risk behaviors such as alcohol and drug use and unsafe sex. The adult program, B'More Clubhouse, receives approximately 569 visits each month and obtains most funding support from outside of the behavioral health system. It maintains accreditation through Clubhouse International with a unique approach to transitional employment which guarantees attendance for the employer by ensuring that, if a member is unable to show up to work, another member or staff person will fill in for them.

In FY 2018, Baltimore City residents visited Wellness and Recovery Centers 208,426 times. The Centers provided 14,268 one-on-one peer counseling sessions, over 161,880 group support sessions, and placed 175 persons in jobs. In addition, 1,333 persons were confirmed to have entered a treatment program as a result of a referral from a Wellness and Recovery Center.

To increase the city's capacity to prevent overdoses, BHSB has been exploring several expansions of Baltimore's peer-integrated substance use outreach program. One effort was to assess whether a real-time outreach response could be provided when EMS revives someone with naloxone who subsequently refuses transport to a hospital. After legal review, it was determined that, given the current process EMS uses to obtain consent, the proposed model would not work unless the outreach peers were directly employed by the city.

Another initiative established an alert process so that outreach teams can provide a rapid response to overdose "spikes" when and where they occur. Spike outreach began in FY 2018. Outreach workers have reported anecdotally that this timely response has improved the efficacy of their engagement efforts. The people they talk to are frequently aware that there have been overdoses in the area and, as a result, seem more receptive to conversations about treatment.

A third effort pairs outreach peers with a mobile buprenorphine van operated by the BCHD. This program began in FY 2019 and is expected to increase the number of persons who engage with the van's services.

Medication Assisted Treatment

In January 2017, BHSB released a report that quantified a significant unmet need for medication assisted treatment (MAT) services in the city. The number of individuals potentially in need of MAT is estimated to be 24,887, which is the estimated number of opioid users. The MAT treatment capacity in Baltimore City is 17,587, derived from opioid treatment program (OTP) and buprenorphine provider self-report of capacity. Based on these numbers, BHSB estimated a capacity deficit of 7,300.

Paid claims data shows that 13,869 people received methadone maintenance services during FY 2018, which is nearly level with the 13,698 people in FY 2017. While it is expected that changes in the Medicaid reimbursement structure will support continued increase in this number, many barriers to accessing and engaging with MAT remain. To address this need, BHSB collaborates with state and local partners to expand access to MAT through several initiatives.

BHSB oversees the Baltimore Buprenorphine Initiative (BBI), which provides treatment, care coordination and other support services within nine provider locations in Baltimore City. In addition, one program is funded to provide non-traditional services, in which buprenorphine is available to consumers in a community setting rather than an office-based location, with the goal of reducing barriers to treatment. BBI served approximately 1,000 consumers during FY 2018.

It is important to note that this number represents only a portion of individuals in the city receiving buprenorphine.

The BBI model has demonstrated success in transitioning consumers from traditional opioid maintenance treatment (OMT) treatment to primary care providers for buprenorphine maintenance. The protocol was recently revised to enhance the induction process and to integrate physical health care services into outpatient SUD treatment. BHSB anticipates that the revisions will facilitate increased consumer linkage to treatment while promoting overall health and wellness.

BHSB is partnering with the BHA, the BCHD and other stakeholders to implement the Hub and Spoke Project, which is a continuation of BBI. The Hub and Spoke model was originally developed in Vermont based on chronic disease management principles. This treatment model seeks to change the delivery of medication-assisted treatment in traditional opioid treatment program settings. Individuals with opioid use disorders can initiate treatment at the hub, which then collaborates with other providers and systems to coordinate care, particularly for people at high risk of negative outcomes including overdose.

The 'Hub' site offers low-threshold, intensive, on-demand buprenorphine induction and stabilization. This model also offers peer support services for treatment engagement, counseling, and health integration. Once individuals are deemed stable, they can be referred to a 'Spoke' provider. The Spoke provider is a community care provider that is willing to manage and monitor the individual's buprenorphine treatment. A community care provider can be a primary care, infectious disease, psychiatrist, or any provider that is waivered to prescribe buprenorphine, knowledgeable of the disease model of addiction and willing to work within this integrative model of care.

The goal is to expand buprenorphine medication-assisted treatment by:

1) Offering treatment on demand by minimizing barriers to treatment, such as limited induction times and transportation,
2) Subscribing to an individualized and whole person approach to opioid use disorder treatment that includes health integration, case management, counseling, and peer services, and
3) Increasing the participation of community-based Spoke providers in managing and monitoring buprenorphine for ongoing maintenance.

In October 2018, BHSB released a *Request For Proposals* seeking a qualified OTP to serve as the Hub for the Hub and Spoke project. Implementation is anticipated to begin in January 2019.

In addition, BHSB continues to with the Baltimore City Needle Exchange Van Program to support its initiative to offer peer support services to van consumers. Peer support specialists employ best practices to initiate and maintain relationships with consumers who utilize services

from the BCHD Needle Exchange Program. Best practices include motivational interviewing, a harm reduction model that includes drug education, a non-confrontational/non-judgmental approach, and education concerning the benefits of MAT. Peers support specialists are from IBR Reach and Bon Secours' Next Phase OTPs and work on the van 10 to 15 hours per week.

BHSB continues to work with the BCHD Field Services Unit and Glenwood Life Counseling Center with the Methadone Home Delivery Project. This project ensures consumers who receive methadone medication experience no interruption with their medication regimen while admitted into skilled nursing facilities or are homebound. For FY 2018, this project served 280 consumers, which was well over the annual target.

Homelessness

The U.S. Department of Housing and Urban Development (HUD) competitively awards homeless services funding to local jurisdictions through the Continuum of Care (CoC) Program, which is designed to promote community-wide commitment to the goal of ending homelessness. BHSB participates as a system partner on Baltimore City's CoC board, which is the entity responsible for overseeing the city's plan. BHSB staff also:

- Serves on the Executive Committee, which provides direction and leadership to the full board,
- Chairs the CoC's Health Workgroup, which in the past year developed plans to improve hospital discharge planning and recommendations to improve access to Assertive Community Treatment (ACT) services for people experiencing homelessness,
- Supports cross-system coordination at CoC outreach meetings and community meetings to address outreach needs.

BHSB directly administers two (HUD) CoC grants, Safe Haven and Street Outreach, and provides technical assistance to ensure these projects are accessible, low barrier services and are adept at using the Coordinated Access system. This system is a centralized process in Baltimore City for assessing persons in need of homeless services to determine the appropriate service type and housing option. The goal for both projects administered by BHSB is to transition people into permanent housing as quickly as possible. In addition, through state funds, BHSB provides matching grants to three permanent supportive housing projects that serve people experiencing homelessness, which helps the city leverage additional federal funding for this purpose.

During and prior to FY 2018, BHSB funded five separate outreach programs, some with only one or two staff members, to respond to individuals with substance use needs, mental illness, and homelessness. In July 2018, BHSB released a *Request for Proposals* seeking an organization to braid various outreach funding sources for mental health, substance use, and homeless outreach to create an integrated interdisciplinary outreach team. In addition to the integration of substance use, mental health, and homeless services expertise, this effort is expected to:

- Ensure more consistent and complete geographic coverage,
- Reduce response times to outreach requests,
- Ensure outreach efforts do not duplicate services or work at cross-purposes,
- Effectively coordinate care for individuals served by multiple programs, and
- Ensure that narrow eligibility restrictions set by one or two funding sources do not prevent outreach workers from serving persons who, but for outreach services, would not be able to connect with health or behavioral health care.

In November 2018, the competitive process resulted in awarding the project to People Encouraging People, Inc., and implementation planning has begun.

Criminal Justice

BHSB collaborates with stakeholders across Baltimore City to address the needs of individuals with behavioral health disorders with the goal of preventing and reducing their exposure to the criminal justice system. This work is grounded in SAMHSA's Sequential Intercept Model, which builds on collaboration between the criminal justice and behavioral health systems. The model identifies five key points for "intercepting" individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system. Its person-centered approach is grounded in understanding an individual's experience moving through the criminal justice system and using this information to assess gaps and opportunities and plan for more streamlined service delivery.

BHSB attends and convenes meetings with criminal justice stakeholders and state partners to help troubleshoot access-to-care issues and improve communication processes across the criminal justice and behavioral health systems. This involvement has been particularly helpful to address issues related to the change in funding for this service from local management to the ASO. BHSB also administers partial funding for and works closely with drug treatment and mental health courts at both the District and Circuit court levels in Baltimore City, in addition to the Addicts Changing Together-Substance Abuse Program (ACT-SAP), which is a state-certified substance use disorder treatment program for male and female offenders located at the Baltimore City Detention Center.

In addition, BHSB's Board of Directors has an active committee that consists of key decision makers in the criminal justice system. This group meets regularly to educate each other about resources within their respective departments and to strategize ways of addressing system-level gaps. Current planning efforts are focused on two key priorities: identifying funding to integrate peers into the criminal justice system and supporting availability and continuity of high-quality behavioral health care across systems.

Problem Gambling

When a new billable service line for problem gambling was created beginning in July 2017, BHSB partnered with the BHA to manage grant funds that were allocated to reimburse for problem gambling treatment services, including assessments, outpatient, intensive outpatient, and 3.3 and 3.5 residential levels of care. Effective January 1, 2018, BHA shifted these funds to

the ASO, which now is responsible for managing these services. During the six months managing the service line, BHSB registered 30 SUD treatment providers as problem gambling providers and reimbursed a total of $5,716 for services for 16 individuals. Since the funds have transitioned, BHSB makes an effort to ensure that individuals who call the Crisis Information and Referral line with needs associated with problem gambling are referred to this service.

Challenges

Despite having an integrated crisis response system that diverts many people from unnecessary hospital-based care in Baltimore City, more services are needed. A cursory examination of Baltimore City Fire Department dispatch data estimates that approximately 77% of EMS calls involve at least some connection to alcohol or drug use.[3] Data from a Baltimore study demonstrates that the most common health concern of frequent users of EMS is substance use intoxication and/or mental illness.[4] In addition, 32% of Maryland Medicaid enrollees with a substance use disorder visited the emergency department three or more times in a one-year period.[5]

Our current system of care is not designed to address the crisis needs of individuals and families 24/7. In behavioral health, crises are predictable but the timing of them is not. The crisis services should be expanded to include 24/7 walk-in crisis care and mobile crisis response, increased capacity for emergency respite services, assertive street outreach, overdose education and naloxone distribution, centralized receiving for emergency petition evaluations, peer respite services, jail re-entry services and a data sharing platform that tracks people through the continuum of crisis response services while also providing data needed for partners to more effectively provide care. Funding is the biggest barrier to implementing a full continuum of crisis services. The majority of services within the system are not reimbursable by Medicaid. Relying solely on grant funding is not possible. Alternate, sustainable sources of funding are needed. In particular, hospitals and managed care organizations (MCOs) that stand to directly benefit from the outcome of a comprehensive crisis response system should contribute to the long-term sustainability of the system.

While BHSB continues to pursue exciting new opportunities to expand the depth and reach of the public behavioral health system in Baltimore City, many barriers exist:

- Funding and access are limited for the training and certification of peer support specialists.
- Funding is limited for the development, implementation and ongoing sustainability of peer-delivered services.

[3] Knowlton A, Weir BW, Hughes BS, et al. Patient demographic and health factors associated with frequent use of emergency medical services in a midsized city. *Acad Emerg Med*. 2013;20(11):1101–11. doi:10.1111/acem.12253.
[4] BQUEST study 2008-2013
[5] Hilltop Institute, 2010

- Providers are reluctant to prescribe, and consumers are hesitant to take, medication to assist with substance use disorders.
- Communities are often opposed to behavioral health services being located in their neighborhood, especially MAT services.
- Safe, affordable, supportive housing that meets people's basic needs is not readily available.
- Housing subsidies are limited, especially for families.
- Family-focused interventions are limited in scope and number within the system of care.
- While opioid use and overdose are significant problems and much more is needed to continue addressing the epidemic, reducing the impact of substance misuse cannot be done without acknowledging and making efforts to reduce the impact of alcohol use disorder.
- Implementing, promoting and holding providers accountable for quality clinical and service delivery standards is difficult when payment is not directly linked to outcomes.
- Securing ongoing sustainable funding for services not reimbursable by Medicaid is an ongoing challenge. Too often new services are implemented with time-limited federal and private funding without sufficient long-term sustainable funding readily available to sustain the new service while continuing to sustain other ongoing, grant-funded services.
- Our current system of care is not designed for a consumer to have a no wrong door experience when requesting help, i.e. the provider directly serves the client or fully links them with a warm hand off to a service that would better meet their needs if they are unable to provide the service.

While the items bulleted above represent specific system design and funding barriers across the system of care, one opportunity specific to Baltimore City is the Consent Decree between the Baltimore Police Department and the U.S. Department of Justice. The Gap Analysis will make recommendations of system improvements, particularly as they pertain to decreasing or improving interactions with police. BHSB anticipates that Consent Decree implementation, informed by the Gap Analysis and guided by CPIC, will open opportunities to build a system that provides the services individuals with behavioral health disorders need to minimize or even avoid contact with the police.

3) QUALITY

Quality Initiatives

One of BHSB's key values is *quality,* as reflected in the *Statement of Values* (*Organizational Structure* section of this document). Consistent with this value, BHSB facilitates a high-quality system of care that ensures access to safe and effective behavioral health services. This is essential to promote and support optimal behavioral health and wellness for individuals, families

and communities. To advance efforts toward enhanced quality, BHSB continues to build a highly well-coordinated network of providers that are qualified with appropriate licenses and credentials. In alignment with the evolving configuration of behavioral health, BHSB is exploring robust quality measurement programs that strive to assure that consumers are provided with the best, most appropriate care. Appropriate care at the appropriate time is critically related to the efficient and effective management of costs, which is an essential aspect of preparing the public behavioral health system for a value-based payment model.

To further advance the effort of ensuring providers are compliant with state regulations and standards of care including accreditation standards, FY 2018 activities focused on refining internal processes, site visit protocols and tools. Revisions were data-driven, specifically based on information gathered from both internal and external partners. This data-driven approach resulted in both a higher level of support for providers and greater access to quality care for consumers.

Behavioral health is an essential component of overall health and in the management of chronic health conditions. In recognition of this, BHSB has expanded its monitoring portfolio to include areas of wellness and behavior change. One key area of focus has been smoking. During FY 2018, BHSB collaborated with providers to implement a requirement to create smoking cessation plans. Preliminary review of the plans is informing next steps related to implementation, strategic data-gathering and the identification of critical indicators to evidence behavior change and enhanced wellness.

In addition, BHSB developed measures to review customer satisfaction and has created a new *Consumer Satisfaction Survey*. This tool seeks to evaluate various domains, including cultural sensitivity, patient access, consumer outcomes, treatment planning, quality and the facility. These domains give a broader but more definitive lens to consumer satisfaction and the areas that may require quality improvement. BHSB began engaging providers around implementing the tool during FY 2018. The next stage of work is to support providers in using it to advance a consumer-focused practice of care in which consumers are empowered to determine the array of services most needed.

BHSB implemented the Quality Council during FY 2017, which is a proactive and collaborative forum to engage providers in quality improvement activities and resolve challenges before they escalate. The Accountability staff facilitates the sessions, along with other BHSB staff members that may have direct or indirect involvement with that specific provider. These staff members include but not limited to Program Leads, Grant Accountants and Contract Administrators. Quality Council meetings focus on a specific issue or set of concerns upon request by a provider or BHSB staff person. After discussion of the issues, recommendations and action plans are developed. BHSB documents the recommendations and plans and monitors implementation going forward. During FY 2018, there were a total of four Quality Council meetings. Successful outcomes resulting from those meetings included: providers were offered recommendations

regarding billing practices, clinical documentation, creation of a Continuous Quality Improvement plan and financial sustainability. Some providers also received technical assistance and staff training on clinical documentation. BHSB is currently evaluating the structure and function of the Quality Council to understand how to maximize its utility.

As essential aspect of supporting a high-quality provider network and assuring effective behavioral health services is the provision of technical assistance to a cross-section of stakeholders. BHSB is building its capacity to offer targeted technical assistance. During FY 2018 there were ongoing discussions with providers and other stakeholders to understand the nature of technical assistance that is most needed to support providers in the current dynamic and evolving health care landscape and the best approach to delivery of technical assistance. BHSB is working to develop a set of practices and protocol to guide this work.

BHSB continues to partner with the BHA to utilize a collaborative-consultation approach in delineating and co-facilitating the management of *Critical Incidents.* A *Critical Incident* is an unexpected occurrence involving death, serious physical or psychological injury, or the risk of serious adverse outcome. *Critical Incidents* signal the need for immediate investigation and response to ensure that each consumer is provided the best, most appropriate care available with positive outcomes. They also offer an opportunity to educate the provider about the latest research and encourage implementation of evidence-based practices and protocols, with the goal of focusing the provider's attention on changing the contributing factors to reduce the probability of such an event recurring in the future.

BHSB regularly conducts site visits to monitor quality and compliance. During FY 2018, there were:

- 157 site visits, of which:
    - 88 were with mental health providers
    - 69 were with substance use providers
- 53 audits were conducted in partnership with the ASO.

BHSB also investigates all complaints regarding Baltimore City behavioral health providers. During FY 2018, there were:

- 73 complaints, all of which have been resolved and closed.
- 44 critical incidents, of which:
    - 42 are closed
    - 2 remain under investigation

<u>Screenings and Assessments</u>

As discussed in the *System Management and Integration at the Local Level* section of *Highlights, Achievements and Challenges*, it is a state priority to develop infrastructure and

processes to support continued integration of the behavioral health system. One of BHSB's strategies to advance integration at the service delivery level is to develop a plan for a more integrated and comprehensive approach to assessments across the provider network. Beginning in the latter part of FY 2019, BHSB plans to review various assessment tools and processes to identify best practices and opportunities to increase the effective application of assessment tools to improve outcomes. As part of this review, training needs of providers will be identified and prioritized. One of the priority areas of review will be the 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.

Equity and Inclusion

One of BHSB's key priorities is to increase the capacity of the public behavioral health system in Baltimore City to promote equity, undo racism and increase inclusiveness. BHSB implemented multiple strategies to support this priority, one of which was to launch the internal Equity and Inclusion Workgroup. This workgroup is comprised of BHSB employees at all levels of the organization with representation from every department and most teams. In line with BHSB's organizational value of *Equity*, the focus is on issues related to promoting fair treatment and racial and social justice; ending the effects of bias, discrimination, and injustice; and promoting the value of diversity through greater inclusion.

Another strategy was contracting with a consultant with the National Center for Cultural Competence at Georgetown University to implement a series of trainings during FY 2017. Training events included:

- October 2017: full-day training for all staff to increase knowledge and awareness of the realities of racism at the personal, organizational and systemic levels.

- December 2017: full-day session with the executive team and Equity and Inclusion Workgroup to review the organizational mission, values, strategic plan and advocacy agenda through the lens of cultural and linguistic competency and anti-oppression.

- January - February 2018: sessions conducted with each team to engage team members in discussions that help them identify multiple opportunities to embed equity and anti-oppression activities in its work. The goal was to highlight opportunities to convert theory into action.

- May 2018: half-day training for all staff entitled *Exploring the Intersection between Trauma and Racial Equity*. The formal content was preceded with a brief survey to assess the staff's perceptions of movement on racial justice and its level of optimism/pessimism regarding the organization's ability to reach the goal of supporting racial justice.

- May 2018: half-day session with the executive team and Equity and Inclusion Workgroup with a follow-up meeting with the CEO. The focus was to review the status of BHSB's racial justice planning and implementation by reflecting on the responses to the brief staff survey and to work on potential action steps and narrow to a few items that could be quickly implemented that would be visible and meaningful to the staff and other actions that may require more long-term implementation.

In June 2018 BHSB sponsored *Paving the Road for Behavioral Health Equity Conference*. The conference objectives were to: 1) learn techniques to tailor services to an individual's culture and language preferences and 2) advance health equity, improve quality and reduce health care disparities.

Additionally, BHSB contracted with the People's Institute for Survival and Beyond to facilitate an Undoing Racism® Workshop during June 2018 for BHSB staff, providers and community partners. It focused on understanding what racism is, where it comes from, how it functions, why it persists and how it can be undone. The workshop utilized a systemic approach that emphasized learning from history, developing leadership, maintaining accountability to communities, creating networks, undoing internalized racial oppression and understanding the role of organizational gatekeeping as a mechanism for perpetuating racism. One of the trainers for the workshop was the President for Equity Matters, which is a local network of equity practitioners that promotes Equity-In-All Policy™ through greater attention to the social determinants of well-being.

To build on the Undoing Racism® Workshop, BHSB contracted with Equity Matters during FY 2019 to support BHSB in planning and implementing next steps. In September 2018, BHSB reconvened participants from the June training for a session led by Equity Matters, with the goal of building an action-based coalition engaged in organizing to implement solutions centered in anti-racism principles. In January 2019, Equity Matters facilitated a healing session for BHSB staff that was based in part on the work of Dr. Joy Degruy in *Post Traumatic Slave Syndrome*, as well as other research focused on healing from the impact of racism.

Cultural and Linguistic Competency

Health inequities and the prevalence of racial and ethnic disparities in health care delivery and outcomes in the United States are well-documented.[6] Culturally and linguistically diverse groups and individuals with limited English proficiency typically experience less adequate access to care, lower quality care and poorer health status and outcomes.

Providing culturally and linguistically appropriate services (CLAS) is one strategy toward eliminating health inequities. The U.S. Department of Health and Human Services (HHS)

[6] Culturally and Linguistically Appropriate Services. U.S. Department of Health and Human Services. https://www.thinkculturalhealth.hhs.gov/clas

developed the National CLAS Standards to advance health equity, improve quality, and help eliminate health care disparities. By tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations.

Cultural and linguistic competence in the delivery of behavioral health services affecting limited English proficient (LEP) persons has a profound impact on access to and the quality of care. To advance an agenda that minimizes health disparities and addresses the behavioral health needs of this growing population, BHSB participated in preliminary discussions with targeted informants during the summer and fall of 2017 to better understand the landscape of available resources and prioritize needs. The next step was to work with stakeholders to create a plan, including trainings and workforce development opportunities, for behavioral health providers. Stakeholders include Baltimore City Mayor's Office of Immigrant Affairs, Maryland Legal Aid and MDH's Office of Immigrant Health. BHSB continues to work with the providers and other stakeholders to identify treatment gaps and find ways to ensure individuals with LEP are receiving culturally and linguistically competent treatment.

For consumers who are deaf or hard of hearing and meet criteria for public behavioral health services, BHSB provides communication assistance by clinicians and interpreters fluent in American Signed Language (ASL) and trained to provide signing communication as part of clinical and rehabilitation services. ASL services are available within the following levels of care: outpatient mental health treatment, residential and psychiatric rehabilitation programs (RRP, PRP) and supported employment program (SEP). During FY 2018, 12 consumers were served in outpatient mental health treatment, 12 in PRP, 7 in RRP and 1 in SEP.

Workforce Development

BHSB sponsored an array of free professional development opportunities during FY 2018 to increase capacity across the network to provide high quality, evidence-based and evidence-informed services. A total of 864 individuals participated in 20 trainings and conferences, including:

- Sensory and Behavioral Issues in Treating Adults with Autism Spectrum Disorder
- Seeking Safety
- Trauma-Informed Supervision
- Understanding the Impact of Grief in Urban Poverty and African American Families
- Person-Centered Planning
- Providers as Part of Resilient Communities
- Suicide Prevention
- Undoing Racism
- SMART Recovery Facilitator Training
- Conscious Discipline Early Childhood Initiative Consortium

- Intersection of Intimate Partner Violence and Behavioral Health Training
- Moving Past Shame and Blame to Recovery and Resilience Conference
- Paving the Road for Behavioral Health Equity Conference

High Intensity Utilization

Frequent use of acute behavioral health care services is referred to as high intensity utilization (HIU). Individuals with HIU are often highly vulnerable and have co-morbid or tri-morbid conditions. BHSB's clinical team works in partnership with the ASO to ensure that the needs of individual with HIU are met. A higher level of care management is provided to assess what services would be most beneficial and to increase the likelihood of maintaining stability in the community, resulting in a decrease in hospitalizations.

During the fall of 2017, BHSB convened an internal work group to develop a systematic approach to this work that more broadly includes all populations served by the PBHS. Key goals that have been identified include: improving wellness, providing more effective care, increasing community-based as opposed to institutional care, and reducing the cost of care.

Smoking Cessation

BHSB believes that health and wellness are vital components of the recovery process for individuals with behavioral health disorders. To assist individuals with achieving health and wellness, BHSB promotes smoking cessation by actively participating on the state's MDQUIT Advisory Board, disseminating MDQUIT resources to providers and consumers, and facilitating discussions and presentations in provider meetings. BHSB also requires contracted providers to implement the use of evidenced-based approaches to reducing tobacco use.

Challenges

BHSB values quality and appreciates the opportunity to partner with providers across the system of care to promote access to safe and effective treatment. One of the challenges to quality services is the lack of safe and sanitary housing. BHSB receives complaints from consumers, families and providers about housing for individuals who have behavioral health disorders. Programs promote themselves as supportive housing or recovery housing but do not have State of Maryland certification. Unfortunately, the BHA does not monitor housing that is not certified, and the LBHA does not have authority to investigate complaints. A comprehensive approach at the state level that creates a mechanism to monitor non-certified programs and far reaching communication on how concerned citizens can file a complaint is needed.

Another persistent challenge is a lack of behavioral health practitioners who speak Spanish and other languages. There are not enough bilingual professionals, and those who exist are in high demand. Salaries that community-based providers can afford are often not competitive.

An additional workforce issue is the lack of licensed social workers, counselors and certified addiction counselors and high turnover rates. The HOPE Act, which authorized funding for community behavioral health providers, was important legislation, but it does not address the systemic underfunding that has resulted from many years of level funding of the PBHS.

4) BEHAVIORAL HEALTH AND WELLNESS OF INDIVIDUALS, FAMILIES AND COMMUNITIES

BHSB recognizes that to achieve health and wellness in the city, we need more than a high quality, accessible public behavioral health system. We also need thriving communities that nurture families and children and support access to needed resources. BHSB's organizational structure supports its commitment to promoting population health, community resilience and behavioral health and wellness.

NEAR Science

NEAR science is a cluster of fields of study that includes neuroscience, epigenetics, adverse childhood experiences (ACEs) and resilience. These fields, when understood as complex, separate and overlapping, can help strengthen individuals, families and communities.[7]

An ACE describes a traumatic experience in a person's life occurring before the age of 18. The ACE score is a measure of cumulative exposure to ten specific adverse experiences during childhood. Exposure to any single ACE is counted as one point. With each point, there is increased vulnerability to more adversity. Adverse community environments include a lack of affordable and safe housing, community violence, systemic discrimination, and limited access to social and economic mobility. Such environments compound ACEs, creating a negative cycle of ever-worsening effects because systemic inequities make it difficult to support thriving communities, which in turn increases the risk of ACEs. Together, these are referred to as the Pair of ACEs[8].

People who have high exposure to ACEs and the Pair of ACEs are more vulnerable to adaptive behaviors such as substance use, binge eating, self-harm and violence. Importantly, because the science is predictive, it is also preventable. Understanding what supports and promotes resilience helps us develop policies, practices and interventions that prevent and buffer the negative effects of toxic stress and adversity so that those who struggle more can thrive.

[7] NEAR@Home Toolkit: A Guided Process to Talk about Trauma and Resilience in Home Visiting. Prepared by Region X ACE Planning Team. https://thrivewa.org/nearhome-toolkit-guided-process-talk-trauma-resilience-home-visiting

[8] Milken Institute School of Public Health, The George Washington University. https://publichealth.gwu.edu/departments/redstone-center/resilient-communities

Based on this science, BHSB is undertaking a system-wide transformation initiative with the following goals:

- Increase behavioral health providers' capacity to create cultures and implement policies and practices that mitigate and/or prevent the impact of toxic stress and trauma.
- Collaborate with providers to support, reinforce and build upon resilience in the individuals, families and communities we collectively serve.

The initiative was launched in November 2017 during BHSB's annual gathering. Dr. Sandy Bloom, who was co-founder and developer of the Sanctuary Model® training and implementation process and who presently co-chairs the national *Campaign for Trauma-Informed Policy and Practice*, was the keynote speaker. Dr. Bloom spoke about the science that points to stress being the major public health challenge of the 21st century. She highlighted the need for a fundamental paradigm shift across systems, institutions and communities.

Subsequent to the annual gathering, BHSB offered an array of training and professional development opportunities for providers, including:

- *Seeking Safety*, an evidence-based, present-focused therapy model that assists people to attain safety from trauma and/or substance use.
- *Moving Past Shame and Blame to Recovery and Resilience Conference*, a full-day conference to 1) increase knowledge of the body of science about ACEs, toxic stress and trauma, 2) connect impact with hope and recovery and 3) expand knowledge of protective factors that buffer and/or prevent ACEs.
- *Trauma-Informed Supervision*, a full-day training to improve clinical outcomes by integrating the science of ACEs, neurobiology and resilience into supervision.
- *Not Just a Service Provider: Providers Are Members of Resilient Communities*, a half-day training to 1) integrate the impact of toxic stress and trauma into service delivery; 2) improve providers' programmatic/ business outcomes; 3) enhance community resilience and 4) enhance providers' viability as business entities.

In addition, a small group of system leaders committed to partnering with BHSB to develop a framework to effect transformation at the city-wide level. The group named itself *A Beloved Community* (ABC), which is based on a Martin Luther King, Jr. quote. ABC met on a monthly basis throughout 2018, with BHSB providing staff support. A shared vision statement, as well as collective goals and objectives were written, and the next step is to develop implementation strategies.

S.E.L.F. Community Conversations

S.E.L.F. Community Conversations, evolving from The Sanctuary Model®, is a framework of culturally-appropriate exercises and templates for facilitating conversations among small groups or in larger community contexts. Because individual and community responses to such experiences are inevitably complex, the framework offers a set of key and non-threatening

learning points that can be explored and addressed in social, organizational, or community settings.

S.E.L.F. is an acronym (Safety, Emotions, Loss, and Future). The goal of the approach is to focus on the effects of exposure to trauma, which include: loss of safety, inability to manage emotions, overwhelming losses and a paralyzed ability to plan for or even imagine a different future. The S.E.L.F. framework posits that safe spaces and specific structured conversations enhance capacity for self-regulation and healthy coping strategies.

S.E.L.F. Community Conversations recognizes that most of the restorative powers needed to promote the growth and wellness of participants and communities resides in the collective wisdom and strength of community members. It is not intended to replace other evidence-based behavioral health interventions that promote healing in specific cases where trauma or abuse responses have become more severe.

During FY 2018, BHSB provided seven trainings to providers and other system partners, as well as ongoing weekly coaching to support implementation.

U-TURNS

U-TURNS (Trauma, Unity, Recovery, Navigation and Safety) launched in February 2017. It utilizes a trauma-informed approach, with the goal of creating a safe space where young people who have been exposed to violence, chronic stress and trauma can be supported to fulfill their positive potential. It is funded by a five-year award from SAMHSA under the National Child Traumatic Stress Initiative.

Outreach workers engage youth through street outreach and support them in reaching their goals through peer support, yoga, tai chi, acupuncture and *S.E.L.F. Community Conversations,* which is a framework of culturally-appropriate exercises that uses structured dialogue, with relevant and culturally-competent exercises, to address the learning points that accompany exposure to trauma, abuses, and other forms of adverse conditions.

S.E.L.F. is an acronym (Safety, Emotions, Loss, and Future) that identifies these four facets of universal human responses to complex and potentially dangerous life circumstances. The goal is to focus on the effects of exposure to trauma, which include: loss of safety, inability to manage emotions, overwhelming losses and a paralyzed ability to plan for or even imagine a different future.

During FY 2018, the outreach workers made 4,160 outreach contacts and formally enrolled 120 young people into U-TURNS. During year two of the U-TURNS grant (October 2017 to September 2018), 73 young people participated in *S.E.L.F. Community Conversations*, and 67 young people participated in yoga or acupuncture.

After one of the key partner organizations decided not to continue participating in U-TURNS near the end of FY18, BHSB made the decision to issue a *Request for Proposals* for a new organization to serve as the U-TURNS provider. As of December 2018, proposals were being reviewed by an external committee.

Family Peer Support

Parents, caregivers and family members of children with behavioral health challenges need significant support and education resources. BHSB supports a state-wide network of parent-peer supports through funding and technical assistance provided to Maryland Coalition of Families (MCF). MCF utilizes a Family Peer Support Specialist (FPPS) model, involving individuals with "lived experience" as caregivers for a child with mental health, substance use and/or other behavioral health conditions, providing supports to parents in similar caregiver roles. These supports can include helping families navigate services and systems, attending meetings with families, explaining rights and responsibilities and providing opportunities to meet with individuals in similar, stressful roles. There is no cost to parents/caregivers for services state-wide, reducing barriers to engagement and support. Expansion of these services to support loved ones of all ages who are impacted by individuals with a Gambling Disorder began during FY 2018.

MCF also provides webinars and family trainings on behavioral health topics and coordinates the Family Leadership Institute, which provides education and resources to parents, caregivers and family members of children with behavioral health challenges. It is also an active partner in the *Children's Mental Health Matters!* campaign with the MHAMD.

Overdose Response

The state of Maryland is experiencing a public health emergency, as the number of opioid overdose fatalities continues to rise. In response, the Maryland Opioid Operational Command Center was established by the Hogan Administration's 2017 Heroin and Opioid Prevention, Treatment, and Enforcement Initiative. Each jurisdiction is required to establish an Opioid Intervention Team (OIT) to coordinate local opioid response efforts and integrate with statewide efforts. As the city's public health agency, the BCHD leads the overdose response and chairs the OIT. BHSB participates on the OIT, as well as on the city's Opioid Fatality Review team, which is also chaired by BCHD. To facilitate communication and coordination, a BCHD staff person attends BHSB's internal overdose response work group.

In response to the public health emergency in Baltimore City, BHSB is collaborating with state and local partners to implement a wide array of strategies. Some of those discussed in previous sections of this document include: the Maryland Crisis Stabilization Center, expanding peer-delivered outreach services, rapid response to overdose spikes, peer-delivered overdose education and naloxone distribution, pairing outreach peers with a mobile buprenorphine van

operated by the BCHD, the Baltimore Buprenorphine Initiative and the Hub and Spokes Project. Additional initiatives are described in the following sections.

Harm Reduction

Harm reduction is an approach that utilizes practical strategies to reduce negative consequences associated with drug use. It is based on an understanding that drug use is complex and that some ways of using drugs are safer than others. It is grounded in respect for the rights, experiences, and knowledge of people who use drugs, as well as a commitment to centering the voices of people who use drugs in discussions about services and policies that impact them. Harm reduction is of particular value in engaging with people who use drugs and are not connected to the public behavioral health system and supporting them in improving their physical, emotional, and social well-being. BHSB collaborates with state and local partners to support and expand several initiatives that are grounded in a harm reduction framework.

Since 2015, BHSB has supported the development of Bmore POWER (Peers Offering Wellness Education and Resources), which is a network of people with lived experience related to drug use. During FY 2018, Bmore POWER grew to approximately 40 active members who provided harm reduction street outreach (including resource connection and distribution of naloxone, safer sex supplies, and educational materials), educated legislators, and represented their communities on a number of coalitions.

BHSB continued providing overdose education and naloxone distribution during FY 2018. Through targeted street outreach and classroom trainings, BHSB staff and Bmore POWER members trained 9,112 people to respond to overdoses and distributed 8,779 naloxone kits.

BHSB and Bmore POWER collaborated in February 2018 to create a behavior change campaign (*Go Slow*, www.20secondssaves.org) about how to stay safer when using drugs in the context of a fentanyl-laden market. This campaign was proposed by a Bmore POWER member who wanted to support her community in the midst of a massive increase in overdose deaths due to fentanyl.

BHSB staff and Bmore POWER members participate on the BRIDGES (Baltimore Resources for Indoor Drug-use Grassroots Education & Safety) Coalition, a group of peers, providers, and advocates working together to advance harm reduction strategies, such as safe consumption spaces, to improve health and justice in and around Baltimore.

In collaboration with the BHA, BHSB launched the Harm Reduction Training Institute (HRTI) during the summer of 2018 to provide training, technical assistance, and leadership development to interested stakeholders throughout Maryland. HRTI is working to develop and offer an evolving, core set of trainings open to health, social service, and housing providers working with people who use drugs; respond to individualized requests based on local needs and capacity; and offer specialized training and development opportunities to key groups that are at the forefront of the harm reduction movement in Maryland. HRTI also provides training and leadership

development support to community groups that center the wellness of people who use drugs and other directly impacted individuals.

HRTI has three primary goals:

1. Build local and statewide knowledge, capacity, and expertise in harm reduction-related philosophy and service delivery.
2. Support harm reduction programs to provide the highest quality services for people who use drugs and/or have a history of drug use.
3. Support the leadership development and capacity-building of people who use drugs and/or have a history of drug use.

Opioid Misuse Prevention Plan

Beginning in FY 2015, BHSB underwent a planning process to develop an Opioid Misuse Prevention Plan using SAMHSA's *Strategic Prevention Framework* (SPF), which has a long-term goal of reducing overdose fatalities in Baltimore City. A needs assessment was completed during FY 2015, which informed a strategic plan that was finalized in FY 2016. This plan included two initiatives: 1) provide training and clarity regarding the Good Samaritan Law and its implementation and use for the Baltimore Police Department and at-risk community residents and 2) provide linkages to the public behavioral health system for individuals who experience a non-fatal overdose in the community.

The curriculum for training law enforcement was implemented in FY 2017, and training continued during FY 2018. A revised strategic plan for the second initiative was implemented in May 2017 to investigate why individuals who survive an overdose refuse transport by ambulance to the hospital and to determine what linkages would best meet their needs at the time of an overdose. Key findings of this investigation include the following:

- Intolerable withdrawal symptoms after naloxone administration was a pervasive theme and primary driver of refusal.
- Hospital-related reasons for refusal included perceived poor treatment, inadequate care and/or referrals, insufficient severity of their medical condition and fears of disclosure of drug use by hospital staff to family, friends and the authorities.
- EMS-related reasons for refusal included perceived treatment by EMS providers, fear of the ambulance vehicle itself, and cost.
- Respondents reported increased willingness to accept transport and other services if withdrawal symptoms could be eased (buprenorphine induction was discussed), if they perceived more "sensitive" treatment by EMS providers, and if respondents believed their medical condition was more severe.

To assist in addressing the key findings of this investigation, BMore Power joined the OMPP Coalition, which includes the BCHD and Baltimore City Fire Department, in collaboration with

local and national consultants with related expertise. During FY 2019, BHSB is partnering with the OMPP Coalition to design a curriculum specific to EMS first responders to increase knowledge and raise awareness of overdose, decrease refusal to transport and increase empathy and consciousness of trauma and self-care.

Public Education

BHSB participated in several community-wide events this year that raised awareness of behavioral health issues and addressed stigma. In April 2018, BHSB partnered with the BCHD, BPD and Drug Enforcement Administration to raise awareness about National Drug Take Back Day by co-hosting a press conference reminding people to drop off unused and unwanted drugs at drop-box locations throughout Baltimore City.

A public education campaign is an important strategy to change the public's view of behavioral health disorders and improve access to care. BHSB launched an anti-stigma campaign, *See Past the Stigma*, in September 2018 to coincide with National Recovery Month. This campaign used a personal appeal from a Baltimore Raven player deeply interested in helping others overcome stigma, stories from a range of individuals to make clear that a behavioral health condition does not define them and high-caliber graphic design and video to connect visually with the public. BHSB created a unique website, www.seepastthestigma.org, and used paid advertising, social media, earned media, and community engagement to promote the campaign.

As part of the *See Past the Stigma* campaign, BHSB organized a community art project in which providers and consumers were invited to create post cards representing recovery and addressing stigma. BHSB hosted crafting sessions at 20 provider locations and collected over 200 postcards. The postcards were displayed at an art exhibit in September 2018. Providers, consumers, advocates, and community members attended, and many shared their personal stories of recovery.

In addition to the public education activities conducted by staff, BHSB funds the following organizations to provide public education and support activities for individuals, families and communities in Baltimore City:

- MHAMD provides children's mental health information and campaign materials for Children's Mental Health Matters, participates in health fairs, conducts older adult mental health and advanced directive trainings, collaborates with BHSB to disseminate Mental Health First Aid throughout the city, and oversees a public education project to address the behavioral health needs of new mothers.
- NAMI (local and state chapters) provides family support trainings and workshops on mental health topics and coordinates its annual NAMI Walk, a public education event that promotes awareness of mental illness.

- MCF provides webinars and family trainings on mental health topics and coordinates the Family Leadership Institute, which provides education and resources to parents, caregivers and family members of children with behavioral health challenges. It also provides education to families on the Good Samaritan Law.
- On Our Own of Maryland provides presentations on the stigma of mental illness, partners with local consumer-run organizations in various educational events and provides assistance and referrals to consumers via telephone and in person.

- Bmore POWER developed the *Go Slow* campaign to educate people who use drugs about fentanyl. This campaign utilizes a harm reduction approach to inform users that fentanyl is in their drugs and that injecting slowly could save their life. The website is www.20secondssaves.org.

Prevention

One of BHSB's strategic goals is to promote a comprehensive behavioral health and wellness prevention strategy for Baltimore City. In FY 2018, BHSB engaged in a planning process using SAMHSA's *Strategic Prevention Framework* (SPF) and developed a comprehensive and holistic strategy to prevent substance use, misuse, and related behavioral health problems among young people, ages 12-24, in Baltimore City. This process started with a community needs assessment to understand how community members view behavioral health concerns and what they identify as solutions. Involving and including communities impacted by substance use in identifying, developing, and implementing solutions is a critical component of the SPF process in which BHSB continues to engage.

Through the SPF process, two prevention interventions were identified that are built on community-defined evidence and evidence-based practice. These interventions address the factors known to contribute to substance use, particularly the three categories of substances identified as priority targets: heroin, alcohol, and non-medical use of prescription drugs (NMUPD).

In the fall of 2018, BHSB released a *Request for Proposals* seeking qualified organizations to implement evidence-based interventions in educational and community settings to prevent substance use and misuse among young people. Implementation of services is anticipated to begin in January 2019.

BHSB also continued implementation of the Maryland Strategic Prevention Framework 2 (MSPF2) project during FY 2018. MSPF2 focuses on the reduction of underage and binge drinking among adolescents and young adults, ages 12-24. Based on the data collected from the Youth Risk Behavior Survey (YRBS), the Maryland Youth Survey on Alcohol (MYSA), focus groups and key informant interviews, the MSPF2 needs assessment identified high alcohol outlet density and the lack of responsible drinking practices as priority issues. MSPF2 addresses these

issues in targeted Community Statistical Areas (CSAs), which include: Greenmount, Oliver East, Coldstream, Homestead and Northwood.

A key component of MSPF2 is the community-based MSPF2 Coalition, which developed and implemented action steps to facilitate positive change toward the following goals:

- Increase liquor store sanctions and
- Decrease retail availability of alcohol for adolescents and young adults.

The partnerships include:

- Baltimore Liquor License Commission
- Baltimore City law enforcement
- Baltimore Good Neighbors Coalition
- Baltimore City Health Department
- Morgan State University
- Johns Hopkins Center on Alcohol Marketing and Youth
- Local media
- East Baltimore Drug-Free Communities Coalition
- Oliver Community Association
- Local community-based organizations and businesses located in the targeted CSAs

Challenges

The conditions in which people are born, grow, live, work and age, and which are affected by the distribution of money, power and resources, are referred to as the social determinants of health. These determinants result in enormous health disparities between communities. As described in the *Baltimore City Demographics* section of this plan, Baltimore City has a disproportionate burden of structures and conditions that increase the likelihood of chronic behavioral health conditions.

