Behavioral Health System Baltimore

FY 2019 Activities, Behavioral Health Indicators, System Utilization, and Strategic Goals

February 2020

Table of Contents

A. Introduction ……3

B. New Developments and Challenges……4

C. Organizational Structure ……14

D. FY 2019 Highlights and Achievements ……17

E. Planning Process ……22

F. Service Delivery and Recovery Supports ……29

G. Targeted Mental Health Case Management Capacity Analysis……70

H. Data ……77

Baltimore City Demographics and Social Determinants of Health ……77

Behavioral Health Indicators of Baltimore City ……100

Public Behavioral Health System Utilization ……110

I. FY 2021 Goals ……148

Addendum A: Organization Chart ……154

Addendum B: BHSB 2020 Policy Priorities ……156

Addendum C: Cultural and Linguistic Competency Self-Assessment & Strategies ……159

Addendum D: Board of Directors ……171

Addendum E: Sub-grantee Monitoring Procedures ……174

Addendum F: Behavioral Health Disaster Preparedness Plan ……177

A. Introduction

BHSB is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. In this role, BHSB is tasked by the State of Maryland with a range of activities to plan, manage, and monitor the public behavioral health system at the local level.

BHSB works to build an efficient and responsive system that comprehensively addresses the needs of individuals throughout the lifespan, their families, and communities impacted by mental illness and substance use. We do this by providing local leadership in implementing and overseeing a variety of prevention, early intervention, treatment, and recovery support services as well as developing new and innovative services.

LBHAs operate under the authority of the Secretary of the Maryland Department of Health (MDH), and BHSB has a memorandum of understanding with the MDH Behavioral Health Administration (BHA) that outlines its responsibilities. BHSB has several core functions related to its role and mission:

- Managing public funds and grant awards from multiple sources,
- Building and maintaining relationships with local system partners to advance behavioral health and wellness in Baltimore City,
- Advocating and planning for system changes and improvements,
- Providing public education about behavioral health and how to access the public behavioral health system, and
- Managing a system of care for individuals, families, and communities impacted by mental illness and substance use.

BHSB operates within the context of Maryland's public behavioral health system and is tasked with local oversight and management. In Maryland, most publicly funded behavioral health services are reimbursed through a statewide Administrative Service Organization (ASO), and providers are paid on a fee-for-service basis for services provided to people who have Medicaid or are uninsured.

The MDH also directs grant funds to local behavioral health authorities to fund services and initiatives not reimbursable by Medicaid. The state holds the sole authority to regulate the provider network and add services to the Medicaid benefit package, while local authorities identify the unique strengths and needs of their jurisdictions to direct funding where it is most needed.

Nearly 78,000 people were served through the public behavioral health system in Baltimore City in FY 2019, with annual expenditures of over $510 million, making it the most represented jurisdiction in the system despite not being the most populous jurisdiction in Maryland.

B. New Developments and Challenges

Baltimore City is a large urban jurisdiction with multiple complexities and challenges including a longstanding history of disparities and inequities, a frequently changing political landscape, and several large academic institutions and health systems that have influenced how resources are allocated. BHSB and system stakeholders work closely to address often competing priorities with limited resources. As the LBHA, it is the responsibility of BHSB to be a partner in the work to address the entrenched systemic challenges that have impacted people, their families, and the communities in which they live.

Key Population-Level Indicators

Baltimore City and the State of Maryland have been experiencing a public health emergency with dramatically rising opioid-related fatalities over the past ten years. 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 Baltimore City Health Department (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.

While opioid-related deaths statewide declined by 4.8% percent during the first nine months of 2019 as compared to the first nine months of 2018, the number of deaths in Baltimore City continued to rise. In response to the public health emergency, BHSB collaborates with state and local partners to implement a wide array of strategies. Some of those discussed in other sections of this report include: the Maryland Crisis Stabilization Center; peer-delivered outreach services; rapid response to overdose spikes; integrating peer support specialists with the Syringe Services Program mobile van operated by the BCHD; the Hub and Spokes Project; expanding access to buprenorphine in non-traditional, low threshold peer-run settings; the Maryland Harm Reduction Training Institute and Bmore POWER.

Baltimore City also continues to experience endemic violence. The homicide rate remains extremely elevated compared to the years leading up to 2015. There was a spike of 342 homicides in 2015, which was exceeded during 2019 with 348 homicides. 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 such as a lack of affordable and safe housing, systemic discrimination, food insecurity, food

deserts and limited access to social and economic mobility, can have long-term negative consequences on health and well-being, including mental health conditions, substance use, asthma, autoimmune, cardiac and other chronic diseases.

The increase in suicide rates across the United States, Maryland and in Baltimore City is another alarming trend. BHSB is working to integrate suicide prevention into its overall prevention strategies.

Systemic Racism

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 report, Baltimore City has a disproportionate burden of structures and conditions, which increases the likelihood of chronic behavioral health conditions.

To be an effective partner in building strategies to address the significant challenges Baltimore City faces, as highlighted by the overdose, homicide and suicide rates, it is essential to understand the massive impact of systemic racism. One of the legacies of Baltimore City's explicitly racist housing policies dating back to the early 20th century is a highly segregated city with a poverty rate that is two-and-half times that of Baltimore County.[1] Investment in the city continues to follow the patterns of segregation, with far more investment resources flowing to whiter, wealthier neighborhoods, thus compounding historic disparities.[2]

Many of the dominant cultural norms in the United States are based on the concept of meritocracy, which is the belief that everyone succeeds or fails based on their own, individual merit. This concept is woven deeply into our culture, shaping our thought processes and belief systems. It renders less visible the ways in which external systems shape internal realities. Racism and other forms of discrimination and oppression have resulted in structures that were intended to ensure disparate access to resources and power. These structures continue to exist, and they perpetuate socioeconomic and health inequities. As the local behavioral health authority, it is BHSB's responsibility to work collaboratively with other system partners to do the work of analyzing institutional power in order to collectively build a society in which people thrive in communities that promote behavioral health and wellness for all.

[1] "The Black Butterfly": Racial Segregation and Investment Patterns in Baltimore. Urban Institute. February 5, 2019, https://apps.urban.org/features/baltimore-investment-flows/.
[2] "The Black Butterfly": Racial Segregation and Investment Patterns in Baltimore. Urban Institute. February 5, 2019, https://apps.urban.org/features/baltimore-investment-flows/.

This work is enormously challenging and can only happen with deep commitment across the organization. To support it, BHSB launched an internal Equity and Inclusion workgroup several years ago, which is comprised of BHSB employees representing every department and most teams at all levels of the organization. It functions in the role of change agent to promote a more equitable and inclusive workplace and citywide system of care.

Pair of ACEs

An *Adverse Childhood Experience* (ACE) is 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.

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%.[3]

Adverse Community Environments include a lack of affordable and safe housing, community violence, food insecurity, food deserts, 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*[4].

People who have high exposure to the *Pair of ACEs* are more vulnerable to adaptive behaviors such as substance use, binge eating, self-harm and violence. The prevalence of ACEs in Baltimore City, together with historic and ongoing systemic racism and the disparate rates of poverty, violence, homicide, overdose fatalities and housing instability, increases the risk of behavioral health disorders.

Limited Resources Versus Need

BHSB has limited funding and infrastructure relative to the broad scope of its state-delegated responsibilities and a heavy workload due to local needs. State funding for service delivery has remained flat for years. The responsibilities formally delegated by the state to its local

[3] 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

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

behavioral health authorities continue to grow without a corresponding increase in administrative funding.

The current job market intensifies the fiscal challenges. It is difficult for BHSB to offer competitive salaries for people who have the experience and skill set needed for system management work in a large, complex system like the one in Baltimore City. Large health entities are prevalent in the city and are difficult to compete with in the job market for both BHSB and community-based service providers.

BHSB expends substantial administrative resources writing the program plan that LBHAs are required to submit on an annual basis. Approximately 221 staff hours were spent preparing the program plan section of the FY 2021 Plan and Budget document. Multiplying by BHSB's average salary and fringe of $32 per hour yields a total of approximately $7,000 of public resources. Extending the program report and plan timeline so that LBHAs are required to submit three or five-year plans instead of annual would reduce the fiscal burden and free up staff resources to move the work forward.

The long-term sustainability of grant-funded programs is unclear. Key services within the system of care rely heavily on grant funds, one example being Peer Recovery Specialists. Peers play an essential role in high-quality, person-centered behavioral health service delivery. However, funding for the development, implementation and ongoing sustainability of peer-delivered services is limited.

Behavioral health providers that experience ongoing flat funding face the same fiscal and staff recruitment challenges that BHSB does. Many operate on tight budgets with limited cash flow. As funding mechanisms have changed and administrative burdens have increased at both the state and city levels, BHSB's cash flow has tightened, making it more difficult to identify funds to temporarily cover payments to sub-vendors when reimbursement to BHSB is delayed. In addition, providers that operate within very tight budgets are not able to adapt as readily to the changes occurring within the system as well as make the shift in administrative infrastructure needed to move toward a more value-based payment structure.

An influx of federal and state opioid money in recent years has funded urgently needed services to address the opioid overdose crisis. While these resources have been and continue to be welcome, the challenges with addressing the opioid epidemic are highly complex and require long-term strategies. A plan to sustain these programs is needed. BHSB will need to critically consider the priority needs of the city and prepare to make cuts to ensure that grant funds continue to have maximum impact.

Integrated Service Delivery

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.

BHSB was created in 2013 through the merger of the city's Core Service Agency (CSA) and Local Addictions Agency (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.

During the fall of 2018 and again in 2019, local jurisdictions were required to complete a tool to self-assess the current level of integration across 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, with the highest being a level three. Based on the criteria in the tool, BHSB assessed itself at level three for each domain, with the exception of Quality, which was a level two. This rating changed from the prior year due to more critical thought being paid to the impact on the recipients of services. While BHSB is organizationally structured to perform its training, complaint investigation, and performance improvement activities with an integrated approach, consumers continue to experience service delivery that is not integrated. The full realization of a more integrated experience at the service recipient level is significantly dependent upon factors outside the scope of authority currently granted to the LBHA. Some of the barriers include:

- no reimbursement structure for integrated service delivery,
- no authority at the local level to require specific system-wide programmatic components such as integrated service delivery or evidence-based screening tools or assessments,
- limited access to data beyond the paid claims data from the ASO, and

- limited authority at the local level to enforce quality and provide sanctions for poor service delivery.

Electronic Consent to Share Substance Use Treatment Information

The U.S. Department of Health and Human Services (HHS) implemented changes to Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR Part 2) in March 2017. These changes were intended 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.

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 that was created by various entities 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 enables 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.

State Financing and Regulatory Structure Change

The work of LBHAs has and will continue to undergo significant change as the landscape of behavioral healthcare financing and regulatory structures shifts to promote integration, increased access, and improved outcomes. States are implementing an array of approaches to value-based payment models, all of which require capacity to use data to improve outcomes at the provider level. BHSB is working to develop the internal knowledge of new payment models to help prepare the provider system for these changes through training, technical assistance and change management support.

The all-payor model of reimbursement for hospitals is complicated, which increases the difficulty in devising meaningful partnership strategies between hospitals and community-based providers. Economic incentives are in many cases not aligned across payment systems, which further complicates such efforts.

Discussion at the state level regarding moving from a Medicaid carve out structure to a carve in is another possible challenge. This change would result in all Medicaid funding being managed by the nine Managed Care Organizations (MCO) in the city, rather than the single Administrative Service Organization (ASO). This change could potentially result in unnecessary complications in the management of state general dollars for services for uninsured individuals

or for services that Medicaid does not pay for, both of which are a large component of BHSB's work. Across the country, behavioral health systems that are regarded as the most successful include strong local management. Any change in the system of care should include a well-resourced local system management entity with the proper autonomy and authority to achieve its goals.

Changes in Leadership at State and Local Levels

There have been ongoing changes in leadership at both the state and local levels over recent years, which has made moving the work forward more difficult. The lack of historic knowledge as people change positions results in an increased administrative burden. In addition, the partnerships needed to develop new, innovative and sustainable service delivery have suffered as key positions at the city and state change.

Stigma

Stigma 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.

As is reported throughout this document, BHSB engages in a wide range of activities to address stigma and educate the public on its impact. One key strategy is harm reduction, which is a philosophy and an approach that 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. Another strategy is advancing the professional development and integration of Peer Recovery Specialists into treatment and recovery services across the system of care. Peer Recovery Specialists use their personal experiences to help others make their own journeys to recovery.

BHSB promotes the telling of personal stories to support connection and understanding through storytelling events and a *Stories of Hope* section on its website. For example, a community storytelling event was held in honor of National Recovery Month in September 2019, and BHSB partnered with the National Alliance on Mental Illness Metropolitan Baltimore (NAMI Metro) to plan a *Stoop Storytelling* event in May 2019 that spotlighted seven individuals who shared their personal stories of recovery and resilience. In addition, BHSB's Annual Gathering in December 2019 highlighted three individuals who shared inspiring personal stories

that promoted resilience and recovery. Two professional development opportunities that BHSB sponsored during FY 2019 included *See Past the Stigma and Stigma* and *Trauma and People Who Use Drugs.*

Provider Engagement

BHSB is responsible for overseeing hundreds of providers within Baltimore's public behavioral health system (PBHS). When new providers request agreements to cooperate, BHSB issues a welcome letter with suggestions on how to engage with the local community and with BHSB. BHSB also reaches out to new providers with an invitation to schedule a meet and greet visit for the purpose of helping them become better informed about BHSB's role in the system of care and the ways BHSB can support them. However, providers do not always respond to invitations for meet and greets. Those providers then operate without a full understanding of how to collaborate with their local behavioral health authority, and they are also unaware of the resources BHSB has to offer, such as funding opportunities, advocacy, and training opportunities.

Community Engagement

Authentic engagement with communities requires systems to share power. Historically, this is not something that systems were built to do and is a massive – yet fundamentally critical - undertaking. One of the legacies of systemic racism in Baltimore City is widespread distrust of large institutions and systems. Community engagement will be a long-term process requiring BHSB to continue to evolve its organizational culture and operational processes. Building trust with communities requires operational structures that:

- ensure feedback that is offered is recorded, analyzed and thoughtfully utilized to inform system planning and resource management decisions;
- create transparency in decision making and resource allocation and
- develop equitable opportunities for small, community-based organizations that have been historically marginalized to compete for grant funding,

Due to historic mistrust and the stigma associated with substance use treatment, many providers, particularly Outpatient Treatment Programs (OTPs), experience challenges connecting with the community members of the neighborhoods they wish to locate. Often OTPs looking to operate in a particular community experience significant push back. It can be very difficult for them to build relationships with community members.

Harm Reduction

Bmore POWER (Peers Offering Wellness Education and Resources) is a network of people with lived experience related to drug use. It was started in 2016 by two individuals who participated in BHSB's Harm Reduction Training (HaRT) Program and has grown rapidly due to an infusion of state funds in recent years that has had the goal of addressing the continuing high rates of overdose. Members conduct street outreach, educate community members and elected officials about harm reduction, and participate in coalitions that advocate for policies that reduce harm and promote health and wellbeing for people who use drugs.

In designing the structure for Bmore POWER, BHSB committed to compensating members for their work using an open-door model in which members work as they are able. Many members have limited experience with employment or formal work structures, and many are balancing a number of competing priorities. The rapid growth, inherent complexities in implementing an open-door model and ongoing life difficulties experienced by many members, together have made it challenging to develop structures to appropriately support this work. As described in *Section D. FY 2019 Highlights and Achievements*, Bmore POWER members were formally integrated into BHSB's organizational structure and became BHSB employees in January 2020.

Role of the LBHA

To maximize impact in local planning and management, LBHAs must have the stature and authority to perform those functions. However, the role that the LBHA plays in the system of care is not always clear. Continued work to develop clarity around roles and authority within the behavioral health system would support LBHAs getting to and being successful at the table with hospitals, physical health care organizations and other system partners 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. This is challenging given the sheer number of hospitals and the size and complexity of each health care system. However, it is essential for hospitals, health care organizations, behavioral health providers and other system partners to collaborate 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.

As described in *Section F. Service Delivery and Recovery Supports,* BHSB is building a collaborative partnership with hospitals, other local behavioral health authorities, and local police departments from Baltimore City, Baltimore County and Howard County, and The

Horizon Foundation to begin planning for how to work together to strengthen and expand behavioral health crisis services by implementing the *Crisis Now* model.

Workforce

It is critical that the behavioral health field prepare 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 faces significant changes that impact practice, credentialing, funding, and ability to keep up with changes in practice models driven by changing science, technologies and systems.

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 did not address the systemic underfunding that has resulted from many years of level funding of the public behavioral health system.

As reported in *Section D. FY 2019 Highlights and Achievements*, BHSB sponsored an array of free professional development opportunities during FY 2019 to increase capacity across the network to provide high quality, evidence-based and evidence-informed services. In addition, BHSB become a field placement site for students.

Housing

BHSB regularly receives complaints from consumers, families and behavioral health providers about housing for individuals who have behavioral health disorders. Some programs that promote themselves as supportive housing or recovery housing do not have State of Maryland certification. Unfortunately, the BHA does not monitor housing that is not certified, and BHSB, as 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.

Additional Challenges

Some of the other barriers to expanding the depth and reach of the PBHS in Baltimore City include:

- Baltimore City mirrors the statewide trend of underutilization of the PBHS by individuals over age 65. Transportation and mobility issues have been identified as key barriers, but there is much to be learned about access to care issues in this population.
- Providers are reluctant to prescribe, and consumers are hesitant to take, medication to assist with substance use disorders.

- Communities are often opposed to having behavioral health services located in their neighborhood, particularly Medication Assisted Treatment (MAT) services.
- 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.
- The 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.
- There are not enough bilingual, behavioral health practitioners, and those who exist are in high demand. Salaries that community-based providers can afford are often not competitive.

C. Organizational Structure

As an integrated organization and under the leadership of our Chief Executive Officer (CEO), BHSB's vision, mission and values 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

Organizational Structure

BHSB employs approximately 103 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 A) 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. The organizational chart includes staff and represents the reporting structure up to the CEO.

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 oversight and support for providers in a variety of ways, including training and technical assistance, compliance audits (on-site and desk), and the facilitation of consumer quality activities. The team also manages provider complaints, investigations, and critical incidents.

- Strategy

  The Strategy Department advances BHSB's mission by overseeing organization-wide implementation of the strategic plan. There are several key areas in which the department provides leadership: developing capacity within the system of care to use data to improve outcomes; promoting resilience through educating providers and other stakeholders about the impact of adverse childhood experiences (ACEs), toxic stress, and structural poverty and racism; supporting implementation of science-based practices that mitigate harm and promote culturally relevant healing; collaborating with community members and other stakeholders to develop and implement data-driven prevention strategies that promote mental health and wellbeing; and promoting and implementing harm reduction-related philosophy and service delivery through the Maryland Harm Reduction Institute and Bmore POWER, a peer-driven network of people with lived experience related to drug use.

- 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 Operations

  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.

With the retirement of BHSB's Chief Financial Officer effective December 31, 2019, the position was divided into two: Vice President, Finance and Chief Financial Officer and Vice President, Operations and Chief Operating Officer. This decision was made to support the organization's capacity to be nimble, flexible and adaptive to change. The environment in which BHSB functions is evolving, and finance and operations, which are at the heart of the work, must remain strong and capable. This will mean a structure change for BHSB during 2020 with the creation of an Operations Department.

Relationships with Other Key Entities

As stated above, the attached organizational chart includes staff only, as BHSB is a nonprofit organization. However, BHSB works closely with the other entities listed in the instructions pertaining to this section of the report. BHSB's COO holds an ex officio seat on the Board of Directors for Family League of Baltimore, which is the city's local management board, and staff from BHSB's Child & Family Services team collaborates closely with Family League on an array of projects. As the city's public health agency, the Baltimore City Health Department (BCHD) leads the overdose response and chairs the Overdose Intervention Team (OIT). BHSB participates on the OIT and the city's Opioid Fatality Review team, which is also chaired by BCHD. To facilitate communication and coordination, BCHD staff attends BHSB's internal overdose response work group. Staff from BHSB's Programs and Accountability Departments work closely with the Administrative Service Organization to oversee the provider network in Baltimore City. As noted above, BHSB's Board of Directors serves as the local mental health advisory council and the local drug and alcohol council as defined by the State of Maryland.

D. FY 2019 Highlights and Achievements

Nearly 78,000 people were served through the public behavioral health system in Baltimore City in FY 2019 with annual expenditures of over $510 million, making it the most represented jurisdiction in the system despite not being the most populous jurisdiction in Maryland. Most people accessing care in the public behavioral health system do so in outpatient settings, and even though the cost of inpatient care is much higher per person, most of the expenditures on behavioral health services are for outpatient care.

In FY 2019, BHSB awarded $42 million in grant funds, with 353 contracts issued to 135 organizations and consultants. Grant funds are used to purchase needed services and supports that are not currently reimbursable by public insurance payers.

Key FY 2019 Highlights

- 58,567 people received mental health services, 26% of the total people served in Maryland.
- 34,964 people received substance use disorder services, 30% of the total people served in Maryland.
- 43,482 people called the Crisis, Information and Referral line for assistance.
- 11 of 12 hospitals in Baltimore City (all but the Veterans Administration Hospital), provided Screening, Brief Intervention and Referral to Treatment (SBIRT) in their emergency departments.
- 15,726 people were trained on overdose prevention and how to administer naloxone, and 15,425 naloxone kits were distributed.
- Peer specialists in Wellness and Recovery Centers provided 7,612 one-on-one support sessions.
- 8,293 children and youth received individual treatment services through the Expanded School Mental Health program.
- Over 43,000 teacher and parent consultations were provided through the Expanded School Mental Health program.
- 927 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.
- BHSB released 15 competitive procurements, as compared to eight during FY 2018.

Organizational Operations

BHSB has been focused on improving its procurement and contracting processes to increase its capacity to carry out its mission as efficiently and effectively as possible. A consultant was engaged to strengthen contracting processes so that BHSB can continue to execute contracts in a timely manner, spend funds efficiently, and ensure quality services are delivered.

At the beginning of 2019, a dedicated position was created to enhance procurement processes and oversee the related activities, which has significantly increased the number of competitive procurements completed, diversifying the pool of vendors delivering grant-funded services in the city. In FY 2019 BHSB released 15 Requests for Proposals (RFPs), as compared to eight during FY 2018. With this new position, BHSB has also been able to competitively procure

services and vendors, including individual consultants and small one-time projects. These additional projects resulted in opportunities to fund new partners through transparent and equitable processes.

As described in *Section C. Organizational Structure*, with the retirement of BHSB's Chief Financial Officer effective December 31, 2019, the position was divided into two: Vice President, Finance and Chief Financial Officer and Vice President, Operations and Chief Operating Officer. This decision was made to support the organization's capacity to be nimble, flexible and adaptive to change. The two positions were filled by internal promotions of BHSB staff, who will work collaboratively with each other and the CEO, along with the executive and leadership teams and staff from across the organization, to optimize BHSB's operating capabilities. This will mean a structure change for BHSB during 2020 with the creation of an Operations Department and reorganization of other areas of work.

Collaborative Planning and Implementation Committee (CPIC)

BHSB continues to work closely with the City of Baltimore, the Baltimore Police Department (BPD), the U.S. Department of Justice (DOJ), and members of the Consent Decree Monitoring Team to address the behavioral health requirements in the City's 2017 Consent Decree with the U.S. Department of Justice. This includes co-chairing the Collaborative Planning and Implementation Committee (CPIC) and its four sub-committees and overseeing the completion of a gap analysis of the behavioral health system in the city. The *Baltimore Public Behavioral Health System Gap Analysis* report was approved by the Department of Justice and submitted to the federal court in December 2019. It analyzes existing public behavioral health service systems to identify unmet needs, 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.

CPIC is also engaged in reviewing policies related to BPD's interactions with city residents who may have behavioral health conditions and recommending changes that will lead to modifications in police operations. The below policies have been revised and are in final form. They will be implemented once all BPD personnel have been trained.

- Behavioral Health Crisis Dispatch
- Crisis Intervention Program
- Petitions for Emergency Evaluation and Voluntary Admission

Community Engagement

Community engagement is an organizational priority. BHSB works with communities and behavioral health providers to respond to concerns that are reported by community leaders

and elected officials. Many substance use providers, particularly Outpatient Treatment Programs (OTPs), face stigma when locating in neighborhoods throughout Baltimore City.

BHSB acts as a facilitator to bring together the provider and the surrounding community members to foster conversation and relationship building. In addition, at the request of a community and provider, BHSB facilitates the creation of a *Good Neighbor Agreement.* This process includes facilitated discussions aimed at developing partnerships. The goal is to address issues and conditions in the neighborhood that may have a negative impact on consumer safety, treatment outcomes, provider staff, and the quality of life enjoyed by community residents and business owners. During FY 2019, BHSB facilitated two meetings for *Good Neighbor Agreements.*

Community engagement will be a long-term process requiring BHSB to continue to evolve its organizational culture and operational processes. To build capacity, BHSB developed an internal community engagement plan during the fall of 2019 to align strategies across the organization. Additionally, an internal workgroup was formed to support communication and coordinate activities across teams. BHSB resourced this work with the creation of a Community Engagement Coordinator position. The newly created Chief Operating Officer position will also have a critical role in developing BHSB's organizational capacity to authentically engage with communities.