Baltimore City's Department of Planning has collected and analyzed data that shows enormous disparities in the city's investment between neighborhoods that are predominantly white, versus predominantly communities of color.[9] Historical federal and local policies, such as redlining, racial zoning city ordinances and racially restrictive housing covenants, have resulted in disinvestment that continues to be structured into the systems, policies and procedures that guide resource distribution today. As a steward of public funds, it is incumbent on BHSB to work to ensure that resources are distributed equitably, in ways that intentionally address the harm to communities that resulted from disinvestment. This work will be ongoing, and BHSB anticipates

[9] Abello, Oscar Perry. Baltimore Reckons With Its Legacy of Redlining. Next City. November 22, 2017. https://nextcity.org/daily/entry/baltimore-reckons-legacy-redlining

that many challenges will arise, some of which will be internal. Others may arise from conflict between the requirements of funders and BHSB's broader equity vision. BHSB also recognizes that to maximize outcomes from the investment of public funds, systems, institutions and funders must collaborate to align resources around shared goals. Effective collaboration, however, is very challenging. It requires the sustained commitment of leadership, strong communication and ongoing relationship-building.

An additional challenge is funding for prevention services, which is limited and primarily targeted toward preventing or reducing substance use. The process for distributing these resources is highly structured at the state level, which can result in conflict between community-driven processes and funding requirements. There is a need for a primary prevention strategy that promotes wellness and mitigates the impact of trauma and toxic stress.

The increase in suicide rates across the United States, including in Maryland, is an alarming trend. There is an urgent need for a comprehensive prevention plan. However, BHSB lacks capacity to undertake a planning process to create one.

5) DATA AND SYSTEM OUTCOMES

One of BHSB's strategic priorities is using data to support practice. In support of this priority, the epidemiology team implemented multiple strategies to increase the capacity of BHSB staff and the wider provider network to use data.

RecoveryStat

BHSB launched RecoveryStat during January 2017. RecoveryStat analyzes and reports on utilization of the public behavioral health system in Baltimore City using paid claims data. In collaboration with a provider work group, BHSB identified the following key indicators:

- Average expenditures per consumer
- Number of providers using public dollars and volume
- Average number of consecutive months of outpatient engagement
- Percent of consumers who transition from inpatient to outpatient care within 30 days
- Percent of consumers reporting good health, employment, homelessness

Providers are invited to participate in quarterly meetings, during which analyses are presented and discussed. The goals are to support providers in increasing their capacity to use data to enhance practice and to increase the collective understanding of how the provider network functions as a system of care. During FY 2018, RecoveryStat presentations were held during July, October, January and June.

To support BHSB's priority of continuing to develop capacity at the organizational and systemic levels to use data to inform decision making, BHSB's epidemiology team will work with programmatic staff to incorporate data analyses and presentations as a standing agenda item for regularly scheduled convenings of providers. This will replace the RecoveryStat convenings. BHSB anticipates that this approach will increase interest in and demand for more data and deeper analyses.

Evaluation Projects

BHSB's epidemiology team engaged in several research and evaluation projects during FY 2018. One such project is the Refusal to Transport (RTT) study, aimed at identifying reasons why overdose survivors refuse emergency medical services (EMS) transport to the hospital following an overdose, and conditions under which overdose survivors would be more likely to accept transport and behavioral health linkages to care in the prehospital setting. Intolerable withdrawal symptoms after naloxone administration was a pervasive theme and primary driver of refusal. Due to these symptoms, many participants described resistance to naloxone administration by EMS, and many reported drug consumption immediately after resuscitation with naloxone to ease these symptoms.

Study participants cited reasons for transport refusal related to the hospital and EMS staff. Hospital-related reasons included perceived poor treatment; inadequate care and/or referrals; insufficient severity of their medical condition; and fears of disclosure of their drug use by hospital staff to family, friends and the authorities. Reasons for transport refusal related to EMS included perceived treatment by EMS providers, fear of the ambulance vehicle itself and cost. Respondents reported increased willingness to accept transport and other services if withdrawal symptoms could be eased (buprenorphine induction was discussed), if they perceived more "sensitive" treatment by EMS providers and if respondents believed their medical condition were more severe. Alternative destinations (e.g. stabilization center), particularly if withdrawal symptoms were relieved, alternative transport (e.g. peer transport) and buprenorphine induction were favorably discussed by participants. Focus groups were also held with EMS providers and leadership to triangulate findings and identify practical opportunities for intervention.

As part of the Maryland SBIRT Project, BHSB is collaborating with the BHA and the University of Maryland's Systems Evaluation Center (SEC) on SEC's Hospital-based Peer Support Interventions Evaluation (HPSIE). Six hospitals that implemented SBIRT are participating in the study that will identify factors that both facilitated and impeded SBIRT implementation. In FY 2019, SEC will also conduct 1) a survey of training needs among hospital-based peer recovery specialists and supervisors and 2) an in-depth analysis of Government Performance and Results Act (GPRA) data. BHSB will contract with Health Management Associates to conduct a survey of Marylander's exposure to SBIRT services and the perceived value of speaking with health care providers about alcohol and drug use.

The Expanded School Behavioral Health (ESBH) Evidence Based Assessment (EBA) Initiative was begun during FY 2016 with the goal of collecting information and data from the school-based behavioral health providers serving all school grades, from kindergarten through 12th grade, to understand the characteristics of students served and continue to improve services provided. The tool that is used is the Pediatric Symptom Checklist-17 (PSC-17), which is a validated, brief questionnaire intended to provide an assessment of psychosocial functioning.

The PSC-17 is administered twice during the school year, with the first administration providing baseline data. Annually, after the full EBA data collection is complete for the school year, an Impact Evaluation is developed. The Impact Evaluation is used by individual providers to inform their practices and is also utilized by BHSB and system partners to support quality improvement efforts and advocate for continued ESBH implementation.

During FY 2018, the initiative collected 451 surveys, of which 414 were from mental health providers, and 37 from SUD providers. Of the 451 surveys, 60% of the students identified as male, and 40% as female. The racial demographic breakdown was 82% African American, 9% white, and 5% other, with 4% identifying as Hispanic. Overall, 18% of the students experienced depression or depressive disorders, and 23% experienced anxiety disorders.

The comparison of data between the baseline and subsequent administration of the PSC-17 showed an overall 7% reduction in mental health risk, from 44% to 37%. Breaking down the analysis by gender, mental health risk decreased from 50% at baseline to 37% for males. There was a slight increase in risk for females, but it was not statistically significant. Analyzing the data by race did not show any statistically significant changes.

BHSB has partnered with the Johns Hopkins Bloomberg School of Public Health to conduct a Bmore POWER evaluation. The principle investigator, Susan Sherman, is leading a team of researchers to evaluate the impact of Bmore POWER's street outreach, as well as the BHA-supported expansion of a similar model in Anne Arundel County. The evaluation is planned to conclude in the fall of 2019, at which time results will be disseminated.

System Capacity Tracking Projects

One of the pressing needs in Baltimore City and other jurisdictions across Maryland is a centralized mechanism to access real-time information regarding the capacity of behavioral health treatment programs to admit new consumers into various levels of care. BHSB is collaborating with state and local partners to develop systemic strategies to address this need.

During October 2017, BHSB convened a group of individuals from jurisdictions across Maryland that were working on and/or interested in projects to use technology to track treatment availability and track consumers across the system of care. The goal was to identify opportunities to align projects and resources. The group decided to continue meeting, and leadership transitioned to the Maryland Hospital Association. After several working sessions, two shared

goals were identified: 1) to identify guiding principles to ensure that infrastructure developed by local jurisdictions under various funding projects connects seamlessly across the statewide system of care, and 2) to describe the "gold standard" technological infrastructure that is needed to support Maryland's statewide behavioral health system.

Participants in this workgroup included representatives from: the MDH, the BHA, the Maryland Hospital Association, the BCHD, Anne Arundel County, the City of Annapolis, Howard County, Prince George's County and the Chesapeake Regional Information System for our Patients (CRISP), which is the regional health information exchange (HIE) serving Maryland and the District of Columbia.

In September 2017, BHSB partnered with the BCHD to launch the Real-Time Capacity Tool (RTCT) pilot project. The goals of the project are to 1) track real-time capacity for admissions across programs, 2) rapidly connect individuals with needed treatment and 3) maximize utilization of available treatment services. A small group of providers agreed to participate in the project by utilizing a shared tool to record available capacity. The group meets monthly to identify systemic, technical and operational challenges, collectively problem-solve and inform planning for modifications to the tool.

The RTCT project will inform a project launched by the BCHD to build a Community Health Information Exchange for Baltimore City. Its goal is to develop an integrated social needs screening tool and resource directory that links existing inventories with new tools, all connected via CRISP. BHSB is collaborating closely to plan development of a tool within this exchange to manage real-time capacity tracking and referrals for behavioral health services.

Challenges

The U.S. Department of Health and Human Services (HHS) finalized changes to Confidentiality of Alcohol and Drug Abuse Patient Records regulations, (42 CFR Part 2) to facilitate health integration and information exchange within new health care models, while continuing to protect the privacy and confidentiality of patients seeking treatment for substance use disorders. The changes went into effect in March 2017.

In parallel to the regulatory changes at the federal level, during FY 2017 CRISP began preparing to implement Consent2Share in Maryland. Consent2Share is an application created in partnership with SAMHSA to enable consumers to determine and indicate through an online consent process, the type and amount of health information they would like to share and the providers with whom they would like that information shared. Among other positive outcomes, this would enable timely access to behavioral health data for primary care and behavioral health providers, hospitals, and other individuals involved in a consumer's care, supporting improved clinical decision-making and care coordination. However, Consent2Share has not yet been implemented in Maryland. This is a significant barrier to integration of care and information exchange.

BHSB has a talented and skilled data team that works to analyze claims data and support BHSB staff and providers in using the data to inform decision making. However, analyzing claims data is challenging and requires a deep knowledge of reimbursement processes, including an understanding of the intricacies of fee schedules and claims coding. BHSB's data team is working with the BHA to advocate for additional standard reports in Intelligence Connect, which would allow certain indicators to be easily tracked without having to perform an in-depth analysis of claims data. In particular, an unduplicated count of people served in the entire behavioral health system, not separate counts for those receiving mental health and SUD services, would be helpful.

It is also important to note that mental health and substance use disorder claims continue to be segmented. This is a significant limiting factor in using claims data to promote system integration and drive decision making about resource allocation.

Data

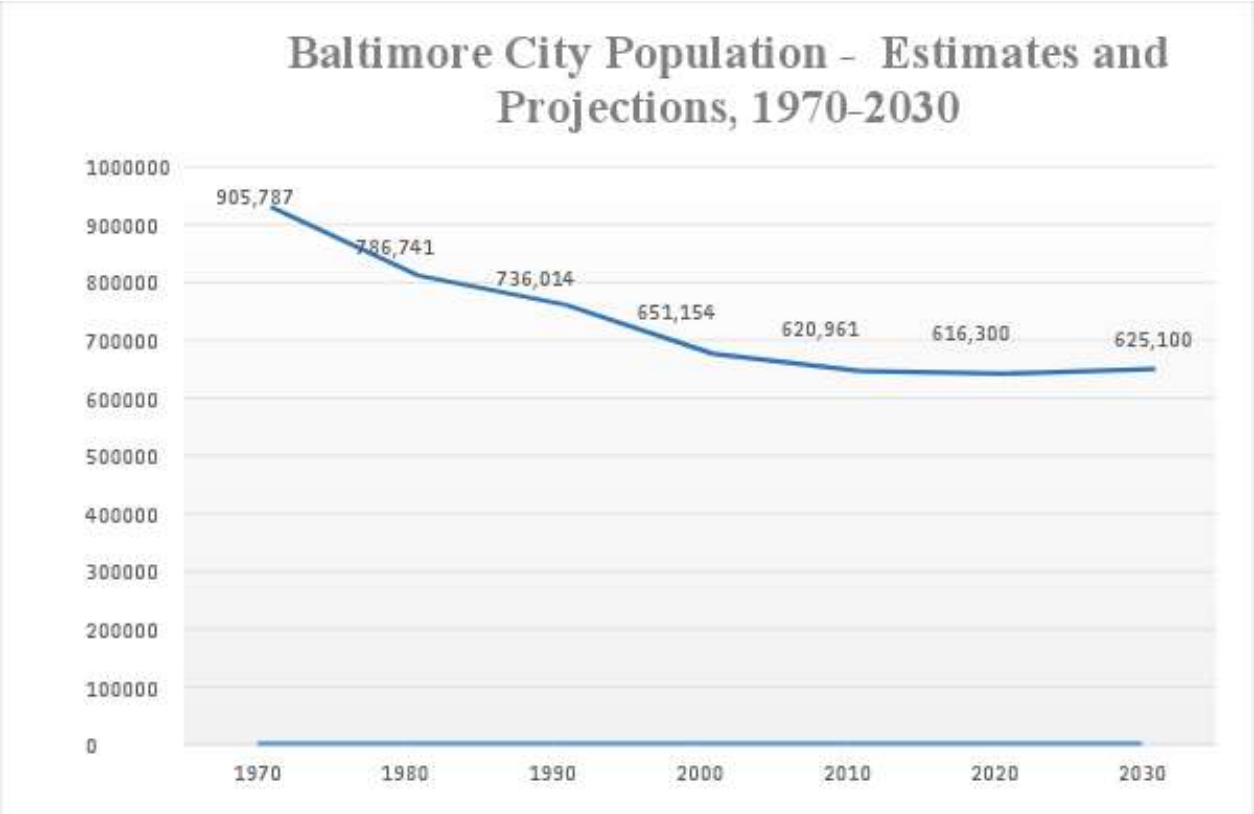
1. BALTIMORE CITY DEMOGRAPHICS AND SOCIAL DETERMINANTS OF HEALTH

The Demographics section of this document presents data describing Baltimore City's population and characteristics of the city relevant to behavioral health. These characteristics include age, race, health, income, and housing status, which are factors that impact the incidence of behavioral health disorders and the utilization of behavioral health services. They highlight the s*ocial determinants of health*, which are the conditions in which people are born, grow, live, work and age, and which are affected by the distribution of money, power and resources. These determinants result in enormous health disparities between communities.[10]

Population

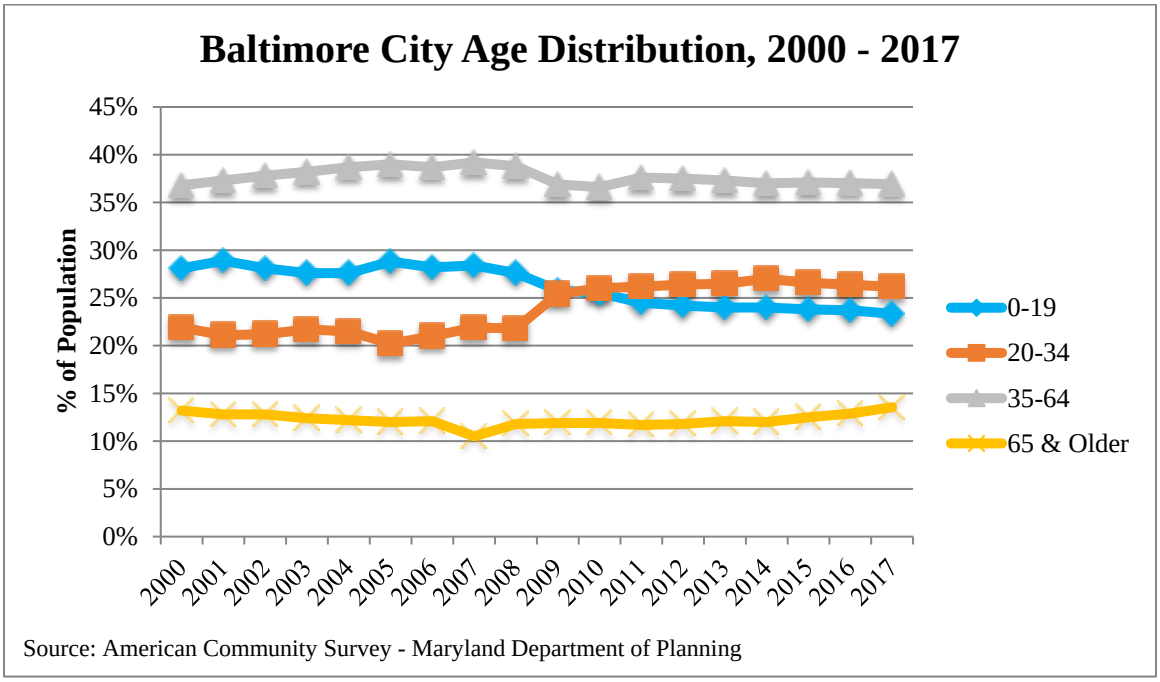
Baltimore City is the 30th most populous city in the nation and the largest city in Maryland, comprising almost 10.1% of the state's population in 2017, with approximately 611,648 people based on American Community Survey (ACS) estimates. Although census data indicate that the city's population has decreased significantly since the 1970s, the Maryland Department of Planning projects an increase of 5,000 people (0.6% growth) by 2030.

[10] World Health Organization. "About Social Determinant of Health." http://www.who.int/social_determinants/sdh_definition/en/



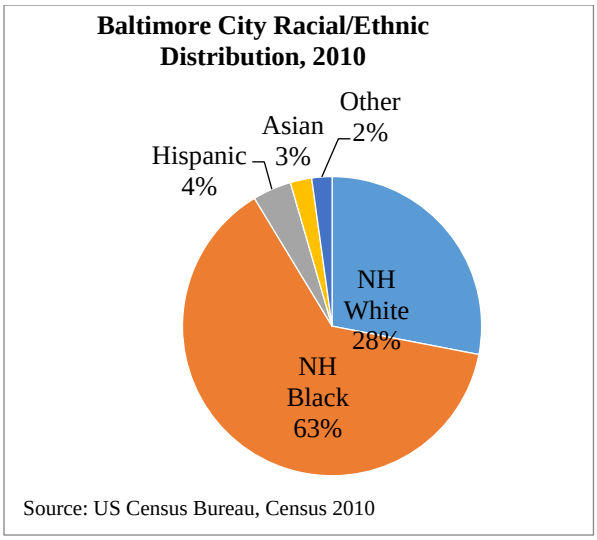
Source: Maryland Department of Planning - July 2016

As evidenced by the chart below, the age distribution has shifted slightly in the last seven years. Between 2010 and 2017, the population aged 65+ experienced an increase, while the remaining age groups experienced a stable line or slight decrease. In 2017, there were an estimated 126,316 children under the age of 18 and 485,332 adults in Baltimore City. Overall, the median age in Baltimore City remained around 35.3 during 2017, whereas the median age in the state is 38.7 years. The distribution by gender was 47.0% (male) and 53.0% (female).

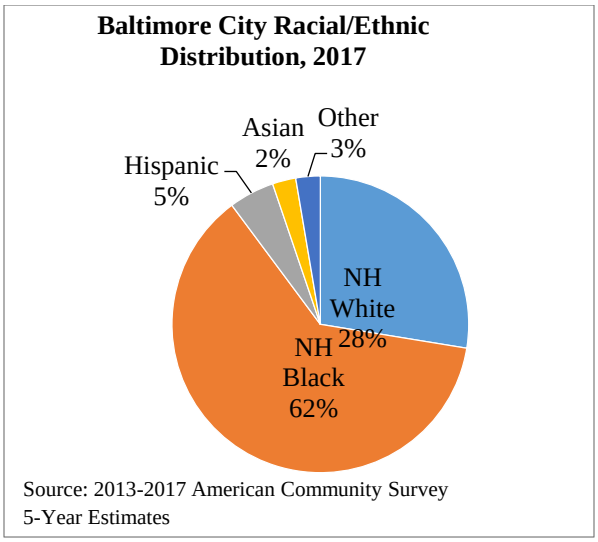


Source: American Community Survey - Maryland Department of Planning

The city's racial/ethnic distribution is bi-modal, with 62% non-Hispanic Black individuals and 28% non-Hispanic white individuals. The remaining 10% is comprised by Hispanic, Asian and other race or ethnicity.

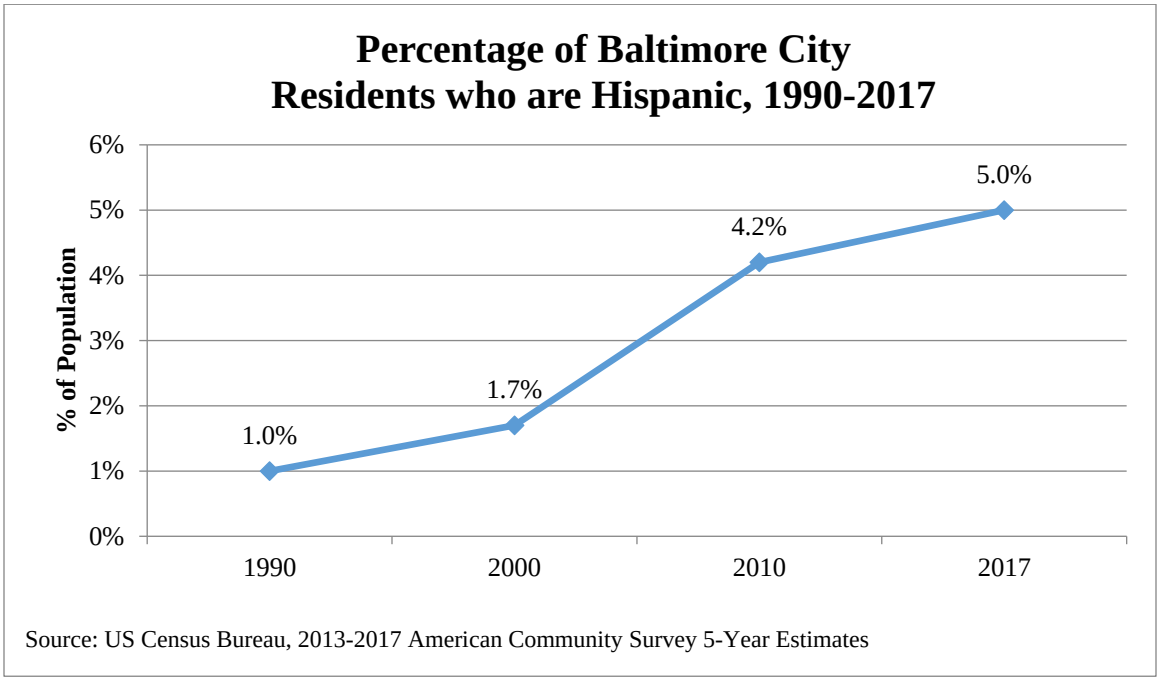


Source: US Census Bureau, Census 2010

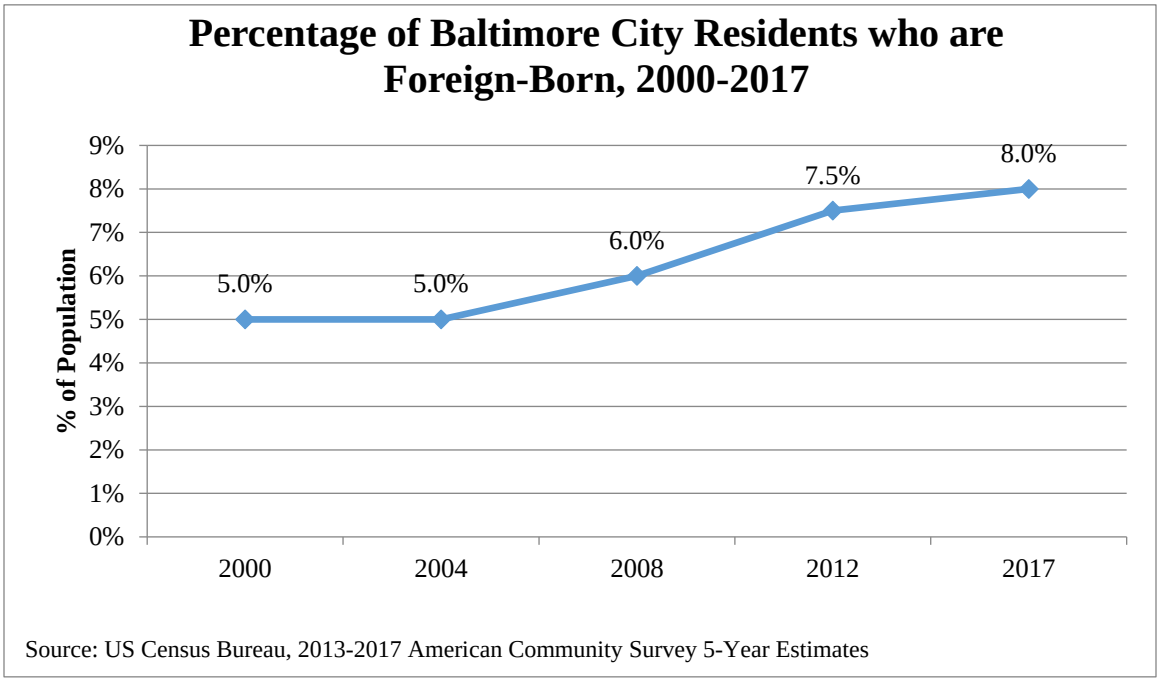


Source: 2013-2017 American Community Survey 5-Year Estimates

The population is slowly becoming more diverse, as indicated by the increase in the percentage of Hispanic and Asian residents, both of which have almost doubled since 1990 and are likely to be under-counts at present. It is difficult to accurately count immigrant residents, many of whom may be undocumented and often do not show up in official population counts.

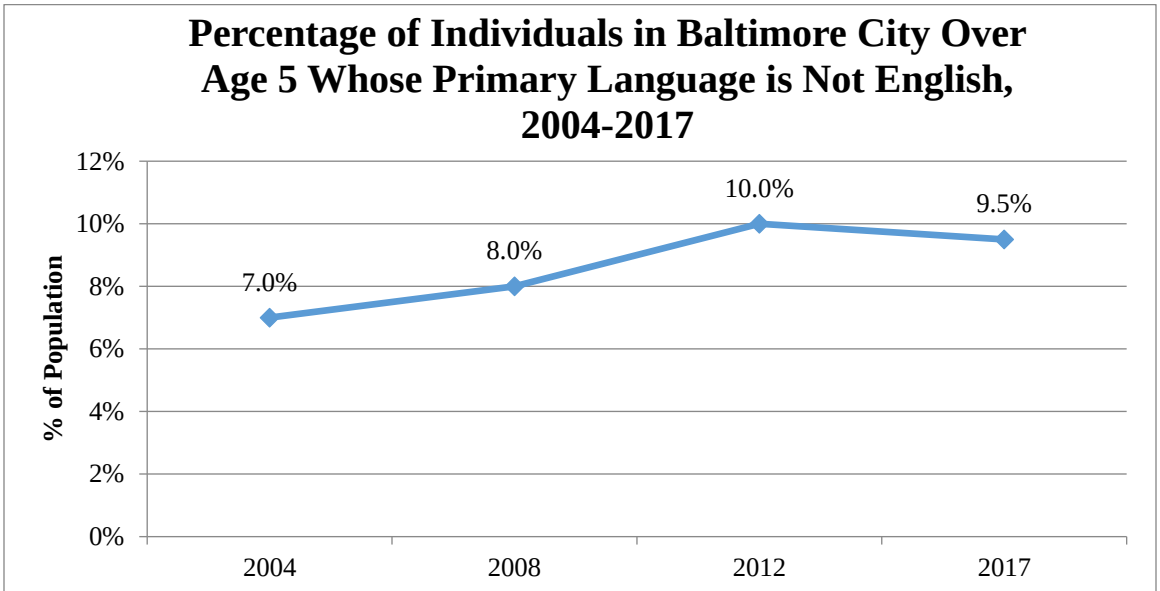


Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

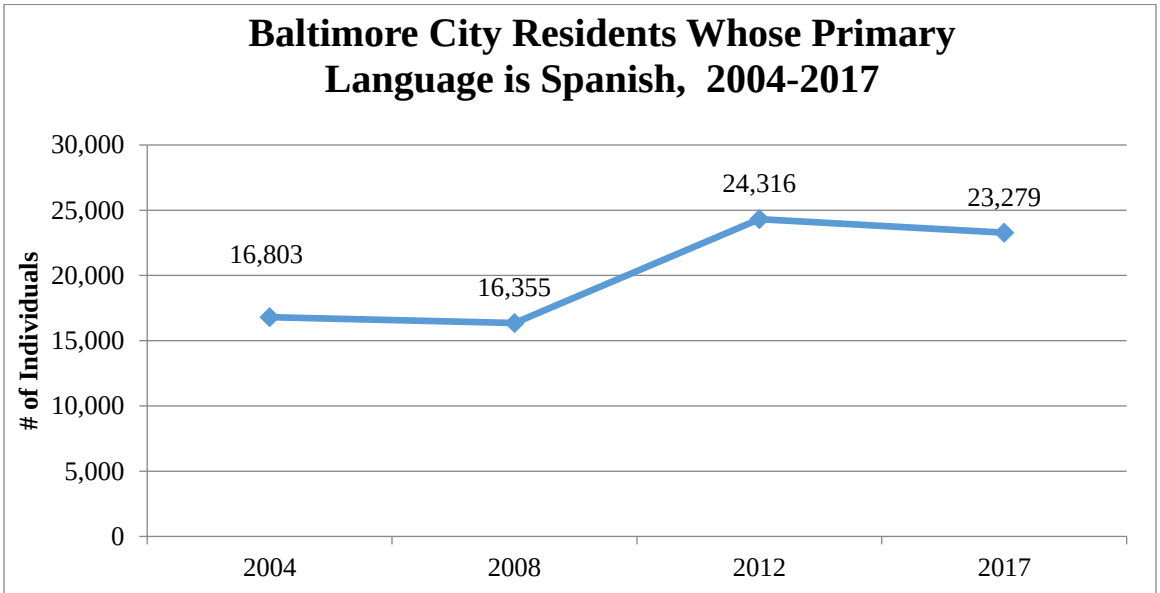


Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Languages other than English were spoken in 9.5% of households in 2017, with Spanish being the most frequently spoken non-English language. Between 2004 and 2017, the number of individuals whose primary language is Spanish increased by 38.5%.



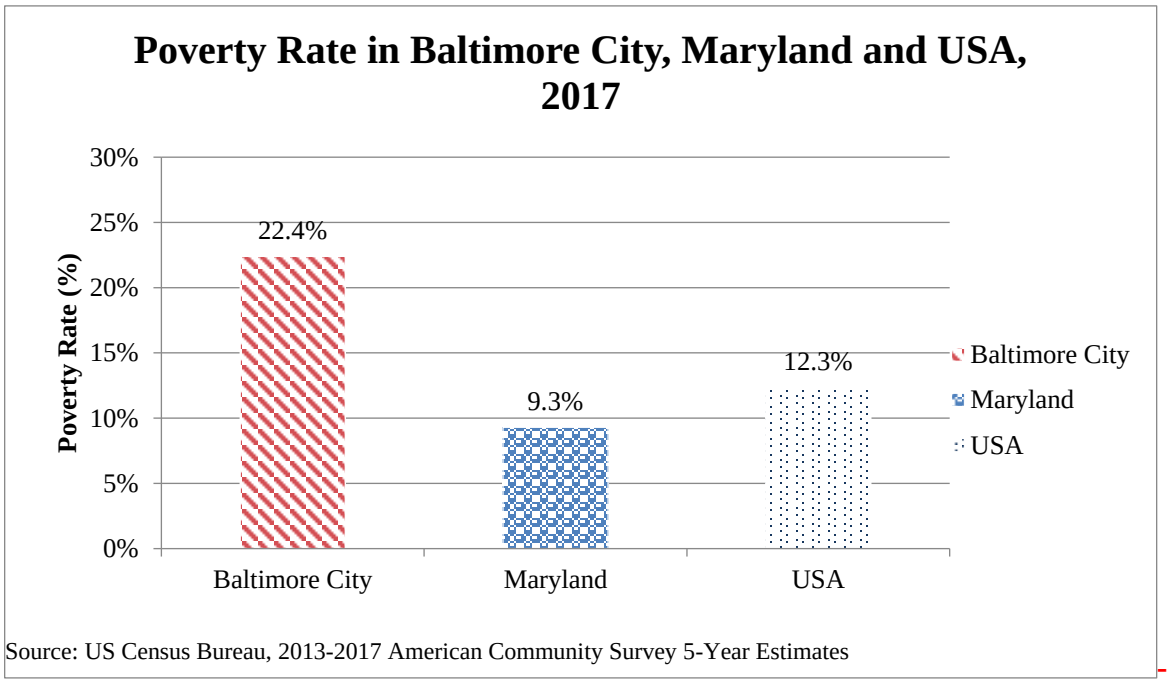
Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates



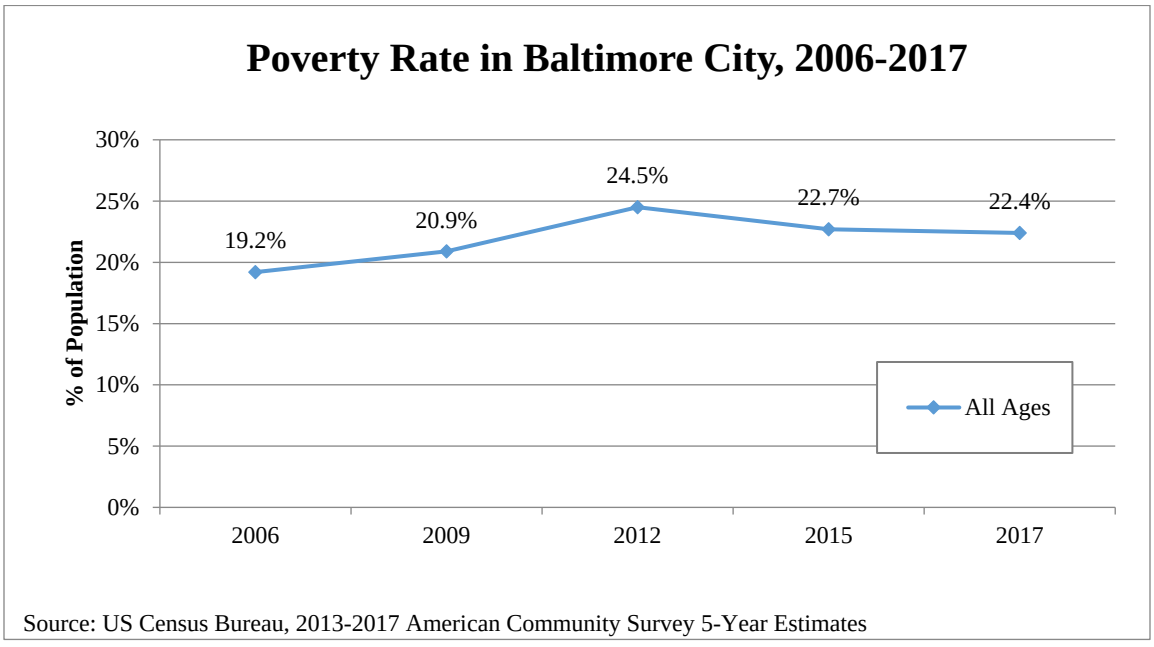
Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Poverty

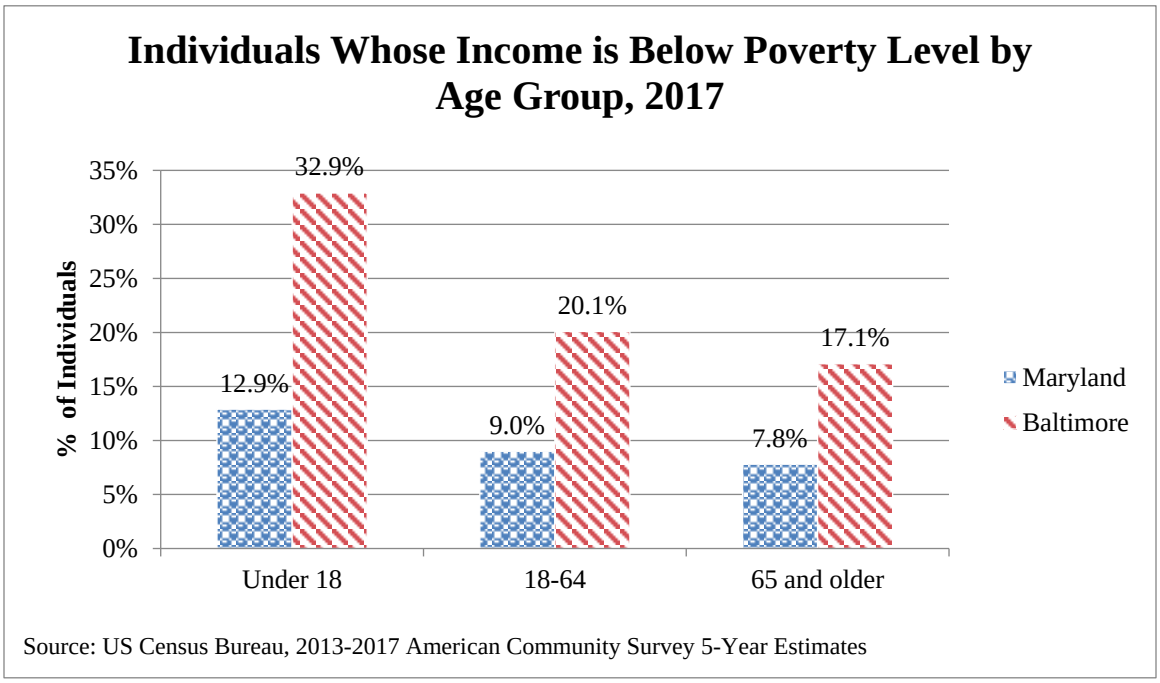
There is a gap in poverty rates between Baltimore City and the state. In 2017 the Baltimore City median household income was $46,641, whereas the state median income was $78,916. In addition, almost one in four city residents (22.4%) was below the poverty line, as compared to one in ten Maryland residents (9.3%).



Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates



Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates



Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Adverse Childhood Experiences (ACE)

The Centers for Disease Control and Prevention's (CDC) landmark 1998 study on Adverse Childhood Experiences (ACE) demonstrated the connection between traumatic childhood experiences and many emotional, physical, social and cognitive impairments that lead to increased incidence of health risk behaviors, chronic disease and premature death.[11] ACEs have a strong dose-response relationship to health and social problems throughout the lifespan. As the number of ACEs increases, there is an increased likelihood of risky behaviors and chronic physical and mental health conditions.

Maryland began collecting ACEs data through the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) in 2015. The BRFSS is a statewide survey that collects data on the behaviors and conditions that put individuals at risk for chronic diseases, injuries and preventable infectious diseases. Over 8,500 Maryland households anonymously participate in this survey each year. Statewide, the prevalence of three or more ACEs was 24%, whereas for Baltimore it was 42%.[12]

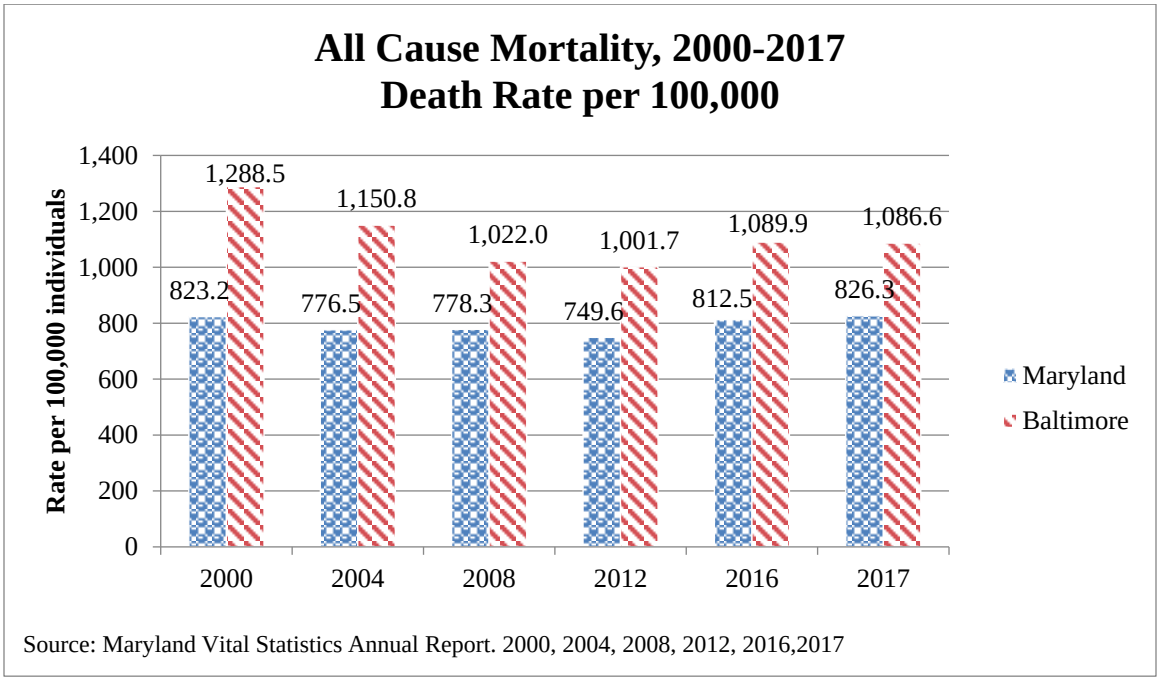
[11] Fellitti, V.J., et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. American Journal of Preventive Medicine, 14(4) 245-258. doi: http://dx.doi.org/10.1016/S0749-3797(98)00017-8

[12] Maryland Behavioral Risk Factor Surveillance System (2017). "Adverse Childhood Experiences (ACEs) in Maryland: Data from the 2015 Maryland BRFSS Data Tables Only." https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/2015_MD_BRFSS_ACEs_Data_Tables.pdf

Health Status

Health indicators suggest that Baltimore City residents experience a significantly greater burden of illness, disability, and mortality compared to the state, with substantial disparities between neighborhoods within the city. The average life expectancy is 72.8 years for Baltimore City residents and 79.2 years for Maryland residents.[13] The Baltimore City Health Department Neighborhood Profiles data comparing Baltimore City neighborhoods found an average life expectancy range of 68.4 years in Poppleton/The Terraces/Hollins Market, versus 83.9 years in Greater Roland Park/Poplar Hill.[14]

While Baltimore's all-cause mortality rate[15] has declined by 15% over the past sixteen years, it remains significantly higher than the state's rate. The gap has been closing over time.



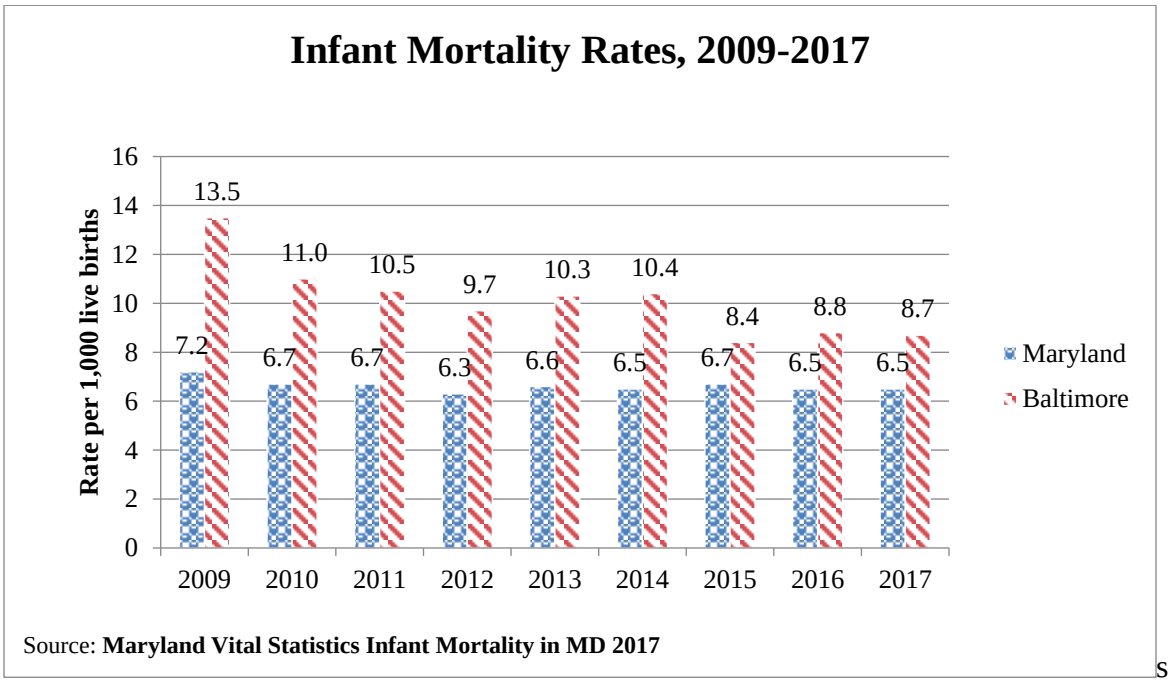
Source: Maryland Vital Statistics Annual Report. 2000, 2004, 2008, 2012, 2016,2017

The Baltimore City 2017 infant mortality rate was 34% higher than the state's overall rate. According to the Healthy Baltimore 2015 Report (Interim Report)[16]:

- There has been a decrease in the overall infant mortality rate of 35% between 2009 and 2016.
- Infant mortality rates among Black infants have decreased by 38.9% in the same period.
- Between 2013 and 2016, mortality rates among white infants in Baltimore City was higher than the previous four-year period (2009-2012), but in 2017 decrease to the lowest

[13] Source: Maryland Vital Statistics Annual Report, 2017. Table 7
[14] Baltimore City Health Department Neighborhood Profiles, 2017
https://health.baltimorecity.gov/neighborhood-health-profile-reports
[15] Maryland Vital Statistics Annual Report 2017.
[16] Healthy Baltimore Report (Interim Report), 2015
https://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_May2016Update_web.pdf

rate in the past 8 years. However, the number of white infant deaths is low enough such that small changes in the number of deaths can lead to great fluctuations in the white infant mortality rate from year to year.



Source: **Maryland Vital Statistics Infant Mortality in MD 2017**

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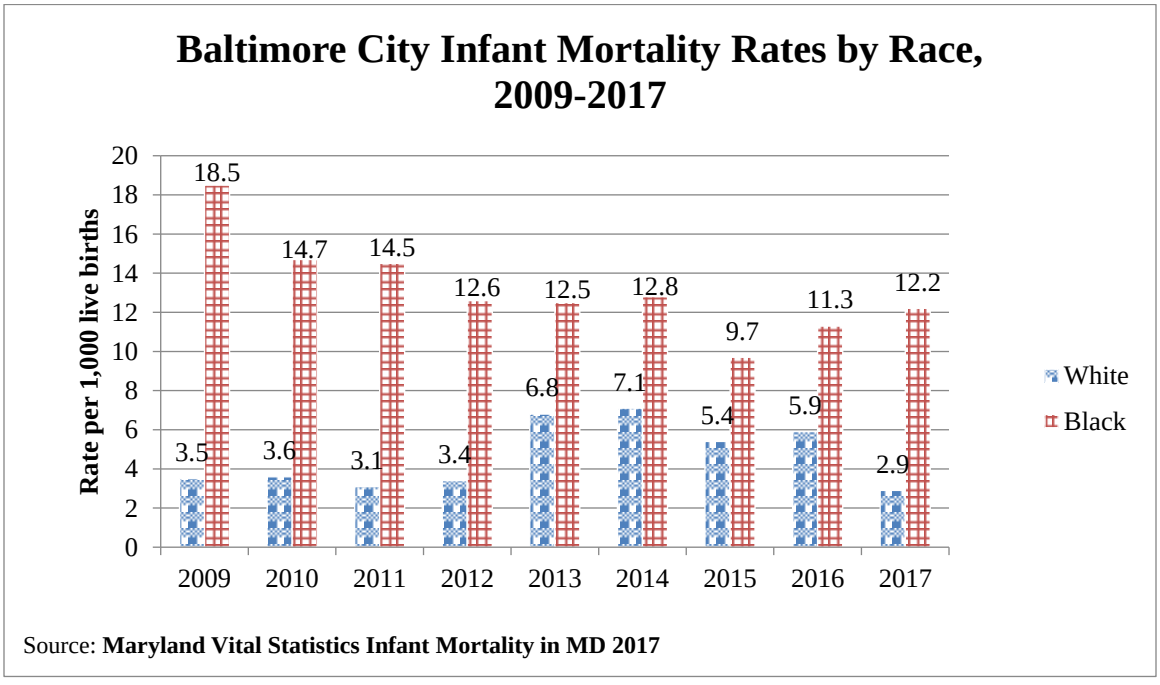
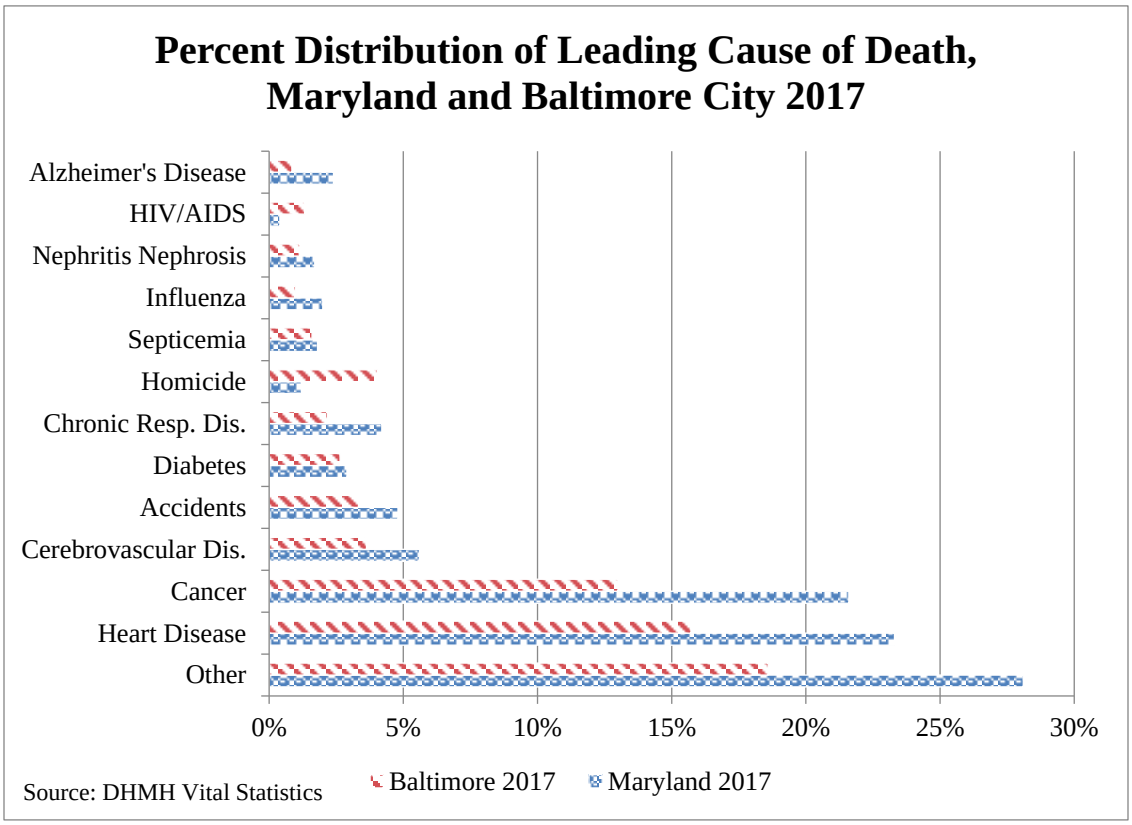
There are significant disparities by race. The mortality rate for Black babies was over four times that of white babies in 2017. It is the biggest gap in the last 5 years.



Source: **Maryland Vital Statistics Infant Mortality in MD 2017**

The leading causes of death vary between Baltimore City and Maryland. HIV/AIDS, septicemia, homicide, and accidents account for significantly more deaths in the city than the state. Homicide was the 15th leading cause of death in the state, and the eighth in Baltimore City in 2016. HIV/AIDS was not in the 15 leading causes in the state, whereas it was tenth in the city.



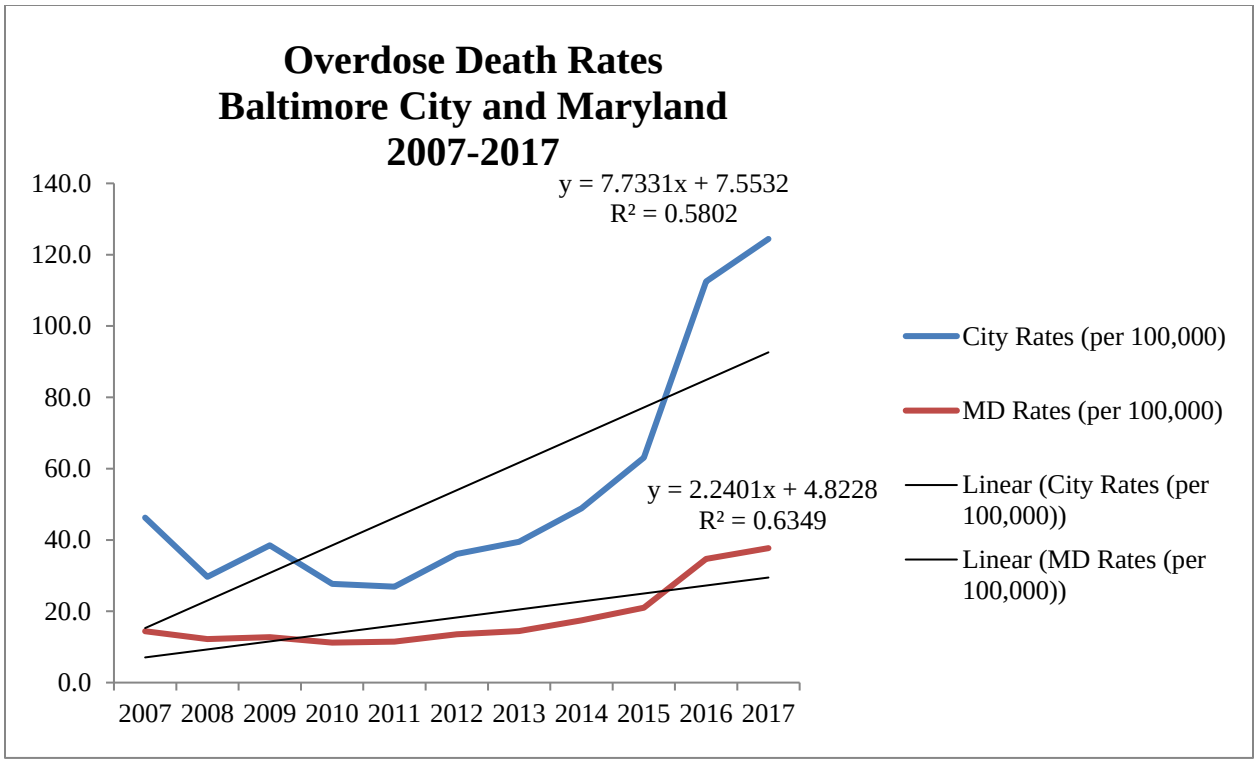
Eight percent (8.0%) of Baltimore City residents have no health insurance, and 4.3% of Baltimore City residents under 18 years are uninsured, which is a significant decline from 2006, when 14% under 18 years of age were uninsured.[17]

[17] U.S. Census Bureau, 2013-2017 American Community Survey 5–Year Estimates

Overdose

Baltimore City has seen an increase in the number of deaths due to overdose for the last five years, with 761 overdose deaths occurring in 2017, which represents a 9.6% over the previous year.

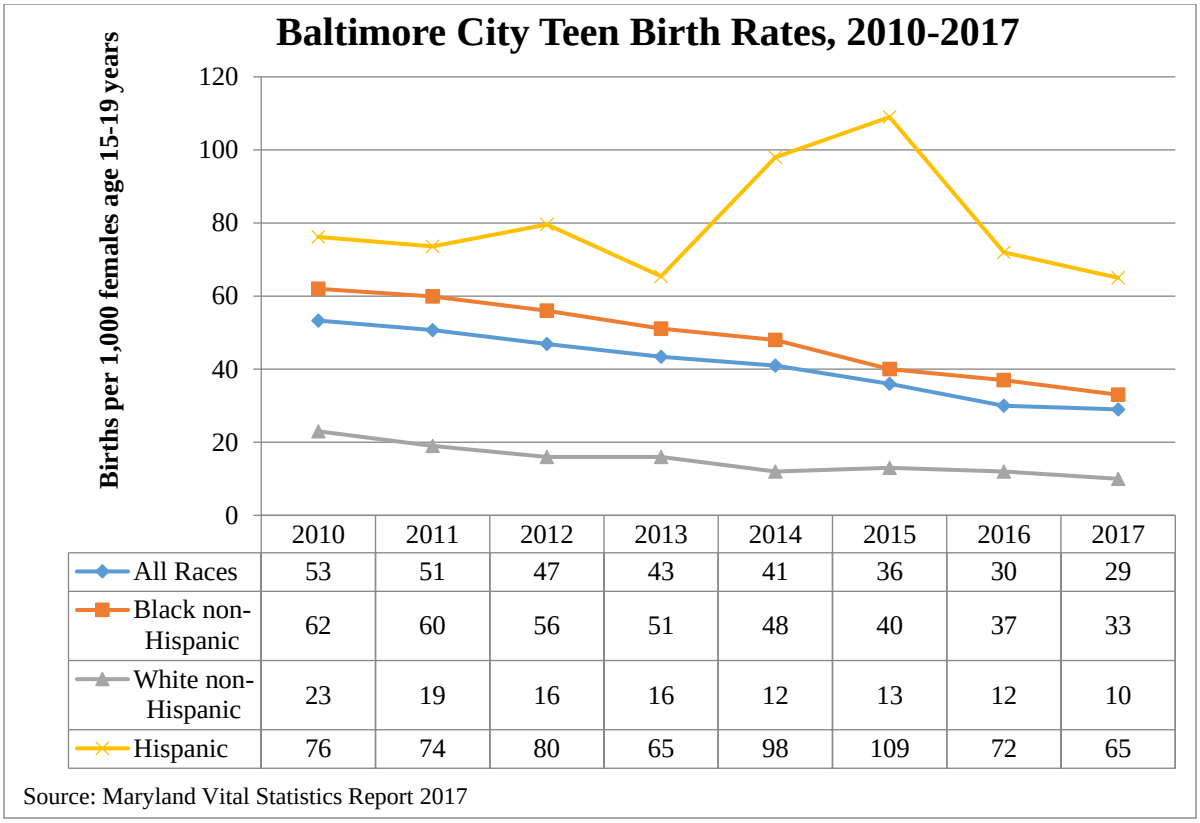
Baltimore City Deaths Due to Overdose			
Year	# of Deaths	Population	City Rates (per 100,000)
2007	287	620,306	46.3
2008	184	620,184	29.7
2009	239	620,509	38.5
2010	172	621,317	27.7
2011	167	620,889	26.9
2012	225	622,950	36.1
2013	246	623,404	39.5
2014	303	622,793	48.7
2015	393	621,849	63.2
2016	694	614,664	112.9
2017	761	611,648	124.4



Source: Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2017 Annual Report. Maryland Department of Health, June 2018

Teen Pregnancy

The overall Baltimore City and non-Hispanic white and Black population teen pregnancy rates have steadily decreased over the last five years, while the Hispanic rates have fluctuated but decreased over the past year. The Hispanic teen pregnancy rates remain significantly higher than the non-Hispanic rates.



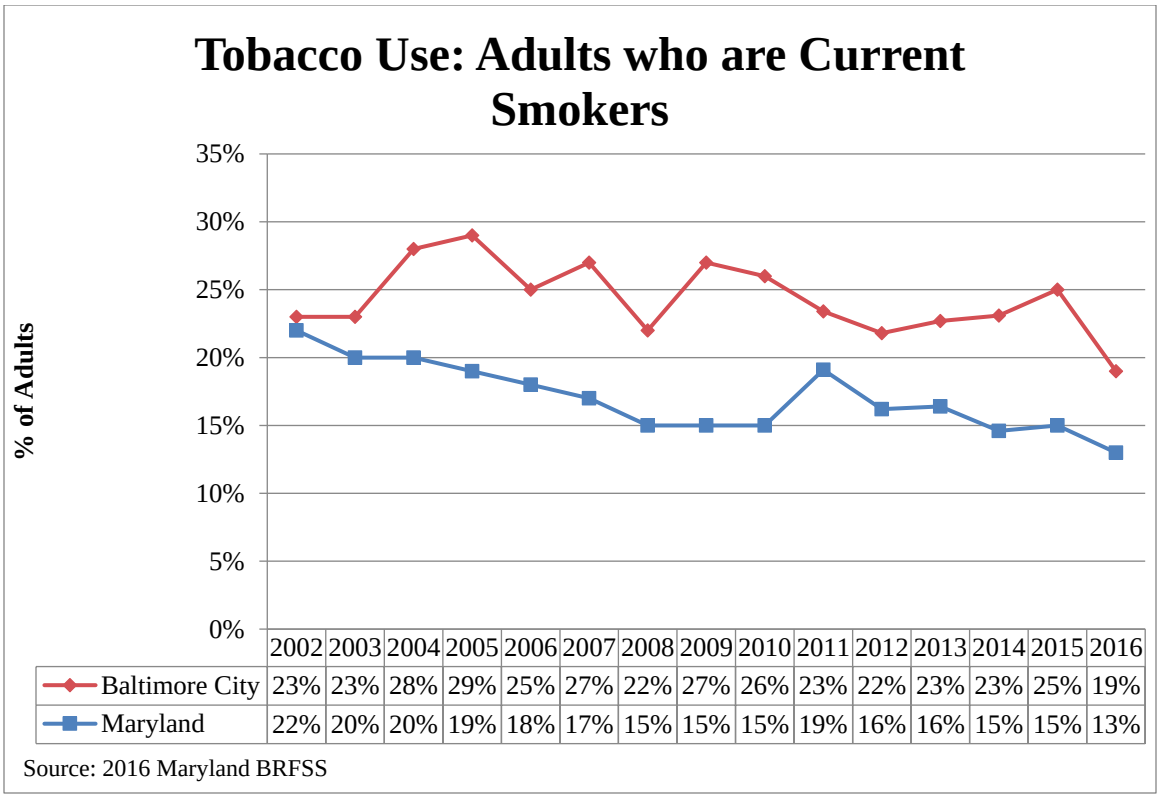
	2010	2011	2012	2013	2014	2015	2016	2017
All Races	53	51	47	43	41	36	30	29
Black non-Hispanic	62	60	56	51	48	40	37	33
White non-Hispanic	23	19	16	16	12	13	12	10
Hispanic	76	74	80	65	98	109	72	65

Source: Maryland Vital Statistics Report 2017

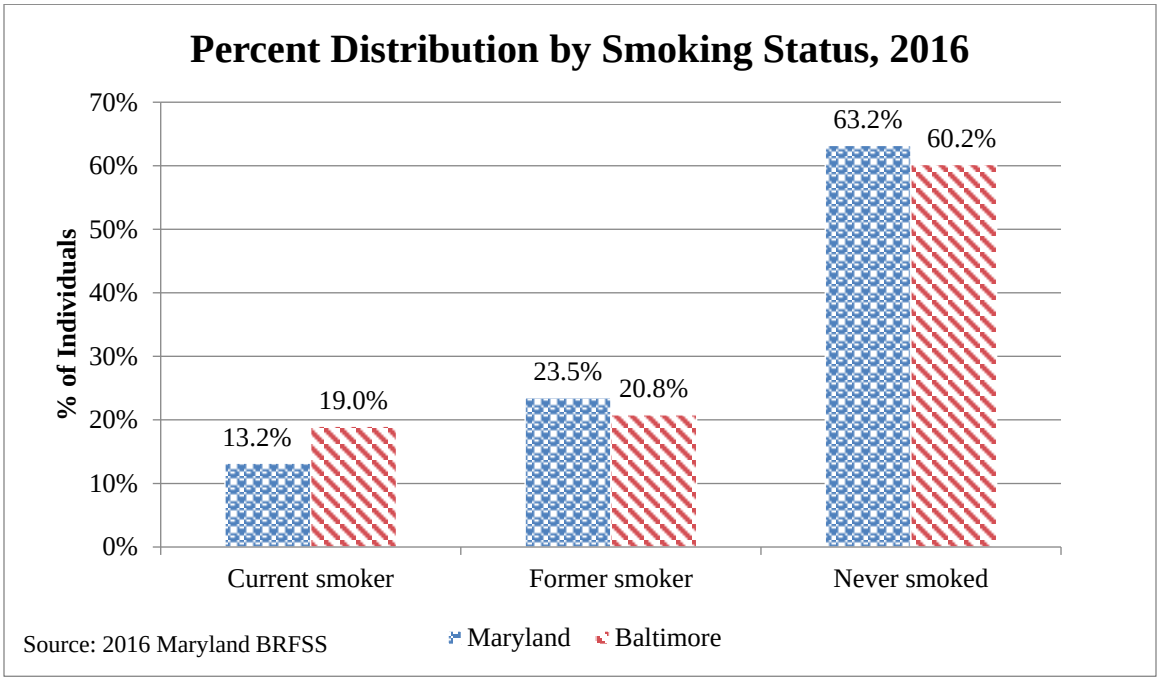
Tobacco Use

Tobacco use is a significant public health status indicator, as it results in approximately 480,000 premature deaths in the United States annually.[18] In the chart below, the BRFSS data shows that a higher percentage of adults in the city use tobacco products, as compared to the state. The BRFSS found that 19% of adults in the city versus 13% of adults in the state were current smokers in 2016. The trend line shows an important decrease in the past year in both city and state settings.

[18] CDC Current Cigarette Smoking Among Adults, United States, 2016



The BRFSS also found that a higher rate of smokers who reside in Baltimore City, compared to Maryland smokers, identify themselves as daily smokers.



Crime and Violence

Crime and violence remain serious problems in Baltimore City with significant disparities between neighborhoods. In the 2015 Mayor's Annual Citizen Survey, only 63% of respondents felt safe or very safe in their neighborhoods at night, and fewer, 37%, felt that way downtown.[19] In 2017, Baltimore's violent crime rate (murder, aggravated assault, robbery, and rape) was more than four times the statewide rate,[20] and there were 30,220 victims of property crime.[21]

Baltimore is one of several large cities to see sizable increases in its homicide rate in recent years.[22] In 2017, the homicide rate was 56 per 100,000 individuals, slightly higher than 2015, which was a time of significant social unrest. The homicide rate remains extremely elevated compared to years leading up to 2015. For all ages, homicide was the fourth leading cause of death in Baltimore City and the leading cause of death for the 15-24, 25-34, and 35-44 age groups. [23]

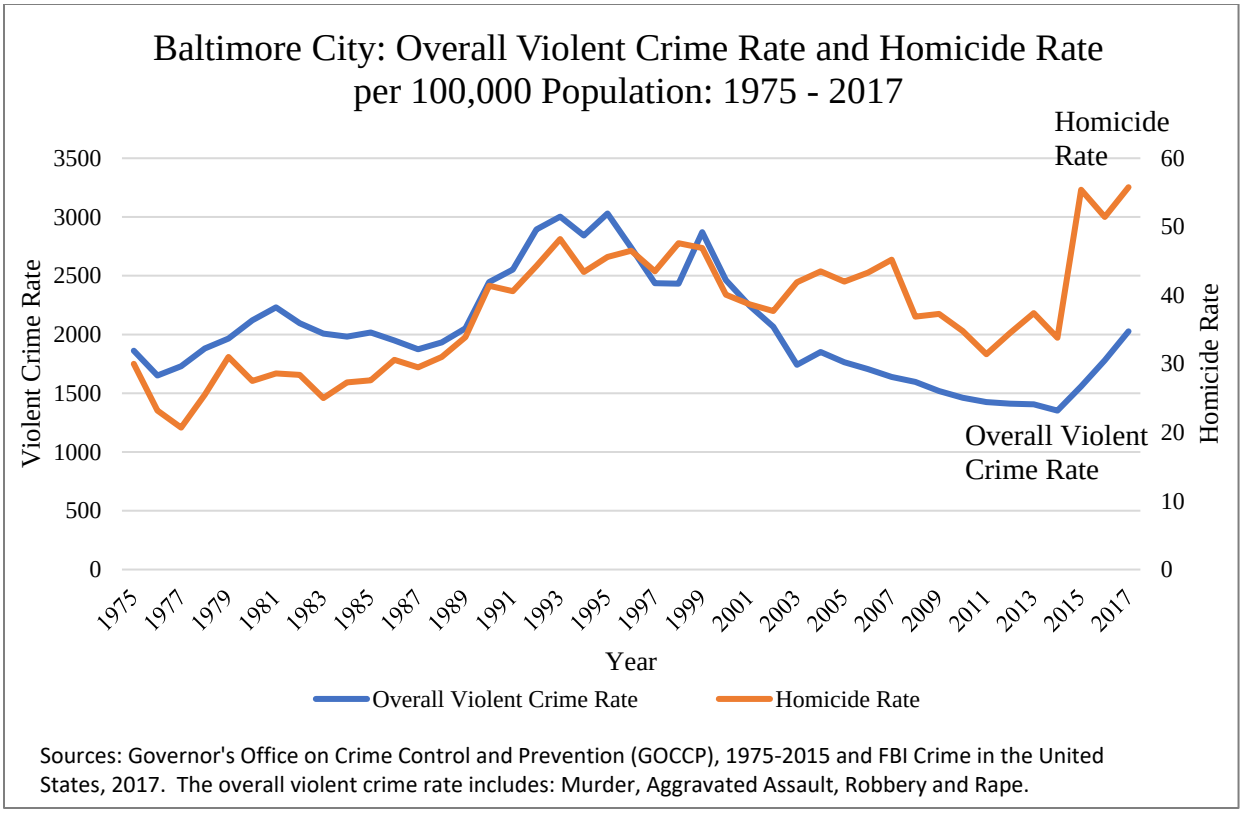
[19] City of Baltimore. 2015 Baltimore Citizen Survey. https://bbmr.baltimorecity.gov/sites/default/files/2015%20CITIZEN%20SURVEY%20FINAL%20REPORT_1.pdf. .

[20] FBI. Crime in the United States, 2016: Tables 5 and 8. https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/tables/table-5 and https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-8/table-8-state-cuts/maryland.xls

[21] FBI. Crime in the United States, 2016: Tables 5 and 8. https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/tables/table-5 and https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-8/table-8-state-cuts/maryland.xls

[22] Rosenfeld R, et al. Assessing and Responding to the Recent Homicide Rise in the United States. Nov 2017. https://www.ncjrs.gov/pdffiles1/nij/251067.pdf.

[23] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Dec 7, 2018 3:14:13 PM



In addition to the tragic loss of life, each homicide has a traumatic impact on the individuals, families and communities that survive the loss of a family member, friend, or acquaintance. Such losses, particularly when compounded by Adverse Childhood Experiences (ACEs) and toxic stressors, can have long-term negative consequences on health and well-being, including mental health conditions, substance use, asthma, autoimmune, cardiac and other chronic diseases.

Although illicit drug use remains a serious epidemic in the city, drug enforcement efforts by the Baltimore Police Department have significantly shifted in recent years to a greater focus on violent crime, resulting in fewer drug arrests. Arrests for illicit drug violations fell 39 percent from 27,800 in 2008 to 17,000 in 2012. More recently, in 2016, the Baltimore Police Department made 6,044 arrests for drug abuse violations.[24]

The rate of juvenile arrests has also fallen significantly but remains higher than most other major jurisdictions in the state. In 2016, the juvenile arrest rate for Baltimore City was 411 per 10,000 youths age 10-17, compared to 347 statewide.[25] In addition, an estimated 20,000 children (15%)

[24] Maryland Department of State Police. Crime in Maryland (2016)-Uniform Crime Report. https://mdsp.maryland.gov/Document%20Downloads/Crime%20in%20Maryland%202016%20Uniform%20Crime%20Report.pdf.

[25] Annie E Casey Foundation. Kids Count. https://datacenter.kidscount.org/data/tables/4461-juvenile-arrests?loc=22&loct=2#detailed/3/106/false/870,573,869,36,868,867,133,38,35,18/any/10020,15102.

in Baltimore City have an incarcerated or supervised parent, according to the Governor's Office for Children.[26]

Because crime victimization and other forms of violence and toxic stress do not always come to the attention of police, Emergency Medical Systems (EMS), or other health and social service professionals, surveys are an important tool to highlight the impact of crime, violence, and toxic stressors. According to the 2015 Youth Risk Behavior Surveillance Survey (YRBS), 12% of Baltimore City high school students reported not going to school at least one day prior to the survey because they felt unsafe. In addition, 8% reported being "hit, slapped, or physically hurt by their boyfriend or girlfriend" one or more times in the last 12 months. The percentage of students who reported ever having been physically forced to have sexual intercourse was 10.7% for male and 10.2% for female high school students.[27]

[26] Governor's Office for Children. Reducing the impact of incarceration on Maryland Children, Families and Communities: https://goo.gl/KuSosh.
[27] Centers for Disease Control and Prevention. YRBS Online (2017). https://goo.gl/Q3qnXG.

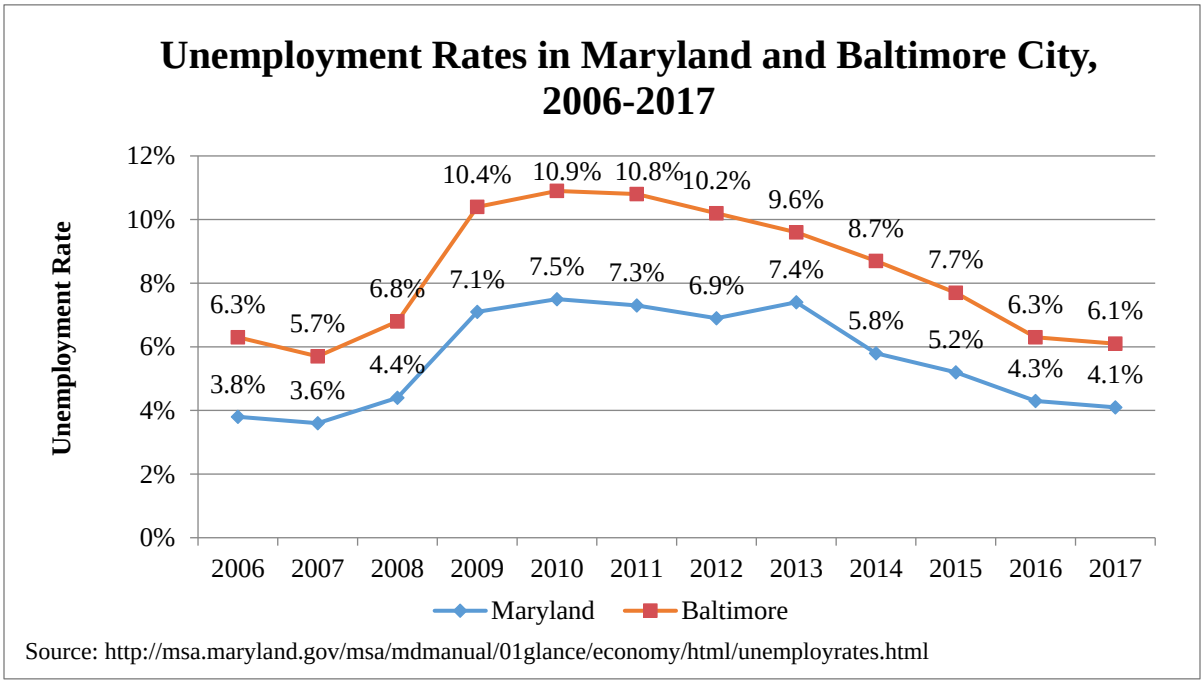
Employment

Baltimore City's unemployment rate is higher than Maryland and the United States, although the trend shows a steady decrease since 2010. In 2017 the average unemployment rate for the city was 6.1%.

Annual Average Unemployment Rates, 2017	
Area	**Rate**
United States	4.1%
Maryland	4.1%
Baltimore City	6.1%

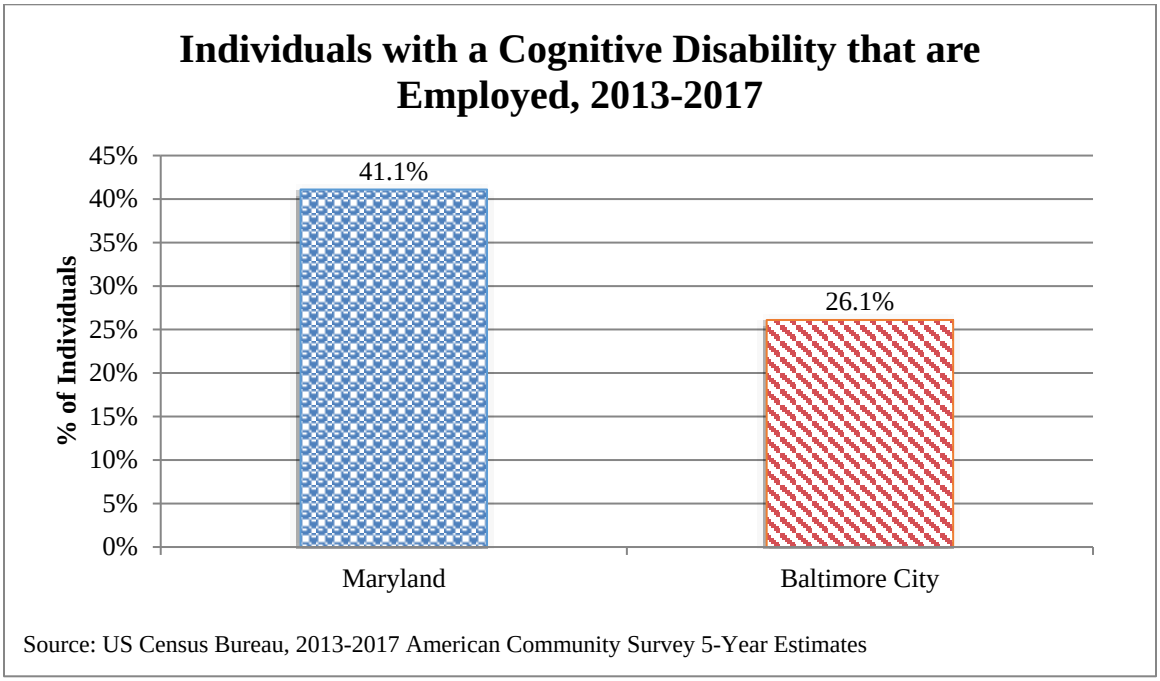
Source: Bureau of Labor Statistics. https://www.bls.gov/news.release/srgune.nr0.htm

Source: https://data.bls.gov/timeseries/LNS14000000 **--11/20/2018**



Source: http://msa.maryland.gov/msa/mdmanual/01glance/economy/html/unemployrates.html

The employment rate of individuals with a cognitive disability was lower in Baltimore City compared to the state.



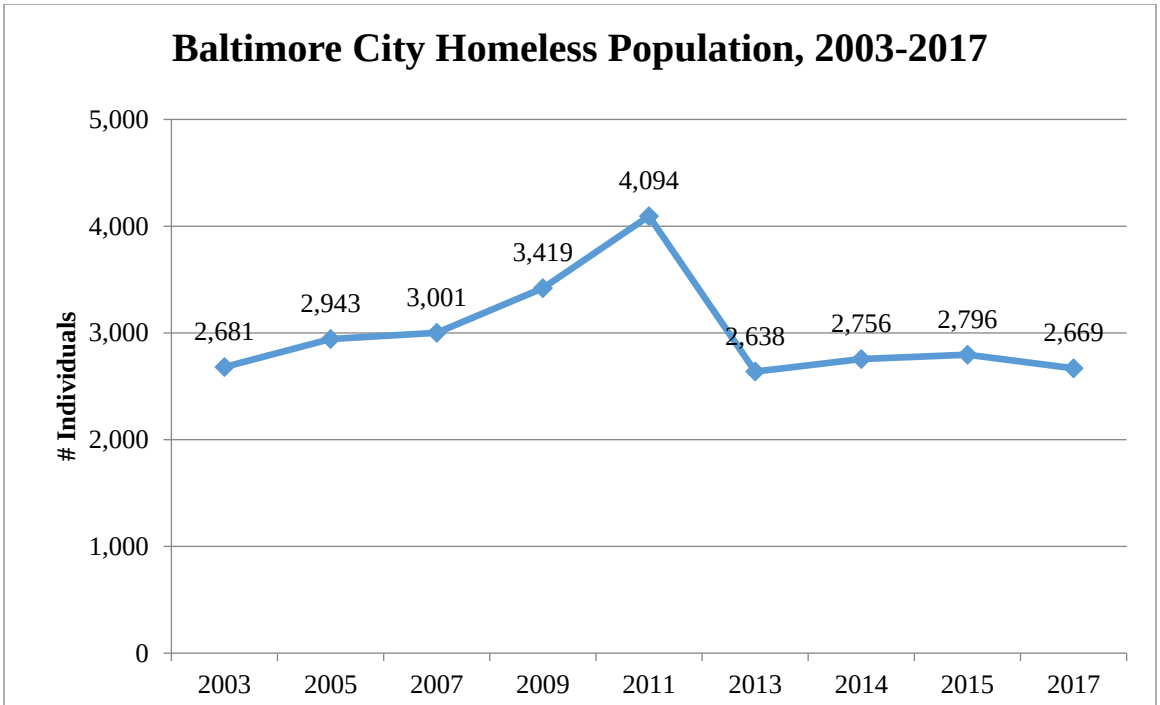
Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Homelessness

Homelessness is a persistent and growing problem in Baltimore City. In 2017, the Baltimore City Homeless Census estimated 2,669 homeless individuals.[28]. However, it is difficult to accurately count the number of homeless individuals, and data on the number are thought to be underestimates.

Many adults and families lack the stability of a home or live in unhealthy conditions. The data below show that on a single night in January 2017, 2,669 persons were identified living in transitional housing, unsheltered, or in an emergency shelter. The population which is identified as unsheltered makes up 20% of the homeless population. Among those living unsheltered, 40% were self-reported to have a mental illness, and 42% self-reported substance use issues.[29] Of this group, 75% were males, 66% were African-Americans, and 53% were considered chronically homeless.

[28] Baltimore Point in Time Count. January 22, 2017. http://human-services.baltimorecity.gov/sites/default/files/Full%202017%20PIT%20%26%20HIC%20Report_0.pdf
[29] Baltimore Point in Time Count. January 22, 2017. http://human-services.baltimorecity.gov/sites/default/files/Full%202017%20PIT%20%26%20HIC%20Report_0.pdf



Source: Baltimore City Homeless Census, 2017. http://human-services.baltimorecity.gov/sites/default/files/Full%202017%20PIT%20%26%20HIC%20Report_0.pdf

Housing

Lack of access to safe and affordable housing is a significant obstacle to the recovery of individuals with behavioral health disorders. Based on a FY 2018 housing wage of $27.13 per hour, in Baltimore City, a person earning minimum wage would need to work 2.7 full-time jobs to rent a two-bedroom apartment at fair market rent.[30] This is less affordable than the U.S. as a whole, but more affordable than Maryland. Baltimore City's high eviction rate adds to the stress of many renters. Although there are no national data tracking evictions, one analysis found Baltimore City's eviction rate for low-income renters ranked in the top 36% of 152 metro areas analyzed.[31]

Even when it is affordable, much of Baltimore's housing stock is aging, substandard, or uninhabitable, with issues such as poor ventilation, mold, inadequate heating, and lead paint adversely impacting the health of residents. Of the city's occupied housing, 47% was built before 1940, and 63% was built before 1960.[32] Owners and tenants struggle to maintain aging

[30] Out of Reach 2018. National Low Income Housing Coalition. https://nlihc.org/sites/default/files/oor/OOR_2018.pdf
[31] Salviati, Chris. *Rental Insecurity: The Threat of Evictions to America's Renters*. Apartment List. October 20, 2017. https://www.apartmentlist.com/rentonomics/rental-insecurity-the-threat-of-evictions-to-americas-renters/
[32] American Community Survey, 2017

properties. As the data below indicate, Baltimore City's vacancy rate is significantly higher than the state as a whole. It is also important to note that vacancy rates are generally underreported.

Characteristics of Housing		
	Baltimore City	**Maryland**
Total housing units	294,858	2,427,014
Occupied units	239,791	2,181,093
Vacant units	55,067	245,921
Vacancy rates		
Homeowner	4.4%	1.7%
Rental	7.7%	6.3%
Gross monthly rent		
Less than $500	19,899	52,712
$500 - $999	40,176	134,419
More than $999	62,847	499,017

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

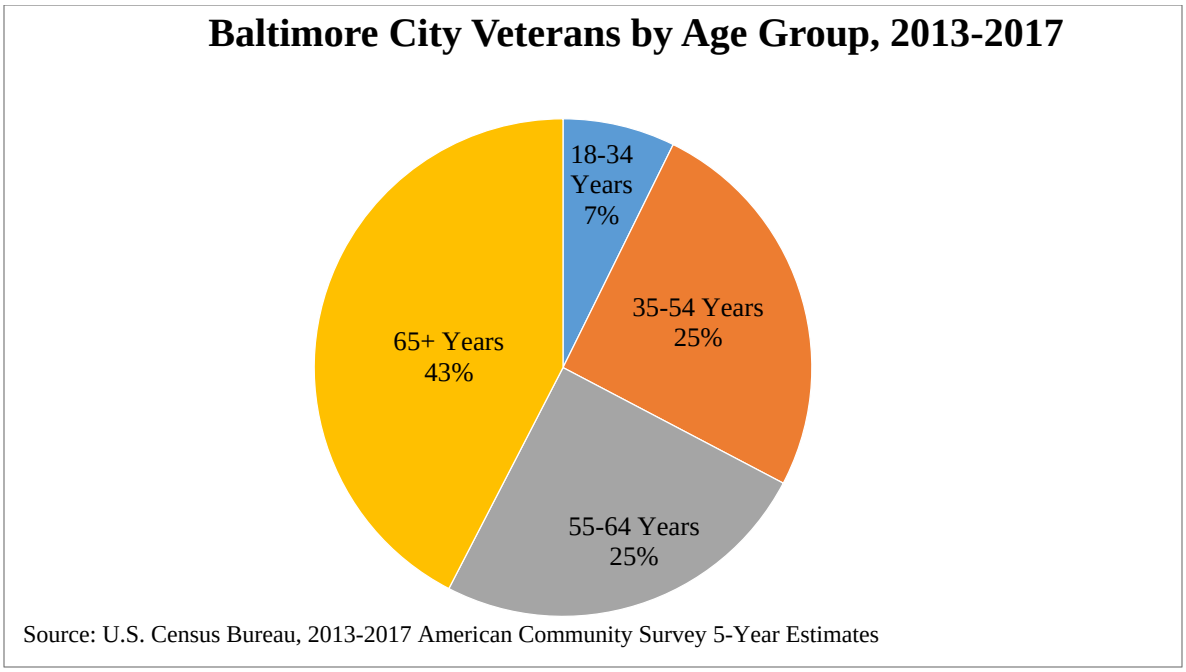
The cost of housing relative to income is a significant barrier to safe and stable housing. According to the 2017 American Community Survey, 33% of Baltimore City residents with any disability live below the poverty level.[33] The median monthly housing cost for renter-occupied units in Baltimore City was $1,009, and 44% of renters were spending more than 35% of their household income on rent.