Provider Relations

BHSB's provider relations efforts have several notable achievements. In FY 2019, BHSB:

- Issued 165 Agreements to Cooperate to programs operating in Baltimore City's PBHS.
- Launched an Opioid Treatment Program (OTP) Service Line meeting, which brings together the over 30 OTPs in Baltimore City to discuss changes in the system of care.
- Completed Meet and Greet visits with six new providers in Baltimore City's PBHS.

Workforce Development

BHSB sponsored an array of free professional development opportunities during FY 2019 to increase capacity across the network to provide high quality, evidence-based and evidence-informed services. A total of 1,827 individuals participated in 62 trainings and conferences, including:

- Advocacy 101
- Brain-Based Approach to Working with Complex Trauma
- Recovery Coach Academy
- Conscious Discipline

- Drugs 101
- Fentanyl Testing
- Harm Reduction 101
- Healing & Resilience: The Journey Forward
- HealthCare Access Maryland
- Infectious Diseases
- Intentional Peer Support
- Motivational Interviewing - Introductory and Intermediate
- Overdose Prevention, Targeted Naloxone Distribution & Strategic Planning
- See Past the Stigma
- Safer Injection
- Seeking Safety
- Self-Care, Boundaries and Disclosures
- Stigma, Trauma and People Who Use Drugs
- Trauma-Informed Supervision
- Understanding the Impact of Grief & Trauma on Homicide Survivors
- Undoing Racism
- Whole Health Action Management Peer Support

BHSB has become a field placement site for students, with one social work student interning during the 2018/2019 school year and five students in the 2019/2020 school year. Students have come from the University of Maryland and Morgan State University Schools of Social Work and the University of Baltimore School of Human Service Administration.

Bmore POWER

As described in *Section B, New Developments and Challenges*, Bmore POWER is a network of people with lived experience related to drug use. It has grown rapidly due to an infusion of state funds in recent years that has had the goal of addressing the continuing high rates of overdose in the Metro Area. With this growth, it was determined that all Bmore POWER members should be formally integrated into BHSB's organizational structure and become BHSB employees with a position title of Bmore POWER Outreach Worker. This change became effective in January 2020, adding 27 new BHSB employees, which is a 36% increase.

With this transition in employment classification, BHSB will maintain a flexible structure for Bmore POWER Outreach Workers, and their work and employment will be tailored to the needs of the Bmore POWER network. It marks an exciting moment in the ongoing evolution of BHSB's work to advance a harm reduction philosophy.

E. Planning Process

Access to Care

BHSB collaborates with providers and other stakeholders in an array of projects to increase access points to the system of care and create a "no wrong door" experience for city residents. Some of the key projects and programs are described below.

Crisis Response System Planning

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 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.

During FY 2019 BHSB completed 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.

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 process described in the *Unmet Needs and Gaps* section below. BHSB decided not to seek public feedback because the gap analysis process included significant public input, and the crisis response system plan was incorporated into the analysis. BHSB did release the plan document in June 2019 as a stand-alone plan to honor all the effort that had gone into creating it.

Collaborative Planning & Implementation Committee (CPIC)

As described in *Section D. FY 2019 Highlights and Achievements*, Baltimore City entered into a consent decree with the U.S. Department of Justice (DOJ) in 2017 to resolve DOJ's findings that the Baltimore Police Department (BPD) had violated the U.S. Constitution and federal laws, including laws or protections related to people with behavioral health disorders. As a result,

BHSB has been involved in supporting BPD to meet the requirements in the consent decree related to behavioral health through a Collaborative Planning and Implementation Committee (CPIC) made of various stakeholders: advocacy groups, provider organizations, juvenile/criminal justice partners, Baltimore City representatives, consumers and family members.

This committee is working to ensure that Baltimore's behavioral health system is robust and responsive enough that police interactions are avoided or minimized to the extent possible. When police interactions are necessary, the focus is to ensure that officers have the skills and tools they need to de-escalate crises with the least amount of force necessary and to divert people away from the juvenile and criminal justice systems. A major emphasis has been on enhancing the behavioral health crisis response system so that communities in Baltimore have a reliable alternative to police.

Interdisciplinary Street Outreach

Street outreach is a critical component of BHSB's crisis response system and recovery-oriented system of care. Whereas other service providers are designed to serve clients who initiate care on their own behalf, or to intervene at the time of a crisis, street outreach is designed to proactively canvass communities and develop trusting relationships. This enables outreach workers to identify persons with unmet behavioral health needs early and begin an intervention before the person experiences a crisis.

Historically, BHSB outreach programs have been decentralized, with smaller grants awarded to several different organizations. Although individual programs provided critical services to vulnerable populations, this approach limited BHSB's ability to:

- Ensure consistent and complete geographic coverage,
- Reduce response times,
- Ensure outreach efforts did not duplicate services or work at cross-purposes,
- Effectively coordinate care for individuals served by multiple programs, and
- Integrate mental health, substance use, physical health, and peer support specialties into the care planning effort.
- 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.

To overcome these obstacles, BHSB combined outreach grants to create an interdisciplinary street outreach program that is highly responsive and provides comprehensive care to persons who are not well served by the traditional system. The combined street outreach program was officially implemented on July 1, 2019 following a competitive RFP process and an in-depth outreach implementation plan.

During FY 2019, the various providers that were conducting street outreach achieved the following deliverables:

- Number of residents contacted: 3,040
- Number of residents enrolled in ongoing peer services: 690
- Number of residents referred to treatment: 589
- Number of residents who have been referred and are admitted to treatment: 380

Bmore POWER

As described in *Section B, New Developments and Challenges*, Bmore POWER is a network of people with lived experience related to drug use. Members provide harm reduction street outreach to individuals who are most at risk of overdose. Outreach activities include overdose education and naloxone distribution, distribution of safer sex kits, and referrals to community resources, including substance use treatment.

During FY 2019:

- 9,112 people were trained on overdose prevention and how to administer naloxone
- 8,779 naloxone kits were distributed

Critical Incident and Complaint Investigations

As the LBHA for Baltimore City, BHSB has authority designated by the state to provide local oversight of programs and services within the PBHS and to investigate Critical Incidents and Complaints. BHSB partners with the BHA to manage investigations, utilizing a collaborative and consultative approach.

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.

A Complaint is an expression of verbal or written dissatisfaction that can include, but is not limited to, services, manner of treatment, outcomes or experiences. Complaints may be submitted by anyone, including program participants, family members, behavioral health professionals, behavioral health program staff, community members and other stakeholders. As the entity responsible for investigating Complaints, BHSB serves as the voice of consumers,

family members and program staff. Complainants are educated about standards of care, and information regarding services available in the PBHS is shared with stakeholders.

The investigation of a Critical Incident or Complaint addresses (as applicable) clinical services, quality of care, regulations, rights of consumers, and consumer satisfaction. Strong collaborative relationships are built with programs to facilitate the provision of technical assistance. Program staff is educated on ways to operationalize regulations and standards, best practices, trends, and strategies that BHSB is implementing.

BHSB collaborates with providers that require immediate support to achieve compliance. Providers who have had a recent site visit from the Accrediting Organization or Maryland Medicaid may be required to quickly come into compliance and will be given immediate support. Resolution of a Critical Incident or Complaint could involve addressing consumer satisfaction, revising policies and procedures, complying with regulations, and adopting best practices. The goal of the process is quality behavioral health care that promotes healthy communities and healthy workplaces within the PBHS.

During FY 2019, there were:

- 78 Critical Incidents, all of which have been closed.
- 85 Complaints, all of which have been resolved and closed.

Sub-vendor Monitoring Functions

BHSB employs various processes to monitor administrative, fiscal and programmatic contractual performance. Each contract is assigned a Program Lead, Grants Accountant Lead, Contract Administrator Lead and Quality Coordinator Lead. Each Lead performs assigned oversight functions:

- Program Lead: Reviews and approves the budget and proposed staffing in accordance with the scope of services, as well as the program reports that are submitted on a schedule as required in the contract. If deliverables are not being met or there are concerns about the quality of service delivery, the Program Lead collaborates with the sub-vendor throughout the contract term to ensure that issues are addressed on an ongoing basis. Fee-for-service and consultant contracts require the submission of an invoice, which is reviewed and approved by the Program Lead in accordance with the scope of services. The Program Lead maintains communication with the sub-vendor throughout the contract term and provides collaborative support to manage challenges and resolve problems as they arise. Technical assistance is provided if indicated.

- Grants Accountant Lead: Reviews and approves budgets, fiscal reports and any supporting detail documentation, if applicable, that are submitted by sub-vendors on a schedule as required in the contract. If budgets or fiscal reports include unallowable expenses or other errors, the Grants Accountant Lead explains the issues to the sub-vendor and requests that they make the corrections and resubmit an accurate budget or fiscal report. Mathematical errors can be corrected by the Grants Accountant.

- Contract Administrator Lead: Reviews and ensures all required documentation is submitted by sub-vendors on a schedule as required in the contract. This includes the Risk Assessment Form, W-9, insurance documentation, and independent financial audit(s). The Contract Administrator ensures that BHSB contracts are issued and executed within the appropriate timeframe.

- Quality Coordinator Lead: Conducts an annual audit at the conclusion of the contract term to review if service delivery met contractual requirements and relevant federal, state and local regulations.

BHSB's Chief Financial Officer (CFO) ensures that all financial audits are reviewed to determine if conditions exist that may prevent sub-vendors from delivering services and/or fulfilling the terms and conditions of the contract.

During FY 2019 and the first half of FY 2020, BHSB worked with a consultant to strengthen contracting processes in order to continue to execute contracts in a timely manner, spend funds efficiently, and ensure quality services are delivered. The consultant interviewed staff and reviewed internal documents to collect information regarding existing processes. He also facilitated discussions within teams and across the organization to identify gaps and quality improvement opportunities.

As described in *Section C. Organizational Structure*, with the retirement of BHSB's CFO effective December 31, 2019, the position was divided into two: Vice President, Finance and CFO and Vice President, Operations and Chief Operating Officer (COO). One of the priorities for the CFO and COO during the winter and spring of 2020 is to implement operational changes to strengthen BHSB's contract monitoring. Some of the key strategies include:

- Clarify the tasks assigned to each of the four Leads that has a role in contract oversight.
- Strengthen processes to facilitate communication and collaboration across the four Leads.

Unmet Needs and Gaps

As described in *Section D. FY 2019 Highlights and Achievements*, BHSB works closely with the City of Baltimore, the BPD, the DOJ, and members of the Consent Decree Monitoring Team to address the behavioral health requirements in the City's 2017 Consent Decree with the DOJ. This includes overseeing the completion of a gap analysis of the behavioral health system in the city. The *Baltimore Public Behavioral Health System Gap Analysis* report was approved by the DOJ and submitted to the federal court in December 2019. It analyzes 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. The full report is published on the BPD's website (https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis).

Stakeholder Engagement

BHSB engages stakeholders in a wide array of forums. The process for developing the *Baltimore Public Behavioral Health System Gap Analysis* report involved significant stakeholder involvement, including 166 individuals who participated in key informant interviews or focus groups, including at least 48 consumers or family members. The development of the Gap Analysis report was overseen by the CPIC which was formed to oversee the behavioral health components of the Consent Decree and includes representation from more than 65 entities including community-based and hospital providers, city and state agencies, philanthropists, advocates, people with lived experience, their families and other stakeholders.

As described in *Section D. FY 2019 Highlights and Achievements*, BHSB works with communities and behavioral health providers to respond to concerns that are reported by community leaders and elected officials and facilitate constructive conversations. These forums provide opportunities for significant stakeholder feedback regarding the availability, accessibility and quality of services in the system of care. In addition, BHSB has a dedicated Provider Relations Manager who works closely with providers to understand and resolve community challenges, many of which impact consumers served by those providers. In addition, service line meetings are held with groupings of providers, offering opportunities to engage in dialogue about how to best support and enhance service delivery and promote behavioral health integration.

BHSB also participates in the Language Access Task Force, collaborating with other stakeholders to address the barriers for individuals with limited English proficiency (LEP) to receive equitable services in the city. Together with Legal Aid, the Department of Human Services, the Maryland Department of Health, the Mayor's Office for Immigrant Affairs, and many service providers,

BHSB works to increase the prevalence and accessibility of culturally and linguistically competent behavioral health services for the growing population of LEP consumers.

Local and State Behavioral Health Advisory Councils

The BHSB Board of Directors serves as both the local mental health advisory council and the local drug and alcohol council. The Maryland Behavioral Health Advisory Council is a statewide council that promotes a coordinated, high-quality, and culturally competent system of care. BHSB participates in two committees. One is the Planning Committee, which engages in the year-long planning process to develop the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application. Additionally, BHSB participates in the Cultural and Linguistic Competency Committee, which advises on and advocates for increasing the cultural competency and cultural competency of the statewide system.

Behavioral Health Disaster Plan Activities

BHSB coordinates with 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, determines the types of behavioral health resources required, ensures adequate behavioral health services are available, and ensures 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 and/or 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 and recommendations to improve planning, response, and recovery activities in the future.

Recent planning efforts by BHSB include a comprehensive emergency preparedness plan to ensure the system of care is responsive when critical incidents or emergencies occur and the release of a stakeholder-informed plan on improvements needed in the behavioral health crisis response system in the city. BHSB conducts tabletop exercises to prepare for a disaster

response and debriefs after incidents occur to ensure continuous quality improvement in planning activities.

BHSB updated the plan in November 2018. A copy is attached as Addendum F.

F. Service Delivery and Recovery Supports

Services Across the Lifespan

The behavioral health system of care in Baltimore City is large and complex with multiple funding mechanisms and a diverse spectrum of stakeholders. BHSB manages a full range of services across the life span from prevention and early intervention to treatment and recovery.

The majority of PBHS services are reimbursed through a statewide 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.

Services within the fee-for-service system include:

- Outpatient mental health and substance use disorder treatment
- Medication assisted treatment for substance use disorder
- Intensive outpatient and partial hospitalization
- Inpatient treatment
- Psychiatric and residential rehabilitation
- Residential substance use disorder treatment
- Respite care
- Residential crisis
- Targeted case management
- Mobile treatment
- Assertive community treatment
- Supported employment

Services directly funded by BHSB include, but are not limited to:

- Assertive outreach
- Court-based assessments
- Mobile crisis response
- Methadone home delivery
- Housing supports
- School-based services

- Wellness and Recovery Centers
- Harm reduction training
- Peer support
- Prevention
- Overdose education and naloxone distribution
- Early childhood services
- 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

Special Population Groups

BHA identifies special population groups that are prioritized for substance-related and mental health disorders service delivery:

- Substance-related Disorders (SRD) Services
  - Individuals at risk for relapse due to an unstable recovery/living environment
  - Individuals with opioid-related disorders engaged in Medication Assisted Treatment (MAT)
  - Individuals identified as intravenous drug users
  - Individuals transitioning from incarceration to the community
  - Individuals who are HIV positive
  - Individuals with co-occurring disorders
  - Pregnant women and women with children

- For Mental Health (MH) Services
  - Individuals with serious and persistent mental illness and co-existing conditions, including, but not limited to, court and criminal justice involvement, traumatic brain injury (TBI), homelessness, co-occurring disorders, victims of trauma, and individuals who are deaf and hard of hearing
  - Individuals transitioning from more intensive level residential rehabilitation program (RRP) services to Supportive Housing
  - Individuals transitioning from RRP to independent living
  - Individuals who may have forensic involvement and are ready for discharge from a state hospital
  - Transitional Age Youth (TAY) transitioning from residential treatment centers (RTCs)

While there is some overlap, the special population groups are not integrated across behavioral health, with separate lists maintained for substance-related and mental health disorders. BHSB

oversees a wide array of programs across Baltimore City's PBHS that address the needs of BHA's designated groups. These programs are discussed in more detail below.

Crisis, Information and Referral Hotline

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 operates 24 hours per day, 7 days per week, and is staffed by behavioral health professionals qualified to respond to a crisis or suicidal emergency.

Over the ten years that the hotline has been in operation, there has been an increase in calls, from a total of 26,833 calls in FY 2006 to 35,411 in FY 2019.

Crisis Services for Adults

Crisis services available to adults in Baltimore City include mobile crisis services from 7:00 am to midnight, a 21-bed residential crisis program, targeted case management services, and an 18-bed residential withdrawal management program for adults.

In FY 2019, crisis services:

- responded to 35,411 hotline calls,
- provided mobile crisis response to 2,452 individuals,
- successfully diverted 892 of 1,316 (68%) emergency department referrals from inpatient hospitalization,
- completed 659 admissions to residential crisis services, with 68% of those served having a co-occurring substance use disorder and
- maintained an occupancy rate of 90% for the residential crisis beds.

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 Baltimore City 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), also has worked to support Baltimore City's youth crisis response system through the provision of respite care services in Baltimore City.

In FY 2019, BCARS responded to 1,501 CI&R Line calls. Of those calls, 636 youth received triage services and linkage to community resources, 261 received a formal assessment and 235 were admitted to individualized BCARS services.

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 temporarily located at Tuerk House, which is a provider within the system of care in Baltimore City. Services began on April 2, 2018 with a capacity of 15 beds (10 beds, 5 recliners). The Center operates 24 hours a day, 7 days a week, 365 days a year, and is staffed with a combination of a nurse practitioner, licensed practical nurse, peer recovery specialists, and intake staff. A licensed social worker is on-site 16 hours a day, and staff conducts follow-ups for up to 30 days with individuals admitted to the Center. The Center's permanent space will be in the Hebrew Orphan Asylum, which will have 30-35 bed capacity. The building for the permanent space is done, but inspections and other items must be completed. Scheduling of these items is on hold due to social distance requirements of the COVID-19 pandemic.

Currently, BCFD Emergency Medical Services (EMS), mobile crisis teams, hospital emergency department referrals, referrals from other community-based treatment providers, and walk-ins serve as the modes of access to the Center. When individuals are ready to leave the Center, staff assist them in connecting with transportation to return to their home, treatment services, or another destination.

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, instead ending up in contact with police and/or EMS. The incorporation of direct referral protocol and training for EMS (and other organizations) supports the integration of emergency and other personnel into the behavioral health crisis response system.

A ten-member Advisory Board for the Center was established to ensure oversight and 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 other board members were nominated by the State of Maryland Governor and Baltimore City Mayor.

In conjunction with other Center stakeholders, BHSB utilizes 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 assess the effectiveness of the proposed interventions. Both process and outcome data are being collected, and the data will be used to achieve the following outcomes:

- decrease drug and alcohol-related emergency department visits and
- 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.

Relevant data points for the Center in FY 2019 and so far in FY 2020 include:

- FY 2019: 861 admission with 716 unduplicated consumers
- FY 2020 (through December 31, 2019): 650 admissions with 550 unique consumers
- Since the inception of the project in April 2018 and through December 2019:
    - 1,566 admissions with 1,243 unique consumers
    - 58% of individuals have been linked to community-based behavioral health services upon discharge
    - 451 individuals were diverted through alternative transports from emergency rooms via EMS
    - 683 individuals were referred by hospital emergency departments (Referrals from hospital emergency departments began in February 2019 on a staggered timeline.)

Opioid Crisis Center

In September 2017, BHSB received grant funding through the Maryland Opioid Rapid Response initiative to fund a new service to 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 are 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 recovery care plan with each consumer served in the crisis unit. The recovery care plan is a roadmap for that individual's treatment, as well as being an agreement between the consumer and provider. It identifies the consumer's goals and objectives during the treatment episode and offers relapse prevention education, such as identifying support networks, triggers, etc. to support recovery efforts after the consumer transitions from the Opioid Crisis Center.

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 include:

- urgent/walk-in screening and referral crisis services 24 hours a day,
- clinical crisis stabilization services, such as counseling, de-escalation, treatment and safety planning,
- nursing/medical assessment for medical clearance by a licensed nurse on site upon arrival,
- monitoring of 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,
- comprehensive biopsychosocial assessment to determine treatment needs,
- American Society of Addiction Medicine (ASAM) assessment by licensed staff to determine the appropriate level of care,
- linkage with a peer support specialist,
- residential stay for up to 96 hours with referral to another level of care as appropriate based on medical necessity and
- care coordination to assist with linkage for ongoing care and warm handoff to the next level of care.

During FY 2019, 937 consumers were referred to the Opioid Crisis Center, of whom 912 met criteria and were admitted. Of consumers admitted, 643 (71%) were linked to another level of care upon discharge, 95 (10%) left before completing services and 47 (5%) completed services with no further treatment needed.

Early Childhood Services

Early Childhood Mental Health (ECMH) services supported by BHSB were provided in three of the four Head Start centers in Baltimore City, serving 927 children during FY 2019. 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.

Judy Center Partnership

A partnership between the DRU Judy Center and BHSB affords a mental health consultant who provides the following services to families: Chicago Parent Program, Second Step, mental health workshops, social skills groups, individual and family therapy, consultation with teachers and caregivers and home visits. During FY 2019, 162 youth were served through this partnership.

Behavioral Health Services in Schools

Mental illness and substance use among youth significantly impact youth, families, and communities and contribute to significant challenges 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 youth to behavioral health services to which they 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 122 out of 166 (73.5%) schools to 8,239 youth during the 2018-2019 school year. 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.

Substance use disorder (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 for 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 the behavioral health assessment and linkage needs for TAY. During FY 2019, a significant focus was placed on supporting the transition of this work from BHSB's Adult Services team to the Child and Family team to mirror the transition of oversight occurring at the state level in the BHA. Another priority was evaluating the quality of the TAY RRP enhancements and ensuring alignment with best practices and state-informed expectations.

A competitive procurement for services related to one of the Baltimore City RRPs was released during FY 2019, resulting in the selection of a new provider. With the support of BHA, BHSB worked with the discontinuing provider to ensure appropriate transitions of enrolled youth at the time of the program's discontinuation of services. BHSB has also been working with the new provider to ensure an efficient and appropriate onboarding. This work has continued into FY 2020.

In addition to funding this specific work, BHSB works to ensure TAY are identified as a special population in the larger system of care, providing outreach and education regarding the unique needs of TAY and opportunities for the system of care to be more responsive.

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.

Peer navigators 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 model that uses structured dialogue and culturally-appropriate 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.

After one of the key partner organizations decided not to continue participating in U-TURNS near the end of FY 2018, BHSB made the decision to release a competitive procurement for a new organization to serve as the U-TURNS provider. In late 2019 U-TURNS was re-implemented with a single provider of services. The re-implementation created a project structure in which all U-TURNS staff members are employed and supervised by a single organization that holds site for achieving the goals of the project. It also supports the creation of a continuum of trauma-informed services organized around operationalizing shared values.

During the final quarter of the U-TURNS 2019 grant year (July to September 2019), peer navigators made 679 outreach contacts. Peer navigators also formally enrolled 39 young people into U-TURNS, with 49% of the young people enrolled choosing to meet with the onsite mental health therapists to benefit from deeper clinical interventions. More than half of the participants in U-TURNS engaged in at least one *S.E.L.F. Community Conversation* and attended yoga or acupuncture during the quarter.

Family Peer Support

Parents, caregivers and family members of children with behavioral health challenges need significant support and education resources. BHSB supports a statewide network of parent-peer supports through funding and technical assistance provided to Maryland Coalition of Families (MCF). MCF utilizes a Family Peer Support Specialist (FPSS) model. This model pairs individuals with lived experience as caregivers for a child with mental health, substance use and/or other behavioral health conditions, to provide support 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, 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 and has been continued through FY 2020. BHSB has also utilized funding from the Department of Human Services to expand the work of MCF into the Baltimore City's Department of Social Services.

MCF 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 Mental Health Association of Maryland.

Medication Assisted Treatment (MAT)

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 14,206 people received methadone maintenance services during FY 2019, which is nearly level with the 13,908 people in FY 2018. While it is expected that changes in the Medicaid reimbursement structure will support continued increases 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.

One initiative is the Baltimore Buprenorphine Initiative (BBI), which has the goal of offering buprenorphine within traditional treatment and non-traditional settings. Office Based Opioid Treatment (OBOT) provides services in six substance use treatment programs, serving over 1,000 consumers in FY 2019. The other BBI project locates services in non-traditional, low-threshold, peer-run settings. The primary objective of this service is to reduce barriers to treatment while expanding access to buprenorphine. During FY 2019, this project served over 80 individuals in two peer-run locations.

In October 2018, BHSB released a competitive procurement seeking a qualified OTP to serve as the *Hub* for Baltimore City's second *Hub and Spoke* project. The *Hub and Spoke* model was developed in Vermont based on chronic disease management principles. Individuals with opioid use disorders initiate treatment at the *Hub*, which then collaborates with other providers (the *Spokes*) to coordinate care, particularly for people at high risk of negative outcomes, including overdose.

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.

BHSB partnered with the selected provider to launch the *Hub and Spoke* project. Implementation began in June 2019.

The *Hub* site offers low-threshold, intensive, on-demand buprenorphine induction and stabilization. It 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 or infectious disease practice, 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.

In June 2019, BHSB hosted a provider event to address the need to expand access to buprenorphine in Baltimore City. The event highlighted Baltimore City's response to the opioid crisis, the need to address and eradicate stigma in treating individuals with opioid use disorders, the *Hub and Spoke* model, and support for buprenorphine prescribers. Over 40 providers attended this event.

BHSB continues to fund the methadone home delivery project. This project ensures that consumers who receive methadone medication experience no interruption with their medication regimen when admitted into skilled nursing facilities or upon becoming homebound. During FY 2019, this project served 210 consumers, which was well over the annual target.

Syringe Services Program

BHSB continues to partner with the Syringe Services Program (formerly the Baltimore City Needle Exchange Van) to offer peer support services to van consumers. Peer Support Specialists employ evidence-based and evidence-informed practices to initiate and maintain relationships with consumers who utilize services from the Syringe Services Program. Practices include motivational interviewing and a harm reduction model that includes drug education, a non-confrontational and non-judgmental approach, and education concerning the benefits of MAT. Peer support specialists work on the van 10 to 15 hours per week.

Sexual Health in Recovery

In FY 2018, BHSB received its first funding and technical support from the Maryland Prevention and Health Promotion Administration (PHPA) to train and implement the Sexual Health in Recovery (SHIR) curriculum at four substance use disorder treatment programs. In FY 2019, BHSB collaborated with PHPA to plan continued SHIR training and services and to hire a billing expert to develop a toolkit for providers to use to invoice for SHIR services. In FY 2020, BHSB received a $65,000 award from BHA for SHIR. As of December 2019, BHSB is collaborating with BHA and PHPA to finalize plans for how best to use the available funding for SHIR services and sustainability efforts.

Older Adults

Since FY 2017, BHSB has employed one of the six Older Adult Behavioral Health Pre-Admission Screening and Resident Review (PASRR) specialists in Maryland ("OA Specialist"). This staff person works in close collaboration with the Baltimore City Health Department (which serves as the Area Agency on Aging) as a behavioral health consultant and liaison to systems that serve older adults, such as long-term care facilities, senior buildings, and hospitals. In FY 2019, to assist partners seeking assisted living placements for older adults with behavioral health needs, BHSB's OA Specialist began researching and maintaining a list of assisted living facilities that are known to BHSB to have a high level of behavioral health competency.

The OA Specialist also:

- Conducts follow-up visits with individuals placed in Baltimore-area nursing facilities through the PASRR process, which ensures individuals are appropriately placed in Medicaid-certified nursing facilities in the least restrictive setting possible. Eight visits were conducted in FY 2019.

- Provides consultation to assist hospitals working with older adults who need placement and services in the community. Nine consultations were provided in FY19, resulting in two community placements and seven assisted living placements.

- Conducts presentations and trainings. In FY 2019, the OA specialist conducted two PASRR presentations and three *ENGAGE with Older Adults* trainings to improve behavioral health competencies and reduce caregiver burnout at long-term care facilities.

Additionally, two BHSB-funded older adult outreach teams provided in-home mental health services to 63 older adults who were disconnected from care. Both teams are staffed by a psychiatric nurse, and one of the teams uses telehealth to connect older adults to a geriatric

psychiatrist. Both teams have experienced a reduction in staffing over the last ten years as their flat-funded grants have declined in value. In FY 2020, BHSB and BHA are exploring ways to enhance the staffing model, including: partnering with an NIH-funded Johns Hopkins project that offers older adult peer support and collecting data about enrolled individuals' health benefits in an effort to better understand their eligibility for billable services.

While three of the 63 older adults receiving in-home outreach were able to be transitioned to lower levels of care, the remainder continued to need in-home services at the end of the year. This points to a gap in PBHS services that is further demonstrated in the utilization data. Baltimore City mirrors the statewide trend of underutilization of the PBHS by individuals over age 65 (see "Baltimore City Public Mental Health System Utilization FY 2019," table "Persons Served by Age Group," page 119 and "Baltimore City Public Substance Related Disorders Utilization FY 2019," table "Persons Served by Age Group," page 136). There is much to be learned about access to care issues in this population. The OA Specialist and OA outreach teams have initially identified transportation and mobility issues as primary barriers but are continuing to explore this issue in FY 2020.

State Hospital Transitions

BHSB 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 2019.

In addition, BHSB partners with an Assertive Community Treatment (ACT) team to support people experiencing homelessness 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 four consumers from a state hospital and assisting eight consumers who transitioned from state hospitals in previous years in maintaining housing in the community throughout FY 2019.

Housing First is another project that provides increased support to individuals in Baltimore City, Prince George's County and Montgomery County who are experiencing homelessness. During FY 2019, three consumers were assisted in transitioning from a state hospital into independent community housing. Six consumers who transitioned from state hospitals through the project in previous years maintained independent housing in the community throughout FY 2019.

Residential Rehabilitation Program (RRP) and Capitation Project

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, 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 2019, over 1,000 Baltimore City residents were served in an RRP program, and 367 individuals were served 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.

Recovery Housing and Rapid Re-housing

The Women with Children Recovery Housing Program provides services for adults who identify as women and have at least one child under the age of 18 in their custody. Recovery housing provides a substance-free living environment for up to one year while connecting consumers to care coordination services. The grant that funds recovery housing requires a fee-for-service reimbursement model to pay for housing, and a separate grant pays for care coordination services.

During FY 2019, 36 unique families were served in the program. Of the 24 families who left the program over the year, 17 exited to permanent housing. At any given point, about half of all heads of households were either employed or in school, while all consumers were involved in a recovery-oriented service such as outpatient treatment, 12-step support groups, and/or individual counseling.

BHSB identified a significant unmet need to support transitional services into independent housing. Rapid re-housing, which has a strong evidence base for being highly effective in terms of housing retention and cost efficiency, was identified as the model best-suited to address this unmet need in Baltimore City. A portion of the funds that supports recovery housing was

allocated to support rapid re-housing, and BHSB released an RFP in the fall of 2018 seeking applicants to provide recovery housing and/or rapid re-housing. Two organizations were selected resulted to provide recovery housing, and one to provide rapid re-housing.

The recovery housing services have been implemented, but rapid re-housing is on hold due to a funding issue. Together with the selected provider, BHSB has learned that the funds designated for rapid re-housing are insufficient. Based on the fair standard market rate for rent in Baltimore City, the current rate of reimbursement for the housing costs requires a higher number of rooms in order for the provider to cover its costs. Rapid re-housing requires additional supports for property acquisition and retention, direct case management (separate from care coordination), and landlord relations, which increases costs at the onset of a program. As there are no additional funds that have not already been allocated to the recovery housing providers, BHSB is working to identify alternate funds to address the funding gap so that rapid re-housing can be implemented.

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. The Outpatient Civil Commitment (OCC) program serves Baltimore City residents with a serious mental illness. Access to the program is available if the following three conditions are met:

1. The patient:
    - is currently retained following a hearing at an inpatient psychiatric hospital unit and has been retained during at least one other psychiatric hospitalization within the past 12 months. (This process requires approval from an Administrative Law Judge and can be approved voluntarily or involuntarily.)
      OR
    - had two inpatient psychiatric hospitalizations within the past 12 months and would like to enter the program voluntarily.
2. The patient has a demonstrated history of not engaging in available community treatment.
3. The patient is unlikely to seek and/or participate in community treatment upon discharge.

BHSB received federal funding from SAMHSA to implement a pilot OCC program in Baltimore City and secured funding through the BHA to continue the pilot once federal funding ended. 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), the Mental Health Association of Maryland (MHAMD) and other stakeholders.

Peer specialists work with the individual, family members, hospital treatment team and a community treatment provider of the individual's choice to develop consumer-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 conducts regular qualitative interviews with participants and relays feedback to project partners. A stakeholder group oversees project design and implementation, monitors project impact, and gathers lessons learned to inform how the pilot might best be expanded statewide in the future.

To date there have been 19 referrals and eight enrolled participants, with three participants being referred more than once to the program. OCC staff continues to build relationships with local hospitals that can refer individuals to the project. Additionally, due to the regulation changes addressing voluntary hospitalization, OCC staff has increased marketing of the program to include patients themselves as well as their loved ones.

Traumatic Brain Injury

BHSB contracts with Mary T Maryland to provide neuro-rehabilitative services for individuals with acquired brain injuries. Services include: residential supports that meet COMAR 10.21.05; behavioral management and consultation; cognitive rehabilitation; case management that assists with access to entitlements; coordination of rehabilitation, behavioral health and/or somatic care; habilitation/employment services and assistance that meets COMAR 10.09.46; and individual support services that meet COMAR 10.09.46. During FY 2019, five consumers were served, which met the annual target.

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.[5]

BHSB works closely with the Baltimore Police Department (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 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, in conjunction with the Collaborative Planning and Implementation Committee (CPIC), 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 assists individuals experiencing the crisis and their families, identifies resources, and ensures officers get the training and support needed to respond. BHSB employs a full-time program coordinator 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.

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 and

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

- link individuals with mental illness to treatment and resources in the community.

In FY 2019, seven training classes were held: four classes of new patrol officers, totaling 144 trainees, and three classes of experienced officers, patrol supervisors, Sheriff's deputies, and parole and probation agents, totaling 87 learners. The CIT Sub-Group of the larger CPIC met regularly to oversee the implementation of the project and plan for enhancements. In February 2019 the CIT Sub-Group became the Training and Implementation Subcommittee of the CPIC. The meetings were increased to bi-weekly (from monthly), and the mission was revised. The new mission is to create the four trainings required by the Consent Decree:

- Behavioral Health Awareness (Academy training),
- In-Service training (minimum of 8 hours of behavioral health training for all sworn officers in 2020),
- a training for 911 and BPD Dispatch, and
- a revision of the 40-hour advanced CIT training.

This mission includes developing the training goals, schedules, lesson plans, and subject matter experts to work with the BPD (particularly police instructors), as well as the collaboration with the DOJ and Monitoring Team. The first live Behavioral Health Awareness training is scheduled for January 22-24, 2020. Mental Health In-Service training for 2020 will consist of Mental Health First Aid, in partnership with the Mental Health Association of Maryland (with an additional two hours for BPD policy related to crisis intervention).

An outgrowth of the CIT program, the Crisis Response Team (CRT), also continued to operate. The CRT is a behavioral health unit within the BPD that consists of a specially trained CIT officer paired with a licensed behavioral health clinician to respond to 911 and other dispatch calls believed to be related to behavioral health crises. The team also provides support to officers responding to behavioral-health related calls across the city and provides outreach and follow-up support to individuals who have had prior contact with the police department and/or the behavioral health system.

After two years of funding from the Morton K. and Jane Blaustein and the Leonard and Helen R. Stulman Foundations to support the start-up and establishment of the CRT, ongoing funding has been secured from the BHA that will allow for the continued sustainability of this initiative. 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. Furthermore, CIT was responsible for a 9.2% reduction in citizen complaints against officers in the 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, as 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, peer support, and other services. LEAD has demonstrated that treatment and recovery support services improve health and reduce recidivism.

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 provided one additional year of funding thourgh FY 2019, and state funding has been secured to continue support of the project.

Through the end of FY 2019, LEAD received 265 referrals and served 109 participants.

Maryland Harm Reduction Training Institute

In collaboration with the MDH, BHSB launched the Maryland Harm Reduction Training Institute (MaHRTI) during the summer of 2018 to provide training, technical assistance, and leadership development to interested stakeholders throughout Maryland. MaHRTI develops and offers an

evolving, core set of trainings open to health, social service, and housing providers working with people who use drugs; responds to individualized requests based on local needs and capacity; and offers specialized training and development opportunities to key groups that are at the forefront of the harm reduction movement in Maryland. MaHRTI also provides training and leadership development support to community groups that center the wellness of people who use drugs and other directly impacted individuals.

MaHRTI has three primary goals:

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

During FY 2019, MaHRTI provided 35 trainings, resulting in 784 people trained. The third Syringe Services Program (SSP) training cohort was held, which serves as the educational foundation for newly formed SSPs in the state. MaHRTI also hired a Training Coordinator to work in tandem with the MaHRTI Manager to further develop, deliver, and coordinate statewide training and technical assistance needs.

Individuals who are deaf or hard of hearing

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 2019, 11 consumers were served in outpatient mental health treatment, 12 in PRP, 7 in RRP and 1 in SEP.

Pregnant women and women with children

BHSB is a partner in the Substance Exposed Newborn (SEN) Learning Collaborative, which is led by Baltimore City Department of Social Services. The purpose of the SEN Collaborative is to support and sustain cross-system collaboration to ensure the safety and wellbeing of substance-exposed newborns and their families. BHSB's role in the Collaborative is to:

- educate behavioral health providers on the substance exposed newborn statue § 5-704.2 Family Law Article;

- serve as a liaison between child welfare, Collaborative members, and substance use treatment providers;
- educate the Collaborative on the system of care to promote access to services;
- educate the Collaborative on relevant issues regarding behavioral health services for parents and family members;
- provide outreach and education to community residents, providers, child welfare agencies, and medical providers related to behavioral health services;
- serve as an expert on current and potential resources and best practices related to behavioral health services and building an effective local system of care; and
- provide non-identifying behavioral health data to the Collaborative as agreed.

System Partnerships to Advance Integrated Behavioral Health Services

BHSB works to strengthen the continuum of integrated behavioral health services and ensure access to these services through a broad range of collaborative partnerships, including state and city agencies, hospitals, behavioral health providers, people with lived experience and their families, the community, and other system stakeholders and advocates. It is through partnerships that BHSB will continue to expand access to high-quality care for residents of Baltimore City regardless of which door they enter for services.

Key State and City Partners

Some of BHSB's key state and city partners include: MDH, Department of Juvenile Services, Department of Public Safety and Correctional Systems, Health Services Cost Review Commission, Mayor's Office, Baltimore City Health Department (BCHD), Baltimore City Department of Social Services, Baltimore City Public Schools, Baltimore Police and Fire Departments and the District and Circuit Courts of Baltimore City. Examples of these partnerships are described throughout this report.

It is important to note the close collaboration between BHSB and the BCHD on a broad range of projects and initiatives. BCHD staff attends internal collaborative work groups at BHSB to ensure overlapping bodies of work are coordinated and impact is maximized, particularly in the priority work of overdose response. The Baltimore City Health Commissioner serves as the Chair of BHSB's Board of Directors.

Coalitions and Associations

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 active participation in multiple coalitions and statewide committees including, but not limited to the:

- Baltimore City Substance Abuse Directorate,
- BRIDGES Coalition,
- 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,
- Baltimore Harm Reduction Coalition,
- Maryland State Council on Child Abuse and Neglect, and
- MDH's Behavioral Health Advisory Council and its committees.

BHSB's CEO serves as co-chair of the Maryland Association of Behavioral Health Authorities (MABHA), which is the association that supports all LBHAs and meets monthly with MDH leadership. BHSB staff are active participants in MABHA sub-committees and serve as co-chair for the MABHA Child & Adolescent Sub-Committee. Furthermore, BHSB participates with the Maryland Philanthropy Network (MPN), attending meetings regularly, engaging in discussions regarding system needs and helping MPN plan for educational opportunities for the Health Funders committee to ensure that the voice of behavioral health and the importance of behavioral health integration is incorporated into its work. BHSB also attends Provider Council and Behavioral Health Advisory Council meetings.

Policy and Advocacy

BHSB 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. Through a collaborative stakeholder-informed process, BHSB develops policy priorities that outline the policy efforts for which BHSB will be advocating in the coming year. BHSB has a dedicated staff person 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 neighbor agreements.

BHSB is also actively involved in the state's planning efforts to restructure the system of care. This process involves a 12-member work group, of which BHSB's CEO is a member representing MABHA, and multiple stakeholder collaborative discussion groups in which BHSB regularly participates.

Provider Network

BHSB has a dedicated staff position to serve as the main point of contact for providers and assist with addressing questions, troubleshooting concerns and responding to stakeholder issues that arise. In addition, 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 Administrative Service Organization (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.

Individual service line meetings are held with the following groupings of providers: Psychiatric Rehabilitation Programs (PRP), Residential Rehabilitation Programs (RRP), Opioid Treatment Programs (OTPs), 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.

Hospitals

BHSB works closely with the Maryland Hospital Association and local hospitals to advance behavioral health and wellness. BHSB has been convening hospitals and local behavioral health authorities from Baltimore City, Baltimore County and Howard County in an effort to respond to the new approach from the HSCRC for the Regional Partnership Catalyst Grant Program. A priority for the HSCRC Regional Partnership is behavioral health crisis services. There is interest among these three jurisdictions to come together into one Regional Partnership. BHSB is supporting the process by convening monthly meetings and helping the group to identify consulting support.

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.

After piloting a Real Time Capacity Tool (RTCT) using Google apps from September 2017-May 2019, BHSB supported BCHD's launch of CHARMCare.org in May 2019. Like the RTCT, but more comprehensive, CHARMCare.org provides a no-cost platform for all types of health and human services providers to provide detailed information on their locations and services offered, as well as real-time capacity data. The publicly accessible platform also allows users to filter by different treatment preferences and eligibility criteria such as: type of insurance accepted, levels of care offered, populations served, and specialty services available. BHSB continues to partner with BCHD to plan improvements to CHARMCare.org, update provider information, and organize provider trainings.

Behavioral Health Service Needs

As described in *Section E. Planning Process*, the *Baltimore Public Behavioral Health System Gap Analysis* report was finalized in December 2019. It analyzes existing public behavioral health service systems to identify unmet needs, 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. The full report is published on the BPD's website (https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis). BHSB's activities to address system gaps are described throughout this report.

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 previously received from the ASO a regular list of adults (age 18 and older) who met an agreed-upon criteria for HIU. Although this practice has been discontinued, BHSB's clinical team continues to work to meet the needs of these individuals by developing direct relationships with the local hospitals and other community providers to serve as a resource for guidance and coordination for individuals who are not responding well to traditional interventions. 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. This also occasionally includes working in collaboration with the ASO's clinical staff. BHSB will be partnering with the new ASO to re-initiate the communication of consistent reports of HIU individuals.

ASAM Patient Placement Criteria Training

The BHA, in partnership with the American Society of Addiction Medicine (ASAM), offered free ASAM regional training in Maryland. The training included activities that support the development of the knowledge and skills required to implement the ASAM Criteria. BHSB had staff attend this training and encouraged providers to attend as well.

Safe, Stable and Affordable Housing

Safe, stable and affordable housing in a healthy neighborhood is a social determinant of behavioral health. BHSB works with partners to strengthen a range of housing interventions, including:

- providing supports people need to live independently in their homes through services such as older adults outreach and Assertive Community Treatment;
- improving habitability and affordability of the city's housing stock through advocacy and by administering grants and partnering and writing letters of support on grant applications, including several MDH community bond applications;
- strengthening healthy, resilient neighborhoods through prevention work;
- preventing people from entering homelessness through crisis intervention and effective discharge planning; and
- making homelessness rare and brief.

As discussed in the *Baltimore City Demographics and Social Determinants* subsection of *Section H. Data* of this report, among unsheltered persons surveyed in Baltimore City, 40% were self-reported to have a mental illness, and 42% self-reported substance use issues.[6] 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 Crisis Response System Workgroup, which is planned to convene in late 2019 and will oversee ongoing development of the homeless services system's access points and screening, assessment, and intake processes (collectively known as "Coordinated Access"),
- supports cross-system coordination at CoC outreach meetings and community meetings to address outreach needs.

BHSB directly administers two CoC grants, Safe Haven and Street Outreach, and provides technical assistance to ensure these projects are accessible, low barrier services. The goal for both projects is to transition people into permanent housing as quickly as possible. In addition,

[6] 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

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.

As described in the *Section E. Planning Process* of this report, BHSB combined outreach grants to create an interdisciplinary street outreach program that is highly responsive and provides comprehensive care to persons who are not well served by the traditional system. The combined street outreach program was officially implemented on July 1, 2019 following a competitive RFP process and an in-depth outreach implementation plan. 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.

Office-Based Buprenorphine

The *Medication Assisted Treatment (MAT)* subsection of *Section F. Service Delivery and Recovery Supports* provides detailed information about BHSB's initiatives to expand access to buprenorphine.

Co-occurring Disorders

Behavioral health system integration is a policy imperative set by the General Assembly in the 2017 Maryland state budget. Since then, the BHA has been working to develop infrastructure and processes to support continued integration, using a framework of shared accountability between the BHA and local jurisdictions. While BHSB was created in 2013 through the merger of the city's Core Service Agency and Local Addictions Authority, integration has been an ongoing process.

BHSB's organizational structure supports a fully integrated approach to its role of system oversight. Staff at all levels and across all departments are expected to make decisions that support integration within the scope of their role and assigned areas of responsibility. While separate funding streams for mental health and substance use disorders at the federal and state levels make it difficult to fully integrate service delivery at the consumer and community level, BHSB uses its role to advance an integrated approach to the work.

For example, BHSB convenes regular service line meetings with outpatient clinic and school-based providers in which mental health and substance use disorder programs are grouped together. 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.

As discussed in multiple sections of this report, BHSB expends significant staff resources overseeing the existing crisis response system. While funding for specific crisis services is generally specific to mental health or substance use disorders, BHSB works with providers to ensure that the full range of consumers' needs are met. The crisis response system planning described in *Section E. Planning Process* was done in an integrated way.

As described in *Section E. FY 2019 Highlights and Achievements*, BHSB oversaw the completion of the *Baltimore Public Behavioral Health System Gap Analysis report* in December 2019. It analyzes 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. The analysis is integrated across mental health and substance use disorders.

As reported in *Section H. Data* of this report, the ASO collects behavioral health services utilization for Maryland's fee-for-service PBHS. However, the data for mental health and substance use disorders is collected and reported separately. BHSB's data team has built the capacity to analyze the claims data to identify unique individuals served by both systems and analyze expenditures accordingly.

Crisis Response and Diversion Activities

BHSB expends significant staff resources to oversee the existing crisis response system, identify gaps, and collaborate with state and local partners to develop innovative strategies to increase access. This work is described in detail throughout this document.

Problem Gambling

The Crisis, Information and Referral line connects individuals with problem gambling to services. In addition, Maryland Coalition of Families (MCF) operates a "warm line" in partnership with the Maryland Center for Excellence on Problem Gambling to assist in connecting individuals and loved ones impacted by problem gambling with services. MCF also provides one-to-one support through a Family Peer Support Specialist. Family Peer Support Specialists are spouses, siblings, parents or other loved ones of someone with gambling issues who has been trained to help other families and can help them access services.

During FY 2019, 34 individuals received problem gambling services from a total of 11 treatment providers, with a total of $19,902 expenditures.

Tobacco/Nicotine 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 cessation of tobacco and nicotine use 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 approaches to reduce tobacco and nicotine use, including vaping.

Peer Recovery Specialists and Certified Peer Recovery Specialists

Peer Recovery Specialists ("peers") use their personal experiences of recovery from trauma, substance use, or mental illness to help others make their own journey to recovery. Peers' personal experiences make 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.

Providers and other partners throughout Baltimore City's system of care employ peers in various roles and settings, including:

- Assertive Community Treatment,
- Capitation Project,
- Opioid Crisis Services,
- Housing First projects,
- Hub and Spoke project,
- Outpatient Civil Commitment,
- Drug Treatment Court,
- Family navigation,
- Overdose education and naloxone distribution,
- Street 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 consumers in the Law Enforcement Assisted Diversion and Outpatient Civil Commitment programs and
- 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 support, peer-led groups (e.g. SMART Recovery®, Alcoholics Anonymous, and Narcotics Anonymous), 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. (In this document and in public materials, BHSB uses the term "Wellness and Recovery Centers" to include Recovery Community Centers in an effort to promote integration. We note this here to prevent confusion because BHA uses the term "Recovery Community Centers" to distinguish those that are supported with SUD funds.)

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 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 743 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 2019, Baltimore City residents visited Wellness and Recovery Centers 99,710 times. The Centers provided 7,612 one-on-one peer support sessions, over 10,000 group support sessions, and placed 200 persons in jobs. In addition, over 1,000 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 Interdisciplinary Outreach Team, which includes peer recovery specialists. One effort 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. In FY 2019, 3,040 individuals were contacted during overdose spike alert outreach. Of those contacts, 690 resulted in ongoing peer service enrollment, and 380 individuals were enrolled

and admitted to treatment. 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.

Another effort pairs outreach workers 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. In FY 2019, peers directly served 64 individuals while working on the mobile buprenorphine van.

Public Awareness Education

BHSB uses communications strategies to advance best practices and policy reforms, promote access to the system of care, and mobilize community action, all while solidifying BHSB as a leader in the system of care by adhering to consistently branded communications. BHSB has built strong relationships with media outlets and communities using traditional, social, and earned media and paid advertising, and has developed targeted campaigns to educate the public on service availability and the impact of stigma.

BHSB regularly promotes the Crisis, Information and Referral 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. These materials are also printed in Spanish. 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. To better promote the hotline, BHSB conducted market research to determine what messaging, imagery, and methods would be more effective to market the hotline in Baltimore City. As a result, BHSB will be revising its hotline marketing materials.

BHSB leads community art projects and storytelling events to promote recovery in recognition of recovery month and other milestones throughout the year and also participated in several community-wide events that raised awareness of behavioral health issues and addressed stigma. Specific activities include:

- *Stoop Storytelling* event in May 2019. BHSB partnered with NAMI Metro to organize a storytelling event with seven storytellers who each had seven minutes to share their personal story of recovery and resilience.
- In September 2019, BHSB partnered with the Baltimore Harm Reduction Coalition, the BRIDGES Coalition, and IBR/REACH to host a panel discussion on harm reduction, overdose prevention sites, and recovery.