Veterans and War Returnees

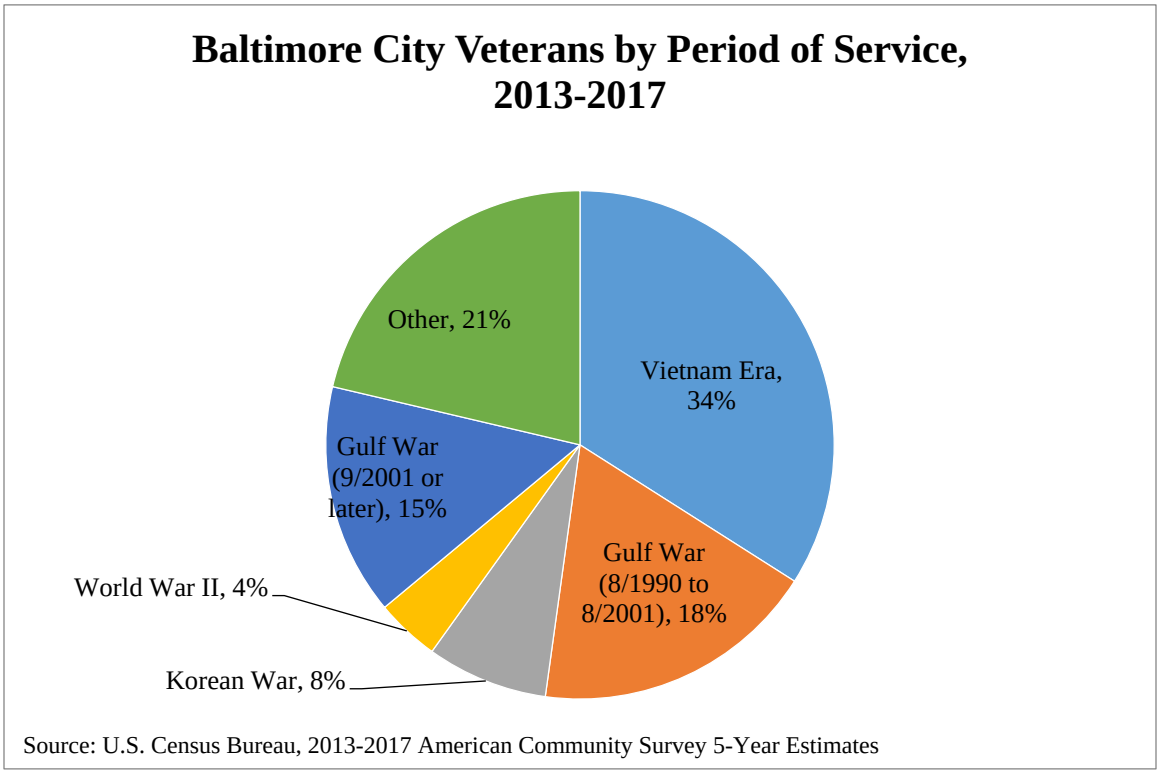
The US Department of Veterans Affairs estimates that there are 29,428 veterans in Baltimore City, representing 7.7% of all veterans in Maryland. Adults ages 35-64 represent 50% of the city's veteran population, and adults over 65 years represent 43%. Because of the high prevalence of behavioral health needs of veterans and war returnees,[34] this is a critical population.

[33] American Community Survey, 2017

[34] War returnee refers to any personnel returning from war zones, regardless of military status, including civilian personnel.



Most veterans served in the Vietnam War (34%) and the two periods of the Gulf Wars (33%).

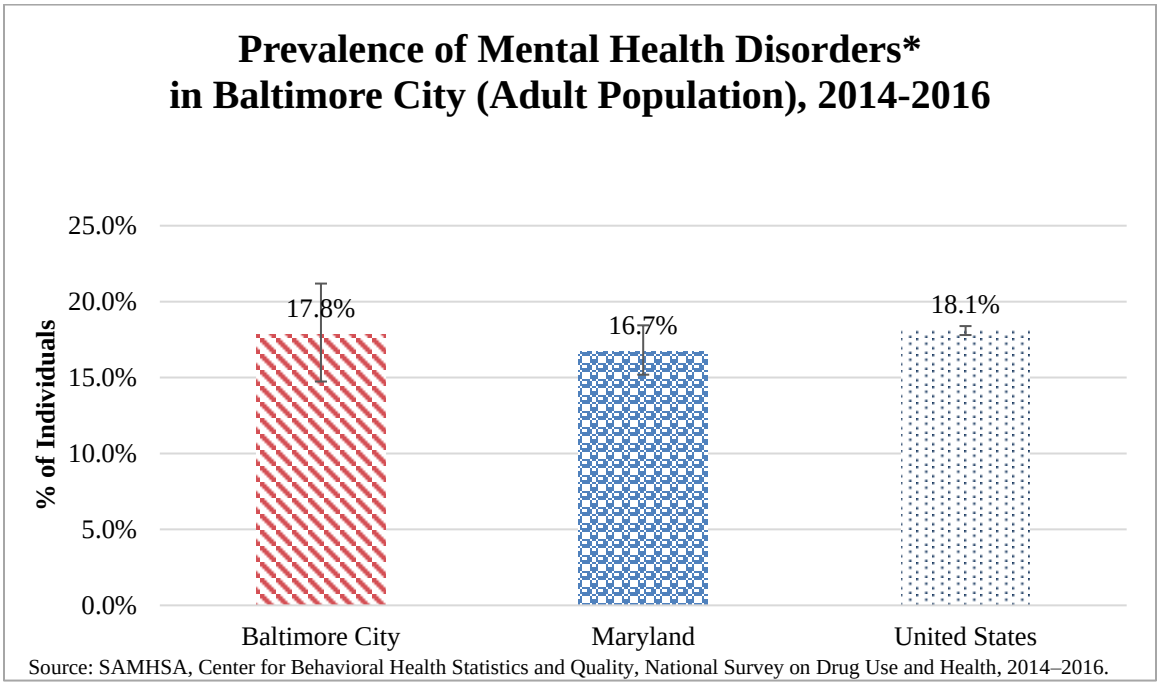


2. BEHAVIORAL HEALTH INDICATORS OF BALTIMORE CITY

Adults

Prevalence of Mental Illness

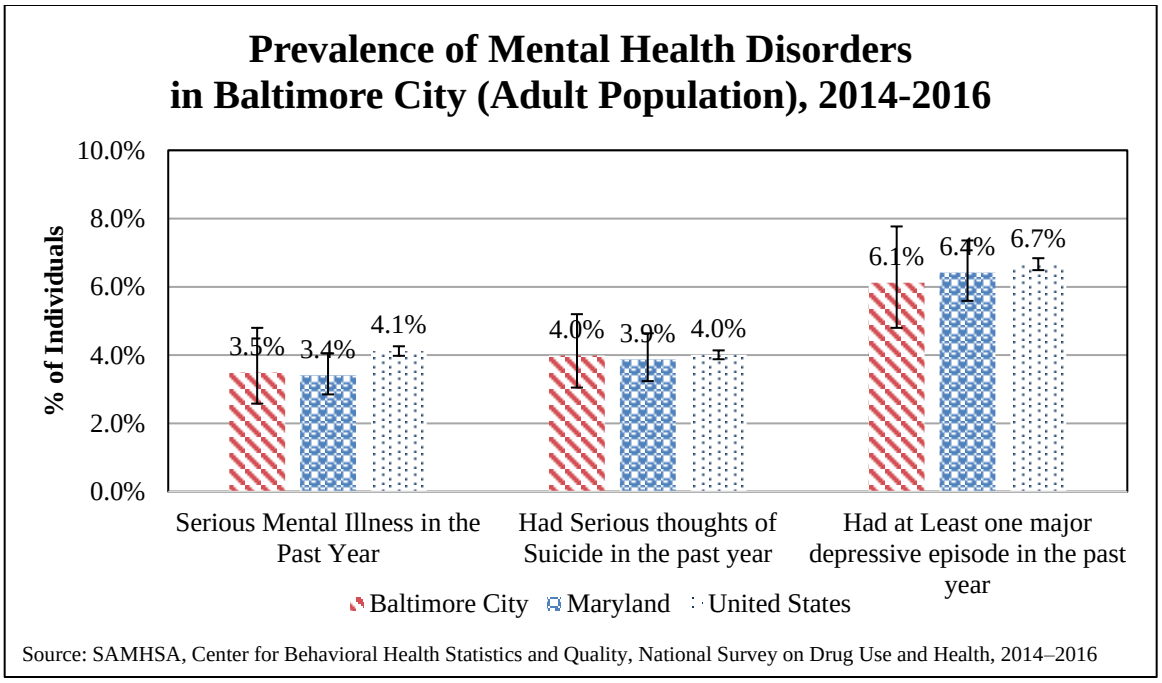
Although the rate of any mental illness in the past year in Baltimore City was higher than the state rate, it remains below the national rate (18.1%). Overall, nearly one out of five adults in Baltimore City suffers any mental illness.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014–2016.

*Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, which met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

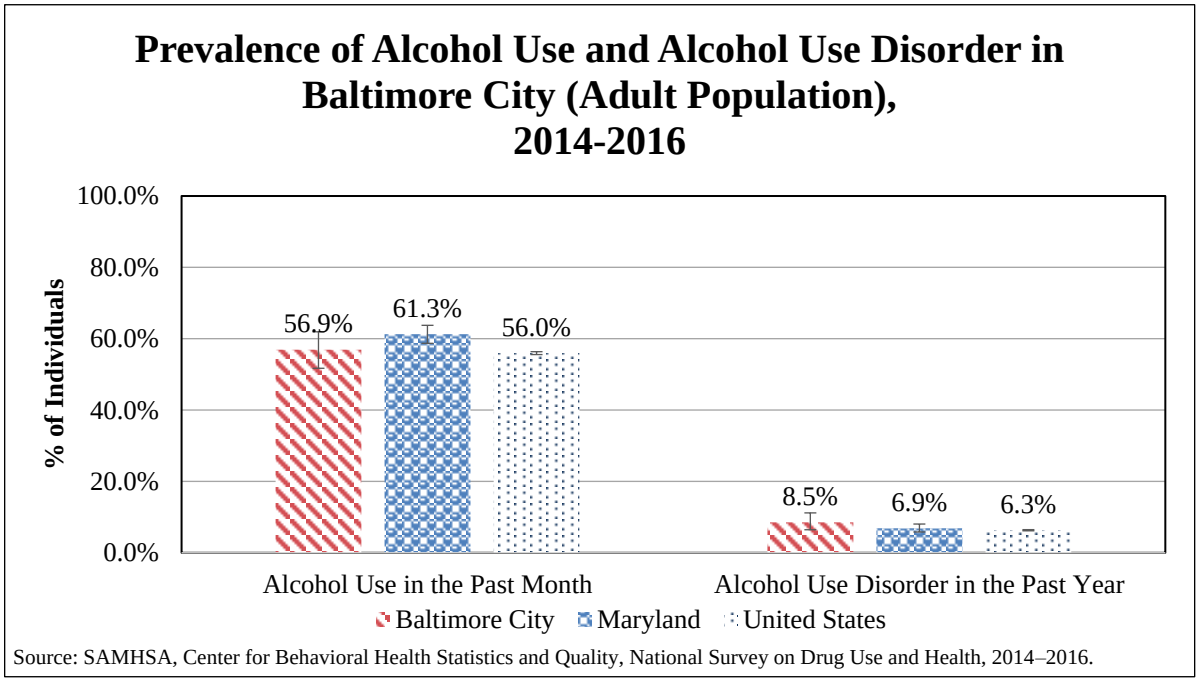
The highest rates of mental illness were for individuals who had at least one major depressive episode in the prior year, with Baltimore City having a rate slightly below the state and nationwide rates. The Baltimore City rates for serious mental illness were similar to the state but below the national rate (4.1%). For those who had serious thoughts of suicide, the rates were very similar to the national rate of 4.0%.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014–2016

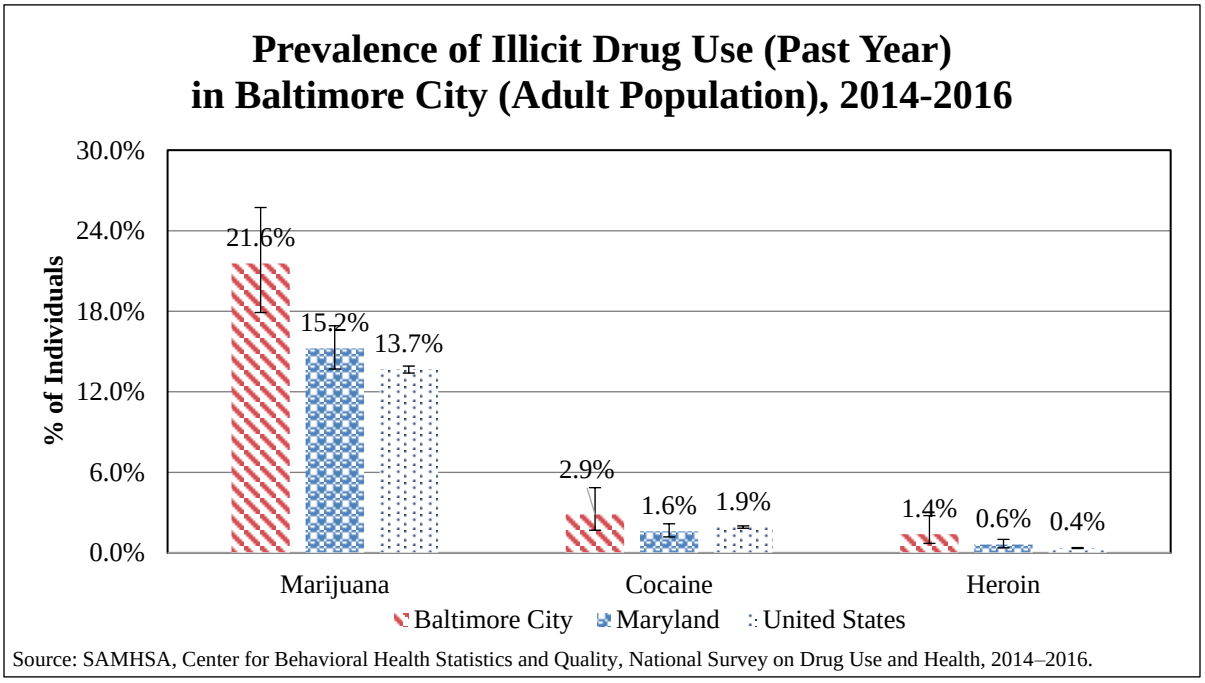
Prevalence of Substance Use Disorders

Rates of alcohol use in the past month are high for Baltimore City, Maryland and the United States. Baltimore showed more than one out of two people used alcohol in the past month. For Maryland, the rate was six out of ten adults. Rates of alcohol use disorders in the past year are also high. Baltimore showed a higher prevalence for alcohol use disorder (8.5%), even though the prevalence for alcohol use was lower than the state.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014–2016.

The prevalence of illicit drug use (marijuana, cocaine and heroin) in the past year for Baltimore City (10.7%) was higher than both the state and national rates. The rate of marijuana use in the past year for Baltimore City (21.6%) was 1.4 times greater than the statewide rate and 1.6 times the national rate. Likewise, the rate of cocaine use in the past year for Baltimore City (2.9%) was greater than the state (1.6%) and national rates (1.9%). A similar pattern is seen with the rate of heroin use.

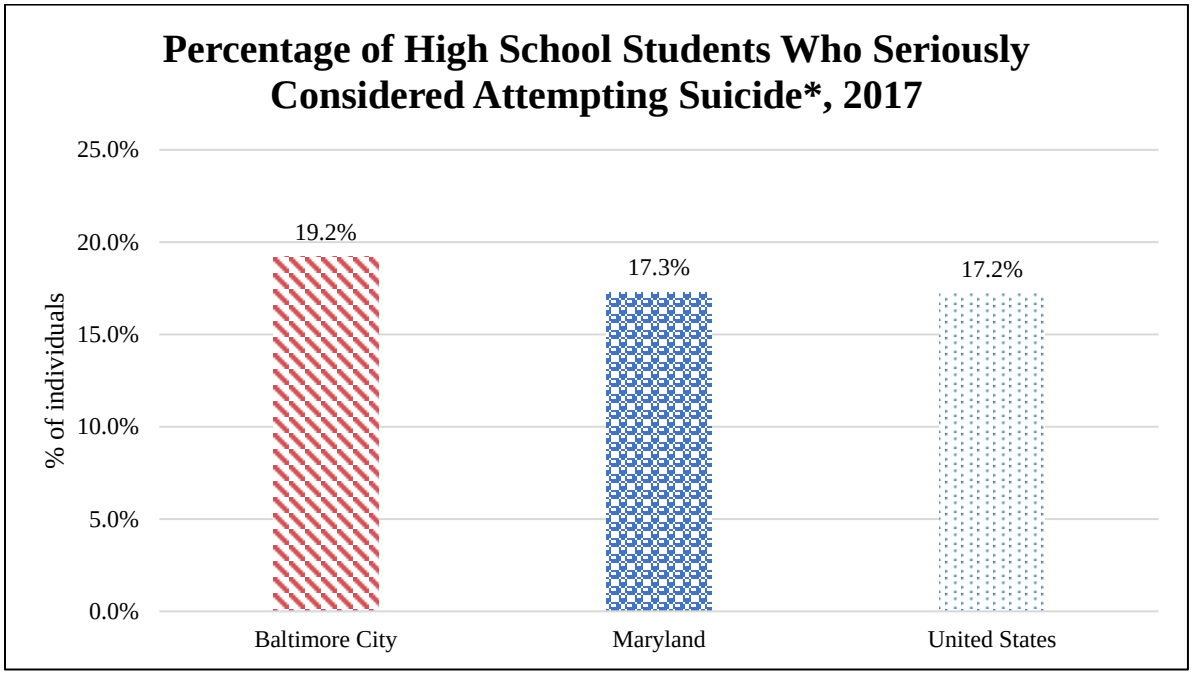


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014–2016.

Youth

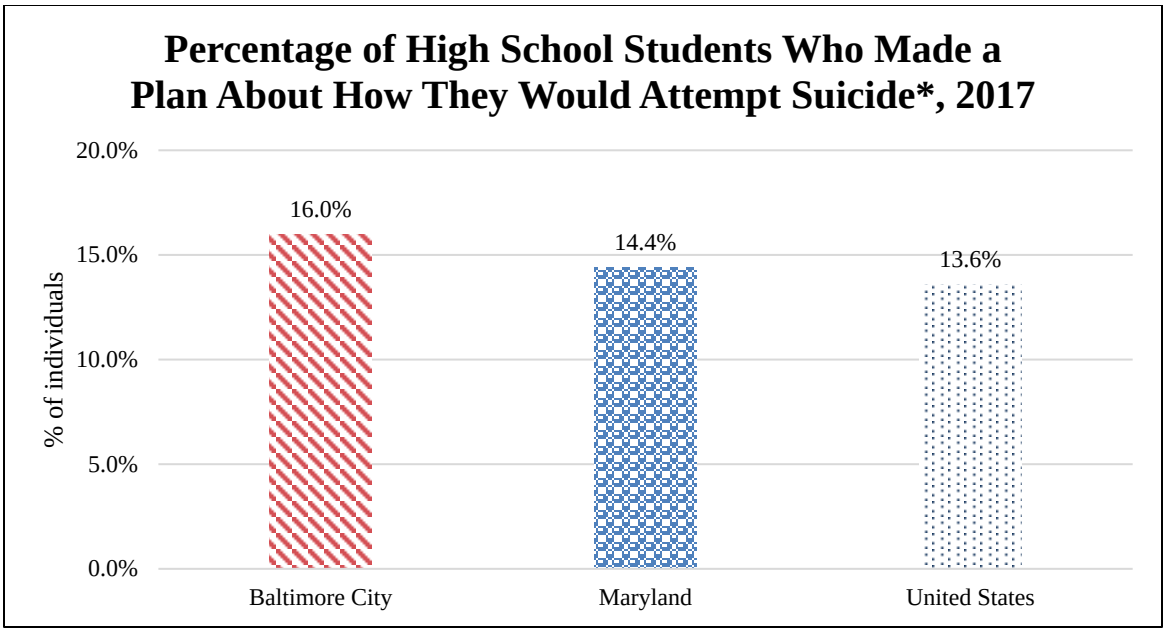
Prevalence of Mental Illness

The Maryland YRBSS offers a unique look into the emotional needs and behavioral health risks of youth in Baltimore City. The percentage of high school students who seriously considered attempting suicide in Baltimore City was higher (19.2%) than both the state and national rates.



Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*During the 12 months before the survey

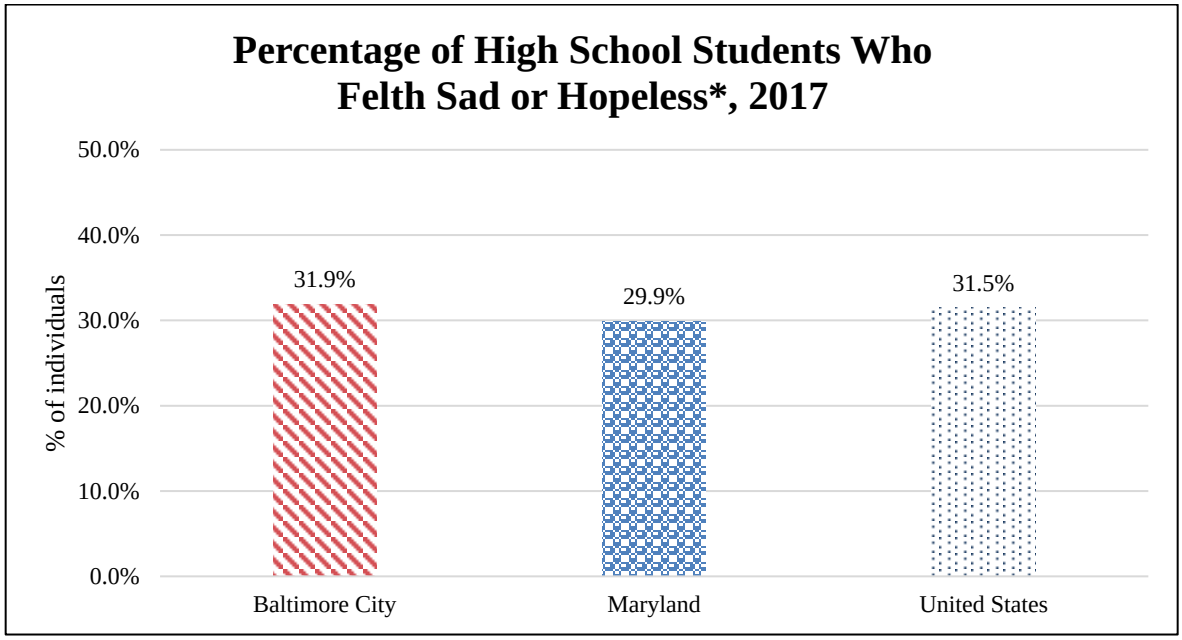
The percentage of high school students who made a plan about how they would attempt suicide was higher (16.0%) in Baltimore City, which is higher than the state and national rates.



Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017

*During the 12 months before the survey

A large percentage (31.9%) of high school students in Baltimore City reported feeling sad or hopeless in the prior 12 months. These rates were similar in Maryland and nationwide.



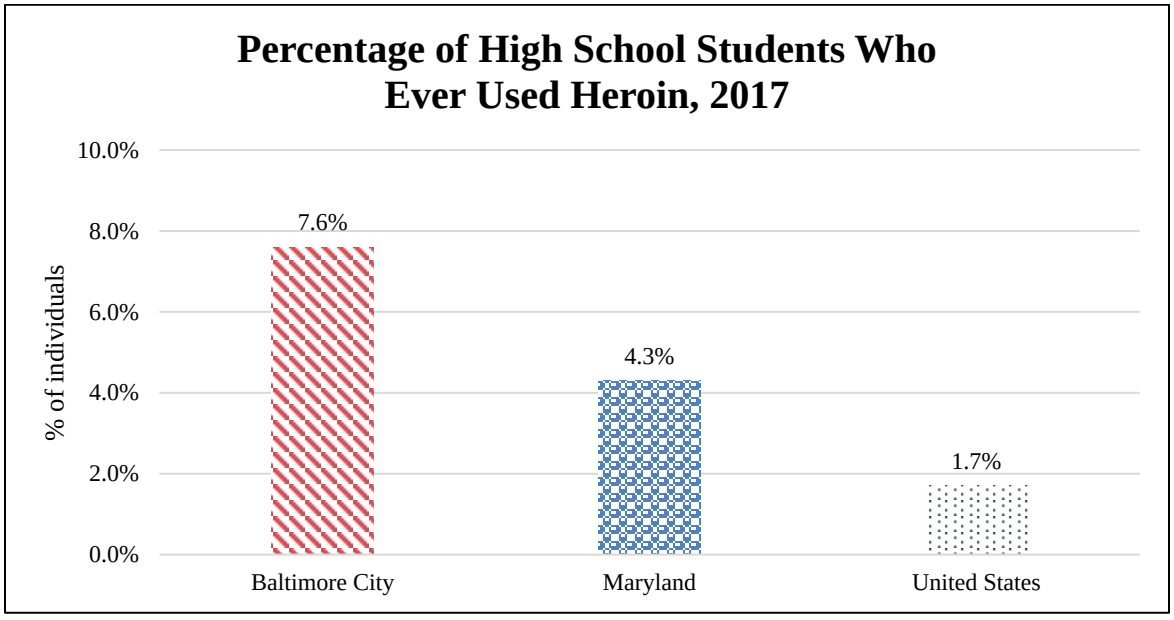
Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017

*During the 12 months before the survey, almost every day for 2 or more weeks in a row so that they stopped doing some usual activities

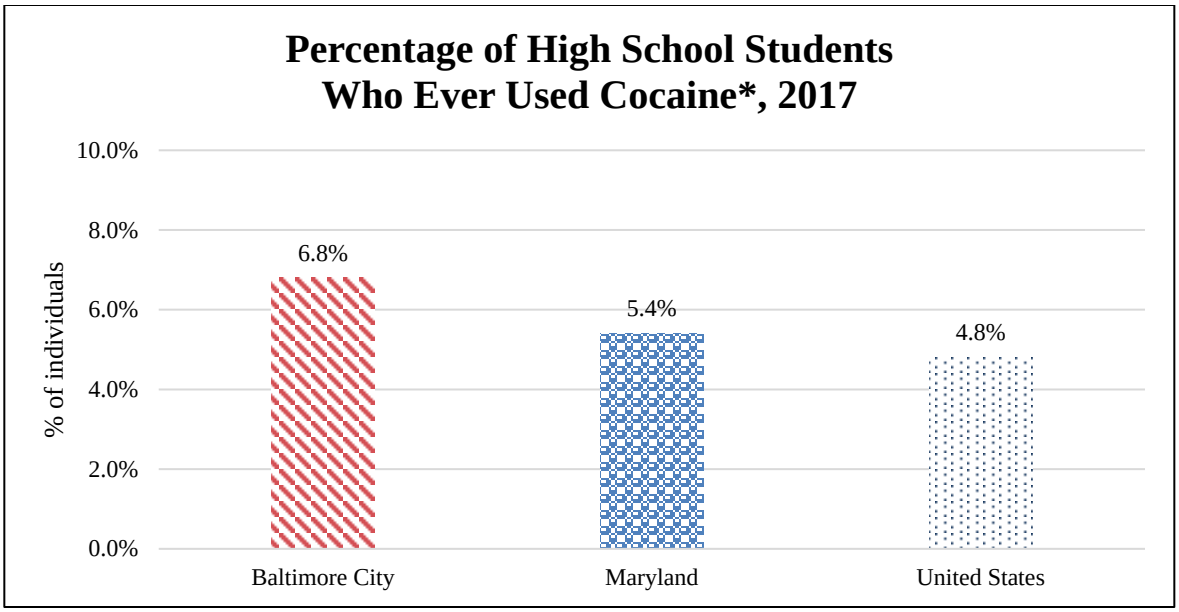
Prevalence of Substance Use Disorders

The next four charts demonstrate that a large percentage of high school students use drugs and alcohol, with the rate of use being substantially higher in Baltimore City than in Maryland and the United States for everything except alcohol. The percentage of high school students who ever used heroin is 7.6% for Baltimore City, versus 4.3% for Maryland and 1.7% nationally. This is a striking finding as a proxy of the heroin incidence and highlights the possible perpetuation of the opioid overdose epidemic in the coming years. It is a warning call for an urgent message in terms of prevention campaigns. Use of cocaine reflected similar disparities between Baltimore City's and the state and national prevalence rates. Use of marijuana is very prevalent. Nearly one out of two students ever used it, and the rate is substantially higher than the state and national rates.

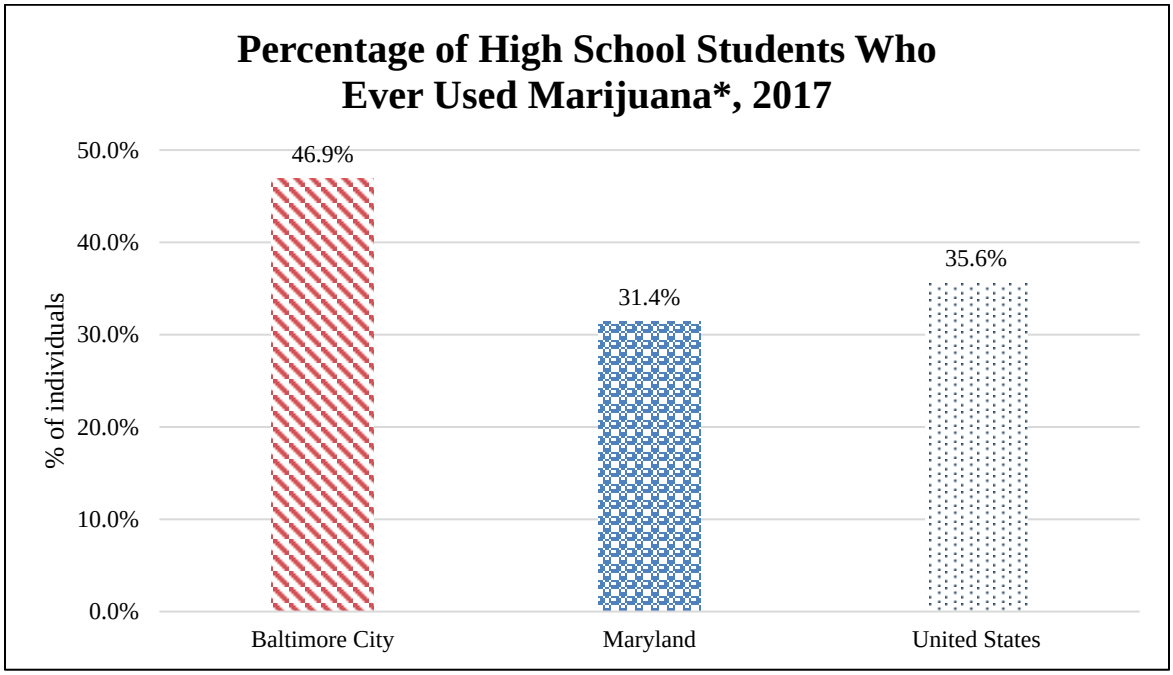
Baltimore City's lifetime prevalence for alcohol use, however, was lower than the national average, although close to the Maryland average.



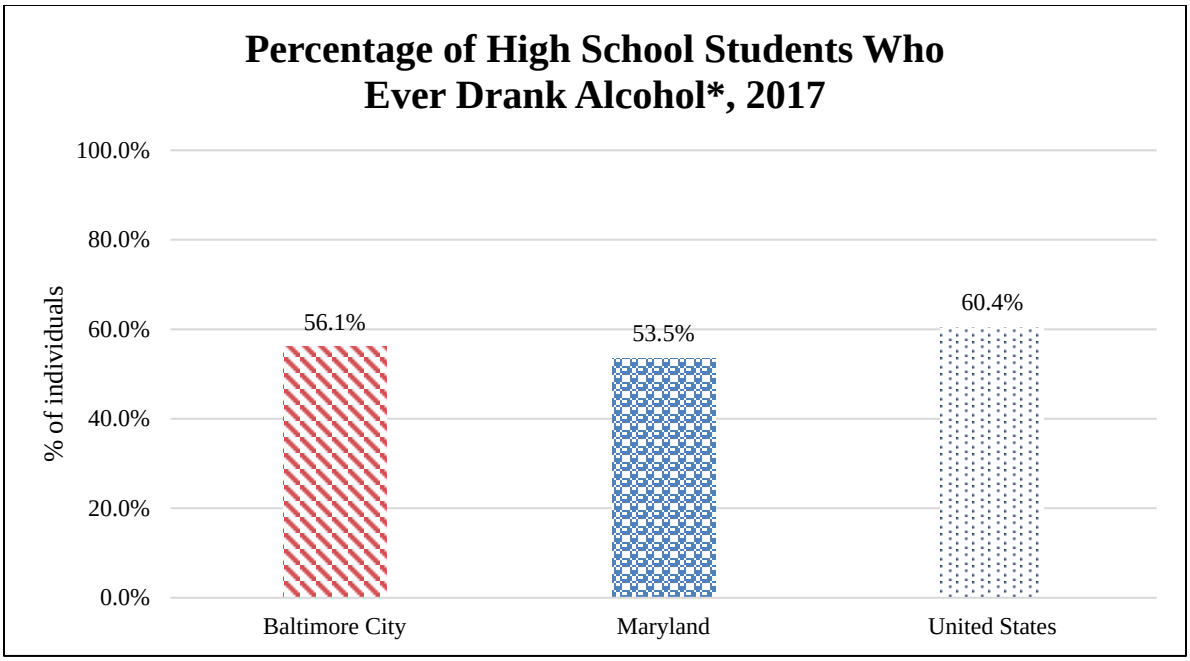
Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017



Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*Used any form of cocaine (e.g. powder, crack, or a freebase one or more times during their life

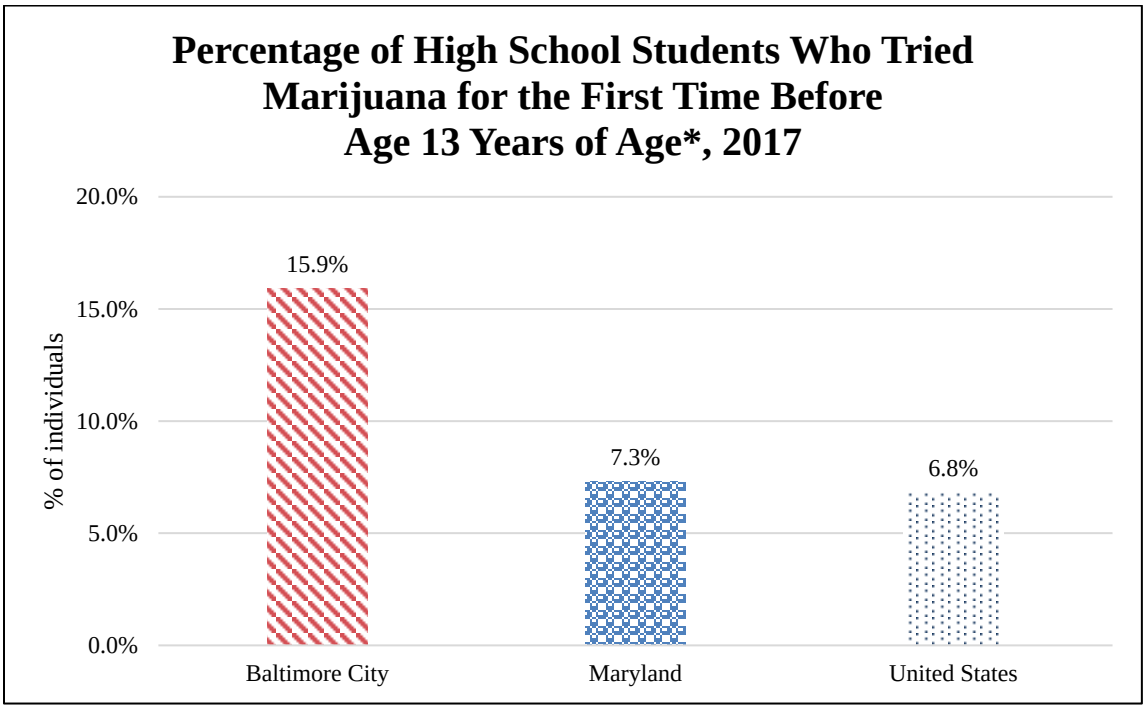


Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*One or more times during their life

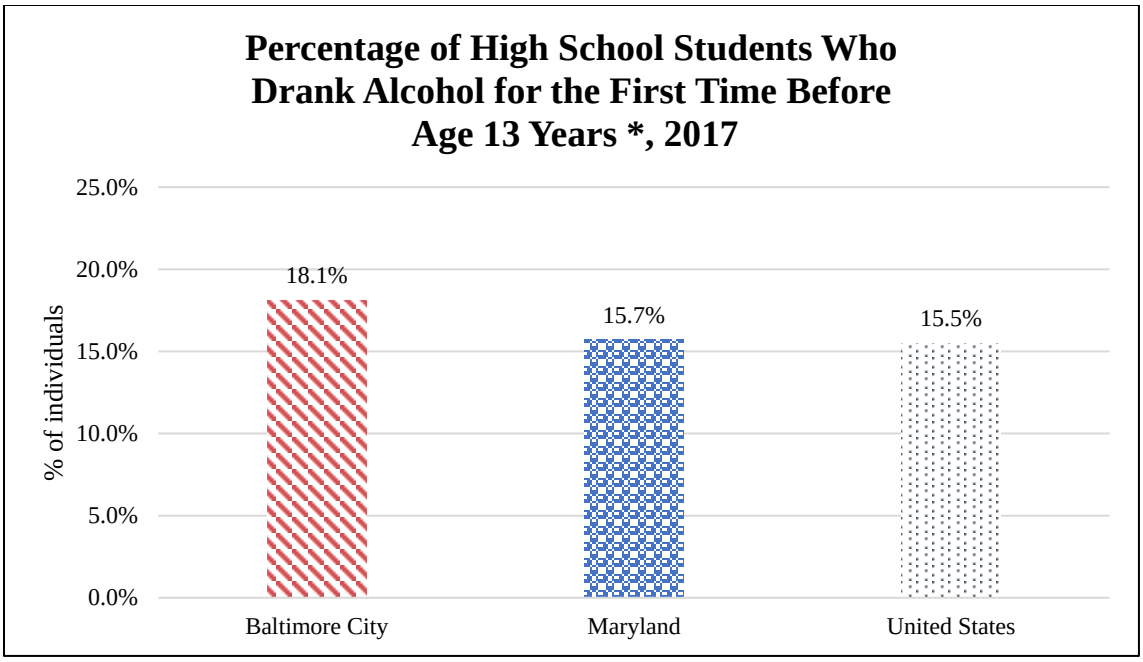


Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*Had at least one drink of alcohol on at least 1 day during their life

The next two charts reflect that a large percentage of youth began using marijuana or alcohol before the age of 13, again with the rate of use being higher for Baltimore City than Maryland or the United States.

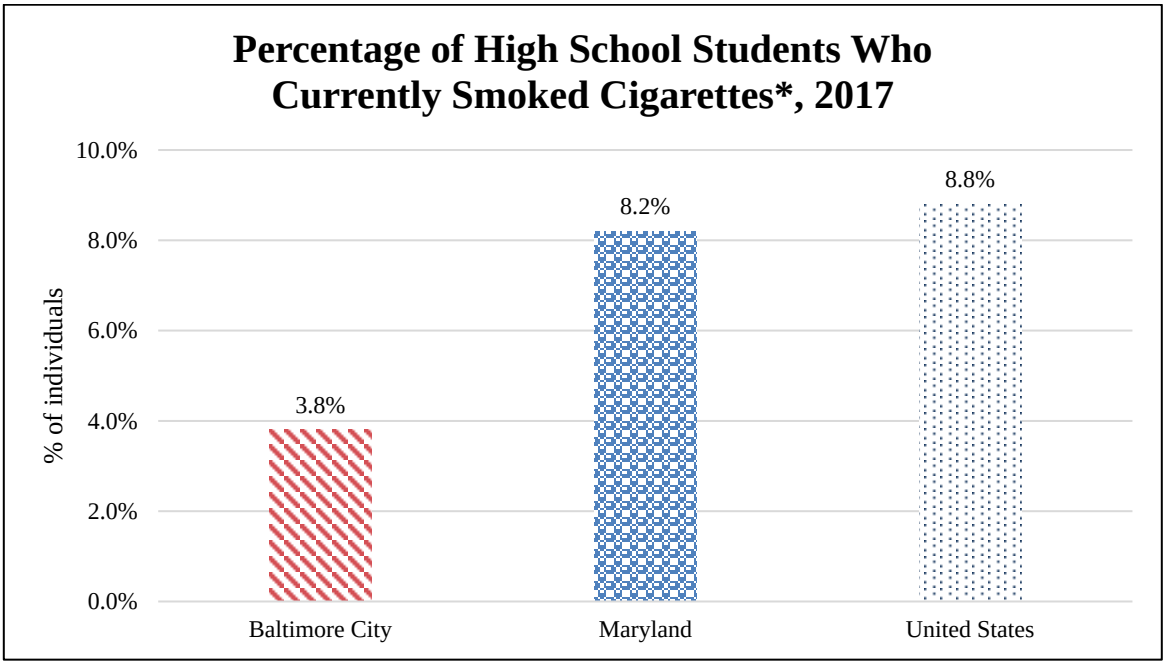


Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*One or more times during their life

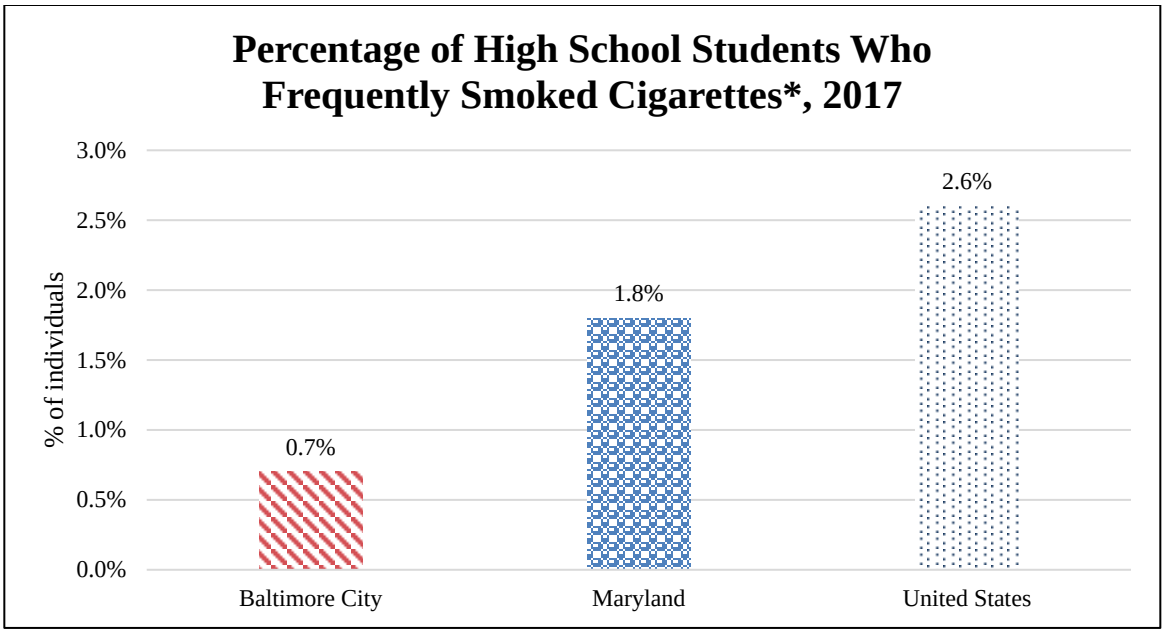


Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*Had at least one drink of alcohol on at least 1 day during their life

The next two graphs show that Baltimore City youth smoke cigarettes less frequently, as compared to Maryland or the United States.



Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*On at least 1 day during the 30 days before the survey



Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017
*Who smoked cigarettes on 20 or more of the past 30 days

PUBLIC BEHAVIORAL HEALTH SYSTEM UTILIZATION

Unless otherwise specified, the data presented in this section of the report are behavioral health (mental health and substance related disorders) service utilization and Outcome Measurement System (OMS) data collected by the Administrative Services Organization (ASO) for Maryland's fee-for-service public behavioral health system (PBHS). These data are collected and reported separately, precluding an analysis of the extent to which individuals utilize both mental health and substance related disorders services.

The mental health utilization data describe the use of mental health services and associated expenditures for children and adults in FY 2018, and the OMS data describe point-in-time outcomes of various dimensions of wellness from the most recent observation for each consumer in FY 2018. Data reports include claims submitted through September 30, 2018 (three months after the end of FY 2018).

The substance related disorders (SRD) utilization data describe the use of SRD services and associated expenditures for children and adults in FY 2018, and the OMS data describe point-in-time outcomes of various dimensions of wellness from the most recent observation for each consumer in FY 2018. Data reports include claims submitted through September 30, 2018 (three months after the end of FY 2018). It is important to note that FY 2016, FY 2017 and FY 2018 represent the first three full years of SRD service utilization data included in the ASO. These data include only SRD ambulatory services (outpatient, intensive outpatient and opioid maintenance therapy) for FY 2016 and FY 2017. While SRD providers were required to report utilization of residential services to the ASO, it is anticipated that this data may be less accurate due to inconsistencies in reporting. Residential services were reimbursed through the ASO beginning in FY 2018, which provide a more comprehensive picture of the public SRD services for Baltimore City, but they were limited to the following American Society of Addiction Medicine (ASAM) levels of care: 3.3, 3.5, 3.7 and 3.7.D. The ASAM level of care 3.1 will be reimbursed through the ASO beginning in January 2019.

MENTAL HEALTH UTILIZATION

As in previous years, the most recent data reported (FY 2018) is incomplete, as claims may be submitted up to 12 months after the date of service delivery. Therefore, the data for FY 2018 does not reflect all the claims for services rendered to Baltimore City individuals, while the data for previous years, to which it is being compared, represents 100% of claims for those years. This needs to be kept in mind when comparing FY 2018 data to FY 2017 and FY 2016 data for trends over time. When comparisons with previous years show increases in FY 2018, it is likely that the actual increase is somewhat greater. Conversely, decreases in FY 2018 compared to previous years will be somewhat offset by the missing claims data. This artifact of the PBHS is more pronounced for expenditures and service data and less for numbers of consumers served,

since most consumers served have a severe mental illness or emotional disorder and receive services for a significant duration.

This is the eighth year that OMS data for mental health disorders is included in this document. The OMS data is gathered through interviews with individuals, ages 6-64, who are receiving outpatient mental health treatment services. Interviews are conducted at the commencement of treatment and then every six months in licensed outpatient mental health clinics, federally qualified health centers, and hospital-based clinics. Consumers who are Medicare recipients or dual recipients of Medicaid and Medicare are not included.

The mental health service utilization tables present summary data from the past three fiscal years for Baltimore City and the past fiscal year for Maryland. It should be noted that previously reported data for the three fiscal years prior to FY 2018 has been updated to include claims that were paid after September 30th following the respective fiscal year and may, therefore, differ from data reported in previous BHSB annual reports. The OMS data tables compare outcomes for Baltimore City and the state for FY 2017 and FY 2018.

Furthermore, it should be noted that the data presented here does not provide a complete picture of the utilization of publicly funded mental health services, since services funded by Medicare are not included, nor are services funded through grant-funded contracts.

Overall, there are several striking observations from the FY 2018 data on mental health service utilization in the PBHS:

- The mental health system continues to serve a significant number of individuals in Baltimore City: 55,833 people in the last year (representing almost 1 out 10 city residents), and 26.2 % of the total people served in Maryland.
- It served a full age-continuum of the population, with the majority (61.4%) being adults.
- Outpatient is the most common service type, with more than 51,000 consumers served in the past year.
- There has been a total of 21,895 people identified as dually diagnosed, representing 39.2% of the total people served in FY 2018.
- The average expenditure per consumer in Baltimore City was $5,460.
- The most expensive service type per person served was residential treatment ($62,410)
- The average cost per person from Baltimore City served for residential treatment was substantially less ($62,410) than for the state ($78,450).

Consumers Served

While Baltimore City represents almost 10.1% of the state's population, it represented 26.2% of those who utilized mental health services in FY 2018. The data presented in the Baltimore City *Demographics and Social Determinants of Health* section help explain this disparity. The conditions in which people are born, grow, live, work and age have a significant impact on

health, and the prevalence of high ACE scores in Baltimore City increases the likelihood of chronic illnesses, including behavioral health conditions.[35]

During the past three fiscal years, the number of city residents served has remained stable, with relatively minor variations among the age groups, with the exception of transition aged youth (18-21 years old) and the elderly (65 and older). These groups showed increases of 9.0% and 8.7%, respectively, in the past fiscal year.

Expenditures

Total expenditures of $304,861,689 for Baltimore City accounted for 30.3% of the state's total expenditures on public mental health services in FY 2018. In the last fiscal year, the city experienced an increase of over $20 million in mental health services expenditures (7.1%). This increase is largely due to variations associated with the following service types: psychiatric rehabilitation program ($12.8 million), inpatient services ($2.8 million), and outpatient services ($3.1 million). There was a decrease of 25.8% in the partial hospitalization ($1.1 million) service line.

The average cost per person served during FY 2018 was $5,460, with the elderly having the highest cost per person at $6,932.

Insurance Coverage

The main source of health insurance coverage for public mental health services is Medicaid, including Medicaid State-funded.[36]

Between FY 2017 and FY 2018, Medicaid expenditures increased by 7.1%, Medicaid State-funded decreased by 4.6%, and the uninsured increased by 24.8%. It is notable that while the number of Medicaid and uninsured individuals served increased by 3.3% and 27.6%, respectively, the Medicaid State-funded individuals decreased by 0.7%. During FY 2017, there were 51,802 individuals with Medicaid. That number rose to 53,532 in FY 2018. Those who were uninsured increased from 1,672 in FY 2017 to 2,134 in FY 2018. This is a considerable change in the number of individuals who are uninsured. Those who were Medicaid State-Funded decreased slightly from 6,292 in FY 2017 to 6,250 in FY 2018.

[35] Maryland Behavioral Risk Factor Surveillance System (2017). "Adverse Childhood Experiences (ACEs) in Maryland: Data from the 2015 Maryland BRFSS Data Tables Only." https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/2015_MD_BRFSS_ACEs_Data_Tables.pdf

[36] Medicaid State-funded expenditures are state-only funds (versus those with a federal match) for State programs for individuals who are eligible based on certain income and assets criteria.

The below tables present overall data for Baltimore City and the State of Maryland. It should be noted that statewide data include data from Baltimore City, which, as previously stated, comprises 26.2% of all consumers served in Maryland and 30.3% of state expenditures.

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	Persons Served By Age Group*				
	FY 2016	FY 2017	% Change	FY 2018	% Change
Early Child (0-5)	2,151	2,027	-5.8%	2,021	-0.3%
Child (6-12)	9,194	9,236	0.5%	9,768	5.8%
Adolescent (13-17)	6,080	6,022	-1.0%	6,138	1.9%
Transitional (18-21)	2,613	2,525	-3.4%	2,751	9.0%
Adult (22 to 64)	32,949	33,338	1.2%	34,294	2.9%
Elderly (65 and over)	630	792	25.7%	861	8.7%
TOTAL	**53,617**	**53,940**	**0.6%**	**55,833**	**3.5%**

**Based on claims paid through September 30, 2018*

	Persons Served By Service Type*				
	FY 2016	FY 2017	% Change	FY 2018	% Change
Case Management	1,217	1,231	1.2%	1,313	6.7%
Crisis	623	661	6.1%	764	15.6%
Inpatient	4,772	4,883	2.3%	4,587	-6.1%
Mobile Treatment	1,170	1,225	4.7%	1,279	4.4%
Outpatient	50,243	50,240	0.0%	51,532	2.6%
Partial Hospitalization	675	663	-1.8%	626	-5.6%
Psychiatric Rehabilitation	11,125	12,898	15.9%	15,455	19.8%
Residential Rehabilitation	1,060	1,090	2.8%	1,173	7.6%
Residential Treatment	173	137	-20.8%	148	8.0%
Respite Care	45	40	-11.1%	36	-10.0%
Supported Employment	498	522	4.8%	449	-14.0%
BMHS Capitation	332	342	3.0%	330	-3.5%
Emergency Petition	16				
Purchase of Care					
PRTF Waiver		10			
****TOTAL**	**53,617**	**53,940**	**0.6%**	**55,833**	**3.5%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Persons Served By Coverage Type*				
	FY 2016	FY 2017	% Change	FY 2018	% Change
Medicaid	51,283	51,802	1.0%	53,532	3.3%
Medicaid State Funded	5,585	6,292	12.7%	6,250	-0.7%
Uninsured	3,185	1,672	-47.5%	2,134	27.6%
****TOTAL**	**53,617**	**53,940**	**0.6%**	**55,833**	**3.5%**
Dually Diagnosed	**19,780**	**20,678**	**4.5%**	**21,895**	**5.9%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	Expenditures By Age Group*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Early Child (0-5)	$6,368,252	$6,251,713	-1.8%	$5,933,833	-5.1%
Child (6-12)	$46,291,551	$48,814,664	5.5%	$51,575,496	5.7%
Adolescent (13-17)	$37,947,969	$37,875,121	-0.2%	$39,182,853	3.5%
Transitional (18-21)	$11,860,032	$13,171,195	11.1%	$14,837,986	12.7%
Adult (22 to 64)	$159,812,494	$173,353,798	8.5%	$187,362,865	8.1%
Elderly (65 and over)	$4,615,187	$5,215,889	13.0%	$5,968,656	14.4%
TOTAL	**$266,895,485**	**$284,682,380**	**6.7%**	**$304,861,689**	**7.1%**

**Based on claims paid through September 30, 2018*

	Expenditures By Service Type*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Case Management	$2,169,989	$2,469,107	13.8%	$2,661,655	7.8%
Crisis	$2,423,792	$2,568,336	6.0%	$3,137,751	22.2%
Inpatient	$66,039,355	$66,990,842	1.4%	$69,832,798	4.2%
Mobile Treatment	$10,821,025	$11,311,023	4.5%	$11,870,548	4.9%
Outpatient	$107,659,762	$115,434,300	7.2%	$118,554,091	2.7%
Partial Hospitalization	$4,694,109	$4,289,447	-8.6%	$3,183,200	-25.8%
Psychiatric Rehabilitation	$50,897,120	$62,704,757	23.2%	$75,594,339	20.6%
Residential Rehabilitation	$1,639,882	$1,694,250	3.3%	$1,695,005	0.0%
Residential Treatment	$11,443,296	$7,950,720	-30.5%	$9,236,666	16.2%
Respite Care	$59,544	$52,213	-12.3%	$40,065	-23.3%
Supported Employment	$872,341	$849,915	-2.6%	$863,862	1.6%
BMHS Capitation	$8,154,134	$8,289,686	1.7%	$8,144,971	-1.7%
Emergency Petition	$9,191				
Purchase of Care					
PRTF Waiver		$50,330			
****TOTAL**	**$266,895,483**	**$284,682,381**	**6.7%**	**$304,861,690**	**7.1%**

**Based on claims paid through September 30, 2018*

	Expenditures By Coverage Group*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Medicaid	$241,977,934	$258,512,098	6.8%	$276,957,187	7.1%
Medicaid State Funded	$21,288,965	$23,556,966	10.7%	$24,641,966	4.6%
Uninsured	$3,628,586	$2,613,315	-28.0%	$3,262,537	24.8%
****TOTAL**	**$266,895,485**	**$284,682,379**	**6.7%**	**$304,861,690**	**7.1%**
Dually Diagnosed	**$134,828,715**	**$144,052,633**	**6.8%**	**$165,033,357**	**14.6%**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	Persons Served: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Case Management	192	250	30.2%	290	16.0%
Crisis					
Inpatient	884	906	2.5%	861	-5.0%
Mobile Treatment	133	166	24.8%	151	-9.0%
Outpatient	16,932	16,732	-1.2%	17,201	2.8%
Partial Hospitalization	337	327	-3.0%	301	-8.0%
Psychiatric Rehabilitation	5,175	5,395	4.3%	6,012	11.4%
Residential Rehabilitation					
Residential Treatment	135	130	-3.7%	140	7.7%
Respite Care	45	40	-11.1%	36	-10.0%
Supported Employment					
BMHS Capitation	0	0	#DIV/0!	0	#DIV/0!
Emergency Petition	0	0	#DIV/0!	0	#DIV/0!
Purchase of Care	0	0	#DIV/0!	0	#DIV/0!
PRTF Waiver		10			
****TOTAL**	**17,425**	**17,285**	**-0.8%**	**17,927**	**3.7%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Case Management	$308,871	$626,462	102.8%	$606,215	-3.2%
Crisis					
Inpatient	$13,882,694	$14,334,435	3.3%	$13,834,297	-3.5%
Mobile Treatment	$890,842	$978,505	9.8%	$972,400	-0.6%
Outpatient	$46,964,038	$49,727,399	5.9%	$50,817,757	2.2%
Partial Hospitalization	$2,643,397	$2,398,088	-9.3%	$1,669,285	-30.4%
Psychiatric Rehabilitation	$14,839,276	$17,312,083	16.7%	$19,868,305	14.8%
Residential Rehabilitation					
Residential Treatment	$11,002,849	$7,442,049	-32.4%	$8,842,392	18.8%
Respite Care	$59,544	$52,213	-12.3%	$40,065	-23.3%
Supported Employment					
BMHS Capitation	$0	$0	#DIV/0!	$0	#DIV/0!
Emergency Petition	$0	$0	#DIV/0!	$0	#DIV/0!
Purchase of Care	$0	$0	#DIV/0!	$0	#DIV/0!
PRTF Waiver		$50,330			
****TOTAL**	**$90,607,773**	**$92,941,498**	**2.6%**	**$96,692,184**	**4.0%**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	Persons Served: Adult (Age 18+ Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Case Management	1,025	981	-4.3%	1,023	4.3%
Crisis	621	657	5.8%	763	16.1%
Inpatient	3,888	3,977	2.3%	3,726	-6.3%
Mobile Treatment	1,037	1,059	2.1%	1,128	6.5%
Outpatient	33,311	33,508	0.6%	34,331	2.5%
Partial Hospitalization	338	336	-0.6%	325	-3.3%
Psychiatric Rehabilitation	5,950	7,503	26.1%	9,443	25.9%
Residential Rehabilitation	1,058	1,086	2.6%	1,171	7.8%
Residential Treatment					
Respite Care	0	0	#DIV/0!	0	#DIV/0!
Supported Employment	497	516	3.8%	445	-13.8%
BMHS Capitation	332	342	3.0%	330	-3.5%
Emergency Petition	16				
Purchase of Care					
PRTF Waiver	0	0	#DIV/0!		
****TOTAL**	**36,192**	**36,655**	**1.3%**	**37,906**	**3.4%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Adult (Age 18+ Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Case Management	$1,861,117	$1,842,645	-1.0%	$2,055,440	11.5%
Crisis	$2,418,644	$2,557,083	5.7%	$3,132,931	22.5%
Inpatient	$52,156,662	$52,656,408	1.0%	$55,998,502	6.3%
Mobile Treatment	$9,930,183	$10,332,519	4.1%	$10,898,149	5.5%
Outpatient	$60,695,724	$65,706,901	8.3%	$67,736,335	3.1%
Partial Hospitalization	$2,050,711	$1,891,358	-7.8%	$1,513,915	-20.0%
Psychiatric Rehabilitation	$36,057,845	$45,392,674	25.9%	$55,726,033	22.8%
Residential Rehabilitation	$1,639,613	$1,693,542	3.3%	$1,693,135	0.0%
Residential Treatment					
Respite Care	$0	$0	#DIV/0!	$0	#DIV/0!
Supported Employment	$871,902	$841,942	-3.4%	$861,773	2.4%
BMHS Capitation	$8,154,134	$8,289,686	1.7%	$8,144,971	-1.7%
Emergency Petition	$9,191				
Purchase of Care					
PRTF Waiver	$0	$0	#DIV/0!		
****TOTAL**	**$176,287,713**	**$191,740,884**	**8.8%**	**$208,169,509**	**8.6%**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	State and County Comparisons Persons Served*			
	STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	7,656	3.6%	2,021	3.6%
Child	38,808	18.2%	9,768	17.5%
Adolescent	27,894	13.1%	6,138	11.0%
Transitional	12,515	5.9%	2,751	4.9%
Adult	123,460	58.0%	34,294	61.4%
Elderly	2,596	1.2%	861	1.5%
TOTAL	**212,929**	100.0%	**55,833**	100.0%
SERVICE TYPE				
Case Management	6,471	3.0%	1,313	2.4%
Crisis	2,524	1.2%	764	1.4%
Inpatient	19,436	9.1%	4,587	8.2%
Mobile Treatment	4,272	2.0%	1,279	2.3%
Outpatient	199,831	93.8%	51,532	92.3%
Partial Hospitalization	2,406	1.1%	626	1.1%
Psychiatric Rehabilitation	37,277	17.5%	15,455	27.7%
Residential Rehabilitation	5,085	2.4%	1,173	2.1%
Residential Treatment	450	0.2%	148	0.3%
Respite Care	333	0.2%	36	0.1%
Supported Employment	3,708	1.7%	449	0.8%
BMHS Capitation	367	0.2%	330	0.6%
Emergency Petition	426	0.2%		
Purchase of Care	27	0.01%		
PRTF Waiver	53	0.02%		
TOTAL	**212,929**	100.0%	**55,833**	100.0%
COVERAGE TYPE				
Medicaid	204,059	95.8%	53,532	95.9%
Medicaid State Funded	29,032	13.6%	6,250	11.2%
Uninsured	8,259	3.9%	2,134	3.8%
TOTAL	**212,929**	100.0%	**55,833**	100.0%
DUALLY DIAGNOSED INDIVIDUALS				
All with DD #	**71,086**	**33.4%**	**0**	**0.0%**

**Based on claims paid through September 30, 2018*

***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	State and County Comparisons Expenditures*			
	STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	$19,008,465	1.9%	$5,933,833	1.9%
Child	$175,008,472	17.4%	$51,575,496	16.9%
Adolescent	$144,979,118	14.4%	$39,182,853	12.9%
Transitional	$52,764,756	5.3%	$14,837,986	4.9%
Adult	$593,122,322	59.0%	$187,362,865	61.5%
Elderly	$19,894,908	2.0%	$5,968,656	2.0%
TOTAL	**$1,004,778,01**	100.0%	**$304,861,689**	**100.0%**
SERVICE TYPE				
Case Management	$13,123,179	1.3%	$2,661,655	0.9%
Crisis	$13,979,347	1.4%	$3,137,751	1.0%
Inpatient	$243,819,961	24.3%	$69,832,798	22.9%
Mobile Treatment	$37,491,459	3.7%	$11,870,548	3.9%
Outpatient	$388,805,274	38.7%	$118,554,091	38.9%
Partial Hospitalization	$9,952,949	1.0%	$3,183,200	1.0%
Psychiatric Rehabilitation	$230,610,102	23.0%	$75,594,339	24.8%
Residential Rehabilitation	$11,847,362	1.2%	$1,695,005	0.6%
Residential Treatment	$35,302,562	3.5%	$9,236,666	3.0%
Respite Care	$966,905	0.1%	$40,065	0.0%
Supported Employment	$9,197,321	0.9%	$863,862	0.3%
BMHS Capitation	$9,118,207	0.9%	$8,144,971	2.7%
Emergency Petition	$135,244	0.013%		
Purchase of Care	$201,873	0.020%		
PRTF Waiver	$226,296	0.023%		
TOTAL	**$1,004,778,01**	100.0%	**$304,861,690**	100.0%
COVERAGE TYPE				
Medicaid	$896,574,924	89.2%	$276,957,187	90.8%
Medicaid State Funded	$92,883,914	9.2%	$24,641,966	8.1%
Uninsured	$15,319,203	1.5%	$3,262,537	1.1%
TOTAL	**$1,004,778,01**	100.0%	**$304,861,690**	100.0%
DUALLY DIAGNOSED INDIVIDUALS				
All with DD #	**$468,185,697**	**46.6%**	**$0**	**0.0%**

**Based on claims paid through September 30, 2018*

***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

	State and County Comparisons Cost Per Person Served*			
	State	**County**	**Difference**	**Index^**
AGE				
Early Child	$2,483	$2,936	$453	118.3
Child	$4,510	$5,280	$770	117.1
Adolescent	$5,198	$6,384	$1,186	122.8
Transitional	$4,216	$5,394	$1,178	127.9
Adult	$4,804	$5,463	$659	113.7
Elderly	$7,664	$6,932	-$731	90.5
TOTAL	**$4,719**	**$5,460**	**$741**	**115.7**
SERVICE TYPE				
Case Management	$2,028	$2,027	-$1	100.0
Crisis	$5,539	$4,107	-$1,432	74.2
Inpatient	$12,545	$15,224	$2,679	121.4
Mobile Treatment	$8,776	$9,281	$505	105.8
Outpatient	$1,946	$2,301	$355	118.2
Partial Hospitalization	$4,137	$5,085	$948	122.9
Psychiatric Rehabilitation	$6,186	$4,891	-$1,295	79.1
Residential Rehabilitation	$2,330	$1,445	-$885	62.0
Residential Treatment	$78,450	$62,410	-$16,040	79.6
Respite Care	$2,904	$1,113	-$1,791	38.3
Supported Employment	$2,480	$1,924	-$556	77.6
BMHS Capitation	$24,845	$24,682	-$164	99.3
Emergency Petition	$317			
Purchase of Care	$7,477			
PRTF Waiver	$4,270			
TOTAL	**$4,719**	**$5,460**	**$741**	**115.7**
COVERAGE TYPE				
Medicaid	$4,394	$5,174	$780	117.8
Medicaid State Funded	$3,199	$3,943	$743	123.2
Uninsured	$1,855	$1,529	-$326	82.4
TOTAL	**$4,719**	**$5,460**	**$741**	**115.7**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM
UTILIZATION FY 2018

VETERANS RECEIVING MENTAL HEALTH SERVICES IN FY 2016-2018
(PERSONS SERVED)

COUNTY	FY 2016	FY 2017	FY 2018
Allegany	148	153	143
Anne Arundel	252	258	268
Baltimore City	1,461	1,461	1,355
Baltimore County	545	547	531
Calvert	73	70	64
Caroline	46	57	50
Carroll	99	100	93
Cecil	105	112	108
Charles	89	87	86
Dorchester	58	49	52
Frederick	145	147	154
Garrett	38	29	27
Harford	160	157	144
Howard	110	116	96
Kent	15	17	17
Montgomery	284	307	305
Prince George's	287	300	277
Queen Anne's	29	33	32
St. Mary's	79	62	65
Somerset	34	37	34
Talbot	39	36	31
Washington	248	238	232
Wicomico	154	145	133
Worcester	71	77	68
Statewide	**4,372**	**4,424**	**4,203**

Note: 1. The total consumer count is unduplicated across counties and therefore, may not equal to the sum of the individual county counts.

2. County is the consumer's county of residence.

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

VETERANS RECEIVING MENTAL HEALTH SERVICES IN FY 2016-2018 (EXPENDITURES)

COUNTY	FY 2016	FY 2017	FY 2018
Allegany	$739,082	$791,768	$835,774
Anne Arundel	$2,444,392	$2,475,495	$2,524,836
Baltimore City	$11,024,670	$11,778,379	$11,014,497
Baltimore County	$4,711,995	$5,136,988	$4,353,176
Calvert	$305,510	$326,144	$266,501
Caroline	$352,262	$356,207	$375,558
Carroll	$888,280	$983,963	$609,185
Cecil	$422,092	$869,535	$484,289
Charles	$350,008	$548,581	$459,635
Dorchester	$419,303	$442,513	$351,548
Frederick	$1,358,920	$1,512,972	$1,739,734
Garrett	$210,823	$186,749	$155,137
Harford	$1,284,057	$1,374,537	$808,829
Howard	$1,040,344	$1,153,122	$1,001,840
Kent	$75,095	$87,857	$81,691
Montgomery	$3,579,832	$3,242,258	$3,338,078
Prince George's	$3,126,916	$3,392,374	$3,223,899
Queen Anne's	$133,141	$123,776	$162,203
St. Mary's	$435,176	$517,044	$607,598
Somerset	$177,828	$212,778	$202,686
Talbot	$167,418	$178,414	$98,580
Washington	$1,225,256	$1,329,471	$1,361,684
Wicomico	$1,141,865	$986,697	$1,141,400
Worcester	$164,654	$161,828	$163,567
Statewide	**$35,778,919**	**$38,169,450**	**$35,361,925**

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

FY 2018 Medicaid Mental Health Penetration Rate

		Accessing the Public Behavioral Health System			
COUNTY	**Total County Population***	**Average MA Eligible**	**% of County MA Eligible**	**MA Served In MH/PBHS**	**Penetration Rate**
Allegany	71,615	22,181	31.0%	4,820	**21.7%**
Anne Arundel	573,235	94,681	16.5%	15,694	**16.6%**
Baltimore County	832,468	197,917	23.8%	30,692	**15.5%**
Calvert	91,502	14,508	15.9%	2,761	**19.0%**
Caroline	33,193	12,017	36.2%	1,806	**15.0%**
Carroll	167,781	23,533	14.0%	4,451	**18.9%**
Cecil	102,746	27,002	26.3%	4,822	**17.9%**
Charles	159,700	31,874	20.0%	3,802	**11.9%**
Dorchester	32,162	13,053	40.6%	2,491	**19.1%**
Frederick	252,022	40,750	16.2%	6,887	**16.9%**
Garrett	29,233	8,808	30.1%	1,222	**13.9%**
Harford	252,160	44,956	17.8%	7,855	**17.5%**
Howard	321,113	45,719	14.2%	5,463	**11.9%**
Kent	19,384	5,074	26.2%	930	**18.3%**
Montgomery	1,058,810	288,590	27.3%	17,409	**6.0%**
Prince George's	912,756	228,525	25.0%	20,225	**8.9%**
Queen Anne's	49,770	8,625	17.3%	1,398	**16.2%**
St. Mary's	112,667	23,037	20.4%	3,249	**14.1%**
Somerset	25,918	8,875	34.2%	1,650	**18.6%**
Talbot	37,103	8,583	23.1%	1,494	**17.4%**
Washington	150,578	44,465	29.5%	8,330	**18.7%**
Wicomico	102,923	34,727	33.7%	5,626	**16.2%**
Worcester	51,690	13,726	26.6%	2,713	**19.8%**
Baltimore City	611,648	264,783	43.3%	53,532	**20.2%**
Statewide	**6,052,177**	**1,408,078**	**23.3%**	**204,059**	**14.5%**

* Maryland Vital Statistics Est. Md. Population July 1, 2018
Data Source: Average MA Eligible supplied by UMBC Hilltop Institute. Data through September 2018.

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

POPULATION IN POVERTY (%), 2018

Jurisdiction	All (%)	Children 0-17 (%)	Ranking Total Population in Poverty (%)
United States	14.0	19.5	
Allegany	17.2	22.1	5
Anne Arundel	7	9.3	20
Baltimore	9	11.9	15
Calvert	5.8	7.4	21
Caroline	15.3	22.1	6
Carroll	5.5	6.5	22
Cecil	10	14.9	12
Charles	7.4	10.1	16
Dorchester	17.4	29.1	4
Frederick	6.9	7.4	19
Garrett	12.8	19.3	9
Harford	7.2	8.5	18
Howard	5.2	6.3	23
Kent	14	19.9	7
Montgomery	6.9	9	19
Prince George's	9.2	13	13
Queen Anne's	7.3	9.4	17
St. Mary's	9.1	11.5	14
Somerset	24.3	31.9	1
Talbot	10.4	16	11
Washington	13.2	17.6	8
Wicomico	18	24.1	3
Worcester	11.4	19.9	10
Baltimore City	21.8	31.3	2
Statewide	**9.7**	**13**	

http://www.ers.usda.gov/data-products/county-level-data-sets/poverty.aspx

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2017

Outcome Measurement System State and County Comparisons Point In Time Observations - FY 2017 *	Child and Adolescent			Adults	
	STATE	COUNTY		STATE	COUNTY
	Percent	Percent		Percent	Percent
Homeless in last 6 months	2.2%	2.6%		12.0%	16.8%
Arrested in last 6 months	3.0%	3.0%		5.5%	4.4%
Problems from your drinking/drug use in the last month					
- Often	N/A	N/A		3.7%	4.7%
- Always	N/A	N/A		4.1%	6.6%
Drink any alcohol during the past month	5.3%	3.3%		N/A	N/A
Smoke any marijuana or hashish during the past month	9.3%	9.0%		N/A	N/A
Use anything else to get high during the past month	1.1%	0.5%		N/A	N/A
Employed now or last 6 months	N/A	N/A		34.9%	22.4%
Adults Served in PBHS Supp. Employment	N/A	N/A		2.8%	1.4%
Cigarette smokers**	3.5%	3.1%		39.0%	40.2%
Use tobacco products in the past month					
- Cigars	1.0%	1.6%		3.5%	4.1%
- Smokeless Tobacco	0.2%	0.0%		0.9%	0.5%
- Electronic Cigarettes	1.1%	0.3%		4.1%	1.9%
- Pipes	0.2%	0.1%		0.6%	0.4%
- Other Tobacco Product	0.4%	0.5%		2.0%	2.6%
Problems with School Attendance	14.4%	12.9%		N/A	N/A
Suspended from school in last 6 months	12.8%	13.1%		N/A	N/A
General Health Status					
Excellent	24.6%	24.8%		6.7%	6.7%
Very Good	36.8%	34.6%		18.7%	16.4%
Good	30.7%	33.8%		35.9%	35.2%
Fair	6.9%	6.2%		29.8%	32.9%
Poor	0.9%	0.7%		8.9%	8.8%

* Most recent observation for each Mental Health consumer in FY 2017; provisional data which may change slightly as Datamart refinement continues

** For children and adolescents, only those ages 11 to 17

Data Source: http://maryland.valueoptions.com/services/OMS_Welcome.html
Most Recent Interview Only, FY 2017

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2018

Outcome Measurement System State and County Comparisons Point In Time Observations - FY 2018 *	Child and Adolescent			Adults	
	STATE	COUNTY		STATE	COUNTY
	Percent	Percent		Percent	Percent
Homeless in last 6 months	2.2%	2.5%		11.5%	16.5%
Arrested in last 6 months	2.6%	2.5%		4.9%	3.7%
Problems from your drinking/drug use in the last month					
- Often	N/A	N/A		3.7%	5.1%
- Always	N/A	N/A		3.9%	5.9%
Drink any alcohol during the past month	5.1%	3.0%		N/A	N/A
Smoke any marijuana or hashish during the past month	9.2%	8.1%		N/A	N/A
Use anything else to get high during the past month	1.1%	0.5%		N/A	N/A
Employed now or last 6 months	N/A	N/A		35.5%	23.3%
Adults Served in PBHS Supp. Employment	N/A	N/A		2.6%	1.2%
Cigarette smokers**	3.2%	1.9%		36.7%	38.6%
Use tobacco products in the past month					
- Cigars	1.0%	1.3%		3.4%	4.1%
- Smokeless Tobacco	0.2%	0.0%		0.8%	0.4%
- Electronic Cigarettes	1.5%	0.2%		3.9%	1.7%
- Pipes	0.2%	0.1%		0.5%	0.3%
- Other Tobacco Product	0.3%	0.3%		1.6%	2.0%
Problems with School Attendance	14.1%	13.1%		N/A	N/A
Suspended from school in last 6 months	11.8%	11.5%		N/A	N/A
General Health Status					
Excellent	24.7%	25.5%		6.5%	6.6%
Very Good	36.4%	35.1%		18.6%	15.5%
Good	30.7%	32.2%		37.8%	38.6%
Fair	7.2%	6.5%		29.2%	31.4%
Poor	1.0%	0.8%		8.0%	7.8%

* Most recent observation for each Mental Health consumer in FY 2018;
provisional data which may change slightly as Datamart refinement continues

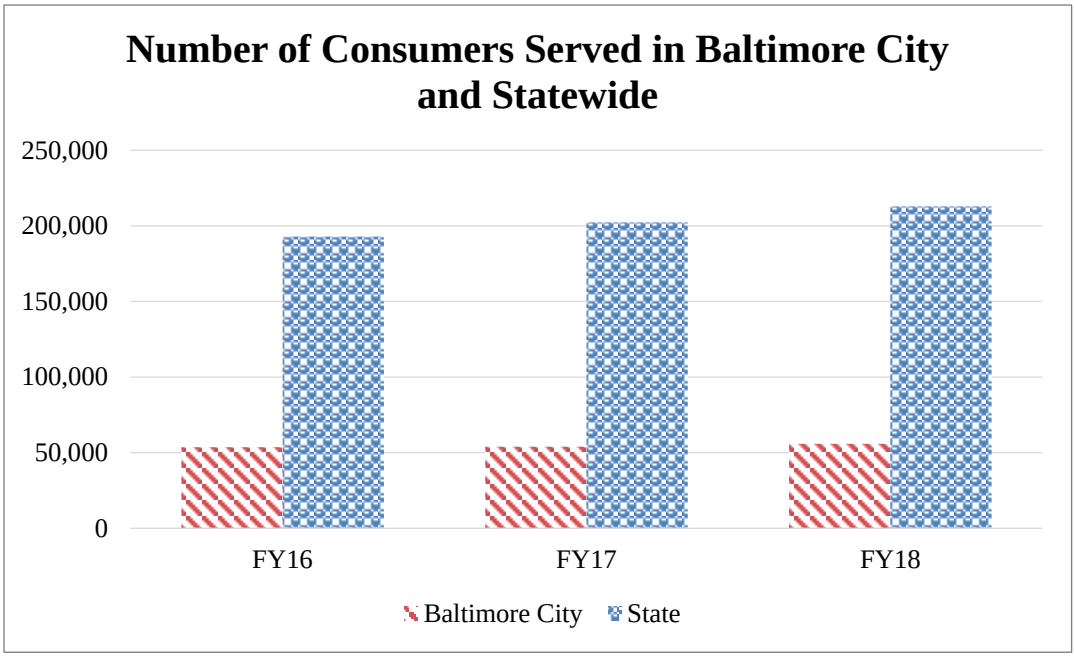
** For children and adolescents, only those ages 11 to 17

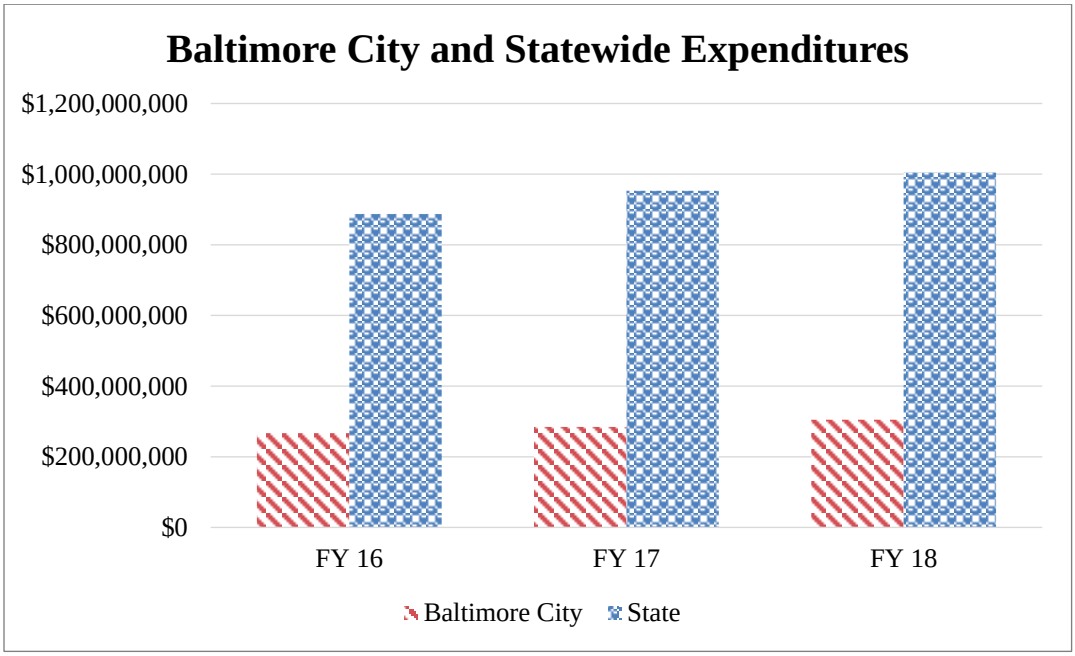
***First administered in January 2015; for Children and Adolescents, data represents only those ages 14 and over

Data Source: http://maryland.valueoptions.com/services/OMS_Welcome.html

Most Recent Interview Only, FY 2018

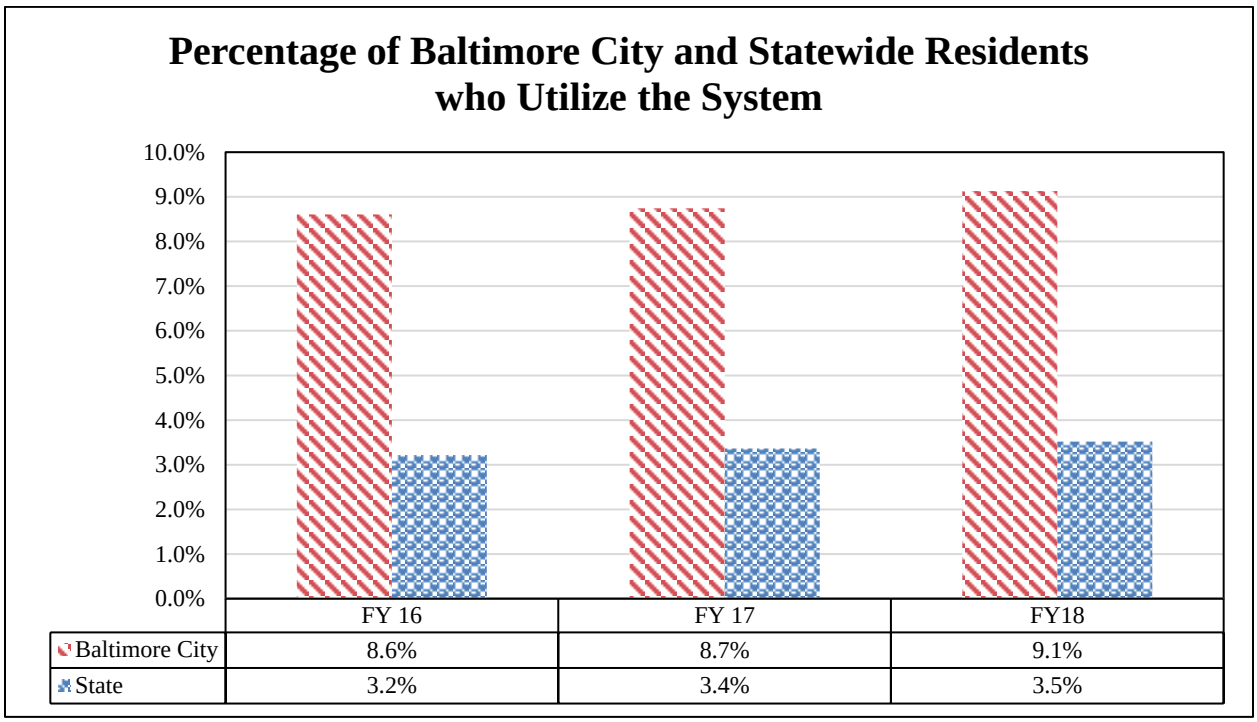
Baltimore City residents comprised 26.2% of all mental health consumers served in the state, and 30.3% of total expenditures for public mental health services.





Source: Beacon Health Options
Based on claims paid through September 30, 2018

A higher percentage of Baltimore City residents (9.1% of the city population) utilized mental health services during FY 2018, compared to the state (3.5% of the population). This is likely related to the prevalence of high ACE scores and other social, economic and educational structures that increase the likelihood of chronic illnesses, including behavioral health conditions. It could also be due to greater access to mental health services in Baltimore City, as compared to other jurisdictions across the state.

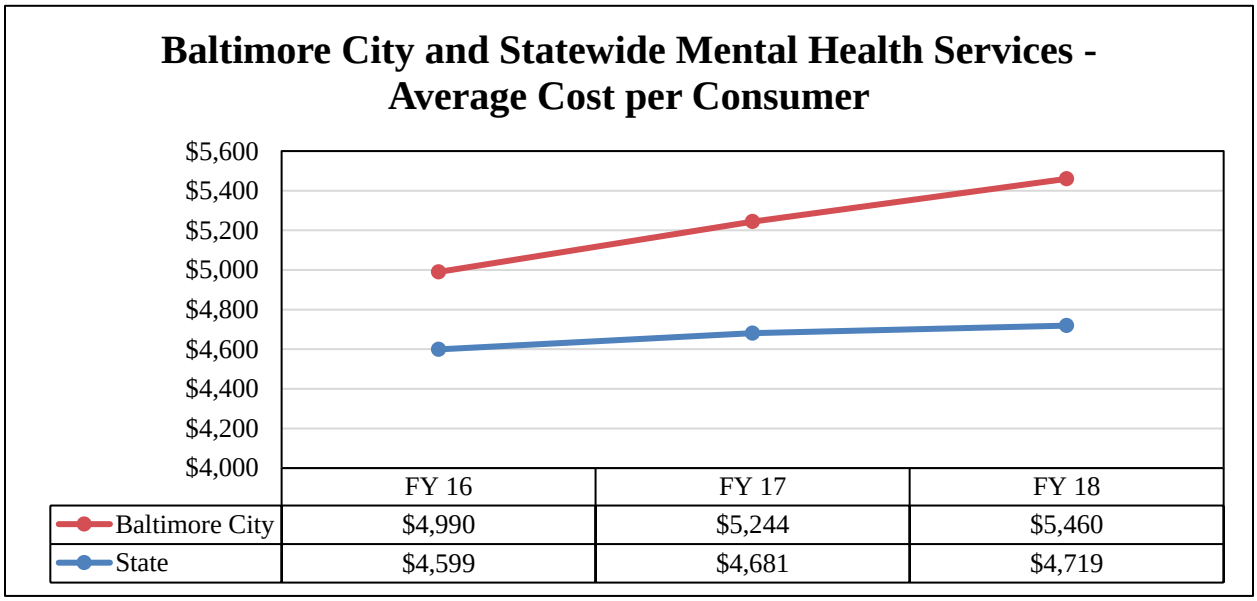


	FY 16	FY 17	FY18
Baltimore City	8.6%	8.7%	9.1%
State	3.2%	3.4%	3.5%

Source: Beacon Health Options
Based on claims paid through September 30, 2018

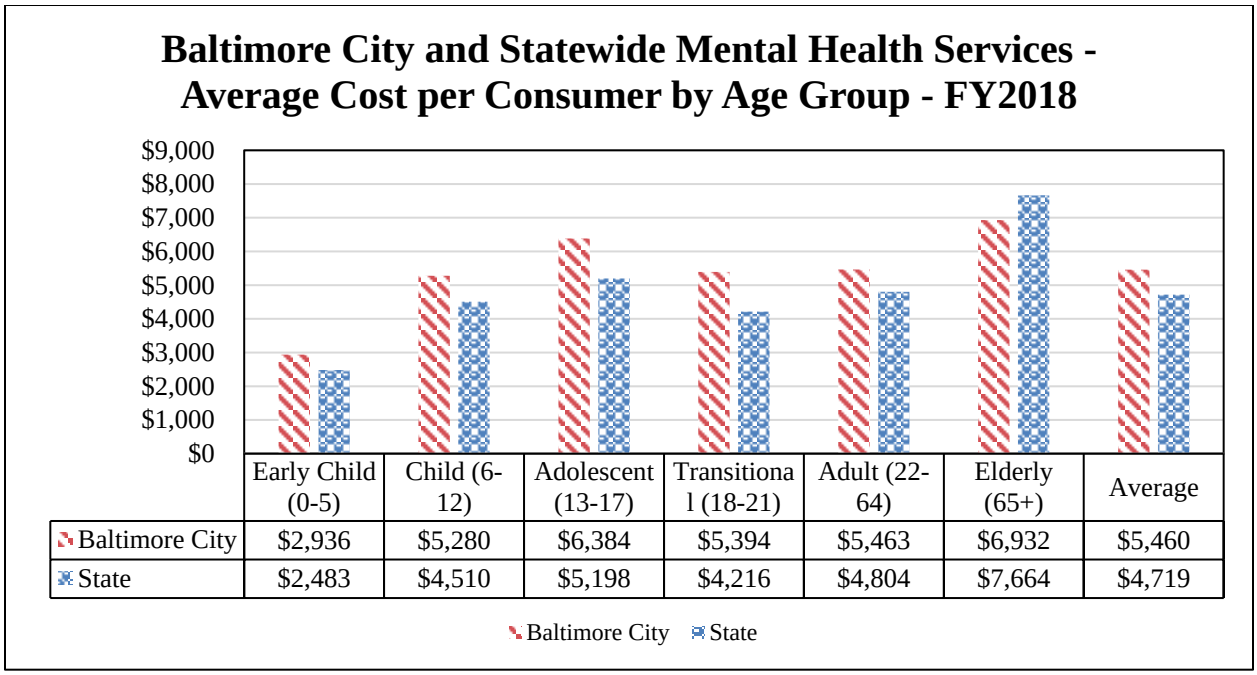
Average Cost Per Consumer

For the last three years, Baltimore City has had a higher overall cost per consumer than the state. Both Baltimore City and the state saw an increase (9.4% and 2.6%, respectively), in the average cost per consumer between FY 2016 thru FY 2018.