- In September 2019, BHSB organized a community storytelling event at Druid Hill Park in recognition of National Recovery Month. During the event people shared their stories with peers and advocates for behavioral health and wellness.
- In December 2019, BHSB's Annual Gathering, *The Power of Resilience and Recovery*, was moderated by WBAL's Jason Newton and featured three inspiring personal stories from individuals who use experience, strength and hope to promote resilience and recovery.
- BHSB created a "Stories of Hope" section of its website to share stories of people, providers, families, and communities that are helped by the system of care in Baltimore City.

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

- Mental Health Association of Maryland provides children's mental health information and campaign materials for the *Children's Mental Health Matters* campaign, 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.
- National Alliance on Mental Illness (local and state chapters) provides family support trainings and workshops on mental health topics and coordinates the annual NAMI Walk, a public education event that promotes awareness of mental illness.
- Maryland Coalition of Families 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 participates in health fairs and provides education to families on the Good Samaritan Law and children's mental health information, as well as campaign materials for Children's Mental Health Matters.
- 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.

Culturally and Linguistically Responsive Services

The U.S. Department of Health and Human Services developed the National Culturally and Linguistically Appropriate Services (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.

To advance organizational and system-level capacity to provide culturally and linguistically appropriate services, BHSB completed a CLAS Standards Self-Assessment and developed strategies to advance this work during FY 2021. The self-assessment and Cultural and Linguistic Competency Strategies are attached as Addendum C.

BHSB participates in several initiatives to advance culturally and linguistically responsive services. As described in *Section E. Planning Process* of this report, BHSB participates in the Language Access Task Force to collaborate with other stakeholders to address the barriers for individuals with limited English proficiency (LEP) to receive equitable services in the city.

In addition, BHSB sponsors a *Sexuality and Gender Training Program*. This program began in FY 2018, when BHSB received funding from the BCHD's Sexually Transmitted Diseases (STD)/HIV Prevention Program to train and provide technical assistance to eight behavioral health programs to build capacity to engage and serve people of all genders and sexual orientations in a culturally competent and affirming manner. The FY 2018 providers successfully revised organizational policies, refreshed program environments and enhanced clinical services to be more inclusive and welcoming. In FY 2020, BCHD awarded funding to BHSB to sponsor training and technical assistance for eight additional providers. In January 2020, selected providers will participate in a kick-off one-day training, after which each provider will receive five two-hour, on-site technical assistance meetings.

<u>Promotion of Evidence-Based Practices</u>

A high-quality behavioral health system is one in which the ever-expanding knowledge base derived from research is rapidly integrated into practice. In a city such as Baltimore, in which health indicators suggest that residents experience a significantly greater burden of illness, behavioral health conditions, disabilities, and mortality than other jurisdictions, this is an urgent need. It is also important to understand and address the racial disparities that exist in establishing an evidence base for effective treatment approaches, as will be discussed in the *Research and Racial and Ethnic Equity Lens* section below.

BHSB supports the integration of a broad array of evidence-informed practices across the PBHS in Baltimore City. Some of these are described in the following sections.

Children & Adolescents

Various behavioral health providers in Baltimore City serving children, adolescents, young adults and families utilize evidence-based and evidence-informed practices during their daily interactions. BHSB also supports the integration of such practices through various contracts. Among some of the practices utilized by contracted sub-vendors are the following:

- Botvin LifeSkills Training (School-Based SUD and MH)
- Chicago Parent Program (CPP) (School-Based MH)
- Circle of Security (Various Providers)
- Conscious Discipline (Early Childhood Mental Health Program)
- Facilitating Attuned Interactions (FAN) (Kennedy Krieger Institute, PACT)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (School-Based MH)
- Maryland TAY Model (Harbor City Unlimited/Empowering Minds Resource Center)
- Mental Health First Aid (Various Providers)
- Mindful Awareness Play (Kennedy Krieger Institute, PACT)
- Motivational Interviewing (Various Providers)
- Roberts' Seven Stage Crisis Intervention Model (BCARS)

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a multi-disciplinary intensive, integrated approach to community mental health service delivery. Mental health services are provided to the individual in the community and address a number of issues, including homelessness and reducing unnecessary hospital stays. The mission of ACT is to help people become independent and integrate into their community as they experience recovery. ACT teams work together to provide mental health, substance use, housing, employment, medical, and legal support. There are currently seven ACT teams in Baltimore City that serve an average of 100 consumers each.

Hub and Spokes

As described in *Section F. Service Delivery and Recovery Supports*, the *Hub and Spoke* model was developed in Vermont based on chronic disease management principles. Individuals with opioid use disorders can initiate treatment at the *Hub*, which then collaborates with other providers and systems (the *Spokes*) to coordinate care, particularly for people at high risk of negative outcomes including overdose. There are two *Hubs* operating in Baltimore City.

Crisis Now

Crisis Now is a model to provide to safe, effective crisis care that diverts people in distress from emergency department and jail by developing a continuum of crisis care services that matches people's clinical needs. This reduces and prevents suicides while providing more immediate and

targeted help for a person in distress. It also cuts the costs of services by reducing the need for psychiatric hospital beds, emergency department visits, and law enforcement response.

The model identifies core elements of crisis care, which include:

- regional or statewide crisis call centers coordinating in real time,
- centrally deployed, 24/7 mobile crisis,
- short-term, "sub-acute" residential crisis stabilization programs and
- essential crisis care principles and practices.

BHSB is collaborating with hospitals, other local behavioral health authorities, and local police departments from Baltimore City, Baltimore County and Howard County, and The Horizon Foundation to begin planning for how to work together to strengthen and expand behavioral health crisis services by implementing the *Crisis Now* model.

NEAR science

The 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, food insecurity, food deserts, 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 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

[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

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.

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, and
- collaborate with providers to support, reinforce and build upon resilience in the individuals, families and communities we collectively serve.

During FY 2019, BHSB offered an array of training and professional development opportunities for behavioral health providers, including:

- *Healing and Resilience: The Journey Forward Conference*, a full-day conference to 1) increase ability to recognize when trauma is creating dysregulation, chaos and interpersonal suffering, 2) increase understanding of the similarities between the impact of trauma and substance use on the brain, 3) develop skills that promote healing and wellness for professionals and consumers, and 4) increase capacity to connect using stories of strength and adversity that support movement from trauma to healing.
- *Seeking Safety*, an evidence-based, present-focused therapy model that assists people to attain safety from trauma and/or substance use.
- *Trauma-Informed Supervision*, two full-day trainings to improve clinical outcomes by integrating the science of ACEs, neurobiology and resilience into supervision.
- *A Brain-Based Approach to Working with Complex Trauma*, a full-day training to 1) understand the importance of integrating the science of ACEs, neurobiology and resilience in order to improve clinical outcomes, 2) increase capacity to provide services in a manner that is trauma-informed, and 3) interpret the necessary application of brain-based treatment approaches and develop practical skills through various holistic models.

In addition, BHSB facilitates *B-More Resilient*, which is a network that aims to support transformative change in Baltimore City by increasing understanding of trauma and knowledge of practices that promote healing and resilience. The group gathers stakeholders, providers, individuals and community members that are committed to this work to engage in open discussion, trainings, sharing of resources and supportive collaboration. Monthly topics have included: Adverse Childhood Experiences (ACEs), poverty, community violence, immigration, mindfulness and healing. This collaboration aims to shift perspectives, increase trauma-informed practices and bolster the pervasiveness of individual, community and system-wide resilience in this city.

Motivational Interviewing

From April 2019 - September 2019, BHSB collaborated with the Danya Institute to hold six motivational interviewing (MI) trainings for 169 behavioral health practitioners and peer specialists. There were three levels of training, including three introductory MI trainings, two intermediate MI trainings, and one advanced MI training. Post-training evaluations showed 98% of attendees "strongly agreed" or "agreed" that training objectives were met, training was relevant and useful, and the presenter was knowledgeable and well-prepared. Danya is considering offering in-depth MI technical assistance for ten programs that participated in the previous training if funding and resources become available.

S.E.L.F. Community Conversations

S.E.L.F. Community Conversations evolved from The Sanctuary Model®. It is an evidence-supported model of culturally appropriate exercises and templates for facilitating conversations among small groups or in larger community contexts. The goal of S.E.L.F. (Safety, Emotions, Loss, and Future) 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 model 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 2019, BHSB provided five *S.E.L.F. Community Conversations* trainings and five ongoing, weekly coaching sessions to support community-based organizations that are implementing the model to promote resilience and recovery.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

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 in Maryland to systemically implement SBIRT and served as the project lead for 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 394,611 individuals from April 2015 to June 2019.

SBIRT provides prevention and early intervention using 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. By June 2019, BHSB's efforts, through multiple SBIRT funding sources, expanded to include 61 organizations with 155 sites in 19 Maryland jurisdictions, including:

- Ten Federally Qualified Health Center (FQHC) organizations with 42 sites
- One non-FQHC primary health care organization
- 28 unique hospitals with:
  - 11 hospital primary care centers with 27 sites
  - 24 hospital emergency departments with 25 sites
  - Five hospital obstetrics units
  - Six hospital-affiliated obstetrics/gynecology practices with 12 sites
  - Two hospital pediatrics clinics
- Four local health department family planning clinics with seven sites
- Two large pediatric practices with four sites
- Five county school systems with 17 schools
- Three college/universities
- One mental health/family support organization with three sites
- Seven county detention centers with seven sites

In FY 2020, BHSB continues to fund Peer Recovery Specialists to delivery SBIRT services at four hospital emergency departments in Baltimore City: Bon Secours Hospital, Mercy Medical Center, Harbor Hospital, and University of Maryland.

Project Towards No Drug Abuse

Project Towards No Drug Abuse (Project TND) is being implemented as one of BHSB's prevention strategies. It is a drug abuse prevention program that targets high school-aged youth and can be implemented in classrooms or community settings. Project TND is designed to stop or reduce the use of cigarettes, alcohol, marijuana, and other drugs. It teaches behavioral and coping skills and enables the student to state accurate information about environmental, social, psychological and emotional consequences of drug use and misuse.

Communities That Care

Communities That Care (CTC) is being implemented as another of BHSB's prevention strategies. It is a prevention system grounded in science that gives communities the tools to address their adolescent health and behavior problems through a focus on risk and protective factors. CTC provides a structure to engage community stakeholders, a process to establish a shared community vision, tools to assess levels of risk and protective factors, and a process to set specific, measurable community goals.

Evidence-based Practices: A Racial and Ethnic Equity Lens

As noted above, a high-quality behavioral health system is one in which the ever-expanding knowledge base derived from research is rapidly integrated into practice. However, a substantive evidence base establishing effective treatment approaches does not exist for the majority of Baltimore's residents. Baltimore City's population is 62% Black, and research specific to effective mental health treatment for Blacks is severely lacking. Most prevention and treatment interventions have been tested in majority white populations and have either not included an adequately-sized sample of Blacks to develop evidence for this population or have not analyzed outcomes across racial groups.[9] Studies proposed by Black scientists are also less likely to be funded than those proposed by white researchers. Furthermore, health disparities research projects, which are more often proposed by Black scientists, are among those least frequently funded.[10]

In addition, mistrust of health care providers and stigma in regard to mental health conditions among Blacks are significant barriers to accessing behavioral health services. Evidence-based practices that have been tested in majority white populations may not be effective in addressing these barriers.

Embedding a racial and ethnic equity lens into how research is conducted and integrated into practice requires authentic partnerships with community-based organizations that facilitate collaborative exchange and ongoing learning. Such partnerships open up opportunities to conduct research that aligns with guiding principles such as those put forth by Child Trends[11]:

1. Examine backgrounds and biases.
2. Commit to dig deeper into the data.
3. Recognize that the research process itself has an impact on communities, and researchers have a role in ensuring research benefits communities.
4. Engage communities as partners in research.
5. Guard against the implied or explicit assumption that white is the normative, standard, or default position.

<u>Prevention</u>

[9] *The Crisis of Black Youth Suicide in America*. A Report to Congress from The Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health, p. 20-21. https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

[10] *The Crisis of Black Youth Suicide in America*. A Report to Congress from The Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health, p. 6. https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

[11] Kristine Andrews, Jenita Parekh, and Shantai Peckoo, *How to Embed a Racial and Ethnic Equity Perspective in Research*, A Child Trends Working Paper (2019). https://www.childtrends.org/wp-content/uploads/2019/09/RacialEthnicEquityPerspective_ChildTrends_October2019.pdf

The majority of prevention funding allocated to Baltimore City is focused on preventing substance use disorders. While BHSB adheres to the requirements of each funding source, it also works to align strategies to promote an integrated behavioral health and wellness prevention strategy that prevents and mitigates the impact of ACEs, trauma, systemic racism, violence and other adverse community events.

Effective February 4, 2019, MDH reassigned oversight of multiple prevention and health promotion programs to the Office of Population Health Improvement (OPHI) in MDH's Public Health Services (PHS) division. To streamline administrative processes, OPHI merged the previously separate annual funding processes for the Prevention Services, Opioid Misuse Prevention Program (OMPP) and Strategic Prevention Framework Partnerships for Success (SPF-PFS) programs into a single application process.

Prevention Services

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 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.

The focus population is youth and young adults ages 12-24 years old and opportunity youth (defined as people between the ages of 16 and 24 who are not in school and not employed) who may have experienced some ACEs. 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: marijuana, alcohol and non-medical use of prescription drugs (NMUPD).

There are two main strategies to connect with young people: 1) School-Based Approach and 2) Community-Based Approach.

1. School-Based Approach

   The intervention identified for implementation in school settings is *Project Towards No Drug Abuse (Project TND)*. It is an effective drug abuse prevention program that targets high school-aged youth and can be implemented in classrooms or community settings. *Project TND* is designed to stop or reduce the use of cigarettes, alcohol, marijuana, and other drugs. It teaches behavioral and coping skills and enables the student to state

accurate information about environmental, social, psychological and emotional consequences of drug use and misuse. In addition to *Project TND*, selected applicants are required to implement job readiness, mentoring, workforce development, and/or prevention opportunities for participating youth. The goal of this strategy is to enhance soft skills, academic aspirations, social engagement, and school attendance. This work is done in collaboration with Baltimore City Public Schools (City Schools), and through this partnership, City Schools selects the schools to participate in this project.

2. Community-Based Approach

   The intervention identified for implementation in community settings is *Communities That Care (CTC)*, a prevention system grounded in science that gives communities the tools to address their adolescent health and behavior problems through a focus on risk and protective factors. *CTC* provides a structure to engage community stakeholders, a process to establish a shared community vision, tools to assess levels of risk and protective factors, and a process to set specific, measurable community goals.

   The community-based strategy offers a unique opportunity for innovative practices. Selected applicants provide a range of activities, such as arts and cultural enrichment, sports and fitness, mentorship, mindfulness, college and career readiness, and life skills, that foster positive youth engagement and promote optimal behavioral health and well-being for youth and their families.

BHSB released a competitive procurement during FY 2019 that resulted in the selection of three community-based organizations to provide services. Project TND was implemented in nine schools, and CTC in six communities. In June 2019, another competitive procurement was released seeking additional service providers to embed these two interventions into the places where young people naturally congregate, including schools and educational settings, extra-curricular and workforce readiness programs, summer camps, and other youth development opportunities. The scope of services changed to reflect ongoing learning from the initial implementation.

During the first half of FY 2020, BHSB staff began engaging with community leaders and stakeholders, neighborhood associations, youth-serving organizations, community members and youth to build capacity for implementing CTC in the designated area. Outreach to engage youth was conducted in a broad array of settings, including seven City Schools, the University of Maryland, Morgan State University, youth townhall meetings, Baltimore City Recreation and Parks activities, and BHSB-sponsored community conversations and focus groups.

Beginning in January 2020, an additional 15 community-based organizations were selected to implement the revised scope of services. In January these organizations began introducing the strategies to schools and communities and holding kick off events to enroll participants.

Strategic Prevention Framework Partnerships for Success (SPF-PFS)

BHSB is continuing implementation of the SPF-PFS project, which focuses on the reduction of underage and binge drinking among adolescents and young adults, ages 12-24, with four key strategies:

1. regulating alcohol outlet density through licensing,
2. supporting the city-wide initiative on alcohol outlet density through policy change,
3. conducting compliance checks (underage and over-service compliance) and issuing alcohol citations to retailers and
4. advancing community-based processes to support media, advocacy and capacity-building.

During 2019 BHSB monitored Baltimore City's Board of Liquor License Commissioners for violations involving alcohol outlets within the designated catchment area and attended a total of 22 hearings. A citation was issued to Eric 500, which resulted in permanent closure of the outlet.

BHSB also facilitated two coalition meetings and attended five community meetings to advance community mobilizing and leverage relationships with and resources of partners and other stakeholders. Four TIPS (Training for Intervention ProcedureS) trainings were held, with a total of 45 attendees. TIPS is a skills-based, alcohol training and certification program that is designed to prevent intoxication, underage drinking, and intoxicated driving.

During FY 2020, BHSB continues to leverage partnerships with community organizations that have shared goals, as well as developing a new partnership with City Schools. One TIPS training was conducted thus far, with a total of 8 attendees, and monitoring of the Board of Liquor License Commissioners continues.

Opioid Misuse Prevention Program (OMPP)

During FY 2020 BHSB is continuing implementation of OMPP, focusing on two key strategies:

1. refusal of transport to the hospital after a non-fatal overdose and
2. community-based opioid prevention.

BHSB partners with City Schools, the Baltimore Police Department (BPD) and Baltimore City Fire Department (BCFD) to advance the OMPP strategies. *Operation Prevention*, which is a national educational program developed by the U.S. Drug Enforcement Administration (DEA) and

Discovery Education to prevent opioid misuse among elementary, middle, and high school students, is being used in school settings. Kick off events were held in several schools during American Education Week, and BHSB promotes prevention activities and resources during community events sponsored by City Schools. BHSB partners with BPD and BCFD to address the secondary trauma of first responders by providing self-care kits, resources and information.

G. Targeted Mental Health Case Management Capacity Analysis

Baltimore City is a community of resilient neighborhoods, families, adults and youth working to overcome barriers that have limited their access to opportunities to thrive. Through the provision of Targeted Mental Health Case Management (TCM) as a distinct and separate service that is part of Baltimore City's PBHS, we have an opportunity to shift the outcomes for individuals and families toward greater recovery, resilience and wellness.

The TCM service is available throughout the State of Maryland and in Baltimore City for adults, adolescents and children. TCM is reimbursable through the PBHS when an individual meets eligibility and medical necessity criteria. Adult TCM offers two levels of service, and Child and Adolescent TCM offers three. The level of service available for each individual is based on the severity of their needs.

Targeted Case Management for Children and Adolescents

TCM for children and adolescents utilizes a Care Coordination service delivery model premised on the individual strengths and needs of each child, adolescent, and family. Services are delivered through the work of a Child and Family Team (CFT) that is organized and coordinated by the case manager or care coordinator and comprised of formal and informal supports. The goals of this approach are to ensure caregivers and youth have access to the people and processes in which decisions are made about care and needed resources and services. The family's voice drives decisions that are made, and the plan belongs to the family in partnership with the team. TCM for youth is often referred to as Care Coordination, and providers are often referred to as Care Coordination Organizations (CCOs).

Utilization and Capacity Analysis

In FY 2019, as noted in Section H of this report, 2,043 youth across the state received TCM services, representing 2.6% of the total youth served in the PBHS. In comparison, 324 youth received TCM in Baltimore City in FY 2019, representing 1.80% of the total Baltimore City youth residents served through the PBHS.

During the last years, there has been an increasing trend in total youth served in Baltimore City. Claims data shows these total numbers to be:

- FY 2017 = 250
- FY 2018 = 293
- FY 2019 = 324

Currently, there are two TCM providers that serve children and adolescents in Baltimore City. One provider currently serves 165 youth, and a second provider serves eight youth. This represents a low point in recent enrollment. BHSB started the five-year contract span for youth TCM with four providers and higher capacity to serve eligible youth; however, two providers discontinued their youth TCM programs during this period.

As noted in Section H of this report, the prevalence of mental illness in the past year in Baltimore City was 17.8%, which was higher than the state rate of 16.7%. YRBSS data shows higher prevalence of mental health symptoms and risk factors among youth compared to state and national averages.

Based on this data, it appears that the overall need for mental health services in Baltimore City is higher than the need statewide and that this disparity exists among the city's youth. Despite an increase in overall number of youth served in recent years, TCM utilization data for Baltimore City indicates that a proportionately lower number of youth were served compared to statewide averages and compared to the need suggested by prevalence data. Furthermore, the number of providers and their current combined utilization do not appear to be sufficiently flexible to expand to meet the needs of youth in Baltimore City.

Strengths and Challenges

BHSB has demonstrated sustained commitment to supporting the implementation of the nationally recognized values and practices that are known to make care coordination for youth and families successful. Through our close partnership with BHA, training consultants, and local TCM/Care Coordination providers, BHSB has worked to ensure that jurisdictional implementation remains aligned with state priorities.

BHSB becomes involved in consultation regarding youth/family specific situations where needs are complex. In these instances, BHSB consistently prioritizes referral and enrollment in TCM/Care Coordination, as this service is well-positioned to coordinate multiple child-serving agencies to effectively address the needs of the youth and family. This approach is often applied for youth referred to residential treatment centers or upon discharge from inpatient psychiatric care. It is also frequently utilized with youth and families involved with the local Department of Social Services and Department of Juvenile Services, as quality Care Coordination is effective in sustaining family functioning and preventing out of home placement.

While BHSB has maintained its commitment to the values and practices of high-quality Care Coordination, the regulations governing the services are relatively new and evolving in Maryland. BHSB remains committed to continued partnership with stakeholders at the local and state levels to continue to maximize service effectiveness. It is also recognized that the significant growth in utilization in PRP services for youth has outpaced Care Coordination utilization, and there is need for further clarification on which service better meets individual youth and family needs and under what conditions.

Strategies to Increase Utilization and Capacity

BHSB is currently conducting a competitive procurement for Mental Health Case Management for Children and Adolescents. BHSB has concluded that there is a need to expand the availability of TCM for children and adolescents in the city. It is likely that a greater number of providers will be selected at the conclusion of the procurement, which will be based on the identified needs as described above, along with the provider estimates as to their capacity to serve individuals during the first and subsequent years of the contract. In addition, as it is expected that the 1915i Medicaid Waiver renewal will expand the population of children and adolescents in Baltimore City who are eligible for Care Coordination, BHSB has incorporated the need for additional capacity to accommodate this anticipated change.

BHSB recognizes Care Coordination can be instrumental in reducing unnecessary use of inpatient psychiatric care and residential treatment by creating and sustaining connections to ongoing resources and services youth need in the community. Section H of this report shows a modest increase in utilization of psychiatric inpatient care for Baltimore City youth, from 877 in FY 2018 to 888 youth in FY 2019. However, this represented an 18.7% increase in overall costs for this service. For residential treatment there was a more substantial increase in utilization for city youth, from 147 in FY 2018 to 196 youth in FY 2019, with a 41.7% increase in the cost of this service. BHSB intends to work in collaboration with CCOs, the community crisis response system, the ASO, local Emergency Departments and inpatient psychiatric units, and residential treatment centers to strengthen these relationships and maximize referral efficiency with the intent of increasing more effective service delivery and reducing unnecessary inpatient and residential utilization and costs. As the analysis indicates a need to serve more youth with unaddressed needs, BHSB will also work with current and future CCOs to improve publicity of the service and strengthen communication and collaborative partnerships between providers and stakeholders who serve populations likely to be eligible and in need of TCM.

The adult TCM section below outlines disparities in employment data and low Supported Employment Program (SEP) enrollment. It is likely that the population of youth who are 16 to 18 years old is similar. This presents an opportunity for TCM providers serving youth to

establish relationships with SEP providers and offer assistance to young people in connecting and maintaining their involvement in supported employment.

Furthermore, BHSB continues to conduct technical assistance to local Care Coordination providers to refine implementation of the nationally recognized values and practices of high-quality services, which would lead to more positive outcomes and increased interest in and utilization of the service.

Provider Selection

BHSB is nearing the close of the current competitive procurement for Mental Health Case Management for Children and Adolescents, but the final number of selected providers is yet to be determined. The anticipated service term following the close of the procurement will be March 1, 2020 – June 30, 2020, with options to renew annually for Fiscal Years 2021-2024. Selections and contracting will be conducted in such a manner as to ensure continuous availability of TCM for children and adolescents in Baltimore City both for existing recipients and newly referred individuals. The planned short duration of the first contract period is intended to align provider contracting with state fiscal years and has been previously approved by BHA.

Targeted Case Management for Adults

The purpose of TCM for adults is to assist participants in gaining access to services. TCM provides each consumer an assigned case manager, who is responsible for psychosocial assessment, coordination of care, and linkage to community resources such as mental health treatment, somatic care, housing, entitlements, substance use treatment, and educational and vocational supports. TCM serves individuals with:

- priority population diagnoses,
- risk of or who have experienced homelessness,
- risk of or who have a history of psychiatric hospitalization and
- risk of or who have experienced incarceration.

Utilization and Capacity Analysis

In FY 2019, as noted in Section H of this report, 4,538 adults across the state received TCM services, representing 3.1% of the total adults served in the PBHS. In comparison, 932 adults received TCM in Baltimore City in FY 2019, representing 2.3% of the total Baltimore City adult residents served through the PBHS. During the last five years, there has been a decreasing trend in total adults served in Baltimore City. Claims data shows these total numbers to be:

- FY 2015 = 1,390

- FY 2016 = 1,543
- FY 2017 = 981
- FY 2018 = 1,025
- FY 2019 = 932

Currently, there are six TCM providers that serve adults across Baltimore City. Each provider currently serves an average of 150 consumers, with individual case managers having 20 to 25 consumers on their caseload. Providers are required to maintain open enrollment and flexibility with respect to staffing and total individuals served in order to be responsive to the needs of the city.