Source: Beacon Health Options
Based on claims paid through September 30, 2018

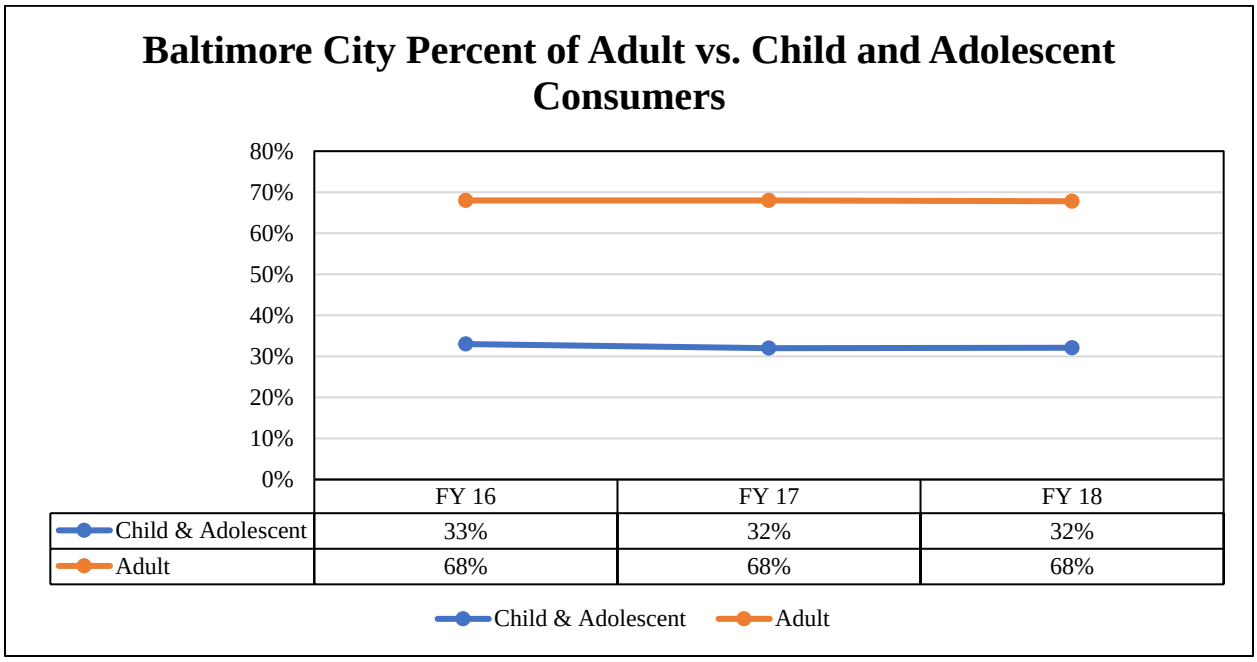
The chart below indicates that the cost per consumer is higher in Baltimore City for every age group except the elderly.



Source: Beacon Health Options
Based on claims paid through September 30, 2018

Adult versus Child

The proportion of adult and youth consumers receiving public mental health services is consistent from FY 2016 thru FY 2018, as roughly two out of three consumers are adults, and one out of three are children/adolescents. Maryland's public behavioral health treatment system is heavily adult-oriented, which reflects the population of Baltimore City. BHSB collaborates closely with BHA and other state and local partners to increase access to services that are appropriate for the unique developmental needs of youth and young adults.

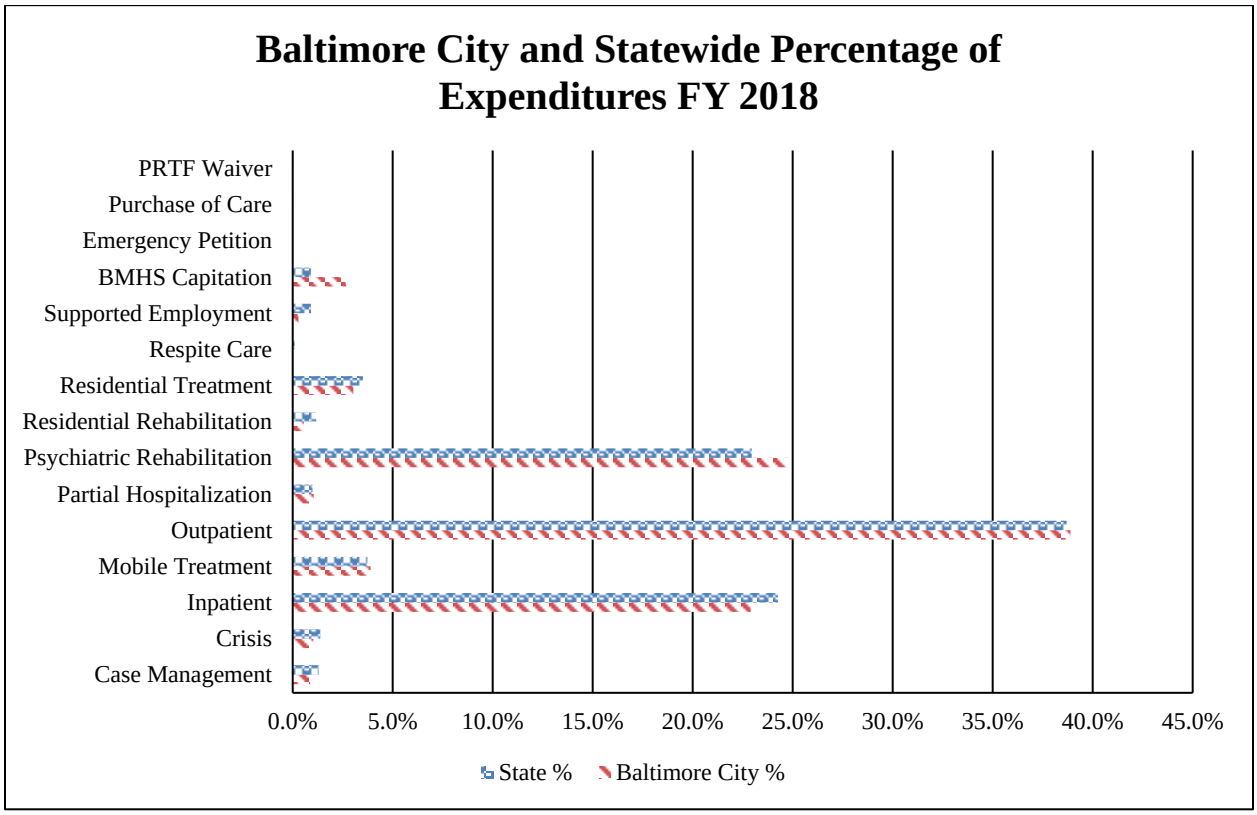


	FY 16	FY 17	FY 18
Child & Adolescent	33%	32%	32%
Adult	68%	68%	68%

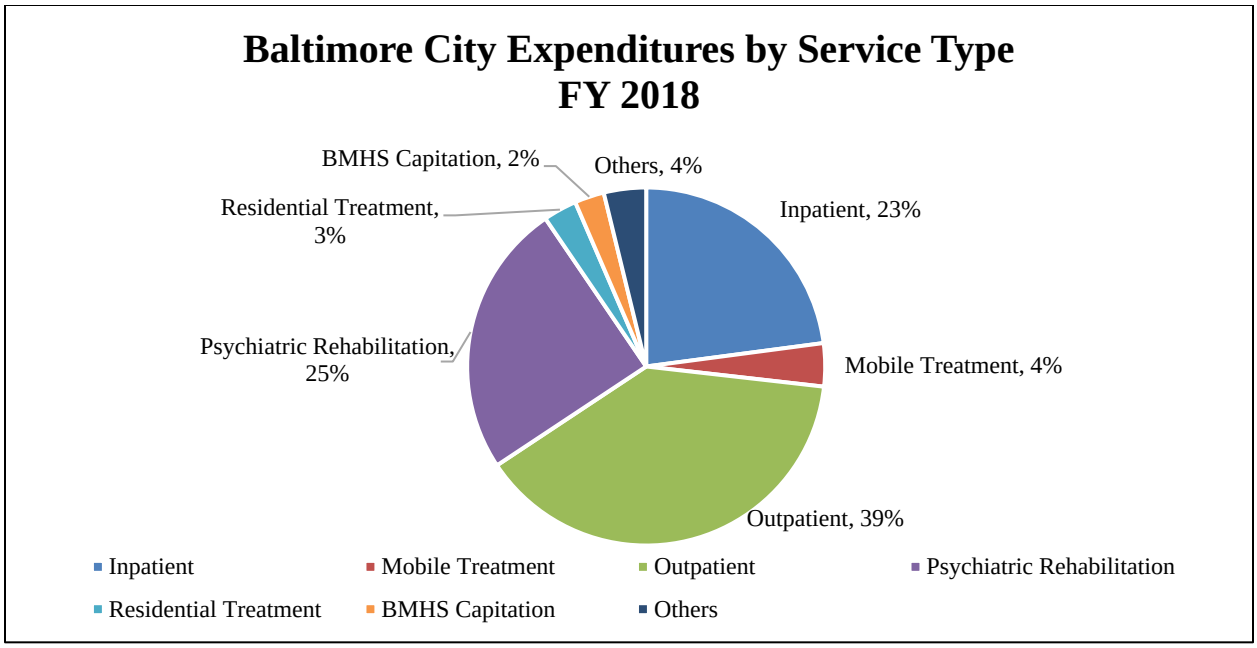
Source: Beacon Health Options
Based on claims paid through September 30, 2018

Expenditures

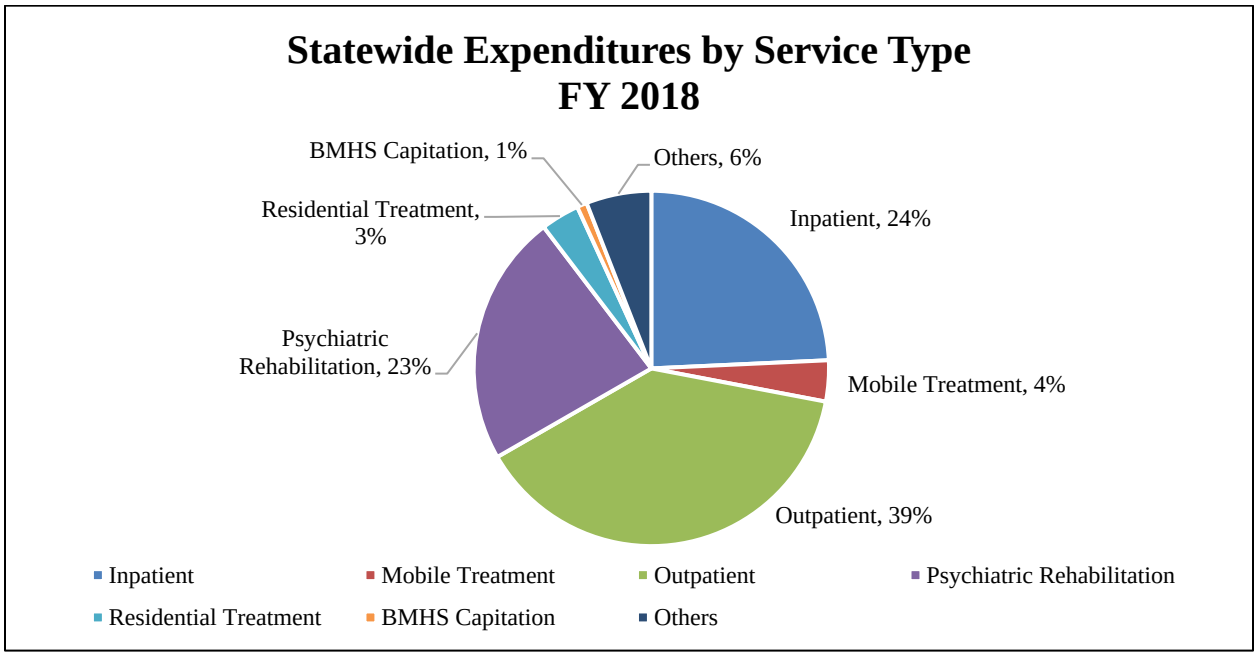
For both Baltimore City and the state, expenditures are higher for outpatient, inpatient, and psychiatric rehabilitation services. However, the charts below show that the distribution of expenditures by service type in Baltimore City differs in several respects from that of the state. A higher percentage of expenditures are for outpatient and psychiatric rehabilitation services in Baltimore City, whereas the state has a higher percentage for residential treatment, inpatient, crisis, and case management services. Of note, despite being a Baltimore City program, the capitation project serves residents of other jurisdictions who are willing to be relocated as Baltimore City residents.



Source: Beacon Health Options
Based on claims paid through September 30, 2018



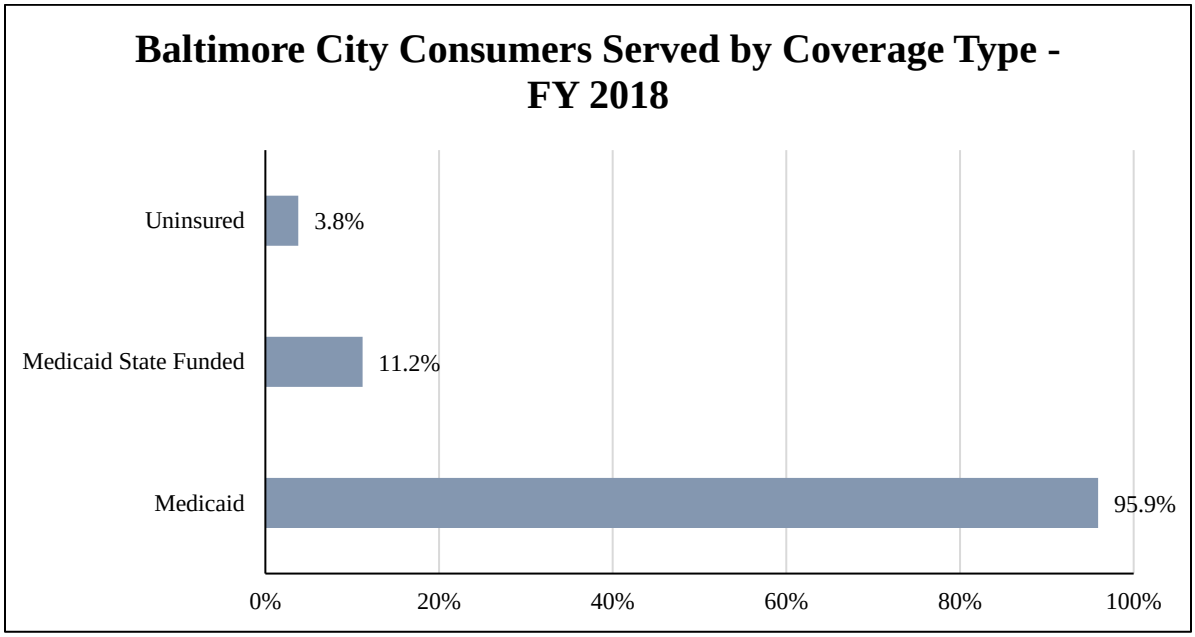
Source: Beacon Health Options
Based on claims paid through September 30, 2018
Others: Case Management, Crisis, Residential Rehabilitation, Respite Care, Supported Employment, BMHS Capitation, Emergency Petition, Purchase of Care, PRTF Waiver



Source: Beacon Health Options
Based on claims paid through September 30, 2018
Others: Case Management, Crisis, Residential Rehabilitation, Respite Care, Supported Employment, BMHS Capitation, Emergency Petition, Purchase of Care, PRTF Waiver

Insurance Coverage

Most (96%) of the individuals who received public mental health services were covered by Medicaid (including Medicaid State-funded).[37]



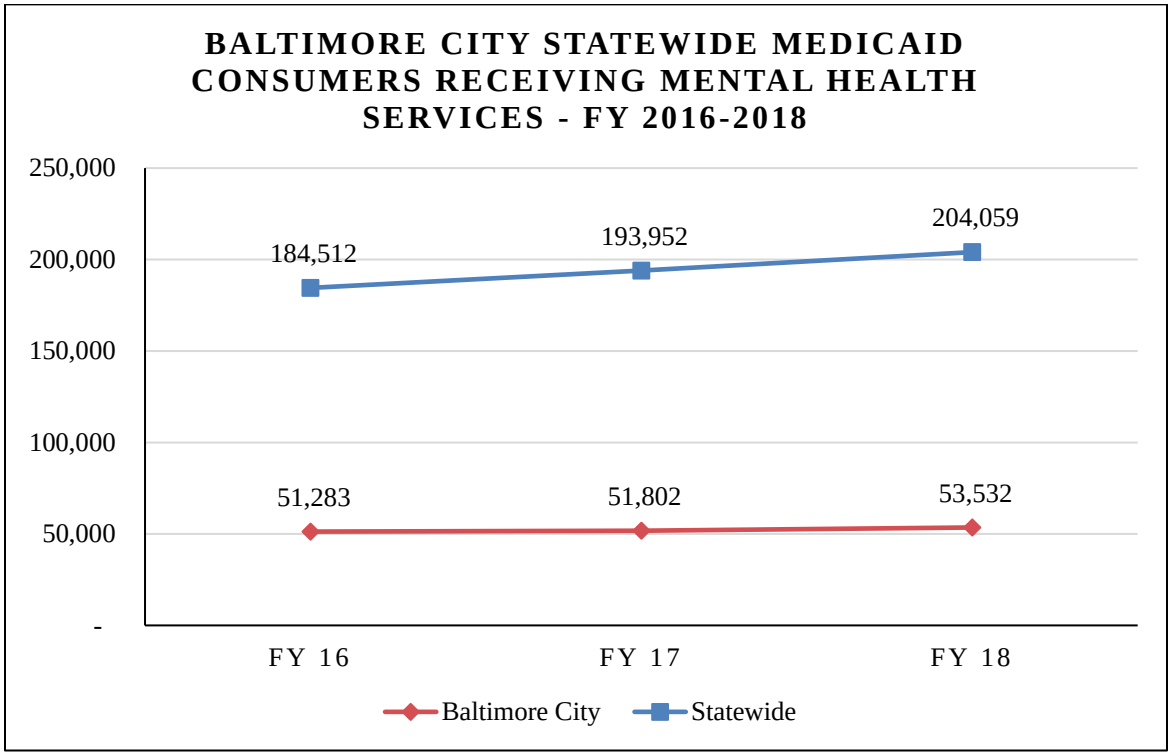
Source: Beacon Health Options
Based on claims paid through September 30, 2018

Medicaid has the highest cost in mental health services per consumer of the three coverage types. This is likely due to restrictions in the set of services that are eligible for uninsured coverage.

Baltimore City Cost per Consumer by Coverage Type			
	Medicaid	Medicaid State-Funded	Uninsured
FY 2016	$4,718	$3,812	$1,139
FY 2017	$4,990	$3,744	$1,563
FY 2018	$5,174	$3,943	$1,529
FY 2016 - 2018 % Change	10%	3%	34%

[37] Many people use services in more than one category. As a result, the sum of the percentage of people served across service categories and across insurance statuses exceeds 100%.

Over the last three years, the number of Medicaid consumers receiving mental health services has increased by 4.3% in the city and 10.5% in the state.



Source: Beacon Health Options
Based on claims paid through September 30, 2018

Veterans

Baltimore City veterans comprised about 32% of all Maryland veterans receiving mental health services and about 31% of total expenditures for veterans in Maryland.

Average Veteran's Cost Per Consumer

The average cost per veteran consumer was $8,128 per year reported in FY 2018. This cost is around 1.5 higher than for non-veterans, with a minimal cost variation over a three-year comparison from FY 2016-2018 ($582). It is also interesting to note that the number of veterans being seen has decreased by 106 people from FY 2016–2018. This highlights the high-priority need of this population for mental health services.

Medicaid Penetration – Mental Health Services Utilization

The number of individuals covered by Medicaid who accessed mental health services increased by 3.3% in the past year, from 51,802 in FY 2017 to 53,532 in FY 2018. This number has increased significantly since the passage of the Affordable Care Act (ACA) in 2014. Since FY

2014, there has been a 14% increase in the number of individuals covered by Medicaid who utilized public mental health services, from 46,861 (FY 2014) to 53,532 (FY 2018).

Under the ACA, Medicaid eligibility criteria are broader, and cost-related barriers to care are reduced. In prior years, Medicaid covered low-income children, pregnant women, elderly, individuals with disabilities, and some parents, but excluded other low-income adults. The criteria now include those with income at or below 138% of the poverty level, and adults without children are eligible. As a result, more people are enrolled in Medicaid, and the overall number of adults with health insurance coverage has increased, including more people who are living with behavioral health conditions.

This landmark policy included key provisions requiring coverage of mental health services at parity with general medical benefits, thus recognizing and promoting mental health as a major health priority in this country.[38] Individuals experiencing mental health disorders often face multiple barriers to care and often have low incomes, in part because the disorders frequently impact the individuals' work and functional capacities.[39] They may be uninsured or have incomplete coverage for mental health and substance use treatment, and depending on their work status pre-Affordable Care Act, they may have even been denied coverage due to "pre-existing conditions."[40]

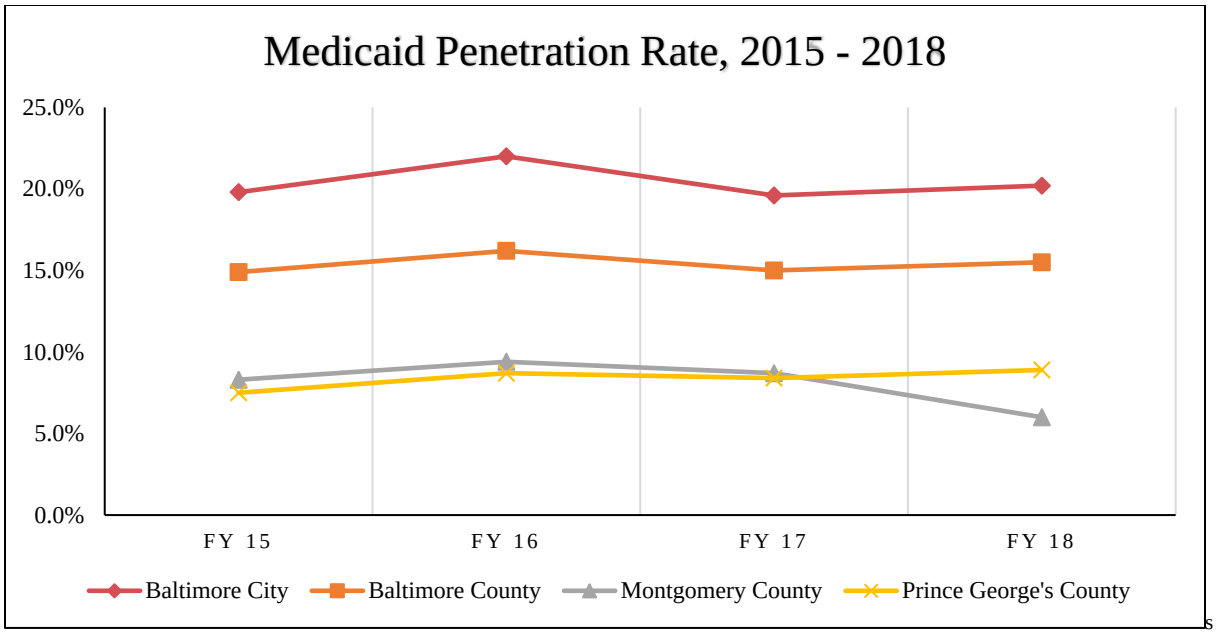
	Persons Served By Coverage Type*					
	FY 2014	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**% Change From FY 2017 - FY 2018**
Medicaid	46,861	51,082	51,283	51,802	53,532	3.30%
Medicaid State Funded	5,582	5,458	5,585	6,292	6,250	-0.70%
Uninsured	2,274	3,456	3,185	1,672	2,134	27.60%

**Based on claims paid through September 30, 2018*

[38] The Affordable Care Act and integrated behavioral health programs in community health centers to promote utilization of mental health services among Asian Americans, 2016 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927455/

[39] Urban Institute Health Policy Center. Health care access and cost barriers for adults with physical or mental health issues: evidence of significant gaps as the ACA marketplaces opened their doors. 2014 [updated 2014; cited December 4, 2015]; Available from: http://hrms.urban.org/briefs/evidence-of-significant-gaps.pdf.

[40] How the affordable care act and mental health parity and addiction equity act greatly expand coverage of behavioral health care. Beronio K, Glied S, Frank R J Behav Health Serv Res. 2014 Oct; 41(4):410-28.



Data Source: Average MA Eligible supplied by UMBC Hilltop Institute. Data through September 2018.

SUBSTANCE RELATED DISORDER UTILIZATION

As noted above, FY 2016, FY 2017 and FY 2018 represented the first three full years of SRD service utilization data. Claims may be submitted up to 12 months after the date of service delivery, so the data for FY 2018 does not reflect all the claims for services rendered to Baltimore City individuals. Grant-funded residential SUD services for all ASAM levels of care except 3.1 transitioned to the ASO starting on July 1, 2017. This is important to note when comparing FY 2016 and FY 2017 data to FY 2018 data.

This is the third year that OMS data for SRD disorders is included in this document. The OMS data is gathered through interviews with individuals who are receiving outpatient SRD treatment services and includes the most recent observation for each consumer in FY 2017 and FY 2018.

The SRD service utilization tables present summary data from the past three fiscal years for Baltimore City and the past fiscal year for Maryland. The OMS data tables compare outcomes for Baltimore City and the state for FY 2017 and FY 2018.

Overall, there are several striking observations from the FY 2018 data on SRD service utilization in Baltimore City:

- The public SRD system served 34,747 individuals.
- Expenditures totaled $155,830,688.
- The most frequently utilized levels of care were the ambulatory services: outpatient, methadone maintenance, and intensive outpatient.
- The SRD Residential levels of care (3.3, 3.5, 3.7 and 3.7.D) served 2,997 people during the first year that these services were reimbursed by the ASO.
- Labs represented 14.7% of the total expenditures.
- Uninsured individuals represented 10.9% of those served.
- The average expenditure per consumer in Baltimore City was $4,485.
- The most expensive service type per person served was SUD invitation for bids, which is substance use disorder services for special populations ($14,457). It was slightly above the state average ($13,799), followed by SUD Court Ordered Placement - Residential ($12,053) and SUD Women with Children/Pregnancy – Residential ($10,256).
- Two of the ambulatory services (intensive outpatient and outpatient) were above the state's average cost per consumer.
- Medicaid costs in Baltimore City were above the state average ($4,162 vs. $3,264).

Consumers Served

While Baltimore City represents almost 10.1% of the state's population, it represented 30.6% of those who utilized public SRD services in FY 2018, with a total of 34,747 consumers served. This is likely related to the prevalence of high ACE scores and other social, economic and

educational structures that increase the likelihood of chronic illnesses, including behavioral health conditions. [41]

Expenditures

Total expenditures of $155,830,688 for Baltimore City account for 38.2% of the state's total expenditures on public SRD services in FY 2018. The average cost per person for the city was $4,485, which is higher than the statewide cost per person, $3,596. Research shows that a high proportion of individuals receiving substance use disorder treatment services have a history of high ACE scores and trauma exposure.[42] The prevalence in Baltimore City of high ACE scores and other stressors such as poverty, racism and community violence is likely a contributing factor to the high proportion of statewide expenditures that are attributed to Baltimore City and the higher cost per person served.

Insurance Coverage

The main source of health insurance coverage for public SRD services was Medicaid, including Medicaid State-funded.[43] In FY 2018 the number of uninsured individuals represented 10.9%.

The below tables present overall data for Baltimore City and the state of Maryland. It should be noted that statewide data include data from Baltimore City, which, as previously stated, comprises almost 31% of all consumers served in Maryland and 38% of state expenditures.

[41] Maryland Behavioral Risk Factor Surveillance System (2017). "Adverse Childhood Experiences (ACEs) in Maryland: Data from the 2015 Maryland BRFSS Data Tables Only." https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/2015_MD_BRFSS_ACEs_Data_Tables.pdf

[42] Funk, R. R., McDermeit, M., Godley, S. H., and Adams, L. (2003). Maltreatment issues by level of adolescent substance abuse treatment: The extent of the problem at intake and relationship to early outcomes. Child Maltreat, 8(1), 36-45.

[43] Medicaid State-funded expenditures are state-only funds (versus those with a federal match) for State programs for individuals who are eligible based on certain income and assets criteria.

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	Persons Served by Age Group*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Early Child (0-5)				13	
Child (6-12)	38	83	118.4%	51	-38.6%
Adolescent (13-17)	715	811	13.4%	764	-5.8%
Transitional (18-21)	973	1,103	13.4%	1,118	1.4%
Adult (22 to 64)	27,464	30,489	11.0%	32,000	5.0%
Elderly (65 and over)	306	593	93.8%	801	35.1%
TOTAL	**29,505**	**33,086**	**12.1%**	**34,747**	**5.0%**

**Based on claims paid through September 30, 2018*

	Persons Served by Service Type*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
SUD Inpatient	1,266	1,482	17.1%	1,207	-18.6%
SUD Outpatient	14,501	21,266	46.7%	23,521	10.6%
SUD Partial Hospitalization	1,110	1,538	38.6%	1,587	3.2%
SUD Labs	19,600	22,793	16.3%	20,883	-8.4%
SUD MD Recovery Net	2,102	1,619	-23.0%	1,744	7.7%
SUD Methadone Maint.	11,801	13,698	16.1%	13,869	1.2%
SUD Residential ICFA	122	132	8.2%	51	-61.4%
SUD Intensive Outpatient	4,190	5,141	22.7%	6,380	24.1%
SUD Gambling	0	0	0	15	0
SUD Invitation for Bid	185	195	5.4%	98	-49.7%
SUD Court Ordered Placement - Residential	0	0	0	107	0
SUD Women with Children/Pregnancy - Residential	0	0	0	34	0
SUD Residential All Levels	0	0	0	2,997	0
SUD Residential Room/Board	0	0	0	2,967	0
****TOTAL**	**29,505**	**33,086**	**12.1%**	**34,747**	**5.0%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Persons Served by Coverage Type*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Medicaid	28,687	31,125	8.5%	32,448	4.3%
Medicaid State Funded	197	1,146	481.7%	5,255	358.6%
Uninsured	2,387	3,178	33.1%	3,793	19.4%
****TOTAL**	**29,505**	**33,086**	**12.1%**	**34,747**	**5.0%**
DUALLY Dx^			**#DIV/0!**		**#DIV/0!**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	Expenditures by Age Group*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Early Child (0-5)				$3,566	
Child (6-12)	$27,819	$32,613	17.2%	$17,965	-44.9%
Adolescent (13-17)	$1,080,196	$1,199,483	11.0%	$726,968	-39.4%
Transitional (18-21)	$1,699,149	$1,740,740	2.4%	$2,014,452	15.7%
Adult (22 to 64)	$98,420,888	$125,928,340	27.9%	$149,849,845	19.0%
Elderly (65 and over)	$982,372	$1,959,617	99.5%	$3,217,892	64.2%
TOTAL	**$102,212,967**	**$130,861,963**	**28.0%**	**$155,830,688**	**19.1%**

**Based on claims paid through September 30, 2018*

	Expenditures by Service Type*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
SUD Inpatient	$5,029,399	$5,357,275	6.5%	$5,345,357	-0.2%
SUD Outpatient	$19,587,322	$23,600,709	20.5%	$32,352,658	37.1%
SUD Partial Hospitalization	$2,366,284	$3,505,826	48.2%	$3,788,145	8.1%
SUD Labs	$18,182,012	$32,107,818	76.6%	$22,849,634	-28.8%
SUD MD Recovery Net	$1,874,048	$1,156,950	-38.3%	$1,344,671	16.2%
SUD Methadone Maint.	$36,292,040	$42,257,498	16.4%	$36,959,878	-12.5%
SUD Residential ICFA	$695,634	$791,227	13.7%	$311,288	-60.7%
SUD Intensive Outpatient	$15,478,440	$19,378,337	25.2%	$26,829,112	38.4%
SUD Gambling	$0	$0	0%	$9,425	0%
SUD Invitation for Bid	$2,707,789	$2,706,321	-0.1%	$1,416,783	-47.6%
SUD Court Ordered Placement - Residential	$0	$0	0%	$1,289,679	0%
SUD Women with Children/Pregnancy - Residential	$0	$0	0%	$348,688	0%
SUD Residential All Levels	$0	$0	0%	$19,575,978	0%
SUD Residential Room/Board	$0	$0	0%	$3,409,391	0%
****TOTAL**	**$102,212,968**	**$130,861,961**	**28.0%**	**$155,830,687**	**19.1%**

**Based on claims paid through September 30, 2018*

	Expenditures by Coverage Group*				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
Medicaid	$97,394,191	$122,512,040	25.8%	$135,043,689	10.2%
Medicaid State Funded	$201,691	$2,175,796	978.8%	$13,283,443	510.5%
Uninsured	$4,617,085	$6,174,126	33.7%	$7,503,556	21.5%
****TOTAL**	**$102,212,967**	**$130,861,962**	**28.0%**	**$155,830,688**	**19.1%**
DUALLY Dx^			**#DIV/0!**		

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	Persons Served: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
SUD Inpatient	11	12	9.09%		
SUD Outpatient	358	433	20.95%	369	-14.78%
SUD Partial Hospitalization	14				
SUD Labs	593	692	16.69%	657	-5.06%
SUD MD Recovery Net		0			
SUD Methadone Maint.				0	
SUD Residential ICFA	85	94	10.59%	32	-65.96%
SUD Intensive Outpatient	136	134	-1.47%	91	-32.09%
SUD Gambling	0	0	0%		
SUD Invitation for Bid	0	0	0%	0	0%
SUD Court Ordered Placement - Residential	0	0	0%	0	0%
SUD Women with Children/Pregnancy - Residential	0	0	0%	0	0%
SUD Residential All Levels	0	0	0%		
SUD Residential Room/Board	0	0	0%		
****TOTAL**	**762**	**901**	**18.24%**	**828**	**-8.10%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
SUD Inpatient	$11,327	$32,266	184.86%		
SUD Outpatient	$177,770	$208,276	17.16%	$185,985	-10.70%
SUD Partial Hospitalization	$40,894				
SUD Labs	$171,015	$244,727	43.10%	$200,962	-17.88%
SUD MD Recovery Net		$0			
SUD Methadone Maint.				$0	
SUD Residential ICFA	$452,912	$539,126	19.04%	$209,489	-61.14%
SUD Intensive Outpatient	$254,935	$185,375	-27.29%	$136,388	-26.43%
SUD Gambling	$0	$0	0%		
SUD Invitation for Bid	$0	$0	0%	$0	0%
SUD Court Ordered Placement - Residential	$0	$0	0%	$0	0%
SUD Women with Children/Pregnancy - Residential	$0	$0	0%	$0	0%
SUD Residential All Levels	$0	$0	0%		
SUD Residential Room/Board	$0	$0	0%		
****TOTAL**	**$1,110,558**	**$1,233,266**	**11.05%**	**$746,097**	**-39.50%**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	Persons Served: Adults (Age 18+ Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
SUD Inpatient	1,255	1,470	17.13%	1,201	-18.30%
SUD Outpatient	14,143	20,823	47.23%	23,152	11.18%
SUD Partial Hospitalization	1,096	1,531	39.69%	1,586	3.59%
SUD Labs	19,007	22,101	16.28%	20,226	-8.48%
SUD MD Recovery Net	2,101	1,619	-22.94%	1,743	7.66%
SUD Methadone Maint.	11,799	13,697	16.09%	13,869	1.26%
SUD Residential ICFA	37	38	2.70%	19	-50.00%
SUD Intensive Outpatient	4,054	5,007	23.51%	6,289	25.60%
SUD Gambling	0	0	0%	14	0%
SUD Invitation for Bid	185	195	5.41%	98	-49.74%
SUD Court Ordered Placement - Residential	0	0	0%	107	0%
SUD Women with Children/Pregnancy - Residential	0	0	0%	34	0%
SUD Residential All Levels	0	0	0%	2,996	0%
SUD Residential Room/Board	0	0	0%	2,966	0%
****TOTAL**	**28,743**	**32,185**	**11.98%**	**33,919**	**5.39%**

**Based on claims paid through September 30, 2018*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Adults (Age 18+ Years) *				
	FY 2016	**FY 2017**	**% Change**	**FY 2018**	**% Change**
SUD Inpatient	$5,018,072	$5,325,009	6.12%	$5,341,951	0.32%
SUD Outpatient	$19,409,551	$23,392,433	20.52%	$32,166,674	37.51%
SUD Partial Hospitalization	$2,325,390	$3,483,216	49.79%	$3,778,613	8.48%
SUD Labs	$18,010,997	$31,863,091	76.91%	$22,648,672	-28.92%
SUD MD Recovery Net	$1,873,943	$1,156,950	-38.26%	$1,344,516	16.21%
SUD Methadone Maint.	$36,290,440	$42,256,612	16.44%	$36,959,878	-12.53%
SUD Residential ICFA	$242,722	$252,101	3.86%	$101,800	-59.62%
SUD Intensive Outpatient	$15,223,505	$19,192,962	26.07%	$26,692,724	39.08%
SUD Gambling	$0	$0	0%	$9,245	0%
SUD Invitation for Bid	$2,707,789	$2,706,321	-0.05%	$1,416,783	-47.65%
SUD Court Ordered Placement - Residential	$0	$0	0%	$1,289,679	0%
SUD Women with Children/Pregnancy - Residential	$0	$0	0%	$348,688	0%
SUD Residential All Levels	$0	$0	0%	$19,573,850	0%
SUD Residential Room/Board	$0	$0	0%	$3,409,116	0%
****TOTAL**	**$101,102,409**	**$129,628,695**	**28.22%**	**$155,082,189**	**19.64%**

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	State and County Comparisons Persons Served *			
	STATE		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	53	0.0%	13	0.0%
Child	264	0.2%	51	0.1%
Adolescent	3,325	2.9%	764	2.2%
Transitional	4,837	4.3%	1,118	3.2%
Adult	103,590	91.4%	32,000	92.1%
Elderly	1,251	1.1%	801	2.3%
TOTAL	**113,320**	100.0%	**34,747**	100.0%
SERVICE TYPE				
SUD Inpatient	2,899	2.6%	1,207	3.5%
SUD Outpatient	71,669	63.2%	23,521	67.7%
SUD Partial Hospitalization	3,919	3.5%	1,587	4.6%
SUD Labs	74,799	66.0%	20,883	60.1%
SUD MD Recovery Net	4,509	4.0%	1,744	5.0%
SUD Methadone Maint.	33,394	29.5%	13,869	39.9%
SUD Residential ICFA	218	0.2%	51	0.1%
SUD Intensive Outpatient	15,399	13.6%	6,380	18.4%
SUD Gambling	65	0.1%	15	0.0%
SUD Invitation for Bid	563	0.5%	98	0.3%
SUD Court Ordered Placement - Residential	429	0.4%	107	0.3%
SUD Women with Children/Pregnancy - Residential	135	0.1%	34	0.1%
SUD Residential All Levels	9,198	8.1%	2,997	8.6%
SUD Residential Room/Board	9,121	8.0%	2,967	8.5%
****TOTAL**	**113,320**	100.0%	**34,747**	100%
COVERAGE TYPE				
Medicaid	107,927	95.2%	32,448	93.4%
Medicaid State Funded	15,031	13.3%	5,255	15.1%
Uninsured	9,808	8.7%	3,793	10.9%
TOTAL	**113,320**	100.0%	**34,747**	100.0%
DUALLY DIAGNOSED INDIVIDUALS				
All with DD ^		0.0%		0.0%

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	State and County Comparisons Expenditures *			
	STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	$17,082	0.00%	$3,566	0.0%
Child	$90,526	0.02%	$17,965	0.0%
Adolescent	$3,813,706	0.94%	$724,385	0.6%
Transitional	$9,654,307	2.37%	$1,678,757	1.3%
Adult	$389,420,862	95.57%	$126,034,374	96.1%
Elderly	$4,479,243	1.10%	$2,738,480	2.1%
TOTAL	**$407,475,726**	100.0%	**$131,197,527**	**100.0%**
SERVICE TYPE				
SUD Inpatient	$11,595,217	2.85%	$5,345,357	3.4%
SUD Outpatient	$82,175,424	20.17%	$32,352,658	20.8%
SUD Partial Hospitalization	$10,061,208	2.47%	$3,788,145	2.4%
SUD Labs	$67,267,776	16.51%	$22,849,634	14.7%
SUD MD Recovery Net	$3,527,570	0.87%	$1,344,671	0.9%
SUD Methadone Maint.	$88,827,872	21.80%	$36,959,878	23.7%
SUD Residential ICFA	$1,391,725	0.34%	$311,288	0.2%
SUD Intensive Outpatient	$57,622,147	14.14%	$26,829,112	17.2%
SUD Gambling	$32,640	0.01%	$9,425	0.0%
SUD Invitation for Bid	$7,768,843	1.91%	$1,416,783	0.9%
SUD Court Ordered Placement - Residential	$6,594,422	1.62%	$1,289,679	0.8%
SUD Women with Children/Pregnancy - Residential	$1,979,188	0.49%	$348,688	0.2%
SUD Residential All Levels	$58,457,094	14.35%	$19,575,978	12.6%
SUD Residential Room/Board	$10,174,601	2.50%	$3,409,391	2.2%
****TOTAL**	**$407,475,727**	100.0%	**$155,830,687**	100.0%
COVERAGE TYPE				
Medicaid	$352,237,806	86.4%	$135,043,689	86.7%
Medicaid State Funded	$34,188,734	8.4%	$13,283,443	8.5%
Uninsured	$21,049,187	5.2%	$7,503,556	4.8%
TOTAL	**$407,475,727**	100.0%	**$155,830,688**	100.0%
DUALLY DIAGNOSED INDIVIDUALS				
All with DD ^		0.0%		0.0%

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

	State and County Comparisons Cost per Person Served *			
	State	**County**	**Difference**	**Index^**
AGE				
Early Child	$322	$274	-$48	85.1
Child	$343	$352	$9	102.7
Adolescent	$1,147	$948	-$199	82.7
Transitional	$1,996	$1,502	-$494	75.2
Adult	$3,759	$3,939	$179	104.8
Elderly	$3,581	$3,419	-$162	95.5
TOTAL	**$3,596**	**$3,776**	**$180**	**105.0**
SERVICE TYPE				
SUD Inpatient	$4,000	$4,429	$429	110.7
SUD Outpatient	$1,147	$1,375	$229	120.0
SUD Partial Hospitalization	$2,567	$2,387	-$180	93.0
SUD Labs	$899	$1,094	$195	121.7
SUD MD Recovery Net	$782	$771	-$11	98.6
SUD Methadone Maint.	$2,660	$2,665	$5	100.2
SUD Residential ICFA	$6,384	$6,104	-$280	95.6
SUD Intensive Outpatient	$3,742	$4,205	$463	112.4
SUD Gambling	$502	$628	$126	125.1
SUD Invitation for Bid	$13,799	$14,457	$658	104.8
SUD Court Ordered Placement - Residential	$15,372	$12,053	-$3,319	78.4
SUD Women with Children/Pregnancy - Residential	$14,661	$10,256	-$4,405	70.0
SUD Residential All Levels	$6,355	$6,532	$176	102.8
SUD Residential Room/Board	$1,116	$1,149	$34	103.0
****TOTAL**	**$3,596**	**$4,485**	**$889**	**124.7**
COVERAGE TYPE				
Medicaid	$3,264	$4,162	$898	127.5
Medicaid State Funded	$2,275	$2,528	$253	111.1
Uninsured	$2,146	$1,978	-$168	92.2
TOTAL	**$3,596**	**$4,485**	**$889**	**124.7**
DUALLY DIAGNOSED INDIVIDUALS				
All with DD ^		0.0%		0.0%

**Based on claims paid through September 30, 2018*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

PRIMARY SUBSTANCE AT ADMISSION (ALL AGES) STATEWIDE VS COUNTY
FY 2016-2018

	FY 2016		FY 2017		FY 2018	
	State	**County**	**State**	**County**	**State**	**County**
Alcohol	8,162	2109	9,056	2206	10,399	2632
Amphetamines	110	27	169	32	205	31
Barbiturates		3		1		
Benzodiazepines	412	120	445	149	527	172
Cocaine	1,974	771	2,616	1006	3,162	1119
Diphenylhydantoin (Dilantin)						
GHB/GBL						
Hallucinogens	59	7	72	12	92	22
Inhalants		2	11	1		2
Ketamine	17	6	24	7	13	5
Marijuana/Hashish	4,862	1448	4,886	1412	5,102	1479
Meprobamate		2		2		2
Opiates	26,975	10589	40,643	15729	27,214	9672
Over the Counter	36	7	46	14	43	9
PCP	270	11	294	12	260	10
Sedatives	25	11	30	7	37	10
Stimulants	83	27	67	14	85	27
Tranquilizers						
Synthetic Cannabinoids	134	30	110	29	87	15
Other Substance	4,663	277	4,238	299	4,454	337
^None	991	391	986	395	17	4
TOTAL	**27,656**	**15,838**	**32,138**	**21,327**	**31,184**	**15,548**
Heroin (Opiates subset)	**21,141,**	**9,398**	**31,565**	**13,872**	**20,536**	**8,432**

**Based on claims paid through September 30, 2018.*

Data Source: ASO Report 151172.1.01

^None=Not Available at the time of initial authorization of Admission. This data is updated.

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

VETERANS RECEIVING SUBSTANCE RELATED DISORDER TREATMENT SERVICES
FY 2016-2018 (PERSONS SERVED)

COUNTY	FY 2016	FY 2017	FY 2018
Allegany	110	133	123
Anne Arundel	190	202	237
Baltimore City	1,300	1,527	1,540
Baltimore County	350	429	444
Calvert	39	53	60
Caroline	22	27	32
Carroll	80	86	79
Cecil	92	104	92
Charles	52	55	52
Dorchester	31	37	40
Frederick	80	99	111
Garrett	18	25	20
Harford	112	137	138
Howard	57	62	53
Kent	11	16	17
Montgomery	110	129	129
Prince George's	90	96	105
Queen Anne's	16	19	23
St. Mary's	29	37	44
Somerset	20	16	23
Talbot	12	22	24
Washington	128	145	159
Wicomico	94	117	106
Worcester	34	54	63
Statewide Total	**2,925**	**3,475**	**3,559**

**Based on claims paid through September 30, 2018.*

Data Source: ASO Report #152820.1.01

Veteran status is based on individual response to question, "Are you a Veteran?"

Fiscal Year is based on date of service. County refers to an individual's county of residence.

Statewide Total is unduplicated and may not equal the sum of individual lines.

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

VETERANS RECEIVING SUBSTANCE RELATED DISORDER TREATMENT SERVICES
FY 2016-2018 (EXPENDITURES)

COUNTY	FY 2016	FY 2017	FY 2018
Allegany	$280,985	$309,975	$373,289
Anne Arundel	$836,287	$970,591	$1,292,287
Baltimore City	$6,536,120	$8,531,520	$10,479,744
Baltimore County	$1,241,487	$1,752,626	$2,460,154
Calvert	$78,569	$142,118	$277,790
Caroline	$79,906	$69,690	$108,295
Carroll	$320,694	$394,070	$407,782
Cecil	$233,690	$277,744	$381,869
Charles	$140,282	$139,123	$273,593
Dorchester	$165,130	$189,179	$191,371
Frederick	$381,935	$500,649	$808,229
Garrett	$32,456	$39,701	$57,709
Harford	$458,839	$431,256	$518,872
Howard	$231,452	$360,711	$301,890
Kent	$24,917	$95,491	$75,208
Montgomery	$631,074	$603,045	$787,366
Prince George's	$192,790	$272,746	$527,616
Queen Anne's	$76,664	$63,697	$135,927
St. Mary's	$67,865	$112,938	$197,917
Somerset	$72,676	$62,417	$142,411
Talbot	$56,209	$118,184	$131,736
Washington	$710,563	$857,275	$911,434
Wicomico	$294,829	$450,255	$560,287
Worcester	$58,168	$113,577	$187,278
Statewide Total	**$13,203,587**	**$16,858,578**	**$21,590,054**

**Based on claims paid through September 30, 2018.*

Data Source: ASO Report #152820.1.01

Veteran status is based on individual response to question, "Are you a Veteran?"

** Note: FY2015 data is for 6 months as the SRD services were not captured in the PBHS until January 1, 2015.*

Fiscal Year is based on date of service. County refers to an individual's county of residence.

Statewide Total is unduplicated and may not equal the sum of individual lines.

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

NUMBER OF OPIOID RELATED OVERDOSE DEATHS BY COUNTY

COUNTY	FY 2016	FY 2017	FY 2018	% Change FY16-18	% Change FY17-18
Allegany	55	36	26	**-52.7%**	**-27.8%**
Anne Arundel	169	198	225	**33.1%**	**13.6%**
Baltimore City	628	692	776	**23.6%**	**12.1%**
Baltimore County	305	323	354	**16.1%**	**9.6%**
Calvert	25	27	29	**16.0%**	**7.4%**
Caroline					
Carroll	44	51	71	**61.4%**	**39.2%**
Cecil	28	57	66	**135.7%**	**15.8%**
Charles	36	34	26	**-27.8%**	**-23.5%**
Dorchester		10			
Frederick	80	66	76	**-5.0%**	**15.2%**
Garrett	0				
Harford	76	93	88	**15.8%**	**-5.4%**
Howard	40	47	40	**0.0%**	**-14.9%**
Kent					
Montgomery	84	91	88	**4.8%**	**-3.3%**
Prince George's	106	124	112	**5.7%**	**-9.7%**
Queen Anne's					
St. Mary's	13	33	33	**153.8%**	**0.0%**
Somerset					
Talbot	10				
Washington	63	51	70	**11.1%**	**37.3%**
Wicomico	44	28	27	**-38.6%**	**-3.6%**
Worcester	20	15	14	**-30.0%**	**-6.7%**
Statewide Total	**1,856**	**2,009**	**2,161**	**16.4%**	**7.6%**

These are deaths caused by an overdose of opioids.

Note: Numbers are based on location of occurrence, so all deaths may not reflect Maryland residents.

Data Source: Maryland Office of the Chief Medical Examiner (OCME)

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

Medicaid Substance Related Disorders Penetration Rate

		Accessing the Public Behavioral Health System			
	Total County Population*	**Average MA Eligible**	**% of County MA Eligible**	**MA Served In SRD/PBHS**	**Penetration Rate**
COUNTY					
Allegany	71,615	22,181	31.0%	3,037	**13.7%**
Anne Arundel	573,235	94,681	16.5%	10,432	**11.0%**
Baltimore County	832,468	197,917	23.8%	16,474	**8.3%**
Calvert	91,502	14,508	15.9%	2,090	**14.4%**
Caroline	33,193	12,017	36.2%	906	**7.5%**
Carroll	167,781	23,533	14.0%	2,692	**11.4%**
Cecil	102,746	27,002	26.3%	4,076	**15.1%**
Charles	159,700	31,874	20.0%	2,417	**7.6%**
Dorchester	32,162	13,053	40.6%	1,241	**9.5%**
Frederick	252,022	40,750	16.2%	3,699	**9.1%**
Garrett	29,233	8,808	30.1%	771	**8.8%**
Harford	252,160	44,956	17.8%	5,223	**11.6%**
Howard	321,113	45,719	14.2%	2,149	**4.7%**
Kent	19,384	5,074	26.2%	543	**10.7%**
Montgomery	1,058,810	288,590	27.3%	5,210	**1.8%**
Prince George's	912,756	228,525	25.0%	6,045	**2.6%**
Queen Anne's	49,770	8,625	17.3%	865	**10.0%**
St. Mary's	112,667	23,037	20.4%	2,450	**10.6%**
Somerset	25,918	8,875	34.2%	865	**9.7%**
Talbot	37,103	8,583	23.1%	701	**8.2%**
Washington	150,578	44,465	29.5%	5,297	**11.9%**
Wicomico	102,923	34,727	33.7%	3,203	**9.2%**
Worcester	51,690	13,726	26.6%	1,384	**10.1%**
Baltimore City	611,648	264,783	43.3%	34,747	**13.1%**
Statewide	**6,052,177**	**1,408,078**	**23.3%**	**107,927**	**7.7%**

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2017

Outcome Measurement System State and County Comparisons Point In Time Observations - FY 2017 *	Child and Adolescent		Adults	
	STATE	COUNTY	STATE	COUNTY
	Percent	Percent	Percent	Percent
Homeless in last 6 months	3.2%	4.0%	13.3%	15.3%
Arrested in last 6 months	31.9%	34.9%	10.4%	5.9%
Problems from your drinking/drug use in the last month				
- Often	N/A	N/A	12.7%	13.6%
- Always	N/A	N/A	10.7%	11.6%
Drink any alcohol during the past month	33.9%	29.8%	N/A	N/A
Smoke any marijuana or hashish during the past month	81.1%	93.6%	N/A	N/A
Use anything else to get high during the past month	10.6%	8.5%	N/A	N/A
Employed now or last 6 months	N/A	N/A	38.5%	24.0%
Cigarette smokers**	30.9%	29.4%	69.7%	72.8%
Use tobacco products in the past month				
- Cigars	10.5%	24.6%	6.0%	7.0%
- Smokeless Tobacco	1.8%	0.0%	2.0%	1.3%
- Electronic Cigarettes	5.4%	1.6%	6.2%	3.9%
- Pipes	1.1%	1.6%	0.5%	0.3%
- Other Tobacco Product	3.0%	4.8%	6.8%	7.9%
Problems with school attendance	32.8%	34.9%	N/A	N/A
Suspended from school in last 6 months	31.5%	24.6%	N/A	N/A
General Health Status				
Excellent	31.0%	20.7%	5.5%	5.2%
Very Good	31.0%	27.6%	20.5%	17.7%
Good	31.3%	46.6%	44.2%	40.8%
Fair	6.2%	3.4%	25.3%	31.2%
Poor	0.4%	1.7%	4.5%	5.1%

* Most recent observation for each Substance-Related Disorder consumer in FY 2017; provisional data which may change slightly as Datamart refinement continues

** For children and adolescents, only those ages 11 to 17

***First administered in January 2016; for Children and Adolescents, data represents only those ages 14 and over

Data Source: http://maryland.valueoptions.com/services/OMS_Welcome.html

Most Recent Interview Only, FY 2017

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2018

Outcome Measurement System State and County Comparisons Point In Time Observations - FY 2018 *	Child and Adolescent			Adults	
	STATE	COUNTY		STATE	COUNTY
	Percent	Percent		Percent	Percent
Homeless in last 6 months	1.6%	2.7%		11.9%	14.6%
Arrested in last 6 months	30.8%	26.0%		8.8%	4.8%
Problems from your drinking/drug use in the last month					
- Often	N/A	N/A		11.3%	12.7%
- Always	N/A	N/A		9.8%	10.6%
Drink any alcohol during the past month	34.4%	28.0%		N/A	N/A
Smoke any marijuana or hashish during the past month	80.8%	92.0%		N/A	N/A
Use anything else to get high during the past month	15.0%	12.0%		N/A	N/A
Employed now or last 6 months	N/A	N/A		36.6%	23.2%
Cigarette smokers**	26.3%	11.5%		71.0%	73.6%
Use tobacco products in the past month					
- Cigars	8.1%	22.1%		5.8%	7.1%
- Smokeless Tobacco	1.3%	1.0%		1.8%	1.2%
- Electronic Cigarettes	6.8%	0.0%		5.7%	3.3%
- Pipes	0.7%	1.0%		0.5%	0.2%
- Other Tobacco Product	2.0%	0.0%		5.3%	5.7%
Problems with school attendance	30.4%	40.4%		N/A	N/A
Suspended from school in last 6 months	30.1%	24.0%		N/A	N/A
General Health Status					
Excellent	26.8%	20.8%		5.8%	4.8%
Very Good	38.9%	30.2%		23.1%	18.4%
Good	39.8%	45.3%		42.7%	42.0%
Fair	4.4%	3.8%		24.0%	30.2%
Poor	0.0%	0.0%		4.4%	4.6%

* Most recent observation for each Substance-Related Disorder consumer in FY 2018; provisional data which may change slightly as Datamart refinement continues

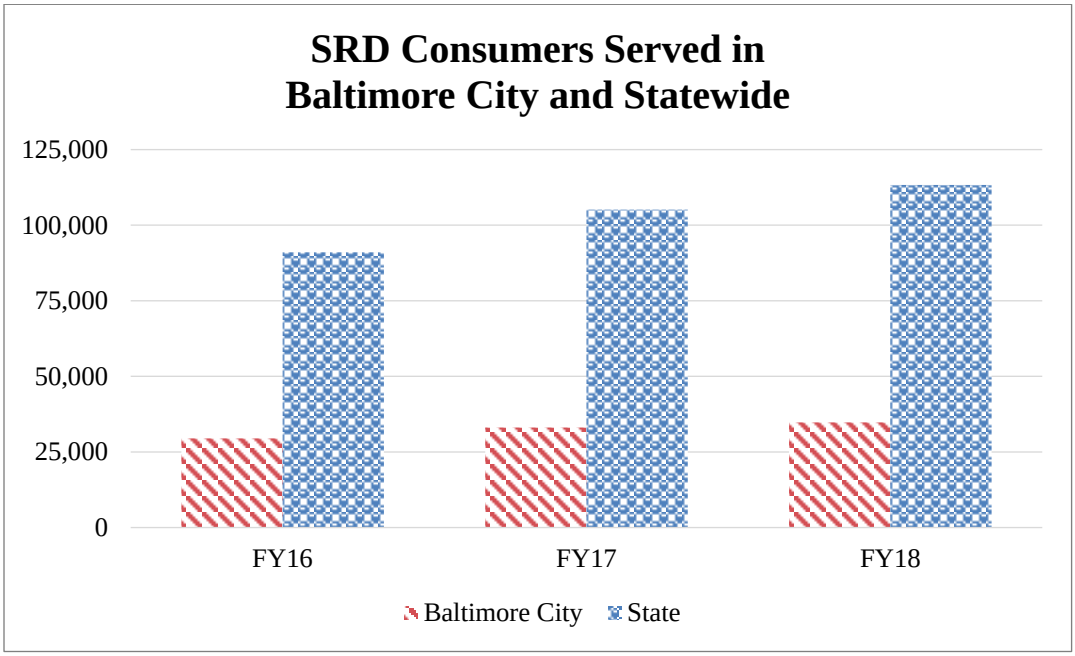
** For children and adolescents, only those ages 11 to 17

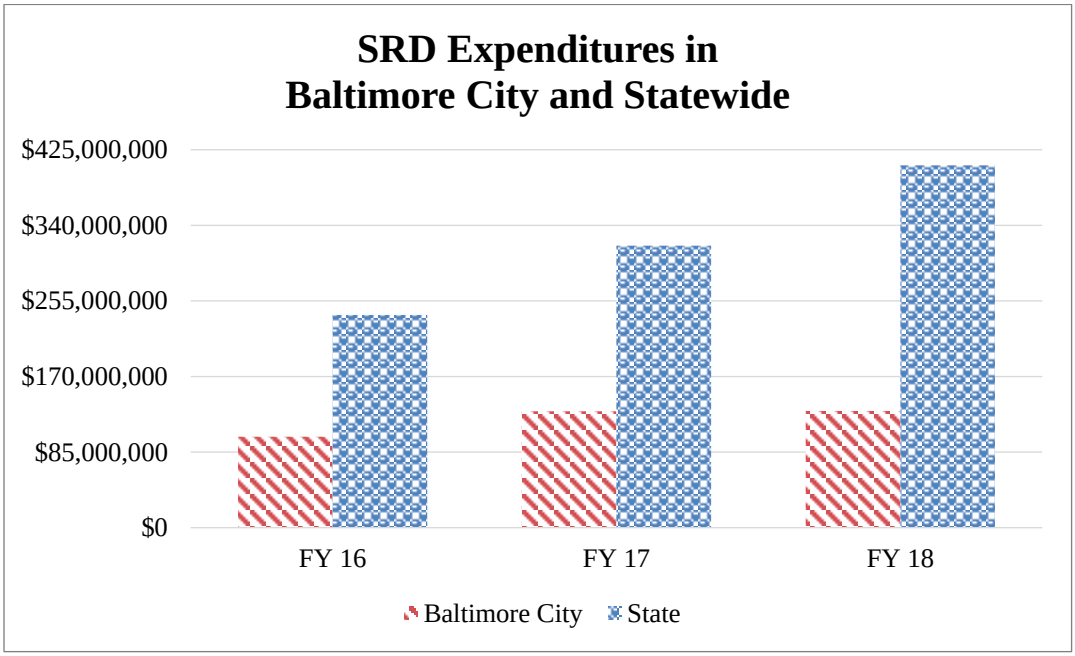
***First administered in January 2017; for Children and Adolescents, data represents only those ages 14 and over

Data Source: http://maryland.valueoptions.com/services/OMS_Welcome.html

Most Recent Interview Only, FY 2018

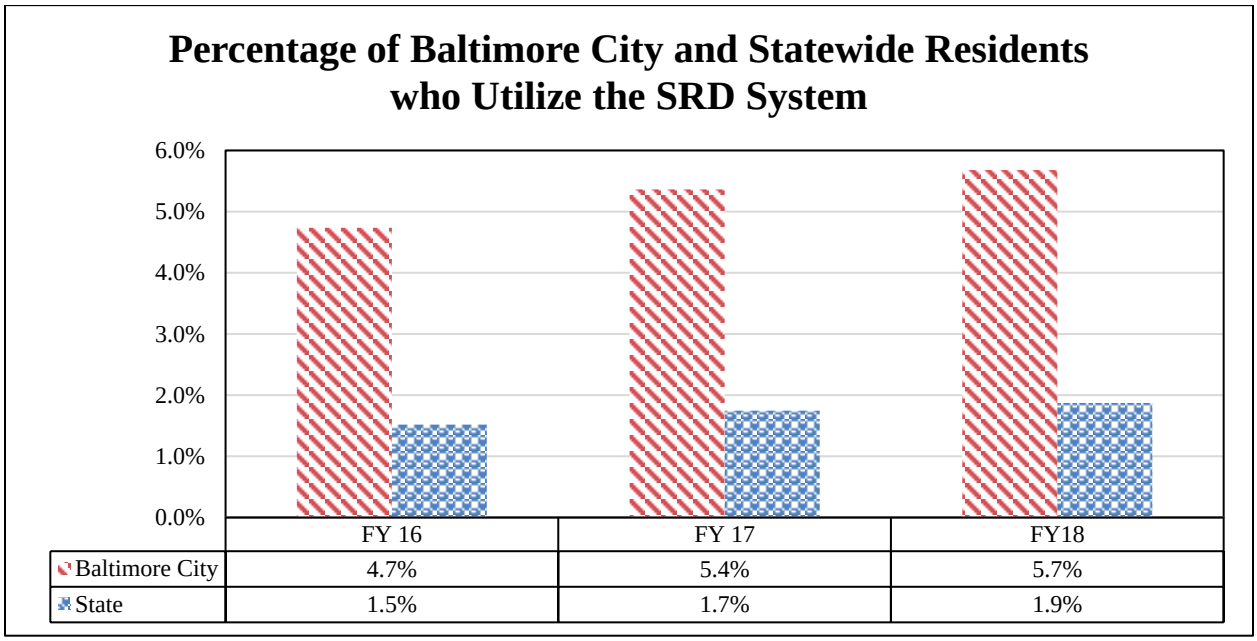
Baltimore City residents comprised 30.6% of all SRD consumers served in the state, and 38.2% of total expenditures for public SRD services.





Source: Beacon Health Options
Based on claims paid through September 30, 2018

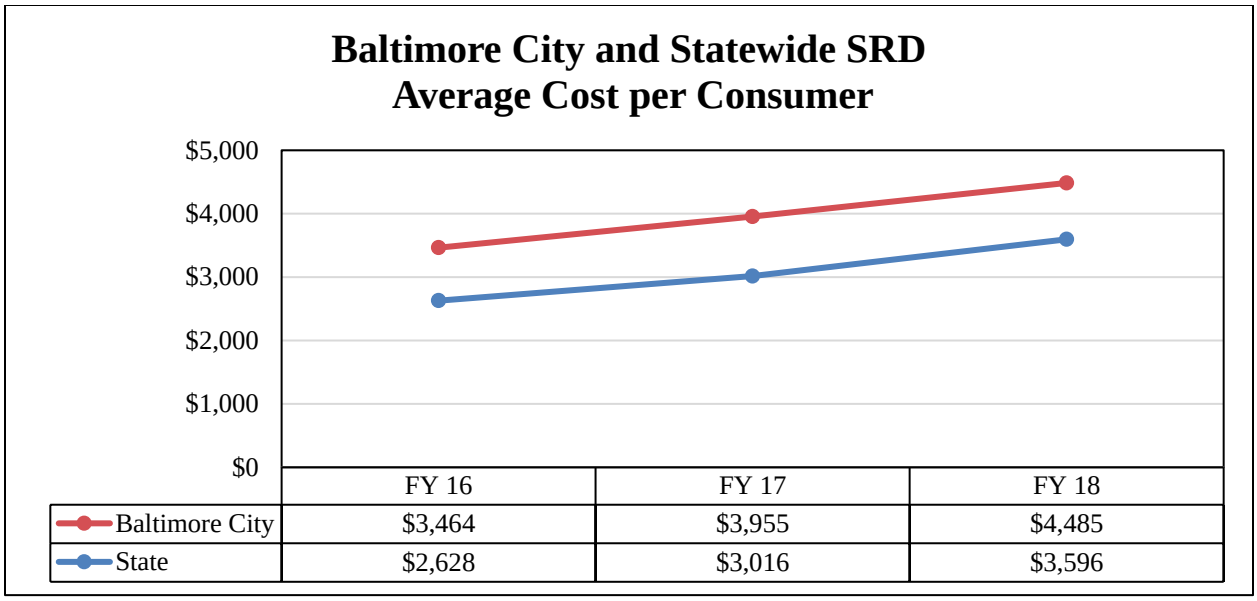
Baltimore City residents utilized SRD services during FY 2018 at a higher rate (5.7% of the city population) than the state (1.9%).



Source: Beacon Health Options
Based on claims paid through September 30, 2018

Average Cost Per Consumer

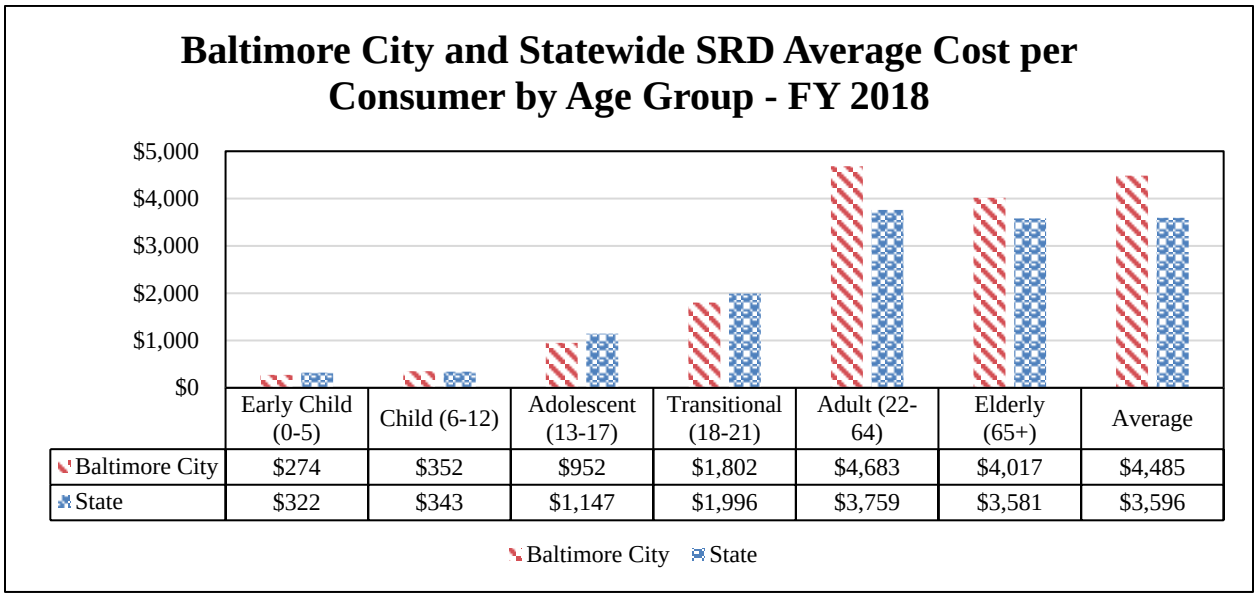
For the last three years, Baltimore City has had a higher SRD overall cost per consumer than the state. Both Baltimore City and the state saw an increase (29.5% and 36.8%, respectively) in the overall cost per consumer between FY 2016 thru FY 2018.



	FY 16	FY 17	FY 18
Baltimore City	$3,464	$3,955	$4,485
State	$2,628	$3,016	$3,596

Source: Beacon Health Options
Based on claims paid through September 30, 2018

The chart below indicates that while the cost per consumer is higher in Baltimore City for adults and the elderly, it is almost equal or lower for children, adolescents and transition age youth.



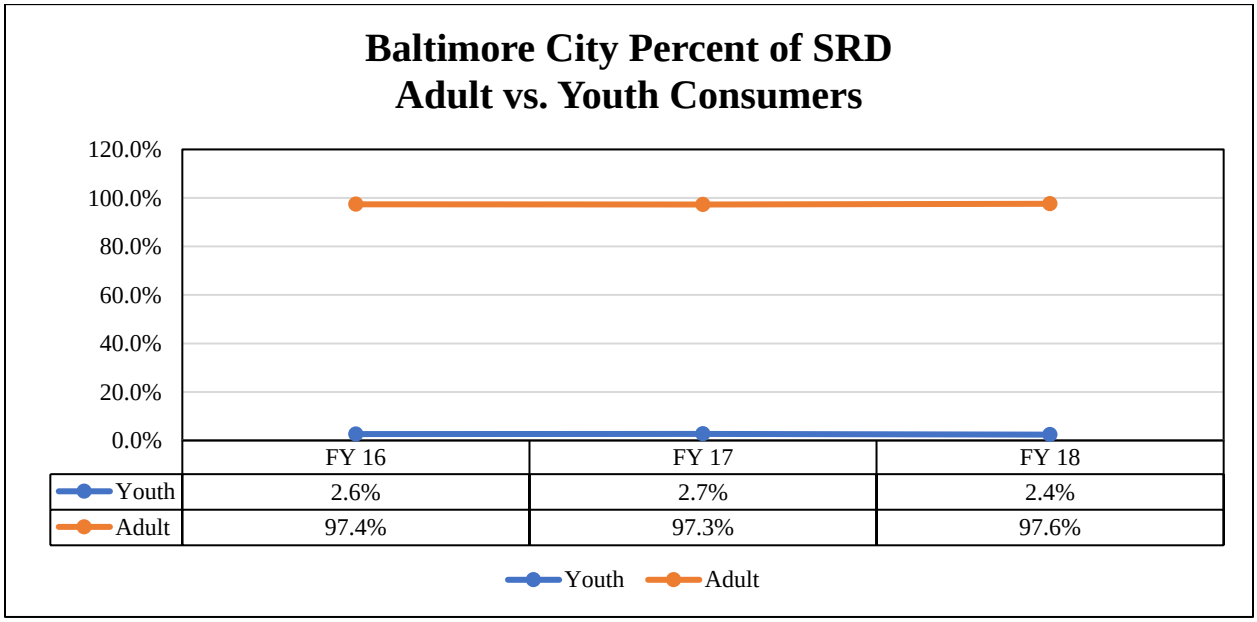
	Early Child (0-5)	Child (6-12)	Adolescent (13-17)	Transitional (18-21)	Adult (22-64)	Elderly (65+)	Average
Baltimore City	$274	$352	$952	$1,802	$4,683	$4,017	$4,485
State	$322	$343	$1,147	$1,996	$3,759	$3,581	$3,596

Source: Beacon Health Options
Based on claims paid through September 30, 2018

Adult versus Child

The gap between adult and youth consumers receiving public SRD services continues from FY 2016 thru FY 2018. Maryland's public behavioral health treatment system is heavily adult-oriented in terms of outreach, intervention models and system planning. BHSB continues to coordinate with state and local stakeholders to increase access to services that meet the unique developmental needs of youth and young adults.

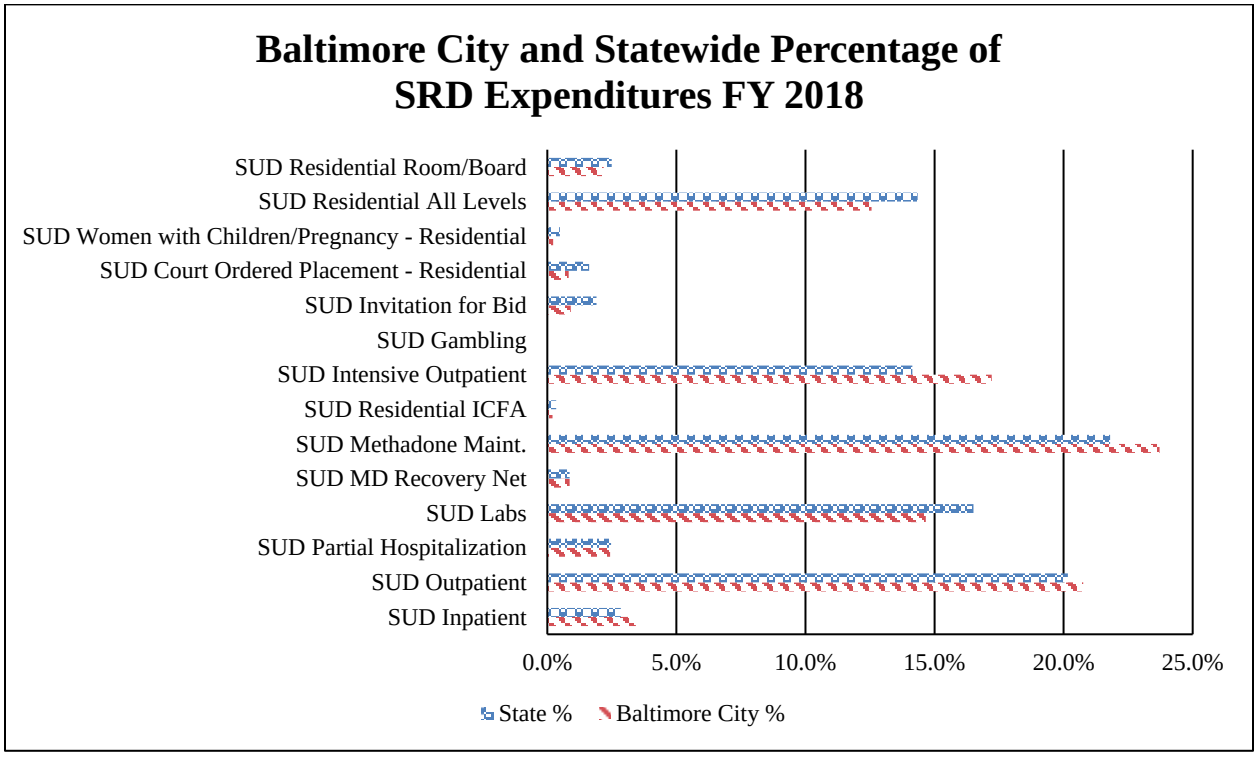
Baltimore City's numbers for youth consumers are consistent with the rest of the state. Relatively few youth have a history of usage that meets diagnostic criteria for a substance use disorder. Much of the investment in youth SRD services is in prevention, which is grant-funded, and school-based services, which are partially grant-funded.



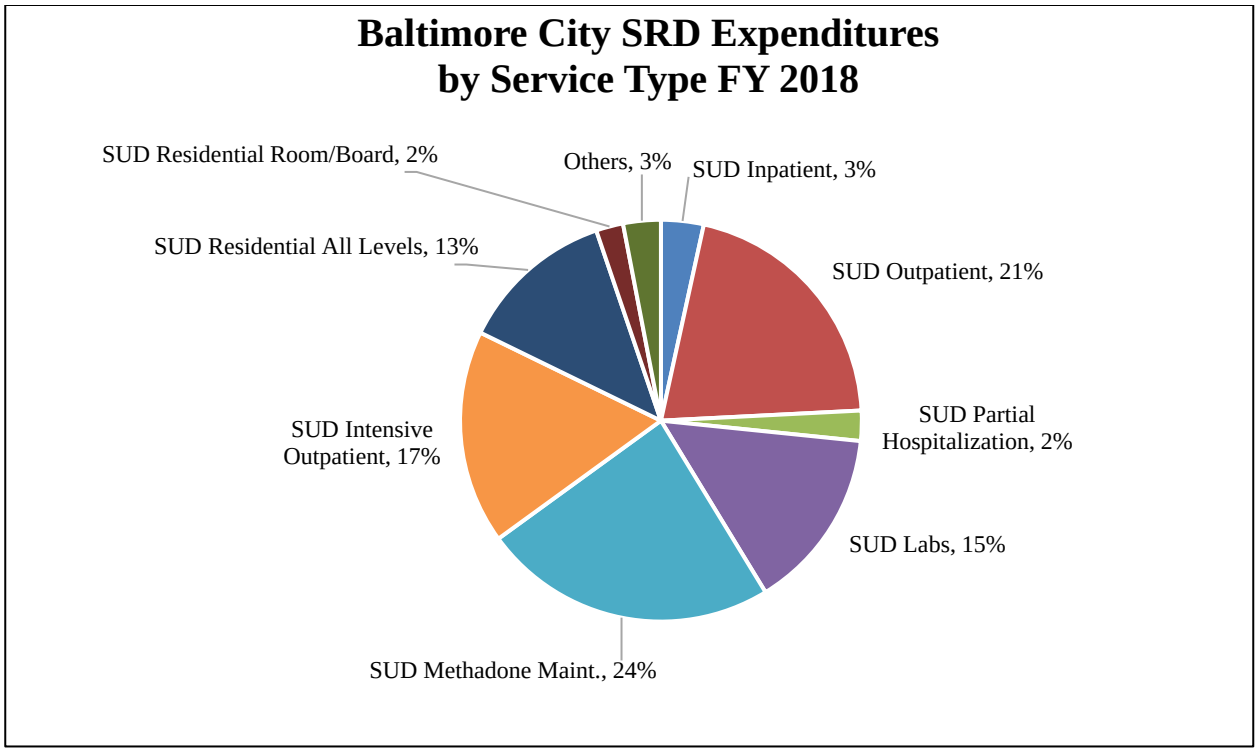
Source: Beacon Health Options
Based on claims paid through September 30, 2018

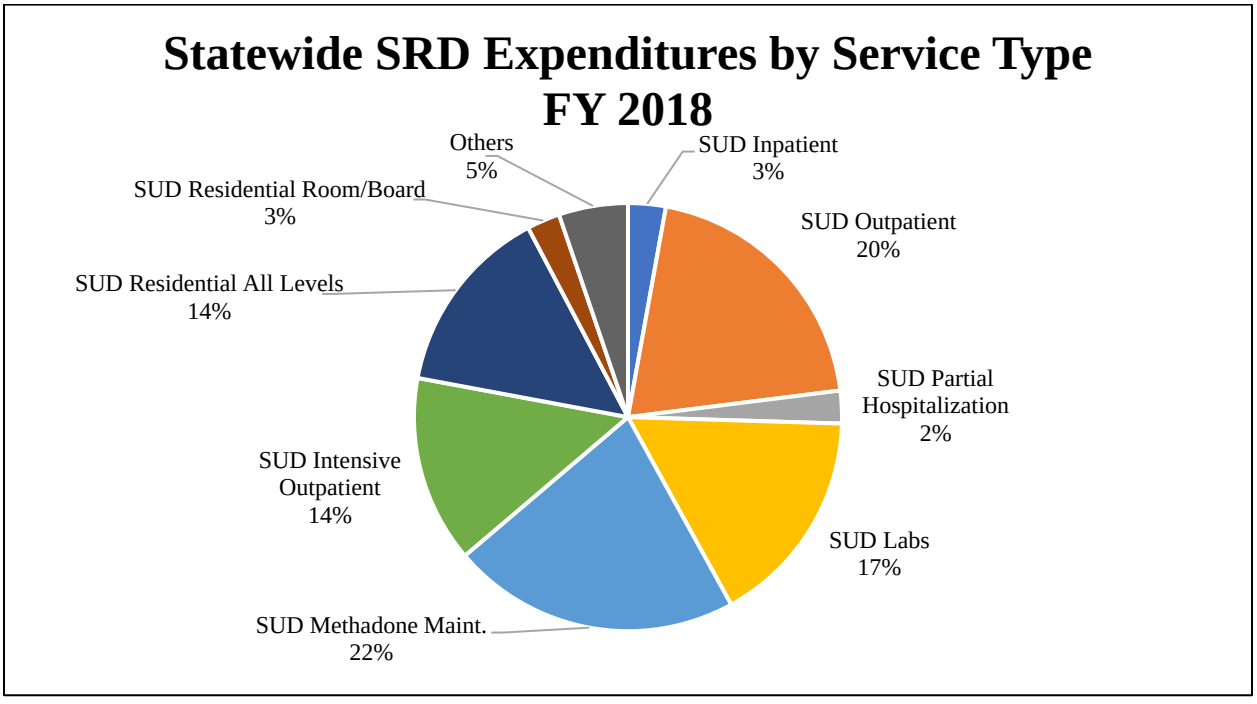
Expenditures

The charts below show that the percental distribution of SRD expenditures in Baltimore City is similar to the state. Baltimore City spent more in ambulatory services (outpatient, methadone and intensive outpatient), inpatient, and labs, while the state spent more in SUD residential and room/board services. There is higher utilization of methadone maintenance in Baltimore City, which is possibly explained by one there being more opioid usage and more individuals with opioid use disorders seeking treatment in Baltimore City. Another factor could be the larger number of OMT programs in the city, as compared to other jurisdictions.



Source: Beacon Health Options
Based on claims paid through September 30, 2018

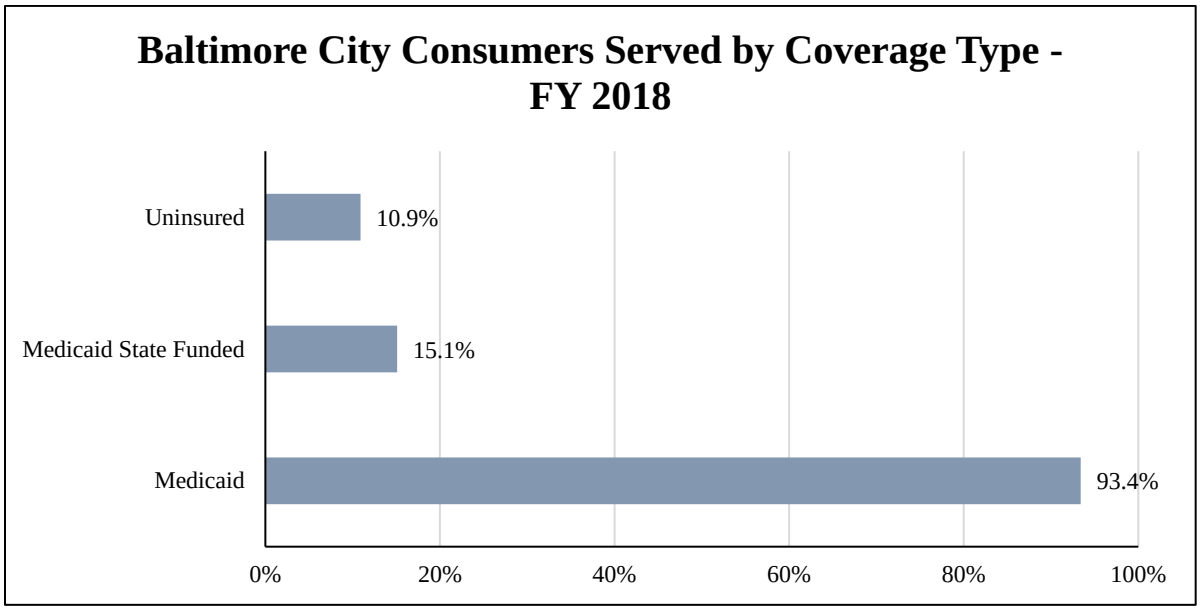




Source: Beacon Health Options
Based on claims paid through September 30, 2018

Insurance Coverage

Most (>90%) of the individuals served by the public SRD system in Baltimore City were covered by Medicaid (including Medicaid State-funded).[44] The uninsured population represented 10.9% of consumers served during FY 2018.



Source: Beacon Health Options
Based on claims paid through September 30, 2018

The total number of uninsured consumers served in Baltimore City increased by 58.9% between FY 2016 and FY 2018. This was possibly related to the transition of SRD services from grant funding to the ASO. Funds were set aside to pay for coverage of uninsured consumers, which likely explains much of the increase.

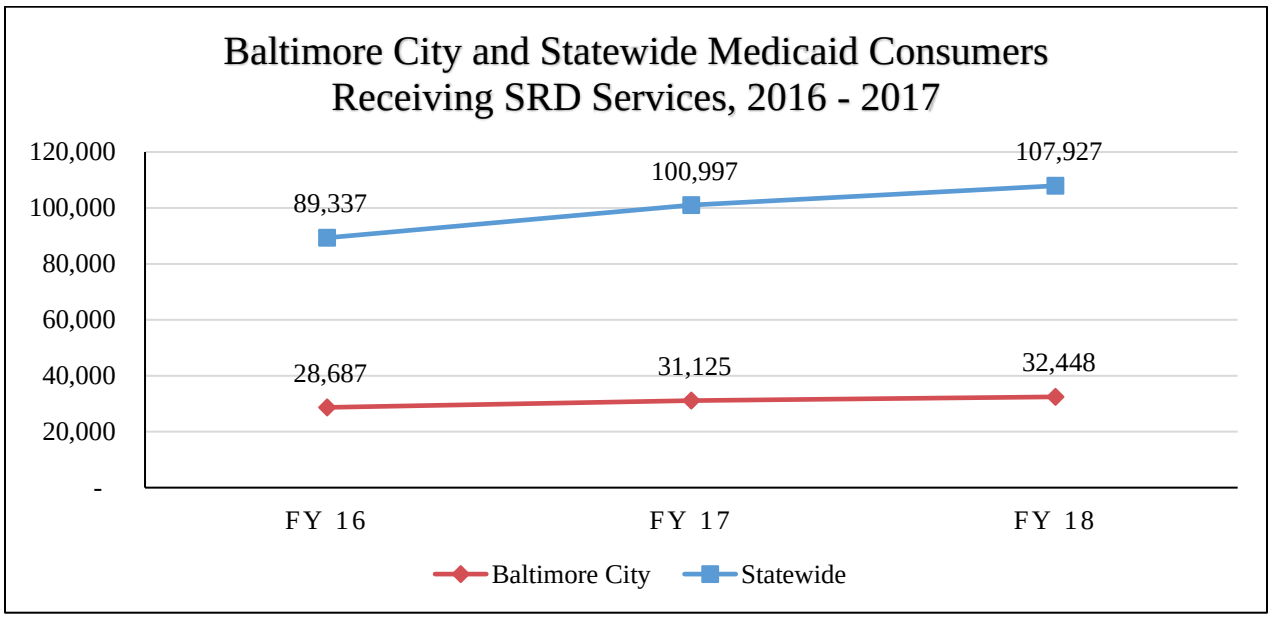
FY 2016	FY 2017	FY 2016 – 2017 Percent Change	FY 2018	FY 2016 – 2018 Percent Change
2,387	3,178	33.1%	3,793	58.9%

Medicaid has the highest cost per consumer of the three coverage types in the public SRD system. This is likely due to restrictions in access to care and services for uninsured individuals.