As noted in Section H of this report, the prevalence of mental illness in the past year in Baltimore City was 17.8%, which was higher than the state rate of 16.7%. Outcomes Measurement System data from FY 2018 reflected that 16.5% of consumers in the city receiving outpatient services reported experiencing homelessness in the last six months, as compared to the state's 11.5%. Additionally, 3.7% of consumers served reported having been arrested in the last six months.

The most recent Baltimore City Point in Time count indicated that on a single night in January 2017, 2,669 persons were identified as living in transitional housing, unsheltered, or in an emergency shelter. The population that is identified as unsheltered comprises 20% of the population experiencing homelessness, with 40% self-reporting having a mental illness, and 42% self-reporting substance use issues.

Based on this data, it appears that the overall need for mental health services in Baltimore City is higher than the need statewide, suggesting that mental health service utilization would in turn be higher than statewide averages. However, actual TCM utilization data for Baltimore indicates that a proportionately lower number of adults were served compared to statewide averages, and the number served has declined over the past five years. This suggests that TCM is not currently meeting the needs of adults in Baltimore City.

Strengths and Challenges

The number of TCM providers in Baltimore City and the current capacity to serve almost 1,000 individuals is a significant strength. Because of this capacity, consumers have significant choice among providers and individual case managers, which makes it more likely that individuals will be able to find a good match to meet their personal situation and needs. However, given the concentrated population in the city, the associated complexity of needs, and the size and scope of the TCM services necessary to adequately address those needs, it is challenging to ensure adequate capacity and consistently high-quality service delivery.

TCM is available as a service separate from other PBHS services, which makes it highly adaptable to individual needs. For example, duration of enrollment varies anywhere between six months to six years. However, this variance creates a level of unpredictability for providers that makes it more challenging to manage capacity, staffing and caseload sizes, while also ensuring prompt responses to new referrals and tailoring training and supervision of staff to meet the needs of the population served.

Strategies to Increase Utilization and Capacity

BHSB is currently conducting a competitive procurement for Mental Health Case Management for Adults and has concluded that there is a need to expand the availability of TCM for adults in the city. It is likely that a greater number of providers will be selected at the conclusion of the procurement. The number will be based on the identified need as described above along with providers' estimates as to their capacity to serve individuals during the first and subsequent years of the contract.

Additionally, as the analysis has indicated a need to serve more people, as well as the unaddressed needs of those experiencing homelessness and criminal justice involvement, BHSB will work with current and future TCM providers to improve publicity of the service. BHSB will also support opportunities to strengthen communication and collaborative partnerships between providers and stakeholders that serve populations likely to be eligible for and in need of TCM, particularly those specific populations identified in the analysis.

TCM can be instrumental in reducing unnecessary use of inpatient psychiatric care and risk of readmission following an inpatient stay by creating and sustaining connections to ongoing, community-based resources and services. Section H of this reports shows a slight decline in utilization of psychiatric inpatient care from FY 2018 to FY 2019. BHSB intends to work in collaboration with TCM providers, the community crisis response system, the ASO, and local emergency departments and inpatient psychiatric units to strengthen these relationships and maximize referral efficiency to increase effective service delivery and reduce unnecessary psychiatric inpatient utilization and costs.

FY 2018 OMS data shows that of all adults participating in outpatient mental health services, 23.3% of city residents are employed, compared with 35.5% statewide. In addition, only 1.2% of city residents are served in Supported Employment Programs (SEP). In an effort to improve employment outcomes for adults experiencing serious mental illness in Baltimore City, BHSB and TCM programs will work together to strengthen relationships with outpatient mental health providers to increase referrals for those in need of TCM, and with SEP providers to increase referrals from TCM to SEP.

Provider Selection

BHSB is nearing the close of the current competitive procurement for Mental Health Case Management for Adults, but the final number of selected providers is yet to be determined. The anticipated service term following the close of the procurement will be March 1, 2020 – June 30, 2020, with options to renew annually for Fiscal Years 2021-2024. Selections and contracting will be conducted in such a manner as to ensure continuous availability of TCM for adults in Baltimore City both for existing recipients and newly referred individuals. The planned short duration of the first contract period is intended to align provider contracting with state fiscal years and has been previously approved by BHA.

H. Data

The *Data* section of this report includes three subsections that describe Baltimore City's demographics and social determinants, behavioral health indicators, and utilization of the public behavioral health system (PBHS).

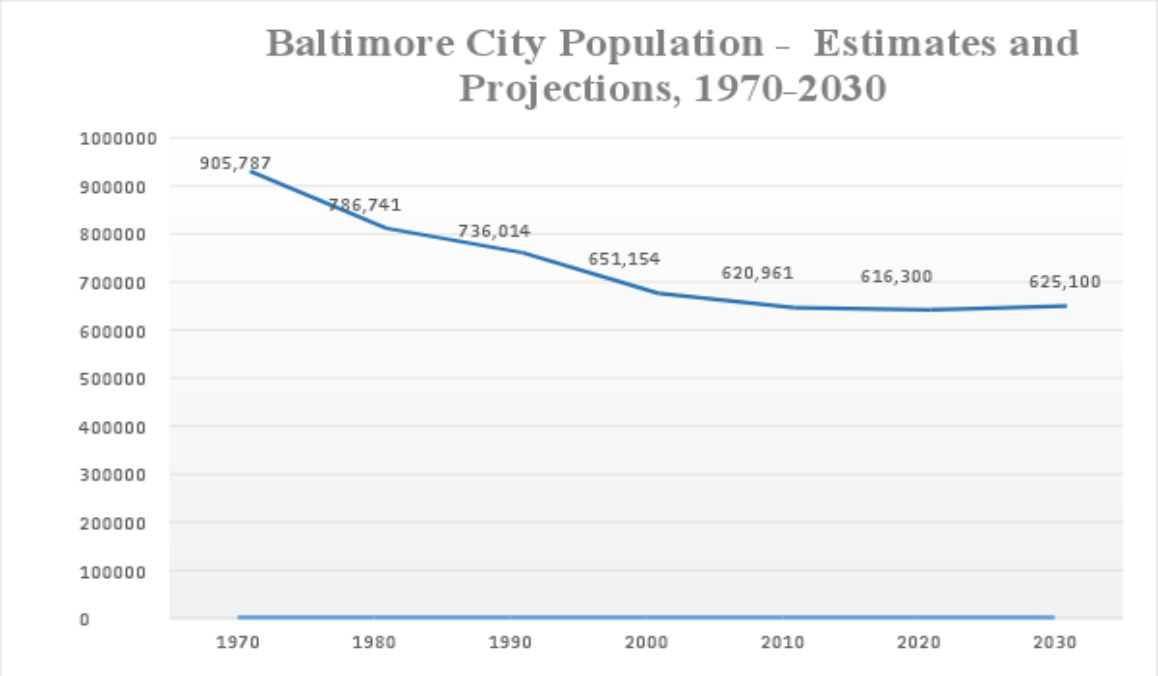
1. Baltimore City Demographics and Social Determinants of Health

The demographics and social determinants section of this report 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.[12]

Population

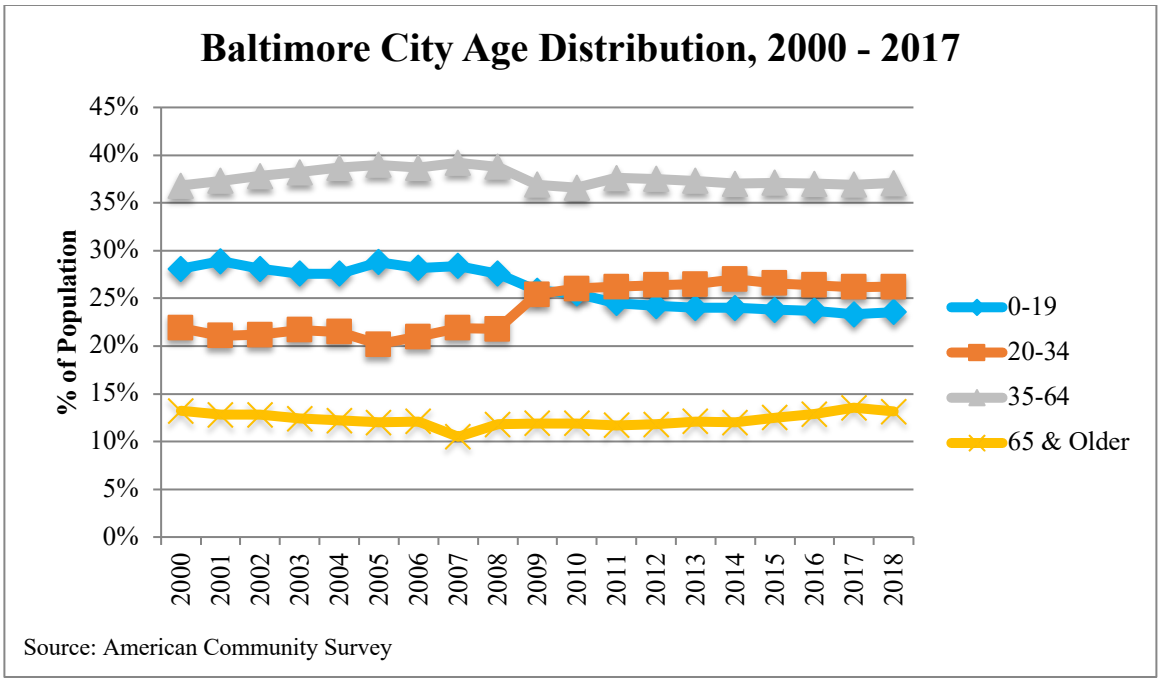
Baltimore City is the 30th most populous city in the nation and the largest city in Maryland, comprising 10.2% of the state's population in 2018, with approximately 614,700 people based on American Community Survey (ACS) estimates. Although census data indicate that the city's population has decreased significantly since the 1970s, the Maryland Department of Planning projects an increase of 10,000 people (0.6% growth) by 2030.

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



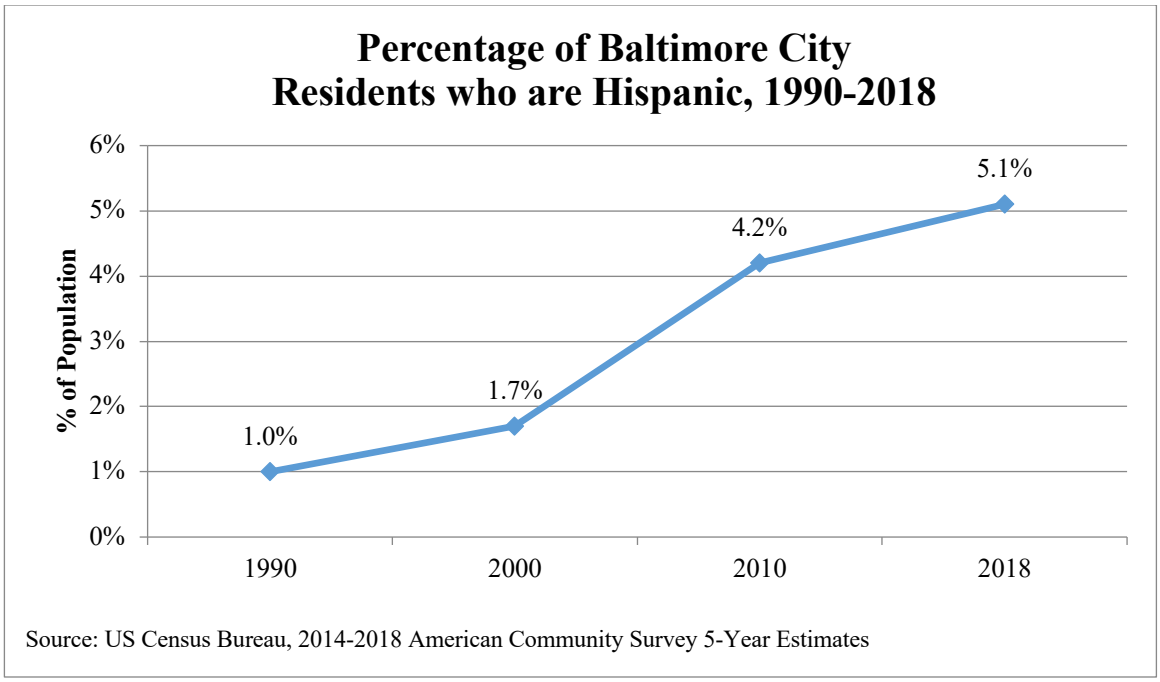
Source: Maryland Department of Planning - August 2017

As evidenced by the chart below, the age distribution has shifted slightly in the last eight years. Between 2010 and 2018, the population aged 65+ experienced an increase, while the remaining age groups experienced a stable line or slight decrease. In 2018, there were an estimated 128,219 children under the age of 18 and 486,481 adults in Baltimore City. Overall, the median age in Baltimore City was around 35.1 during 2018, whereas the median age in the state is 38.6 years. The distribution by gender was 47.0% (male) and 53.0% (female).

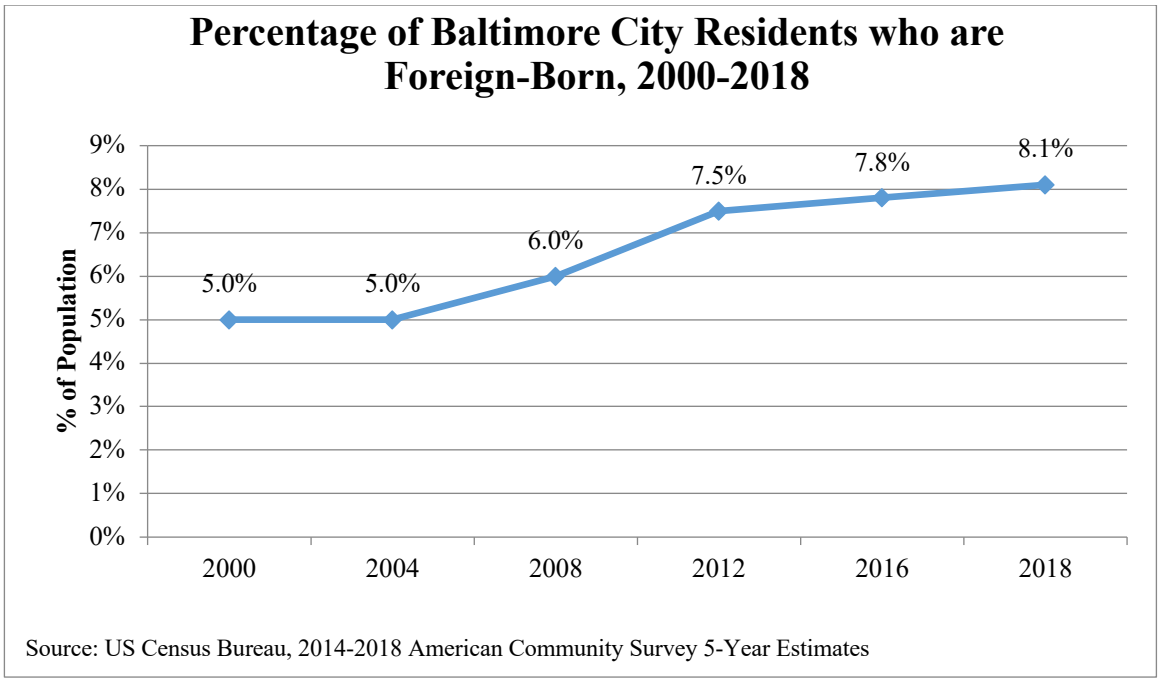


The city's racial/ethnic distribution is bimodal, with 61.9% non-Hispanic Black individuals and 27.5% non-Hispanic white individuals. The remaining 10.6% is comprised of Hispanic, Asian and other race or ethnicity, which includes Native American or Alaskan Native, Native Hawaiian and other Pacific Islander, two or more races, and other race.

The population is slowly becoming more diverse, as indicated by an 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.

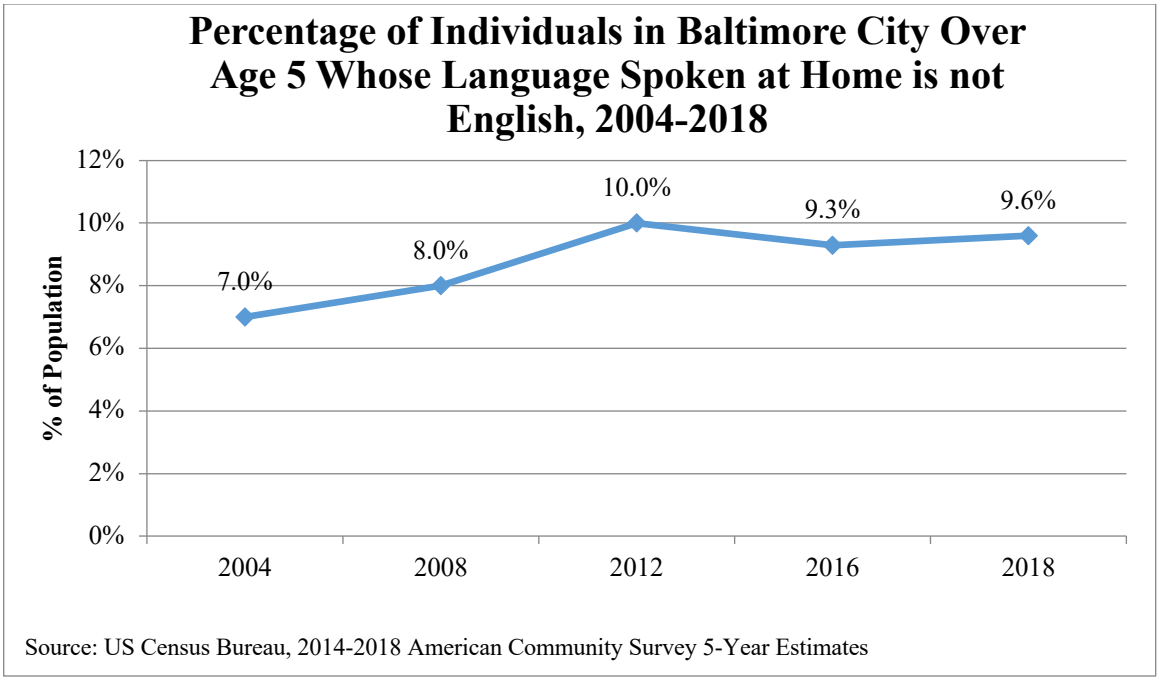


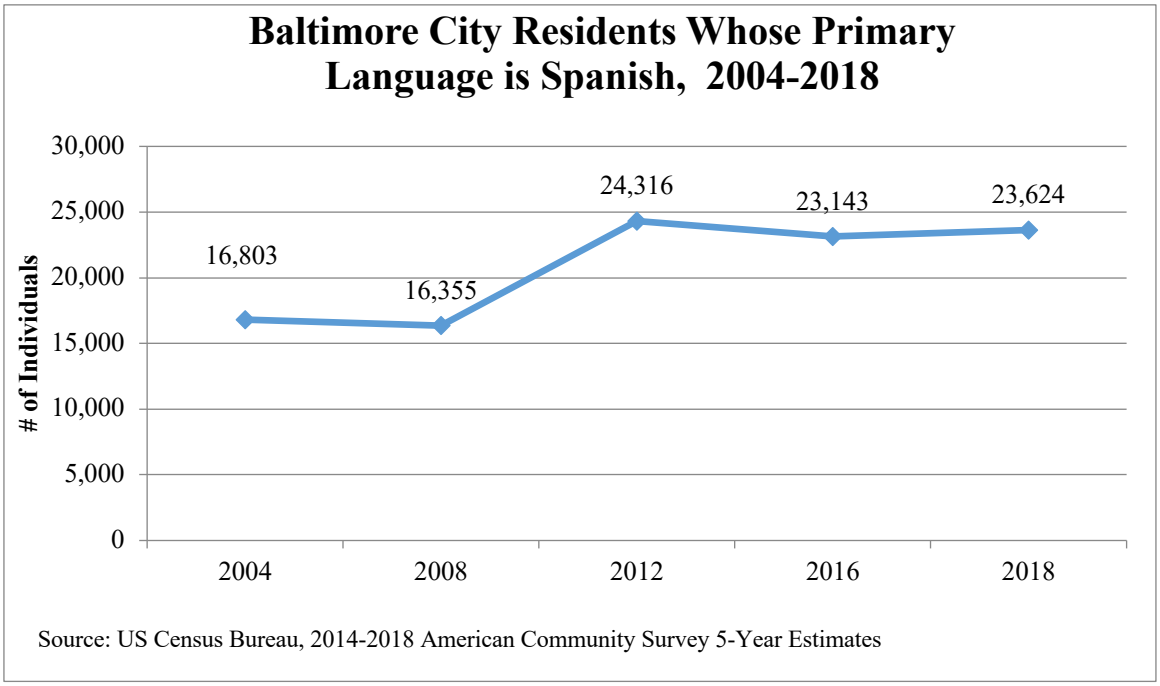
Source: US Census Bureau, 2014-2018 American Community Survey 5-Year Estimates



Source: US Census Bureau, 2014-2018 American Community Survey 5-Year Estimates

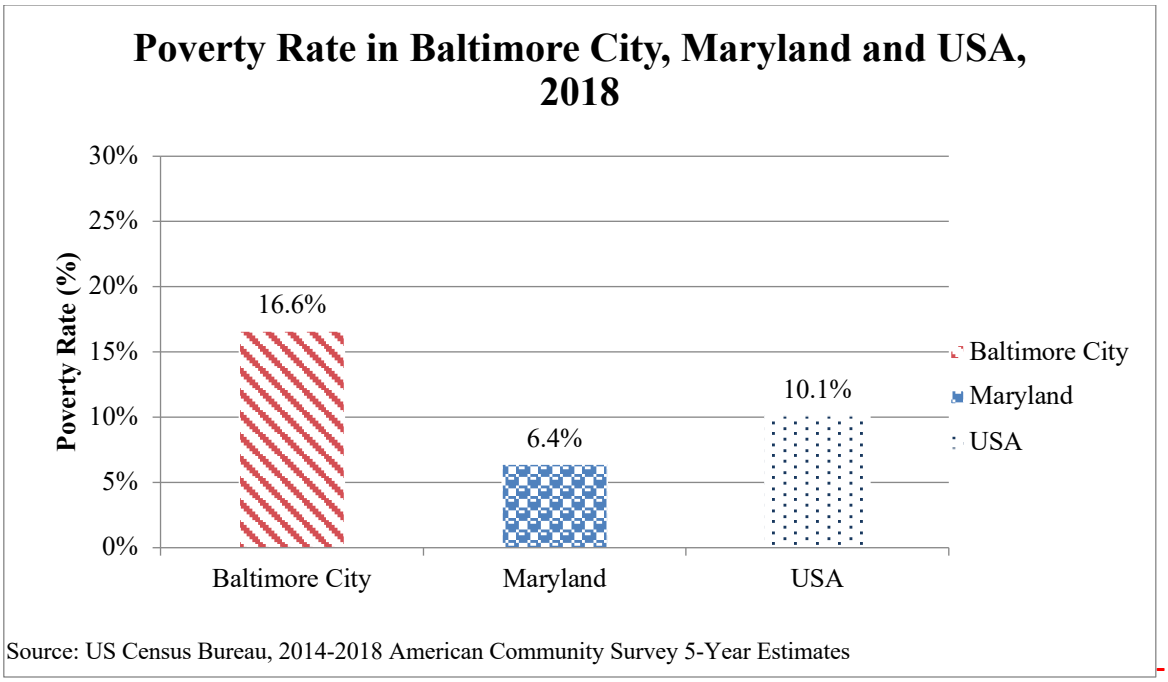
Languages other than English were spoken in 9.6% of households in 2018, with Spanish being the most frequently spoken non-English language. Between 2004 and 2018, the number of individuals whose language spoken at home is Spanish increased by 40.6%.