[44] Many people use services in more than one category. As a result, the sum of the percentage of people served across service categories and across insurance statuses will exceed 100%.

Baltimore City Cost per Consumer by Coverage Type			
	Medicaid	Medicaid State-Funded	Uninsured
FY 2016	$3,395	$1,024	$1,934
FY 2017	$3,936	$1,899	$1,943
FY 2018	$4,162	$2,528	$1,978
FY 2016 - 2018 % Change	23%	147%	2%

Over the last three years, the number of Medicaid consumers receiving SRD services has increased both in the city and state, likely due to expanded access to care facilitated by the transition from grant-funded to ASO-funded services.



Source: Beacon Health Options
Based on claims paid through September 30, 2018

Primary Substance at Admission (All Ages)

In Baltimore City, opiates are the most common primary substance at admission, representing more than two-thirds of total admissions during the past three years, jumping to almost three-quarters in FY 2017. Heroin is the most common substance among the opiates, representing 87% of the total opiates as primary substance in the last three years.

The second most common primary substance is alcohol, representing around 17% of total admissions in FY 2018. The third and fourth most common are marijuana and cocaine, representing 9.5% and 7.2%, respectively.

From FY 2016 to FY 2018, Baltimore City residents represented between 44% to 41% of the total admissions in Maryland for which heroin was the primary substance (All Ages).

Opioid Related Overdose Deaths

Baltimore City showed an increase of 23.6% in opioid-related overdose deaths from FY 2016 to FY 2018. This exceeds the increase for Maryland, which was 16.4% for the same period.

Veterans

Baltimore City veterans comprised about 43.2% of all Maryland veterans receiving SRD services in FY 2018, and about 49% of total expenditures for veterans in Maryland in FY 2018.

Average Veteran's Cost Per Consumer

The average cost per veteran consumer in Maryland was around $6,066 per year, whereas the average cost for Baltimore City was around $6,805 per year. It is important to note the increase (18.4%) in the number of veterans served over the last three years.

Planning Process

BHSB engaged in a strategic planning process during FY 2016 that engaged staff, external stakeholders and the Board of Directors. The goal of the planning process was to develop specific goals, objectives and strategies that will guide the organization through the next few years (2017-2020) and ensure that its work is aligned with its mission and that the role BHSB serves is broader than the management of the existing treatment system.

BHSB contracted with Maryland Nonprofits to facilitate the strategic planning, which began with a Board of Directors retreat at which key priorities and themes were identified that informed and guided the process. The next phase was data collection, which included:

- Staff focus group meetings;
- Staff survey;
- External stakeholders survey and
- Key informant interviews.

The data was compiled, analyzed and presented to the strategic planning committee, which included staff members representing each of BHSB's divisions. The committee participated in several half-day retreats, as well as focused meetings for smaller groups, to develop strategic priorities, goals, objectives and measures. The Operations and Oversight Committee of the Board of Directors was tasked with collaborating with senior leadership to review and revise the plan prior to final review and approval by the full Board of Directors.

BHSB began implementation of the strategic plan during FY 2017, which is included in the next section. The Operations and Oversight Committee reviews progress on a regular basis.

For FY 2020, system integration is a statewide priority. Each jurisdiction is expected to create and implement a plan for to address integration across key system management domains.

In Baltimore City, the work of system integration began six years ago with the planning process for the merger of the city's Core Service Agency and Local Addictions Authority to create BHSB. Substantial progress has been made in the five years since the merger, which is reflected in the self-assessment that BHSB completed during the fall of 2018 as a requirement of the BHA. Based on the criteria in the tool that was used, BHSB assessed itself at the highest level for each domain, with the exception of the stakeholder collaboration domain.

The seven system management domains are addressed throughout BHSB's three-year strategic plan, and specifically in the following objectives:

- Leadership and Governance –11a, 11b and 12a
- Budgeting and Operations – 10a, 10c, and 10d
- Planning and Data-driven Decision Making –9a and 9b

- Quality –3b and 3c
- Public Outreach, Individual and Family Education –7a, 7b, 7c and 7d
- Stakeholder Collaboration – 8a, 8b and 8c
- Workforce – 1d, 9b, 11a, 11b and 11c

Three-Year Strategic Plan 2017-2020

As stated in the introduction of this document, this report replaces what was previously referred to as the Annual Plan and Report for Mental Health and the Local Drug and Alcohol Abuse Council Strategic Plan and Plan Update for substance use. Below is the strategic plan detailing priorities, goals, objectives and action steps for a three-year period, 2017-2020.

STRATEGIC PRIORITIES

I. Comprehensive and Quality Public Behavioral Health System
II. Prevention, Trauma and Resilience
III. Behavioral Health in All Policies
IV. Using Data to Support Practice
V. Organizational Development

STRATEGIC PRIORITY I COMPREHENSIVE AND QUALITY PUBLIC BEHAVIORAL HEALTH SYSTEM

GOAL 1 **Improve access to the public behavioral health system**

Objective 1-a Decrease in use of emergency rooms for mental health and substance use disorder services by establishing a pilot program for stabilization services.

Measures:

- Number of people who use the emergency department (ED) for primary behavioral health diagnoses in the last year.
- Percent of people known to the public behavioral health system (PBHS) who use the ED.
- Number of calls to the CIR line in the last year.
- Number of mobile crisis team runs to hospitals in the last year.

Action Steps:

1. Secure funding and hire a project manager to oversee the development of a stabilization center (Center) that provides EMS diversion for sobering services and real-time connection to ongoing services.
2. Secure operating funding for the Center.

3. Finalize process to expend capital bond funding for the Center and begin construction.
4. Engage with partners to finalize referral protocol for the Center.
5. Conduct a data analysis to assess true need and corresponding potential volume of referrals for a Center.
6. Plan and implement a robust crisis system planning process to identify key gaps and strategies to improve outcomes.
7. Develop a data reporting system to monitor crisis services data on a monthly basis.

Objective 1-b Increase in outpatient provider visits/encounters.

Measures:

- Number of non-acute outpatient service dates per consumer in the last year.
- Number of unique persons using outpatient SUD services in the last year.
- Number of unique persons using outpatient MH services in the last year.
- Number of providers that have implemented same day service availability in the last year.

Action Steps:

1. Develop a plan to educate, support and provide technical assistance for providers to increase the network's ability to implement real-time access to outpatient services (open access).
2. Implement the plan for real-time access to outpatient services.

Objective 1-c Increase diversion from the criminal justice system.

Measures:

- Percent of inmates booked who have authorizations for public behavioral health system services.

Action Steps:

1. Secure sustainable funding for Law Enforcement Assisted Diversion (LEAD) pilot and expand to additional districts.
2. Secure sustainable funding for Crisis Response Team (CRT) pilot and expand to additional districts.
3. Hold an annual forensic training for providers to increase capacity to partner with the criminal justice system.
4. Infuse peers into Pre-Trial and Early Resolution Court.
5. Infuse peers into DPSCS Pre-Booking.
6. Develop linkages between Crisis Response Team (CRT) interventions and PBHS.

7. Remain active in Justice Reinvestment Act (JRA) discussions to identify opportunities to reduce criminal justice recidivism.
8. Advocate for a Safe Injection Site.

Objective 1-d Increase workforce development activities for providers.

Measures*:*

- Number of workforce development opportunities provided by BHSB.
- Number of participants in workforce development opportunities.

Action Steps:

1. Collect and analyze data to identify training needs.
2. Partner with providers/stakeholders to develop system-wide training plan.
3. Identify funding for system-wide trainings.
4. Implement trainings, with goal of training 300 people per quarter.

Objective 1-e Increase access to services by individuals who have limited English proficiency (LEP).

Measures:

- Post on BHSB's website contact information for programs that have capacity to provide public behavioral health services to LEP individuals and update quarterly.
- Update BHSB's website to include welcoming language for persons who have LEP.
- Number of key BHSB materials translated into Spanish and posted on website in the last year.
- Engage providers who are currently working to meet the needs of individuals with LEP in a collaborative process that identifies the scope of need, shared goals and objectives to increase access to services.
- Collaborate with LEP providers to implement identified objectives.

Action Steps:

1. Research/gather information regarding relevant demographics.
2. Research policies/regulations related to services with persons experiencing LEP.
3. Identify the top 3-4 languages spoken in Baltimore City.
4. Identify providers offering linguistically-proficient services to persons experiencing LEP.
5. Inform all providers about relevant policies, regulations and resources available to guide effective, linguistically-proficient services.

6. Post contact information for programs that provide behavioral health services for persons experiencing LEP.
7. Update BHSB's website with relevant information.
8. Translate key BHSB materials into Spanish.
9. Convene providers currently addressing the needs of persons experiencing LEP and identify opportunities to collaborate to increase capacity to meet needs.
10. Support providers in implementing objectives identified to increase capacity to meet needs.

GOAL 2 **Ensure that the public behavioral health system efficiently allocates resources**

Objective 2-a Increase in efficiency of system monitoring activities.

Measures*:*

- Number of data collection activities that have changed to better align what providers are required to report to BHSB with other relevant reporting requirements.
- Increase number of contract deliverables that measure outcomes.

Action Steps:

1. Compile a list of all data collected in contract deliverables and other reports. Identify which are outputs versus outcomes, and which are funder-required.
2. Identify opportunities to use this data to inform resource allocation.
3. Identify opportunities to increase deliverables that track outcomes in subsequent contracting year.
4. Implement internal process to regularly review contracts and evaluate performance.

Objective 2-b Improve coordination of care by leveraging technology for data sharing.

Measures:

- Establishment of a data-sharing collaborative. Number of agencies participating annually.

Action Step:

1. Map existing data sources and data-sharing activities.
2. Identify data-sharing goals and prioritize. Consider if populations and/or particular areas should receive more analysis.
3. Participate in the Accountable Health Communities (AHC) data-sharing work group to develop use cases for social services and behavioral health providers. First year of grant is a planning year.
4. Partner with CRISP to facilitate the development of infrastructure to support data-sharing.

Objective 2-c Decrease the cost per consumer for high utilizers.

Measures:

- Average expenditures per high utilizer of mental health and/or substance use services.

Action Steps:

1. Analyze behavioral health claims data for those served in prior fiscal year.
2. Partner with Beacon Health Options to re-establish BHSB administrative care coordination to selected group of highest utilizers of inpatient psychiatric care.
3. Expand definition of high inpatient utilizer (HIU) to behavioral health focus by establishing threshold criteria defining high use of inpatient or residential substance use disorder treatment and combined use of mental health and substance use care.

GOAL 3 Promote a robust, high quality provider network

Objective 3-a Assure the provision of quality service delivery by developing a provider score card system to be used by BHSB, consumers and the community at large.

Measures:

- Track usage (number and frequency) of provider score cards within BHSB and in the community at large.

Action Steps:

1. Implement internal quality assurance workgroup.
2. Develop and implement process to ensure stakeholder involvement in quality assurance.
3. Plan strategy to communicate with providers about the provider scorecard and how it will support their work and benefit the PBHS.
4. Develop scoring mechanisms to determine overall quality.
5. Implement communications plan.
6. Communicate scoring to individual providers.

Objective 3-b Strengthen quality standards for behavioral health providers by partnering with the state and other stakeholders.

Measures:

- Develop quality standards as a baseline (first year).

Action Steps:

1. Develop specific performance and continuous quality improvement measures using COMAR 10.63 regulations, looking at clinical

documentation, efficiencies in delivery of services, demographics, treatment planning, treatment plan implementation, care coordination, relevant screenings, fidelity to evidence based models, access and outcomes, and issues identified in compliance.
2. Identify barriers as the process is refined.
3. Establish a formalized recognition for top performers.
4. Conduct an annual survey to enable feedback and continuous improvement of the process.

Objective 3-c Increase well-being of consumers as measured by the Outcomes Measurement System (OMS).

Measures:

- Track city-wide and provider-level indicators in the Outcomes Measurement System (OMS)

Action Steps:

1. Review the outcome data shorts information from the OMS with the quality committee.
2. Develop performance outcome measures to improve negative outcomes from the data reported through OMS.
3. Establish dashboards to track OMS indicators over time.
4. Report performance to providers and stakeholders.

STRATEGIC PRIORITY II COMMUNITY STRUCTURES THAT SUPPORT PREVENTION, TRAUMA-RESPONSIVE APPROACHES AND RESILIENCE

GOAL 4 **Promote a comprehensive behavioral health and wellness prevention strategy for the city**

Objective 4-a Strengthen collaboration among community and system partners through the development and implementation of a plan identifying shared goals and key needs for which resources should be sought.

Measures:

- Number and type of shared goals established annually.
- Number and type of resources secured to implement plan annually.
- Number and type of community conversations annually.

Action Steps:

1. Host Listening Sessions with at least two (2) key partners.
2. Facilitate a broad discussion with all BHSB teams to concretely identify current efforts related to prevention throughout the agency.

3. Reconvene an inter-agency workgroup to identify shared goals.
4. Develop a Prevention Plan, prioritizing key areas of work during initial phase of implementation.
5. Implement the Prevention Plan.

Objective 4-b Promote and implement policy and other structural interventions that support behavioral health and wellness.

Measures:

- Percent recently homeless as self-reported in OMS. Increase in current or recent employment as reported in OMS.

Action Steps:

1. Expand number of communities that have working coalitions that advocate for policy changes to enhance behavioral health and wellness for their community (e.g. reduce liquor outlet density).
2. Identify systems that BHSB is best-situated to impact and develop data-informed approach to effect manageable, sustainable changes.
3. Develop methodology to collect data regarding the structural interventions.

GOAL 5 Promote resilience and thriving communities

Objective 5-a Increase provider and community member awareness of research linking exposure to adverse childhood experiences (ACEs) with increased rates of behavioral and somatic disorders, and advance understanding of the science of resilience that identifies the protective factors that support individual, family and community resilience.

Measures:

- Number of organizations that BHSB has supported in implementing new policies and practices reflecting trauma-responsive research annually.
- Number of new trauma-responsive policies and practices implemented annually.

Action Steps:

1. Provide training to peers who work in the PBHS in Baltimore City in the science of ACEs and resilience.
2. Train BHSB staff to infuse ACEs, stress and resilience into projects and forums that convene providers.
3. Implement storybanking to expand understanding of impact of ACEs and protective factors that support resilience.
4. Provide training and technical assistance to expand the capacity of the provider network to provide trauma-responsive services.

Objective 5-b Improve access for families, youth and young adults to culturally-relevant resources, experiences and relationships that serve as protective factors supporting resilience.

Measures:

- Number and type of culturally-relevant resources supported by BHSB that become available in the community annually.

Action Step:

1. Identify and/or create two documents on protective factors that support resilience for the following audiences: 1) BHSB staff (including tips on how to incorporate into BHSB's work) 2) General public.
2. Provide training in SELF framework and support the implementation of SELF Community Conversations.
3. Implement and/or collaborate in the implementation of community-based initiatives to support resilience.

Objective 5-c Increase participation and involvement in opportunities to develop community-based leadership capacity.

Measures:

- Number and type of community-based leadership opportunities supported by BHSB that are developed annually.

Action Steps:

1. Inventory community-based leadership, capacity-building opportunities already occurring at BHSB, and identify ways to increase participation and involvement.
2. Provide 40-hour Harm Reduction Training (HaRT) twice annually to build knowledge, skills, and leadership capacity among people with lived experience related to drug use.
3. Support expansion of Bmore POWER (Peers Offering Wellness Education and Resources), which is a network of people with lived experience related to drug use. Offer practical experience and training in leadership.

GOAL 6 Promote racial justice in all policies and practices

Objective 6-a Reduce the criminalization of behavioral health disorders by partnering with other systems and stakeholders to change existing policies and practices and implement new ones that divert individuals with behavioral health disorders from the criminal justice system.

Measures:

- Number, type, purpose and outcome of partnerships established tracked annually.

Action Steps:

1. Influence the state to divert funds from criminal justice to community-based resources.
2. Conduct anti-stigma training for criminal justice staff.

Objective 6-b

Increase the number of conversations with stakeholders, other systems, providers and communities on racial inequities and the adverse impact that experiences of racism have on behavioral health and wellness.

Measures:

- Number and type of conversations that BHSB promotes about racial inequities annually.
- Decline in racial disparities in self-reported number of days mental health was "not good" annually.

Action Steps:

1. Create an internal workgroup to determine methods, practices and activities that will best help BHSB promote racial conversations about racial inequity.
2. Promote Minority Mental Health Awareness Month (during July) each year with activities and events.
3. Research and develop plan to partner with other local agencies that are already having conversations about racial inequity and the negative impacts on behavioral health and wellness.

Objective 6-c

Increase the dissemination of information with practice-based implications on racial inequalities to the public behavioral health network.

Measures:

- Number and type of inequity-related information distributed to providers annually.

Action Steps:

1. Implement a Health Disparities Workgroup.
2. Analyze claims and other available data to identify racial gaps and incorporate into RecoveryStat.
3. Provide training on Patient Centered Care, which is a culturally competent, evidence-based practice.
4. Provide training for peer specialists and community health workers about health and racial disparities.
5. Hold 3 focus groups with providers to identify strategies to address inequities.

STRATEGIC PRIORITY III BEHAVIORAL HEALTH IN ALL POLICIES

Goal 7 **Lead toward a more informed community around behavioral health and wellness**

Objective 7-a Expand social and traditional media presence to advance priorities.

Measures:

- Number of social media impressions (reach) annually.
- Number of articles in traditional newspaper and peer-reviewed journal articles annually.
- Average open rate of BHSB's e-newsletters annually. First year will create a baseline to guide following year change in percent.

Action Steps:

1. Utilize paid advertising for social media that promotes behavioral health awareness.
2. Maintain BHSB's high average open rate of 25% while growing our list serve by 10%.

Objective 7-b Increase earned media on an annual basis to advance priorities.

Measures:

- Number and type of earned media impressions annually.

Action Steps:

1. Proactively engage media through issuing press releases each quarter (announcement of new program, partnership, or large grant, release of new report, publication of report in peer reviewed journal, awareness events, etc.)
2. Include an earned media strategy as part of MH awareness month, Children's MH awareness week, prevention month, recovery month, and others as identified.

Objective 7-c Reduce misconceptions related to mental illness and substance use disorders through the development of a city-wide anti-stigma campaign.

Measures:

- Targeted communities for pre- and post-survey annually. Number and type of promotions developed annually.

Action Step:

1. Complete communications plan.
2. Develop a vision and funding strategy to implement a city-wide anti-stigma campaign.

Objective 7-d

Increase use of BHSB's website as a known and trusted source for information and resources.

Measures:

- Inclusion of social determinants of health in BHSB's annual report and policy priorities.
- Number of advocacy and other BHSB events that include a focus on social determinants annually.

Actions Steps:

1. Address social determinants of health in BHSB's annual policy priorities.
2. Include social determinants of health lens at the Annual Community Gathering.
3. Provide information on the website about social determinants of health and how they affect behavioral health and wellness.

Objective 7-e

Broaden understanding of behavioral health to include the social determinants of health.

Measures:

- Inclusion of social determinants of health in BHSB's annual report and policy priorities.
- Number of advocacy and other BHSB events that include a focus on social determinants annually.

Action Steps:

1. Address social determinants of health in BHSB's annual policy priorities.
2. Include social determinants of health lens at the Annual Community Gathering.
3. Provide information on the website about social determinants of health and how they affect behavioral health and wellness.

Goal 8

Mobilize behavioral health providers and consumers to engage in advocacy to address policy priorities

Objective 8-a

Engage the community in understanding behavioral health disorders by engaging a core group of consumers to speak about their lived experience.

Measures:

- Number of consumers who speak at BHSB-sponsored events or in BHSB communications about their lived experience annually.

Action Steps:

1. Develop a core group of peers who are engaged in advocating for policies that support behavioral health and wellness.

2. Develop a process for creating a Storybank, which is a collection of consumer stories needed for various types of advocacy efforts.
3. Hold at least two Advocacy 101 Trainings per year for consumers and providers and ensure that they offer CEUs.
4. Identify funding for stipends for consumers who participate in advocacy efforts.
5. Recruit more consumers to serve on the BHSB Board and CAP Committee.

Objective 8-b

Create a behavioral health community council made up of consumers of public behavioral health services, individuals with lived experience, family members and community members to inform BHSB's priorities.

Measures:

- Confirmation of approved council members per category.
- Number of and type of meetings/activities/outcomes of the council annually.

Action Steps:

1. Define what the behavioral health community council's focus will be.
2. Implement behavioral health community council.

Objective 8-c

Increase the amount of community, consumer and provider feedback into the annual policy priorities to develop a more inclusive process.

Measures:

- Number and type of community, consumer and provider feedback received and incorporated into annual policy priorities.

Action Steps:

1. Share draft policy priorities with key partners for feedback.
2. Revise, refine and finalize policy priorities.
3. Release Policy Priorities.

Objective 8-d

Inform and influence policy makers at the local, state and federal levels to advance BHSB's policy priorities on an annual basis.

Measures:

- Meet with members of City Council and State Delegates about behavioral health initiatives.
- Send local leaders policy priorities when they are released. Present to Baltimore City Delegation Meeting and during City Council.
- Send Advocacy Alerts via email during legislative session.
- Host Behavioral Health Policy Forum.

STRATEGIC PRIORITY IV USING DATA TO SUPPORT PRACTICE

GOAL 9 **Promote a robust data-driven system**

Objective 9-a Increase providers' access to, knowledge of and ability to apply data and research to inform decision making.

Measures:

- Number of times BHSB is sought by providers as a resource for data- or research-related information annually.
- Attendance at RecoveryStat and other data-oriented meetings.

Action Steps:

1. Establish data as a standing item on service line meetings.
2. Provide regular technical assistance to providers to ensure provider awareness of research, best practices, noteworthy listservs, etc.
3. Establish a RecoveryStat provider work group to increase value and reach of RecoveryStat presentations as well as inform interpretation of data.

Objective 9-b Increase BHSB staff's knowledge of and ability to use data and research to promote practice, policy and system change.

Measures:

- Number of professional development activities related to data annually.

Action Steps:

1. Administer a staff survey to identify gaps in skills needed and desired by various teams.
2. Create a Data Vision (data strategy) for each service portfolio, including staff skills needed and other barriers to achieving that vision.
3. Identify staff data training needs to achieve Data Vision.
4. Create online repository for on-demand data-related training, building off of existing trainings and with a focus on self-paced learning and bite-sized/"snackable" modules.

Objective 9-c Decrease the barriers to link and share data.

Measures:

- Number of data-sharing activities annually.
- Attendance records of individuals/agencies participating in data-sharing collaborative.

Action Steps:

1. Establish an internal Data Sharing work group that will identify internal capacity and opportunities for data-sharing activities.

2. Conduct a landscape assessment of data sharing.
3. Incorporate standardized data elements into Agreements.
4. Partner with CRISP to facilitate the development of infrastructure to support data-sharing (see Objective 2b).

Objective 9-d Become the recognized source for behavioral health data in Baltimore City by increasing the use and relevance of BHSB's data products in the development and implementation of policies regarding behavioral health.

Measures:

- Number of policy-relevant reports released annually.
- Number of requests for BHSB data from policy makers annually.

Action Steps:

1. Include relevant data in press releases and other communications.

STRATEGIC PRIORITY V ORGANIZATIONAL DEVELOPMENT

GOAL 10: Create an efficient and effective work environment

Objective 10-a Improve the technological infrastructure.

Measures:

- The number and type of new technological enhancements annually.

Action Steps:

1. Migrate BHSB website to Microsoft Azure so as to maintain business continuity in case of local disaster.
2. Implement SonicWall Mobile Connect to remotely access network resources in a safe, easy and secure manner.
3. Replace all IntelCore i3 desktops with i7 and implement automated imaging system.
4. Upgrade all Wireless Access Point to POE, Power over Ethernet. Replace all 10/100 MB ethernet switches with 100/1000 MB.
5. Replace Accounting application: Great Plains with Abila.
6. Implement cloud backup for business continuity.

Objective 10-b Enhance staff's skills to use technology more effectively.

Measures:

- Staff confidence using newly implemented technologies as measured by an annual staff survey.
- Number of professional development activities associated with electronic processes annually.

Action Steps:

1. Introductory Microsoft 365 webinar training made available to staff
2. Microsoft 365 user training provided to teams
3. Electronic signature training
4. Staff and provider training in CMS
5. Electronic training with Great Plains for accountants and grant accountants.

Objective 10-c Identify and implement digital alternatives to paper-based processes.

Measures:

- The number of use of electronic processes that have replaced paper documentation annually.

Action Steps:

1. Scan existing paper documents to electronic files.
2. Establish file naming conventions.
3. Develop CMS to support provider reconciliation and payment reconciliations.
4. Increase the use ACH payments to reduce the number of paper checks.
5. Implement internal process for electronic check requests, purchase orders and employee reimbursements with the capacity to communicate with Great Plains.
6. Develop and implement electronic processes to manage programmatic referrals.

Objective 10-d Ensure that the workspace promotes synergy within and across teams.

Measures:

- Staff satisfaction with intra-office communication and relationships as measured by annual staff survey.
- Staff knowledge of projects/programs assigned to teams other than their own as measured by annual staff survey.

Action Steps:

1. 2 focus group meetings with staff to learn about concerns, opinions, attitudes.
2. Implement staff survey and analyze results to identify issues and concerns.
3. Identify action steps to address concerns and present to staff for feedback.
4. Implement action steps, as informed by staff feedback.

Objective 10-e Improve open dialogue and effective communication through the promotion of a multi-faceted communication strategy.

Measures:

- Staff satisfaction with intra-office communication and relationships as measured by an annual staff survey.

Action Steps:

1. 2 focus group meetings with staff to learn about concerns, opinions, attitudes.
2. Implement staff survey and analyze results to identify issues and concerns.
3. Identify action steps to address concerns and present to staff for feedback
4. Implement action steps, as informed by staff feedback.

GOAL 11: Build the collective ability to achieve the mission

Objective 11-a Ensure equal opportunity for leadership, professional development, and career advancement.

Measures:

- Number of internal promotions annually.
- Number and type of leadership opportunities for non-executive staff annually.
- Number of professional development activities provided per staff on an annual basis.

Action Steps:

1. Provide coaching and mentoring training to supervisors.
2. Define BHSB's culture and values (see Objective 11b) to include language regarding this objective.
3. Implement a policy manual and associated procedures that supports this objective.
4. Implement an employee development plan.
5. Add a section on employee development to the 1:1 form for supervisors to discuss tasks, employee strengths and coaching/mentoring.
6. Create a succession plan and knowledge-sharing system to ensure growth and development of employees.

Objective 11-b Increase the number of opportunities for staff members to build their capacity to contribute to the organizational values and mission.

Measures:

- Number of professional development activities per staff member on an annual basis.

- Estimates of perceived and actual opportunities for staff to develop professionally as measured by an annual staff survey.

Action Steps:

1. Develop an orientation process that ensures that all new hires receive an overview of the public behavioral health system, BHSB's role within that system, and how the organization is structured to support the work.
2. Implement the onboarding plan process for new hires.
3. Implement a process to support staff participation in external opportunities for training and professional development that are aligned to BHSB's mission and to each staff person's role in achieving the mission.
4. Schedule regular brown bag lunches to discuss topics of interest.

Objective 11-c Ensure policies and procedures guide an efficient and equitable workplace.

Measures:

- Development and distribution of clear, consistent, accessible and transparent HR policies and procedures to all current and incoming staff (first year).

Action Steps:

1. Develop and implement clear, consistent, accessible and transparent HR policies and procedures and review annually.

GOAL 12: Lead a strong organization with an effective and engaged Board of Directors

Objective 12-a Increase the level of engagement of individual board members and the collective board.

Measures:

- Attendance records at board meetings and high-level events and activities.
- Participation rate of board members on committees.
- Number of policy-oriented full board decisions as reported in the minutes.

Action Steps:

1. Develop, implement and document a board orientation process. Review effectiveness and update annually thereafter.
2. Develop, implement and review annually thereafter, a Board member commitment review that includes, at a minimum, the previous year's participation in meetings and events and share with individual members. Also review Board member responsibilities and conflict of interest policy with the Board and have Board

members complete and sign the Pledge Agreement and Conflict of Interest forms.
3. Develop a mechanism to track Board participation at Board meetings, committee meetings and other events and activities and share results with individual Board members.
4. Enhance the annual commitment review process by implementing a Board of Directors self-assessment.

GOAL 13: **Lead a strong organization through prudent financial management**

Objective 13-a Increase the level of transparency to the teams managing programs so they can ensure timely delivery of services to consumers through the providers.

Measure:

- Unspent funds at the end of the fiscal year, with a target of less than $250,000.

Action Steps:

1. Develop and implement a detailed work plan with timeline for all tasks during a fiscal year associated with managing grant funds.
2. Provide monthly expenditure reports to program staff.
3. Develop and implement a competitive procurement process that selects vendors to address the needs of the public behavioral health system. This will guide allocation of underspent funds as identified.

Cultural and Linguistic Competency

Cultural and Linguistic Competency Assessment Tool

One of BHSB's key priorities is to increase the capacity of the public behavioral health system in Baltimore City to promote equity, undo racism and increase inclusiveness. This requires processes that address stigma, bias and discrimination on an ongoing basis. Culturally and linguistically appropriate services (CLAS) help reduce health disparities and achieve health equity, improving the overall quality of services provided to all individuals.

BHSB completed the Cultural and Linguistic Competency Assessment tool to serve as a baseline to guide planning going forward.

NATIONAL CLAS STANDARDS SELF-ASSESSMENT TOOL

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES		**LEVEL**			
1	Our Mission and Vision statements reflect organizational commitment to cultural and linguistic competence. (Standard 1)	0	1	2 X	3
2	We have established culturally and linguistically appropriate goals, management accountability, and infused them throughout the organization's planning and operations. (Standard 9)			X	
3	Our organizational governance and leadership promote and use CLAS standards in policies, practices and allocation of resources. (Standard 2)			X	
4	We have created conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. (Standard 14)	X			
5	We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (Standard 15)	X			
GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS OF BEHAVIORAL HEALTH SERVICES					
1	We offer language assistance to individuals who have limited English proficiency and/or other communication needs including individuals who use American Sign Language, at no cost to them, to facilitate timely access to behavioral health services. (Standard 5)			X	
2	We inform all individuals of the availability of verbal, signing and written professional language assistance services in their preferred language or form of communication. (Standard 6)				
3	We ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (Standard 7)			not a direct service provider	
4	We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community. (Standard 8)			X	
GOAL 3: CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES					
1	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. (Standard 12)		X		
2	We collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (Standard 11)		X		

GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS SERVED IN MARYLAND'S PBHS		LEVEL			
		0	1	2	3
1	We conduct ongoing assessments of our organization's CLAS-related activities and integrate CLAS-related quality improvement and accountability measures into program activities. (Standard 10)	X			
2	We partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. (Standard 13)	X			
GOAL 5: ADVOCATE FOR AND INSTITUTE ONGOING WORKFORCE DEVELOPMENT PROGRAMS IN CULTURAL AND LINGUISTIC COMPETENCE REFLECTIVE OF MARYLAND'S DIVERSE POPULATION					
1	We recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the community we serve. (Standard 3)		X		
2	We provide orientation and training to new and existing members of our governing body, leadership and staff on culturally and linguistically appropriate policies and practices on a regular basis. (Standard 4)	X			

Cultural and Linguistic Competency Plan

Increasing cultural and linguistic competency is an important component of BHSB' commitment to promoting equity and inclusion. As described in the *Equity and Inclusion* and *Cultural and Linguistic Competency* in the *Quality* section of *Highlights, Achievements and Challenges* of this document, BHSB has implemented a number of strategies to move this work forward, including education, internal structures to improve policies and practices and training opportunities for staff and partners. To support ongoing progress, BHSB identified the below goals and strategies on which to focus our efforts during FY 20.

Goal 1: Establish and maintain culturally and linguistically competent behavioral health services.

Strategies	Outcome Measures
Enhance organizational commitment to cultural and linguistic competence	1. Board of Directors is reflective of the population BHSB serves. 2. 75% of employees have participated in an Undoing Racism workshop. 3. Progress in implementing key priorities identified by Equity & Inclusion internal workgroup.
Provide organizational resources to support the implementation of culturally and linguistically competent policies and procedures.	1. Training and professional development opportunities are offered. 2. The Equity & Inclusion internal workgroup continues to meet regularly with executive leadership to review progress in implementing key priorities.
Create conflict resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts.	1. Opportunities for staff to increase skills in having difficult conversations are offered.
Communicate BHSB's progress in implementing and sustaining the principles of equity and inclusion and culturally and linguistically competent practices to consumers, providers and other stakeholders.	1. BHSB's website and external communications report on progress in implementing the principles of equity and inclusion and culturally and linguistically competent practices to consumers, providers and other stakeholders.
Increase access to services for individuals with limited English proficiency (LEP).	1. Collaborate with stakeholders to identify treatment gaps and create a plan to ensure individuals with LEP are receiving culturally and linguistically competent treatment.

Goal 2: Eliminate cultural and linguistic barriers to accessing behavioral health services.

Strategies	Outcome Measures
Change the public's view of behavioral health disorders and improve access to care by continuing to implement a public education campaign.	*See Past the Stigma* campaign is continued.

Addendum A: Contract Monitoring

The following is a description of the processes used to hold providers accountable for the delivery of service detailed in the contractual agreement.

BHS Baltimore plays an important role in funding and improving the delivery of safe, high quality prevention, early intervention, treatment, and recovery services. Contractual performance is regularly monitored in a systematic way using a variety of methods and tools, including analysis of utilization data, site visits to providers (quarterly for substance use providers and annually for mental health providers) and technical assistance to improve performance. When site visits are conducted, client records and personnel records are reviewed to ensure compliance with the scope of service detailed in the contract, and interviews are conducted with both staff and clients. Other steps in the contracting process that assist in monitoring the quality of service delivery are:

- All provider contracts include a description of the service delivery expected
- All provider contracts include requirements to meet established performance benchmarks and selected contracts also include financial incentives for meeting utilization benchmarks
- General Conditions of Award are attached to all executed contracts that are funded by substance use disorder funding
- Contract meetings are held on a bi-weekly basis to facilitate communication and coordination amongst staff members who have assigned roles in monitoring the fiscal, administrative, programmatic, and clinical performance of contracts

BHS Baltimore requires all funded substance use treatment providers to:

- Give priority in assessment, admission and placement to all federally-defined priority populations.
- Incorporate at least four of the following evidence-based practices into individualized care: cognitive behavioral treatment, motivational enhancement therapy, contingency management, harm reduction, 12-step facilitation, and pharmacotherapy.
- Provide didactic education on addiction and recovery, including psycho-educational programs that address core issues of human behavior and development associated with addiction and recovery in addition to individual counseling sessions and other therapeutic interventions
- Ensure treatment plans reflect on-going reassessments done with patients around their needs and goals
- Utilize an on-site licensed mental health provider or have a written memorandum of understanding with local mental health providers, to provide mental health consultation

and treatment services for patients with co-occurring substance abuse and mental health disorders

- Employ case management and care coordination strategies to ensure all bio-psycho-social areas of functioning are being addressed while the patient is in treatment
- Ensure involvement of family and/or key supporters as a part of the individual's recovery process
- Provide clinical supervision by professionals licensed under the Health Occupations Act or certified counselors approved as supervisors by the Board of Professional Counselors and Therapists
- Provide HIV risk assessments and education

Addendum B: Organization Chart


Behavioral Health System
Baltimore
DRAFT: Updated January 1, 2019
Crista Taylor
President & CEO
Gayle Jordan-Randolph
Medical Director
Arnold Ross
Vice President
Finance and Operations
CFO
Adrienne Breitenstine
Vice President
Policy &
Communications
Lynn Moreno
Vice President
Strategy
Denise Wheatley-Rowe
Vice President
Accountability
Steve Johnson
Vice President
Programs

Addendum C: BHSB Organizational Structure

Behavioral Health System Baltimore

BHSB ORGANIZATIONAL STRUCTURE

POLICY AND COMMUNICATIONS

Vice President: *Adrienne Breidenstine*

Policy and Communications uses advocacy and communications strategies to advance evidence-based practices, policy reforms, and mobilize community action. The department manages internal and external communications for BHSB, oversees government and community relations, and implements public education and advocacy campaigns to create positive change. BHSB participates on several coalitions and collaborates with a range of partners to advance policies that support behavioral health and wellness. The department has a dedicated provider relations contact to assist providers with getting information and support from BHSB.

Opportunities for Partnership:

- *Sign Up for BHSB's E-mail List* to receive our quarterly newsletters, invitations to trainings and events, and policy alerts. Visit BHSB's website to sign up: http://www.bhsbaltimore.org/
- *Participate in Advocacy 101 Trainings* which are offered throughout the year and by request. BHSB provides this training to providers, peers, and community members on ways to advocate for policies and social change.
- *Distribute Crisis Information and Referral Line Materials* which raise awareness about Baltimore City's 24/7 crisis hotline, 410-443-5175. BHSB can provide posters, cards, and pens to promote this line at your request.
- *Use the provider relations email*, provider.relations@bhsbaltimore.org, to get your questions answered or support from BHSB. For a letter of cooperation contact, agreement.cooperate@bhsbaltimore.org.
- *Follow BHSB on Twitter and like us on Facebook* to garner the power of social media.

ACCOUNTABILITY

Vice President: *Denise Wheatley-Rowe*

Accountability works collaboratively with behavioral health provider organizations to support high-quality behavioral health services in Baltimore City. This department provides oversight and support for providers in a variety of ways, including training and technical assistance, site visits, and consumer quality reports. The team also manages provider complaints, investigations, and critical incidents.

Opportunities for Partnership:

- *Ask for technical assistance to help improve quality within your program* by participating in the Quality Council which meets monthly at BHSB.
- Providers are expected to report a critical incident promptly by sending the critical incident form to critical.incident@bhsbaltimore.org.

- Any person can file a complaint or grievance against a provider. *File a provider complaint* at compaints@bhsbaltimore.org.

STRATEGY

Vice President: *Lynn Mumma*

Strategy seeks to instill an equity lens into all facets of BHSB's internal and external work. The department supports this in a variety of ways, including synthesizing and analyzing data to inform decision making, broadening public health efforts to reduce substance use, implementing community prevention activities based on analysis of data trends, amplifying the voices of people who have lived experience using drugs, expanding harm reduction knowledge and capacity, conducting street outreach to educate the public in preventing and responding to opioid overdoses, expanding knowledge about the science of toxic stress and resilience and supporting providers in implementing policies and practices informed by this science.

Opportunities for Partnership:

- *Participate in the Safe Baltimore Coalition* which meets monthly and includes community members and other stakeholders from East Baltimore. It discusses problems surrounding underage drinking and alcohol outlets and identifies solutions to collectively implement.

- *Participate in training opportunities on harm reduction or the science of toxic stress and resilience* for you and others within your organization.

PROGRAMS

Vice President: *Steve Johnson*

Programs works to develop and manage a range of early intervention, treatment and recovery services for individuals and families with mental illness and/or substance use disorders. The department oversees services within the larger Medicaid fee-for-service system, as well as those directly funded by BHSB through private and public grants, including child and family services, peer support services, medication-assisted treatment, criminal justice diversion, and crisis services for youth and adults. The team collaborates with providers, city and state agencies, and other system partners to implement best practice programming and new or innovative pilots.

Opportunities for Partnership:

- *Participate in a Service Line Meeting* to learn what is happening in the system of care and collaborate with other providers in the city. Most meetings are quarterly and include meetings for outpatient, residential rehabilitation, psychiatric rehabilitation, supported employment, assertive community treatment, residential substance use disorder treatment, and veteran-serving providers.

- *Ask for training on how to better understand the system of care in Baltimore.* BHSB can provide this training upon request.

FINANCE AND OPERATIONS

Vice President and CFO: *Arnold Ross*

Finance and Operations manages the fiscal, contracting and administrative operations of the organization. The department provides oversight of private and public funding awards, contracts issued to sub-vendors, grants accounting, and administrative support for organizational-wide work. Activities include oversight of procurements, issuance of letters of awards, monitoring of budgets and budget modifications, tracking of contract deliverables, and assurance that all funds are properly utilized and expended.

Opportunities for Partnership:

- *Participate in a Contract Management System (CMS) or Echo-Signature training* for sub-vendors. Dates and times for the trainings are posted on the BHSB website, under the "For Providers" tab, "FY 2018 Contract Processes".

Addendum D: BHSB 2018 Policy Priorities

2018 Policy Priorities

Promoting and Supporting Behavioral Health and Wellness

Prevention and Early Intervention

BHSB will promote policies and practices that strengthen and expand prevention and early interventions to reduce risk, mitigate the impact of trauma and toxic stress, increase community resilience, and improve behavioral health and wellness.

Policy Recommendations

- Ensure that Maryland's Youth Risk Behavior Survey (YRBS) collects Adverse Childhood Experiences (ACEs) module data starting in 2020

- Increase opportunities for community input into alcohol outlet locations and practices to reduce violence and create healthier communities

Treatment and Recovery Services

BHSB will advance policies, programs and practices that promote access to comprehensive, integrated community treatment and a full array of support services for people with mental illness and substance use disorders across the lifespan.

Policy Recommendations

- Advance the development of a comprehensive, integrated crisis response system to ensure 24/7 immediate access to a full continuum of crisis behavioral health services

- Ensure Maryland Medicaid has an appropriate rate structure for Targeted Case Management (TCM) to better support service delivery for persons with mental illness and substance use disorders

- Increase resources through Maryland Medicaid for youth Mental Health Case Management (formerly known as Targeted Case Management) to ensure the needs of youth and families impacted by mental illness are effectively supported

- Ensure Maryland Medicaid covers peer support services to assist individuals and their families with recovery from mental illness and substance use disorders

Criminal Justice System

BHSB will identify and promote criminal justice system reforms that redirect spending for corrections toward the behavioral health system and support interventions to improve access to treatment and recovery support services.

Policy Recommendations

- Invest in programs that divert persons in need of behavioral health services from the criminal justice system into community-based treatment and supports. Key diversion activities include:
    - Law Enforcement Assisted Diversion (LEAD) Program
    - Behavioral Health Crisis Response Teams (CRTs) that include a police officer and behavioral health clinician
- Expand re-entry services to assist returning citizens with mental illness and substance use disorders in their transition from incarceration to the community

Behavioral Health System Infrastructure

BHSB will advocate for policies and reforms that promote parity and strengthen the behavioral health system infrastructure and workforce.

Policy Recommendations

- Ensure reimbursement rate increases for community-based behavioral health providers established through the HOPE Act (HB1329) are included in the State's FY 2019 budget
- Build upon the local behavioral health authority (LBHA) model to support system planning and management and continue progress toward integration of behavioral health services in a more accountable system of care
- Establish a taskforce to examine the ability of the current behavioral health workforce to meet the needs for service and make recommendations for how to improve workforce capacity