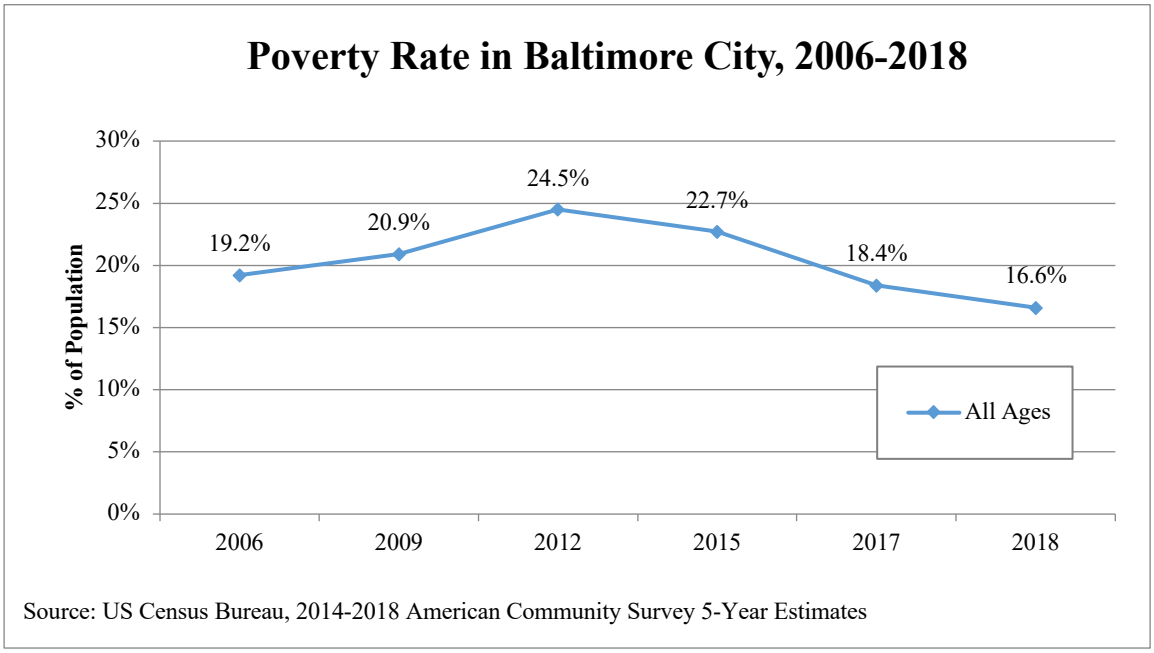


Poverty

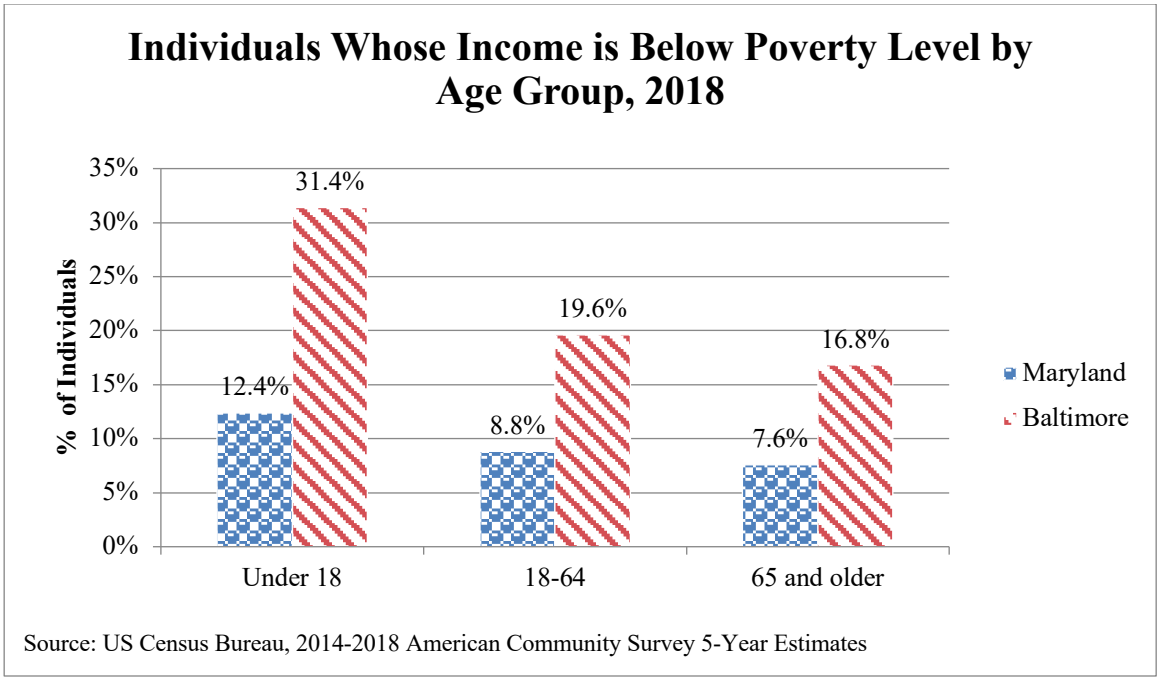
There is a gap in poverty rates between Baltimore City and the state. In 2017 the Baltimore City median household income was $48,840, whereas the state median income was $81,868. In addition, 16.6% of Baltimore households were below the poverty line, as compared to 6.4% of state households.



Source: US Census Bureau, 2014-2018 American Community Survey 5-Year Estimates



Source: US Census Bureau, 2014-2018 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.[13] 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%.[14]

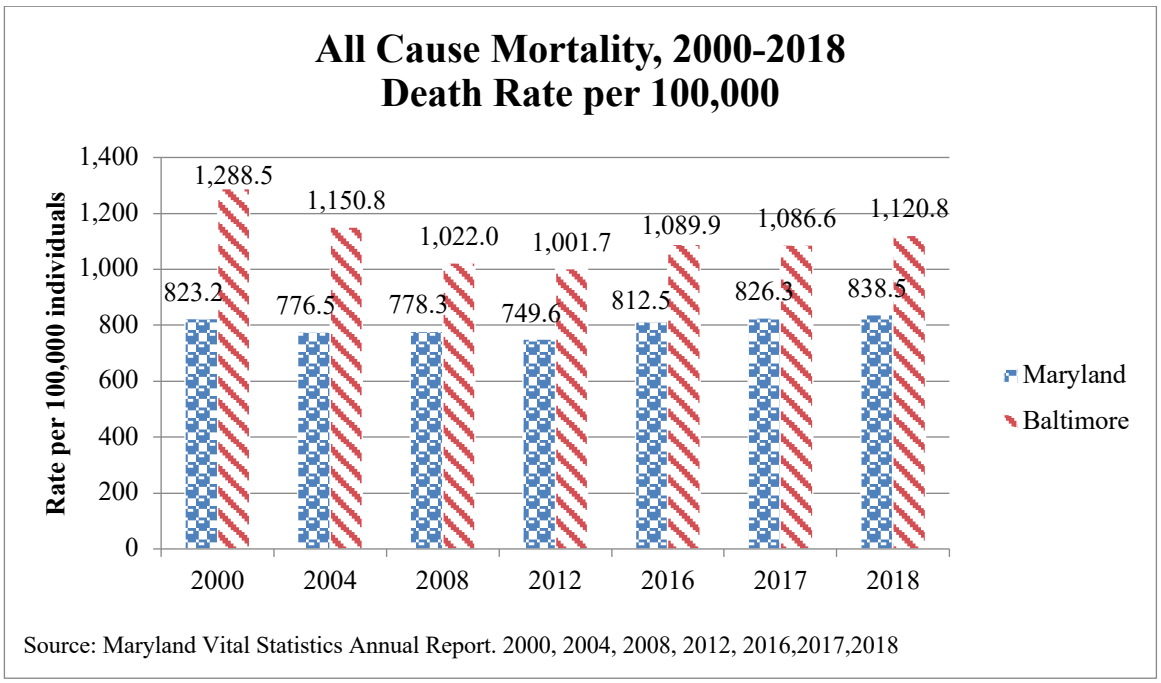
[13] Fellitti, V.J., et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. American Journal of Preventive Medicine, 14(4) 245-258. doi: http://dx.doi.org/10.1016/S0749-3797(98)00017-8

[14] 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.[15] 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.[16]

While Baltimore's all-cause mortality rate[17] has declined by 13% over the past eighteen years, it remains significantly higher than the state's rate and rose 3% in the past year.

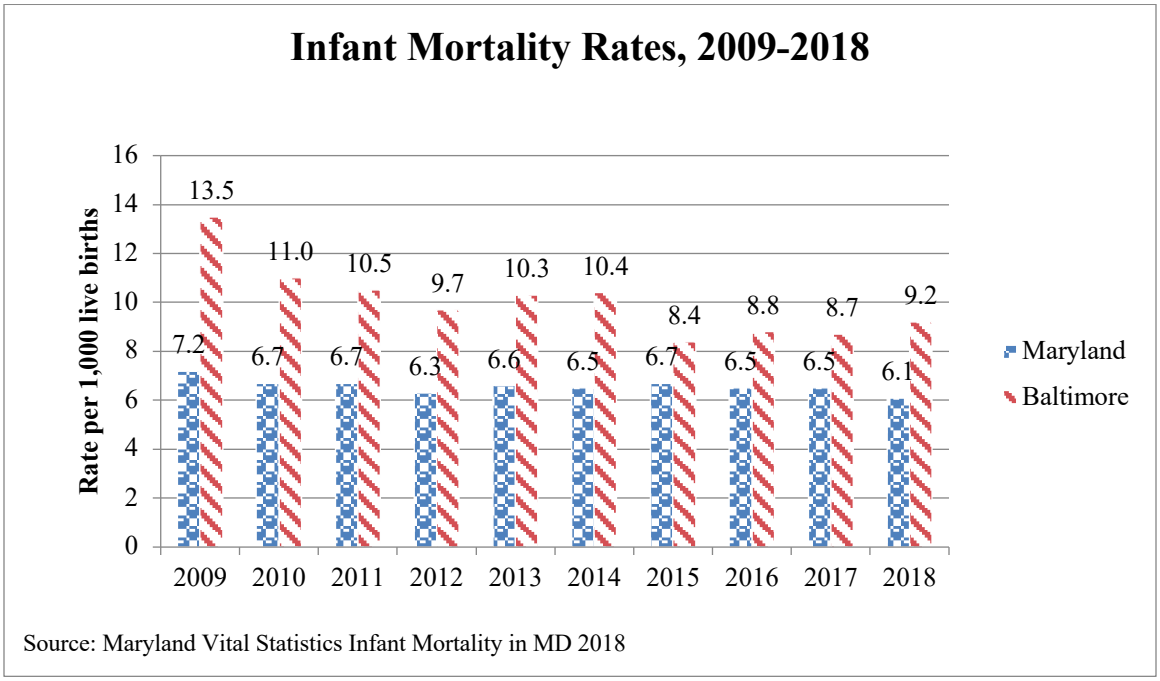


The Baltimore City 2018 infant mortality rate was 51% higher than the state's overall rate. Based on vital statistics data:

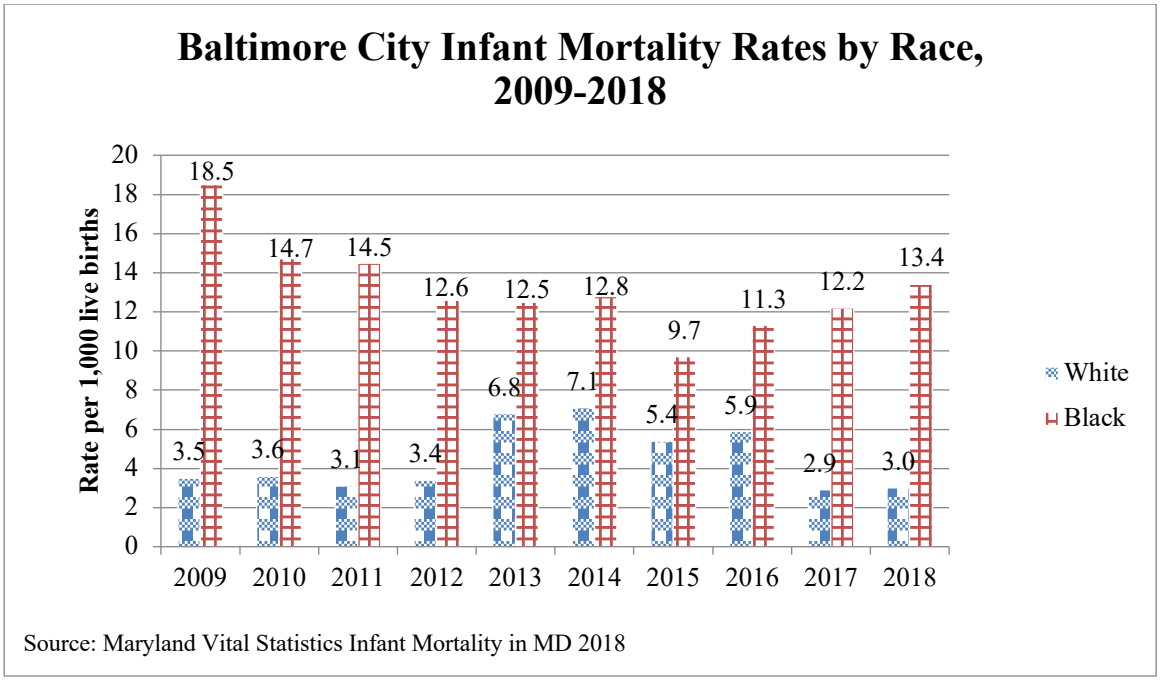
- There has been a decrease in the overall infant mortality rate of 31% between 2009 and 2018.
- There are significant disparities by race. The mortality rate for Black babies was over four times that of white babies in 2018. It is the biggest gap in the last 5 years.

[15] Source: Maryland Vital Statistics Annual Report, 2018. Table 7
[16] Baltimore City Health Department Neighborhood Profiles, 2017
https://health.baltimorecity.gov/neighborhood-health-profile-reports
[17] Maryland Vital Statistics Annual Report 2018.

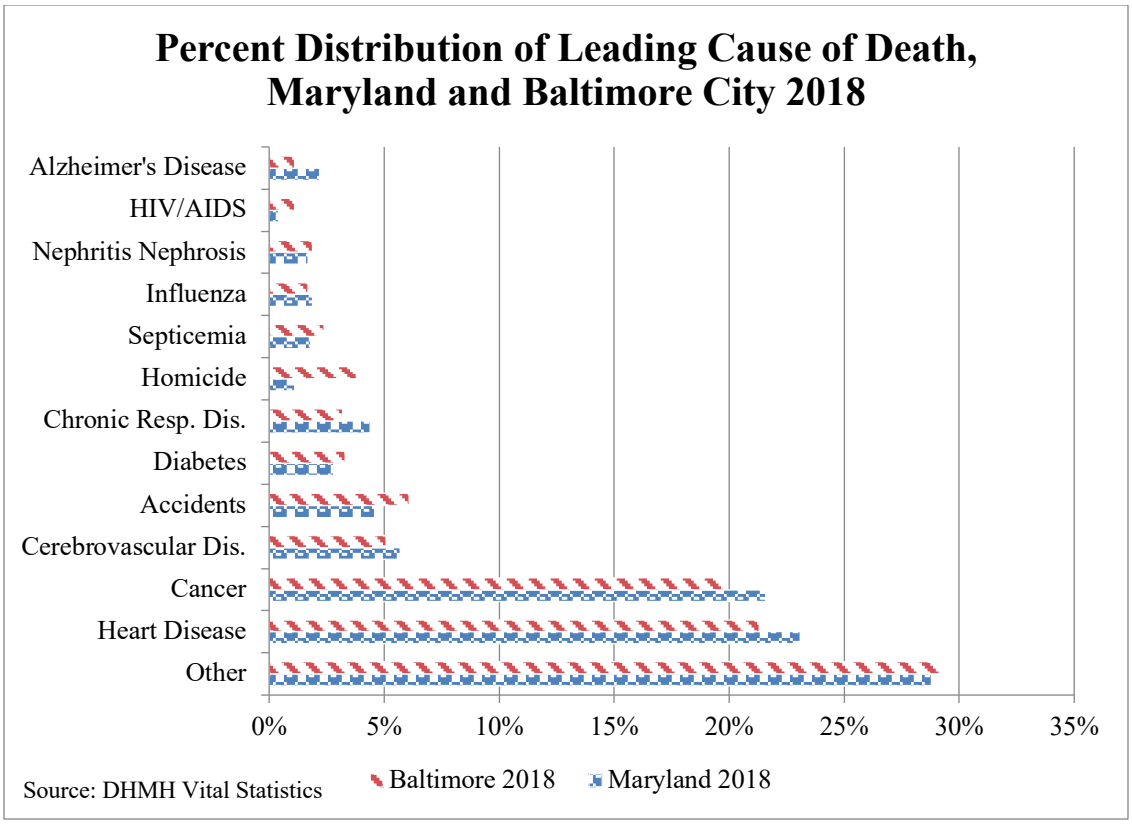
- Infant mortality rates among Black infants have decreased by 28% in the same period; however, after a low point in 2015, the mortality rate among Black infants has increased by 38% over the last three years.
- Between 2013 and 2016, mortality rates among white infants in Baltimore City was higher than the previous four-year period (2009-2012), but in 2018 decreased to the second lowest rate in the past eight 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 2018



The leading causes of death varies between Baltimore City and Maryland. Homicide and septicemia were not in the top eight causes of death in the state in 2018, but were the fifth and eighth in Baltimore City, respectively. Though the Baltimore City population is approximately 10% of the state population, HIV/AIDS deaths in the city made up 41% of the total HIV/AIDS deaths in the state.



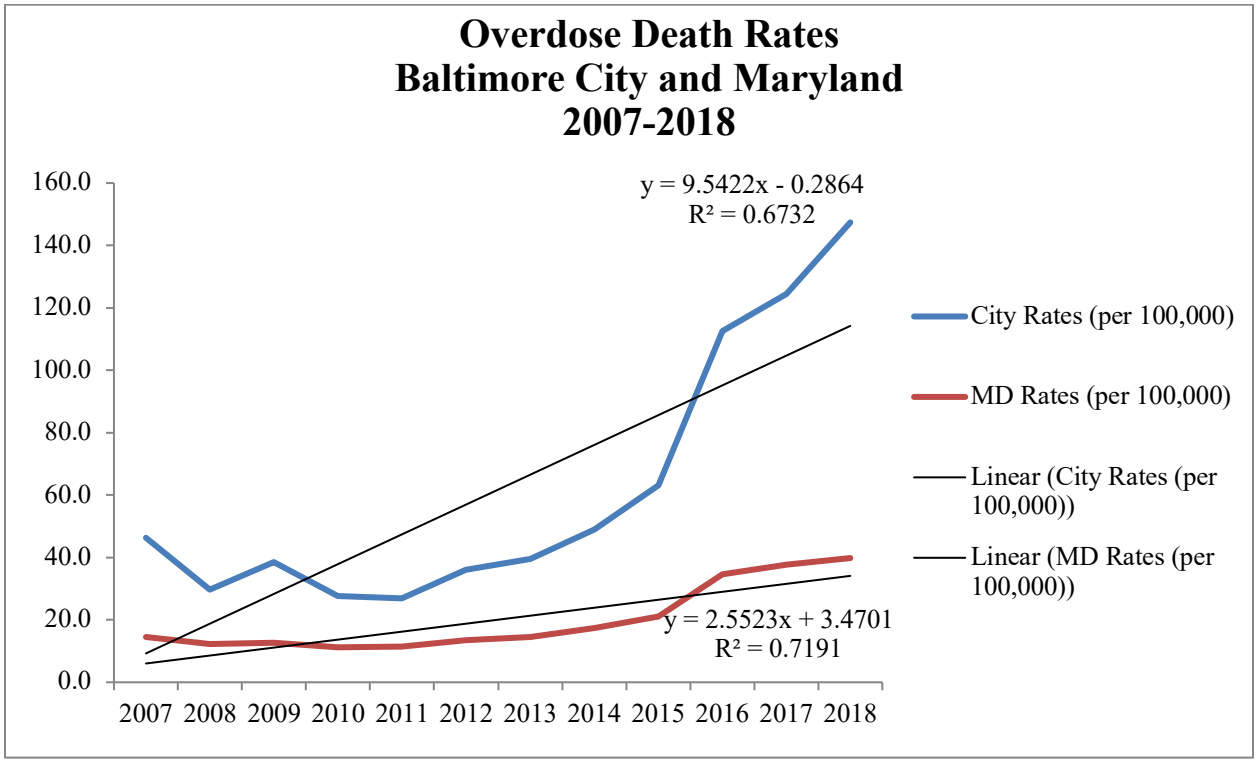
Eight percent (7.2%) of Baltimore City residents have no health insurance, and 4.2% of Baltimore City residents under 18 years are uninsured, which is a significant decline from 2006, when 14% under 18 years of age were uninsured.[18]

[18] U.S. Census Bureau, 2013-2018 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 888 overdose deaths occurring in 2018, which represents a 16.7% 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
2018	888	614,700	144.5



Source: Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2018 Annual Report. Maryland Department of Health, June 2019

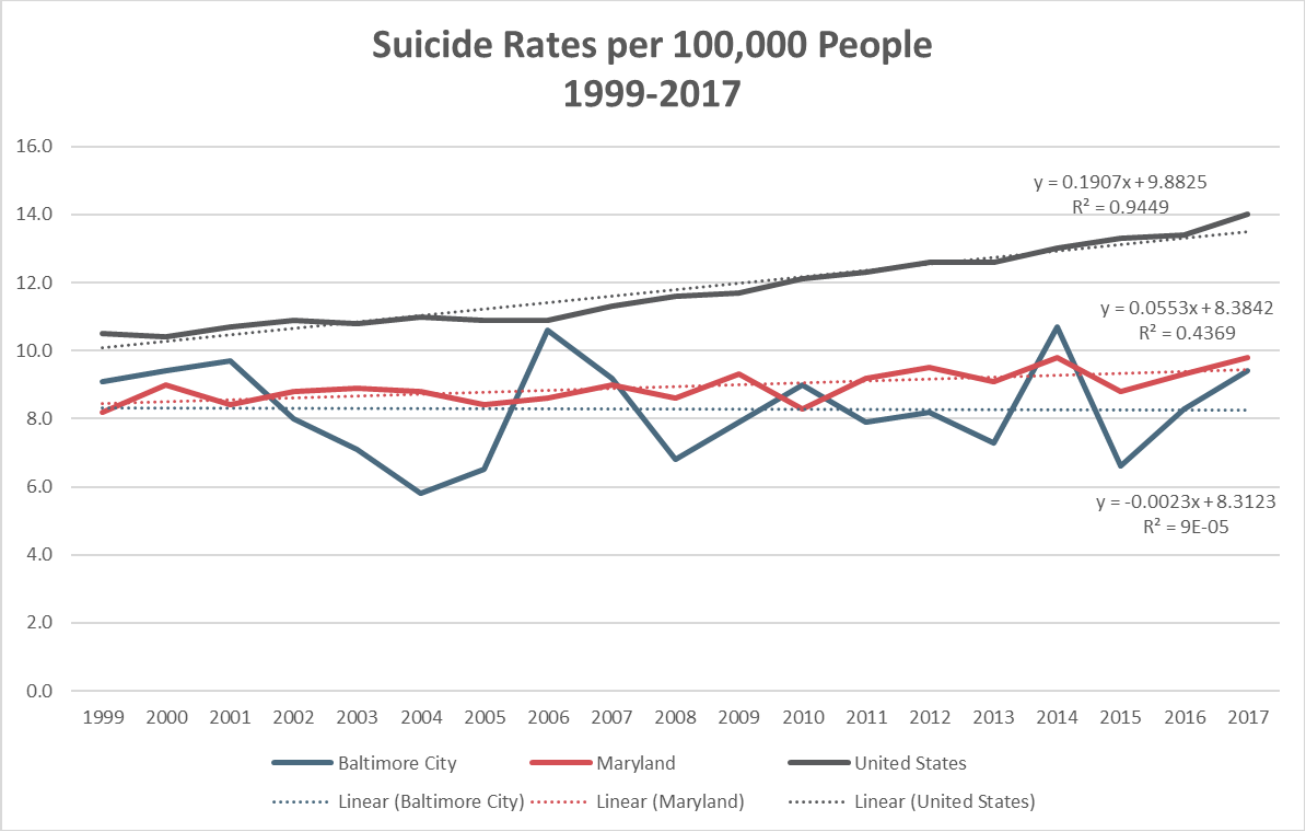
Suicide

Suicide was the tenth leading cause of death in the United States in 2017[19] and was in the top eight leading causes of death among Marylanders aged 15 to 64 in 2018.[20] Suicide rates from the CDC WONDER database indicate the suicide rate is increasing in the United States as a whole and to a lesser degree in Maryland. Though this trend does not seem to extend to Baltimore City, suicide is a rare event, and trends can be difficult to detect in small geographic regions.

A recent report from the Congressional Black Caucus indicates that suicidal behavior, which includes suicides, suicide attempts, and suicidal ideations, is increasing among Black youth, which goes against historical data and public perception regarding suicide rates among Black

[19] https://www.nimh.nih.gov/health/statistics/suicide.shtml
[20] Source: Maryland Vital Statistics Annual Report, 2018. Table 43A.

youth.[21] Given the majority Black population in Baltimore City, as well as the high prevalence of ACEs, a known risk factor for suicidal behavior, the potential for increased suicidal behavior warrants monitoring.

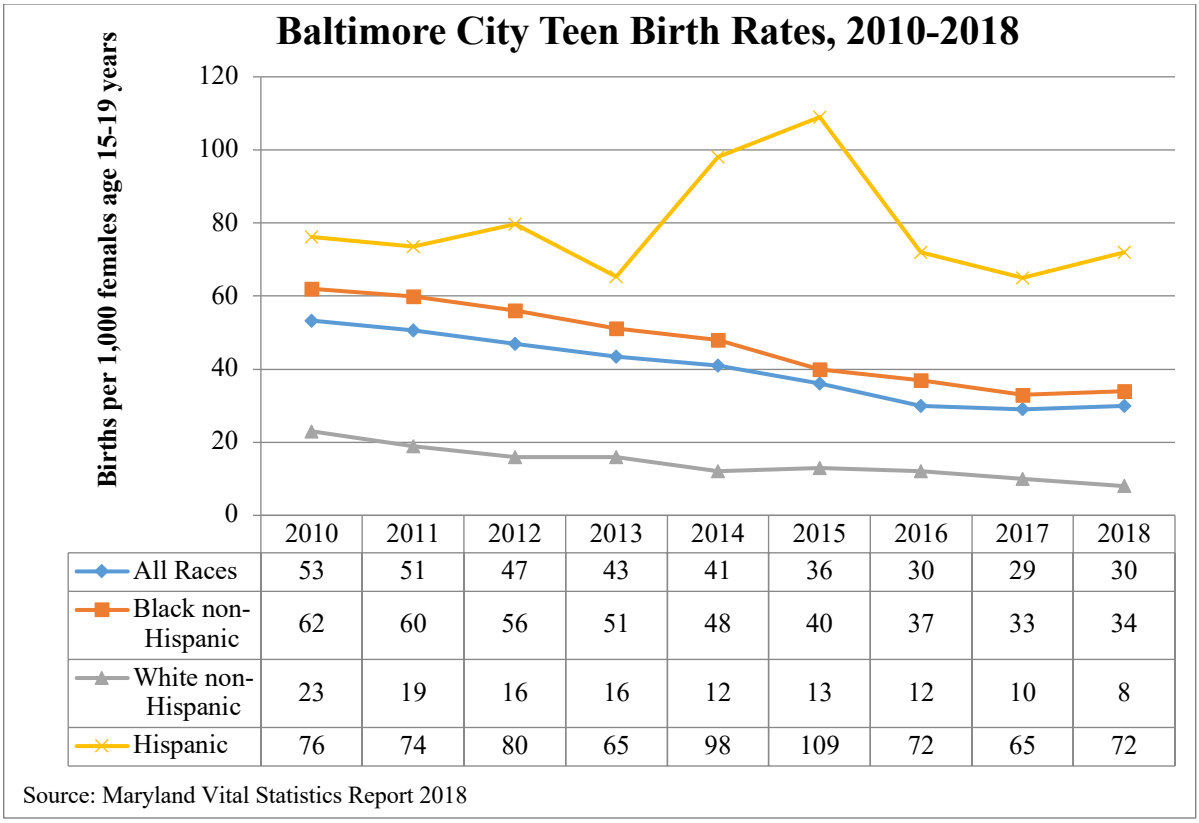


Source: Underlying Cause of Death, CDC WONDER, https://wonder.cdc.gov/ucd-icd10.html
Note: Rates are age-adjusted to the 2000 US Standard Population

Teen Pregnancy

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

[21] Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health. Ring the Alarm: The Crisis of Black Youth Suicide in America.
https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf



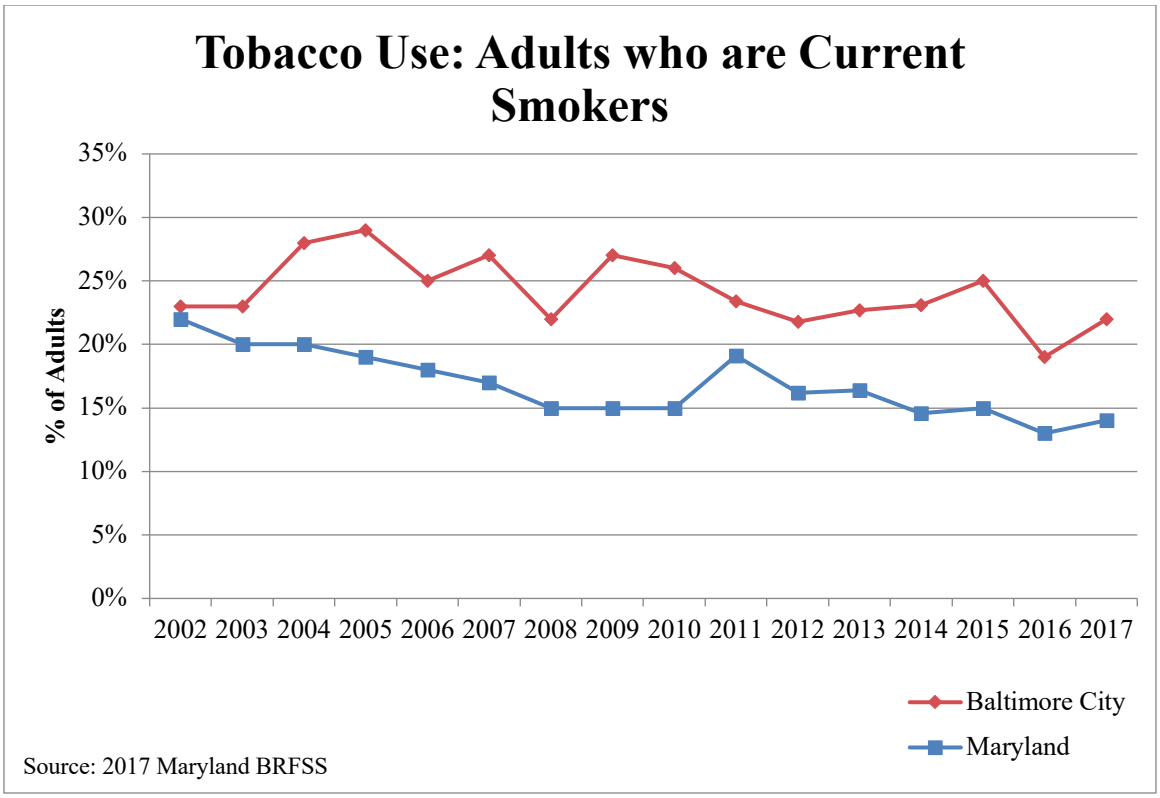
	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	53	51	47	43	41	36	30	29	30
Black non-Hispanic	62	60	56	51	48	40	37	33	34
White non-Hispanic	23	19	16	16	12	13	12	10	8
Hispanic	76	74	80	65	98	109	72	65	72

Source: Maryland Vital Statistics Report 2018

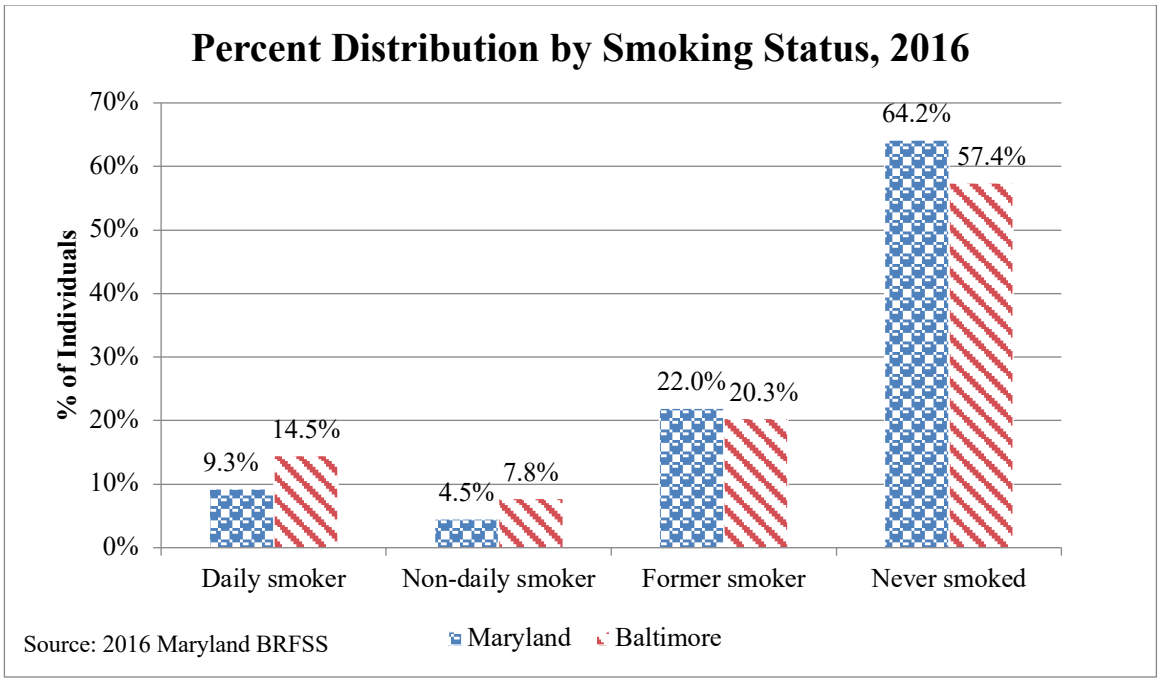
Tobacco Use

Tobacco use is a significant public health status indicator, as it results in approximately 480,000 premature deaths in the United States annually.[22] In the chart below, the BRFSS data shows that a higher percentage of adults in the city smoke cigarettes, as compared to the state. The BRFSS found that 22% of adults in the city versus 14% of adults in the state were current smokers in 2017.

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



The BRFSS also found that a higher rate of cigarette smokers who reside in Baltimore City, compared to Maryland smokers, identify themselves as daily smokers. A lower percentage of Baltimore City residents indicated use of e-cigarettes on the BRFSS (2.4%) compared to the state (3.3%).



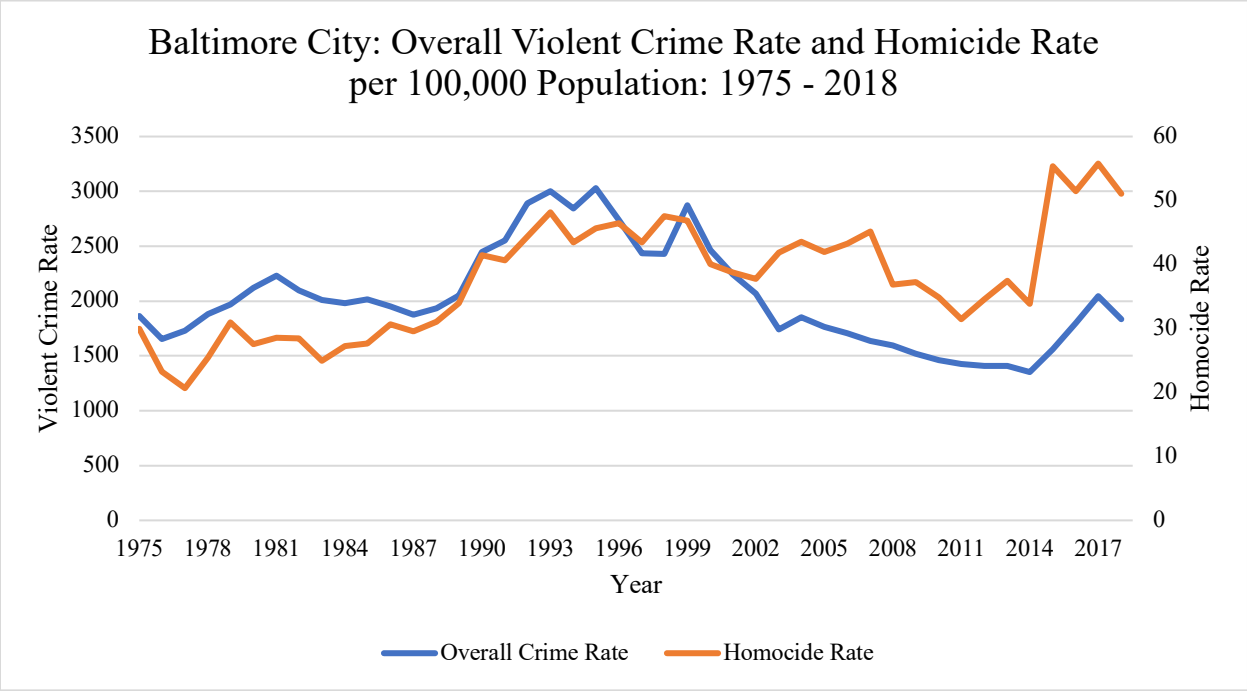
Crime and Violence

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.[23] In 2018, Baltimore's violent crime rate (murder, aggravated assault, robbery, and rape) was almost four times the statewide rate,[24] and there were 27,217 property crimes.[25]

Baltimore is one of several large cities to see sizable increases in its homicide rate in recent years.[26] In 2018, the homicide rate was 51 per 100,000 individuals, slightly lower than 2017, though the homicide rate remains extremely elevated compared to years leading up to 2015, a

[23] City of Baltimore. 2015 Baltimore Citizen Survey. https://bbmr.baltimorecity.gov/sites/default/files/2015%20CITIZEN%20SURVEY%20FINAL%20REPORT_1.pdf.
[24] FBI. Crime in the United States, 2018: Tables 5 and 8. https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/topic-pages/tables/table-5 and https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/tables/table-8/table-8-state-cuts/maryland.xls.
[25] FBI. Crime in the United States, 2018: Tables 5 and 8. https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/topic-pages/tables/table-5 and https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/tables/table-8/table-8-state-cuts/maryland.xls.
[26] 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.

time of significant social unrest. 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. [27]



Sources: Governor's Office on Crime Control and Prevention (GOCCP), 1975-2017 and FBI Crime in the United States, 2018. The overall violent crime rate includes: Murder, Aggravated Assault, Robbery and Rape.

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 ACEs, systemic discrimination, community violence, food insecurity, and a lack of safe and affordable housing, can have long-term negative consequences on health and well-being, including mental health conditions, substance use, asthma, autoimmune, cardiac and other chronic diseases.

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 2017 Youth Risk Behavior Surveillance Survey (YRBSS), 12.2% 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, 8.3% reported being "being physically hurt on purpose… by someone they were going out with" one or more times in the last 12 months. The

[27] 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

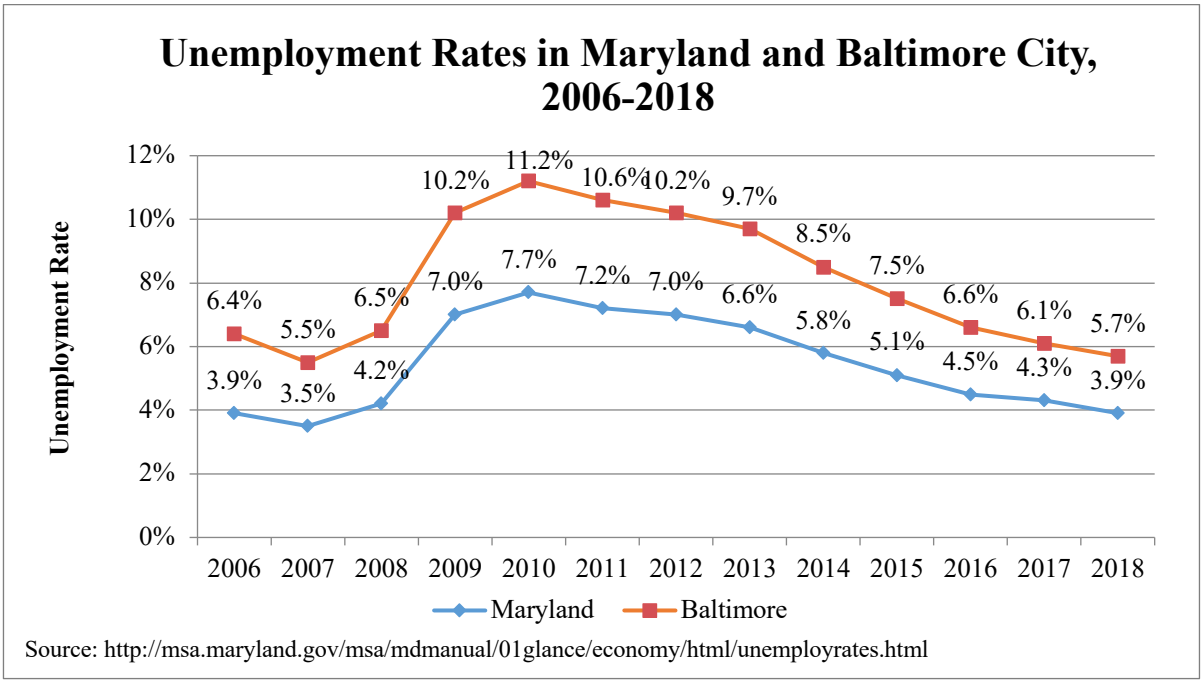
percentage of students who reported ever having been physically forced to have sexual intercourse was 9.9% for male and 9.4% for female high school students.[28]

Employment

Baltimore City's unemployment rate is higher than Maryland and the United States, although the trend shows a steady decrease since 2010. In 2018 the average unemployment rate for the city was 5.7%.

Annual Average Unemployment Rates, 2018	
Area	**Rate**
United States	3.9%
Maryland	3.9%
Baltimore City	5.7%

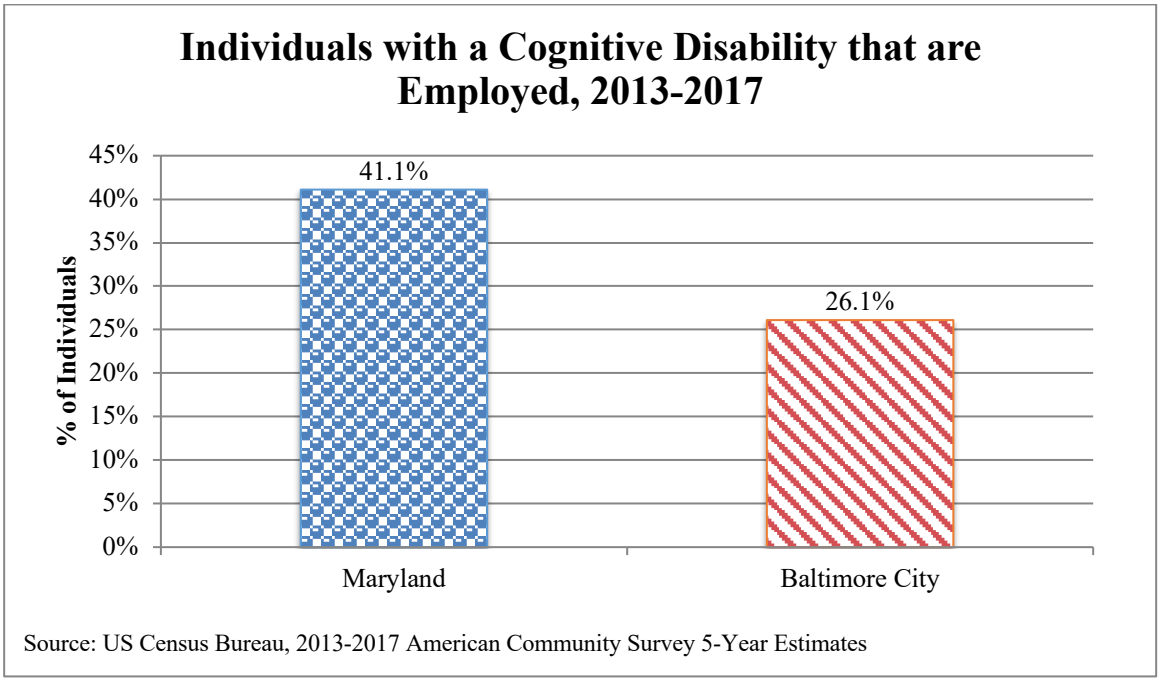
Source: Bureau of Labor Statistics. https://www.bls.gov/news.release/srgune.nr0.htm



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

[28] Centers for Disease Control and Prevention. YRBS Online (2017). https://nccd.cdc.gov/Youthonline/App/Results.aspx.

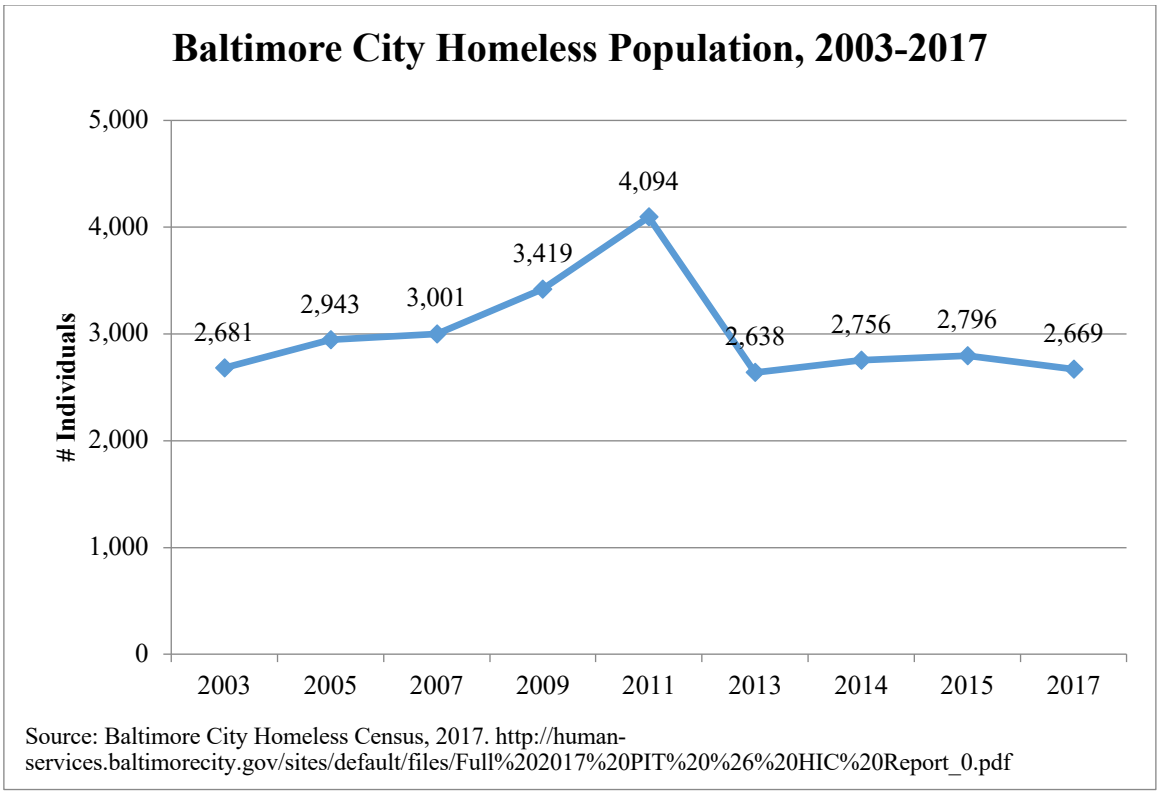
The employment rate of individuals with a cognitive disability was lower in Baltimore City compared to the state.



Homelessness

Homelessness is a persistent and growing problem in Baltimore City. 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. However, it is difficult to accurately count the number of individuals experiencing homelessness, and data on the number are thought to be underestimates. The population which is identified as unsheltered makes up 20% of the population experiencing homelessness. 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% experienced chronic homelessness.

[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. During FY 2019 in Baltimore City, in order to spend 30% or less of their income on housing costs, a person earning minimum wage would need to work 2.6 full-time jobs to rent a two-bedroom apartment at fair market rent.[30] This is less affordable than the United States 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 total housing, 46.4% was built before 1940, and 73.2% was built before 1960.[32] Owners and tenants struggle to maintain aging properties. As the data below indicate, Baltimore City's vacancy rate is significantly higher than

[30] Out of Reach 2019. National Low-Income Housing Coalition. https://reports.nlihc.org/oor/maryland
[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, 2018

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	294,522	2,437,740
Occupied units	238,436	2,192,518
Vacant units	56,086	245,222
Vacancy rates		
Homeowner	4.2%	1.7%
Rental	8.0%	6.2%
Gross monthly rent		
Less than $500	19,775	52,192
$500 - $999	35,927	121,372
More than $999	65,945	528,201

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

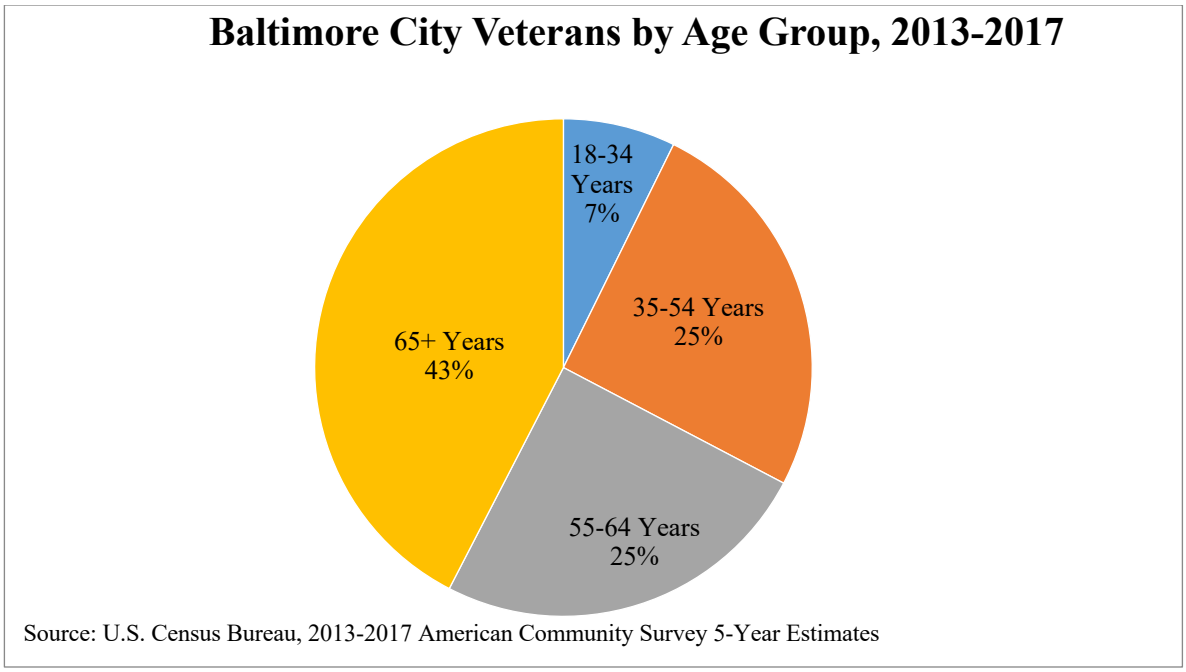
The cost of housing relative to income is a significant barrier to safe and stable housing. According to the 2017 American Community Survey, 33% of Baltimore City residents with any disability live below the poverty level.[33] The median monthly housing cost for renter-occupied units in Baltimore City was $1,051, and 43.1% of renters were spending more than 35% of their household income on rent.

Veterans and War Returnees

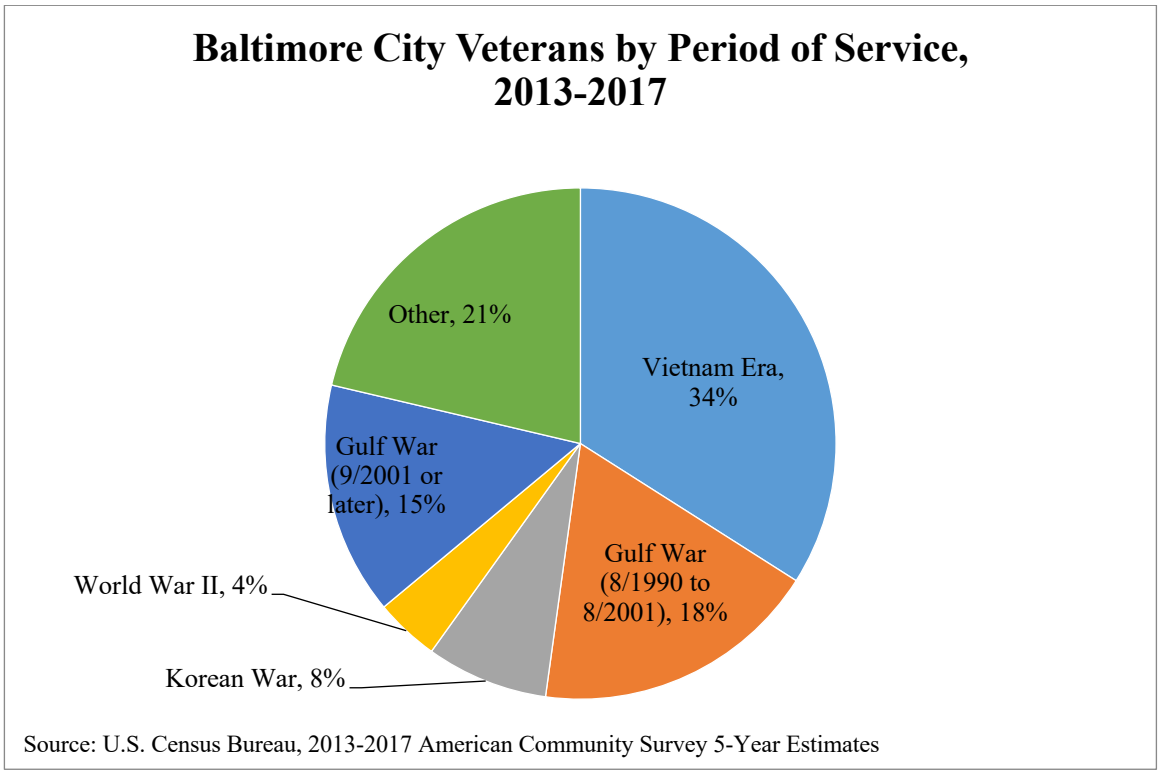
The US Department of Veterans Affairs estimates that there are 29,428 veterans in Baltimore City, representing 7.7% of all veterans in Maryland. Adults ages 35-64 represent 50% of the city's veteran population, and adults over 65 years represent 43%. Because of the high prevalence of behavioral health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

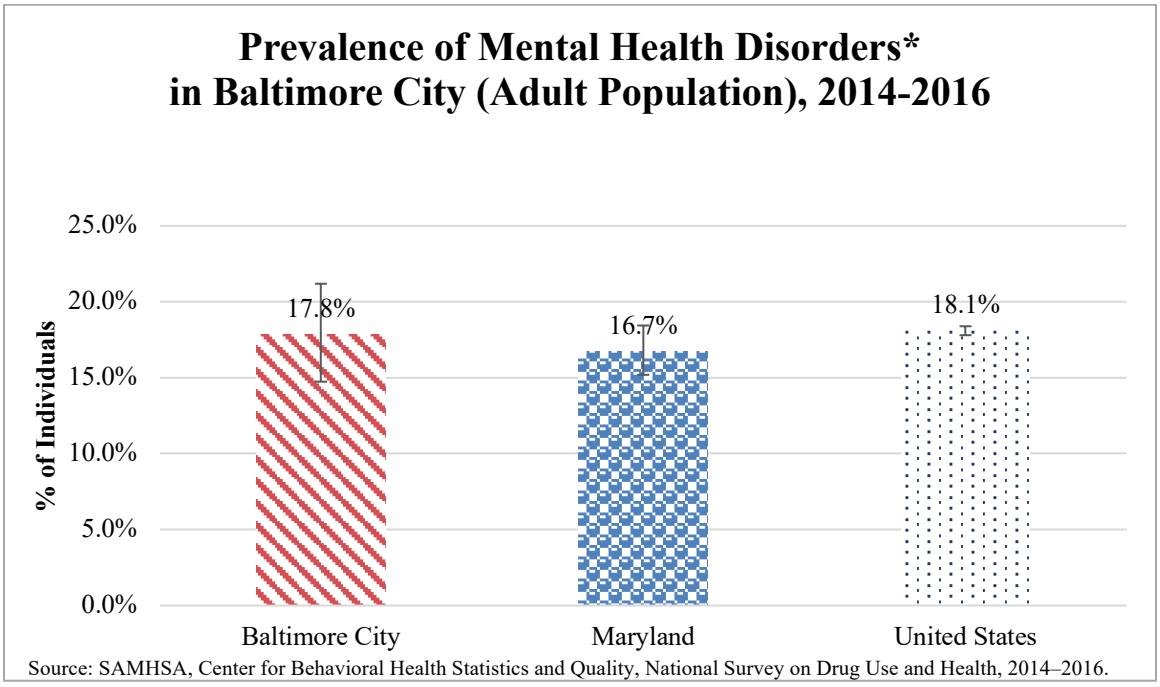


2. Behavioral Health Indicators of Baltimore City

Adults

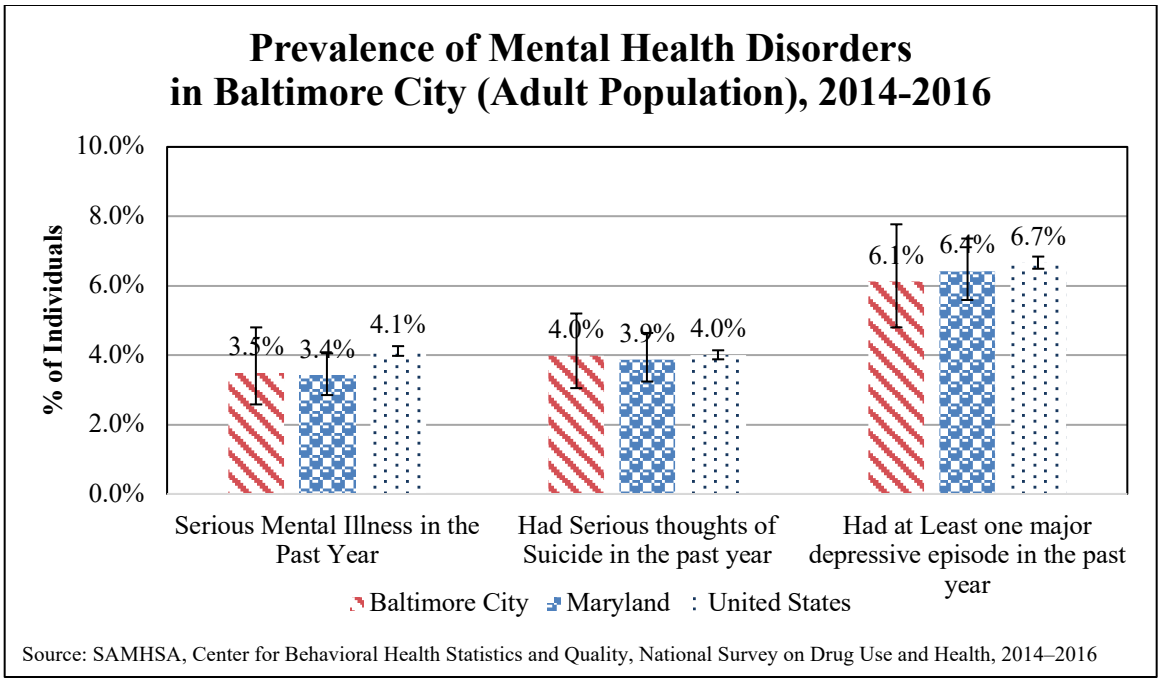
Prevalence of Mental Illness

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.



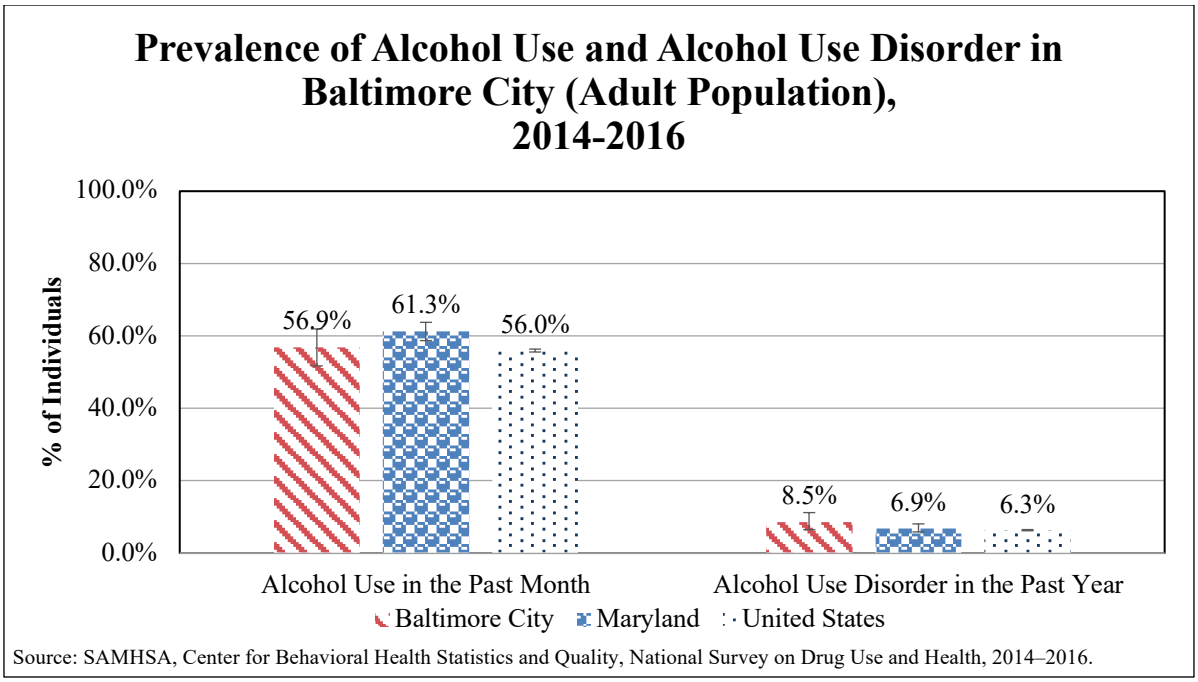
*Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, which met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

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%.

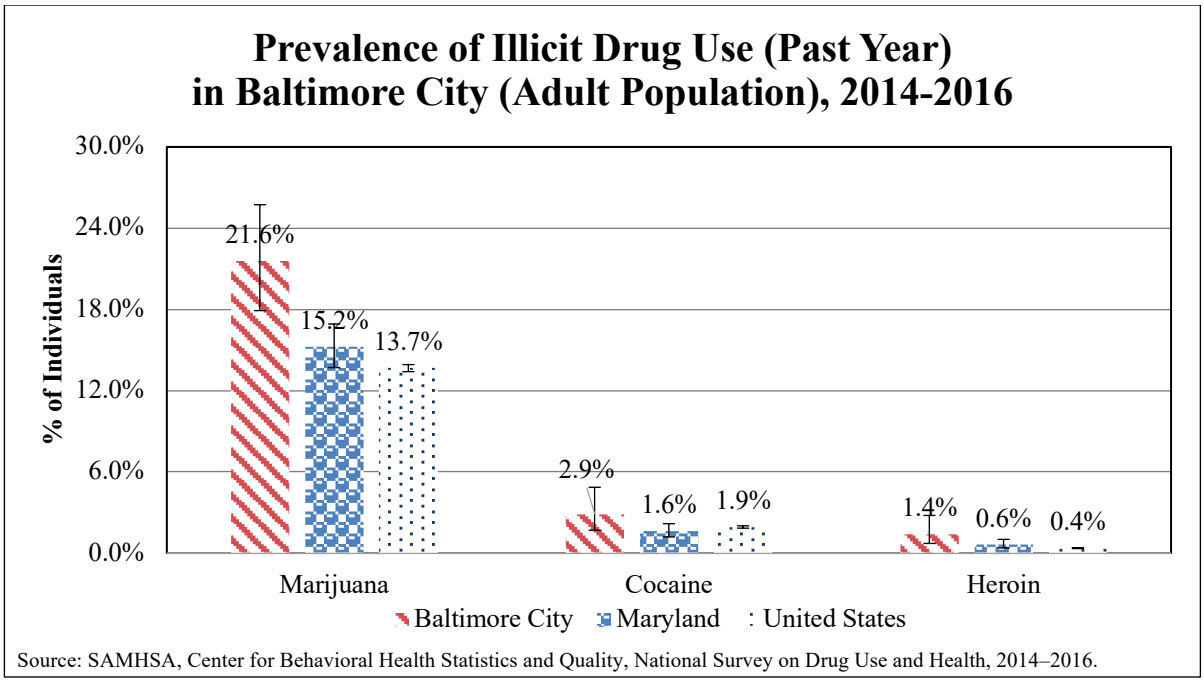


Prevalence of Substance Use Disorders

Rates of alcohol use in the past month are high for Baltimore City, Maryland and the United States. In Baltimore 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.



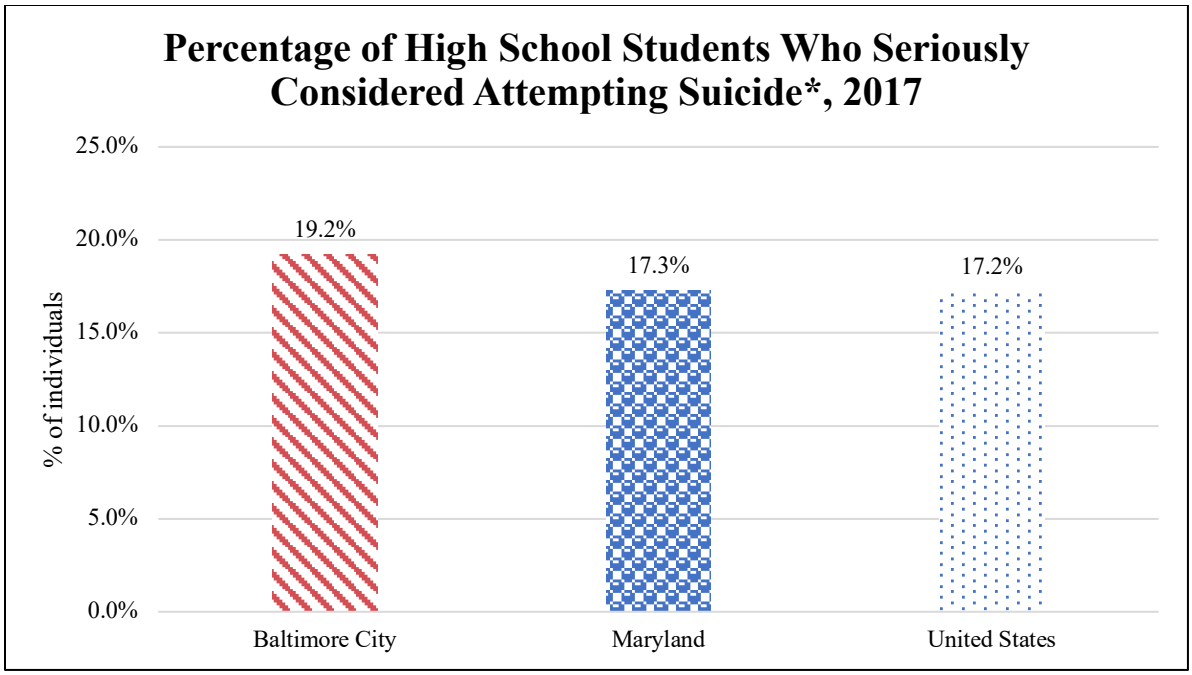
The prevalence of illicit drug use (marijuana, cocaine and heroin) in the past year for Baltimore City (10.7%) was higher than both the state and national rates. The rate of marijuana use in the past year for Baltimore City (21.6%) was 1.4 times greater than the statewide rate and 1.6 times the national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



Youth

Prevalence of Mental Illness

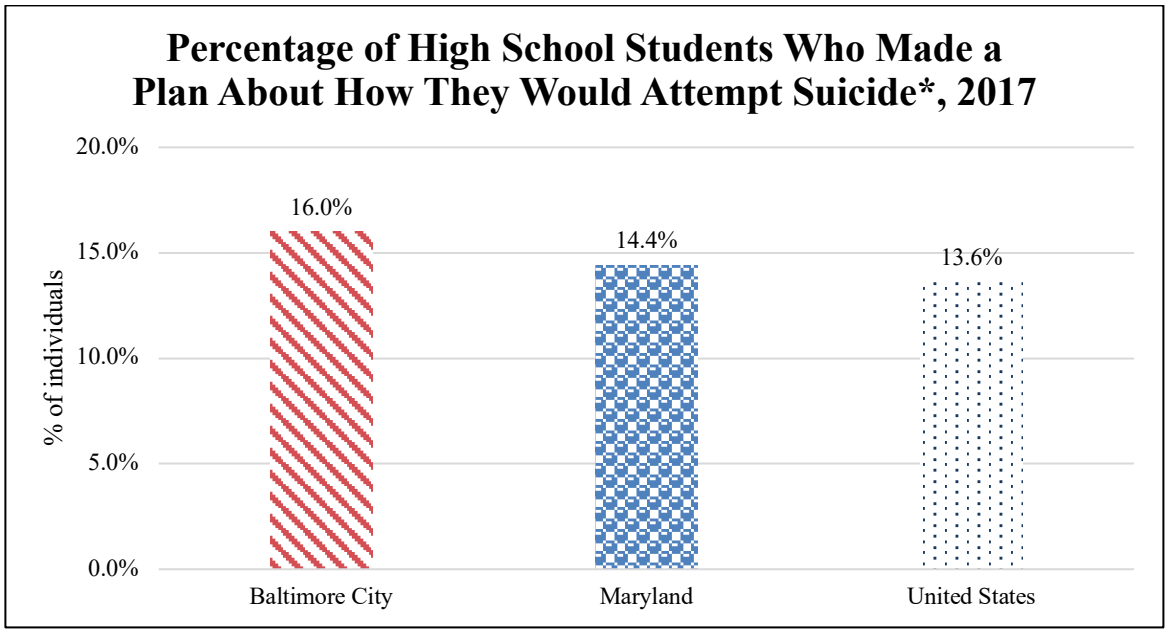
The Maryland Youth Risk Behavior Surveillance System (YRBSS) offers a unique look into the emotional needs and behavioral health risks of youth in Baltimore City. The percentage of high school students who seriously considered attempting suicide in Baltimore City was higher (19.2%) than both the state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



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

*During the 12 months before the survey

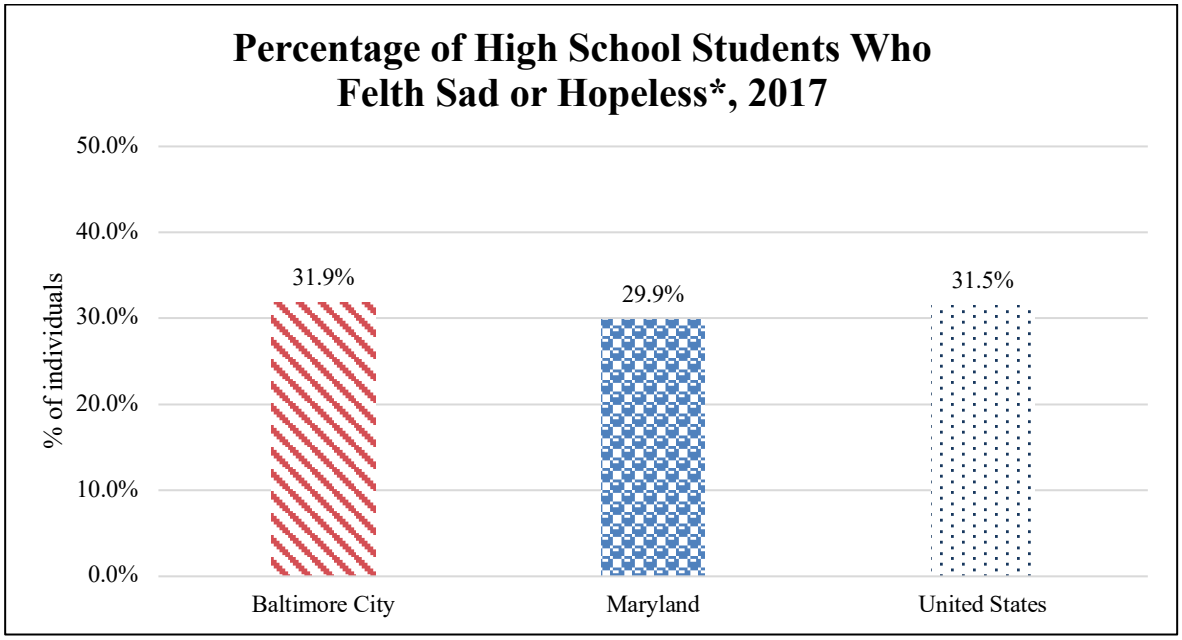
The percentage of high school students who made a plan about how they would attempt suicide was higher (16.0%) in Baltimore City than the state and national rates.



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

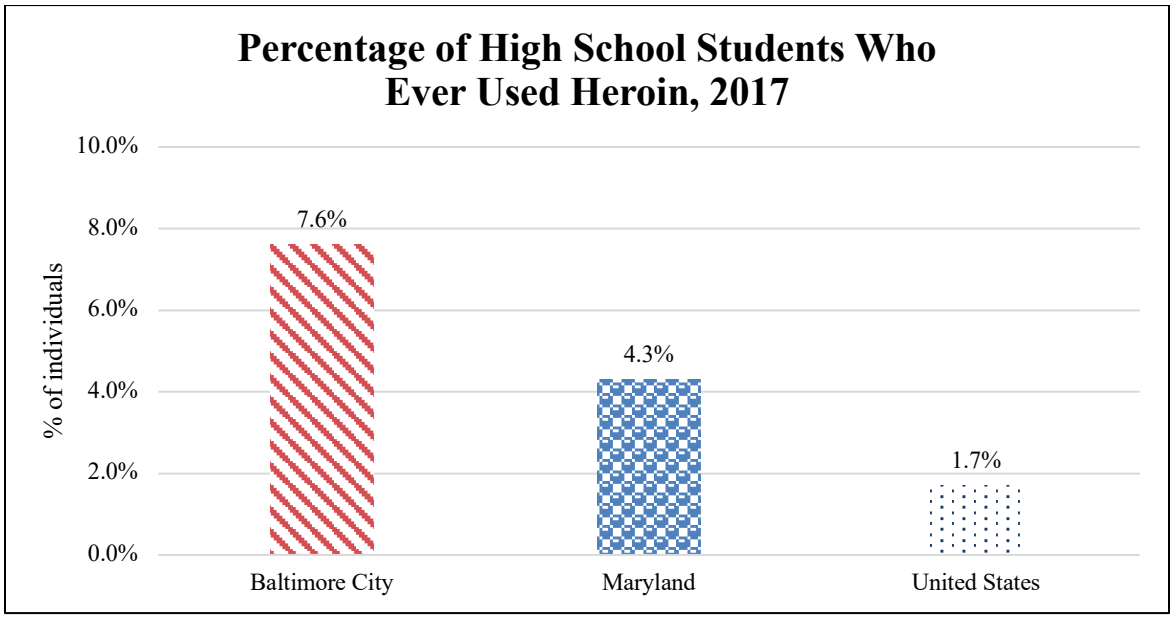
*During the 12 months before the survey, almost every day for 2 or more weeks in a row so that they stopped doing some usual activities

When evaluating YRBSS data, it is important to note the results come from a representative sample of Baltimore City public middle and high school classrooms - which only includes students in attendance at the time of the survey administration. The survey is not required to be completed by all Baltimore City Public School students. Therefore, it is possible data will not reflect the perspectives of disengaged youth (e.g. those youth not in attendance or experiencing other barriers to school engagement).

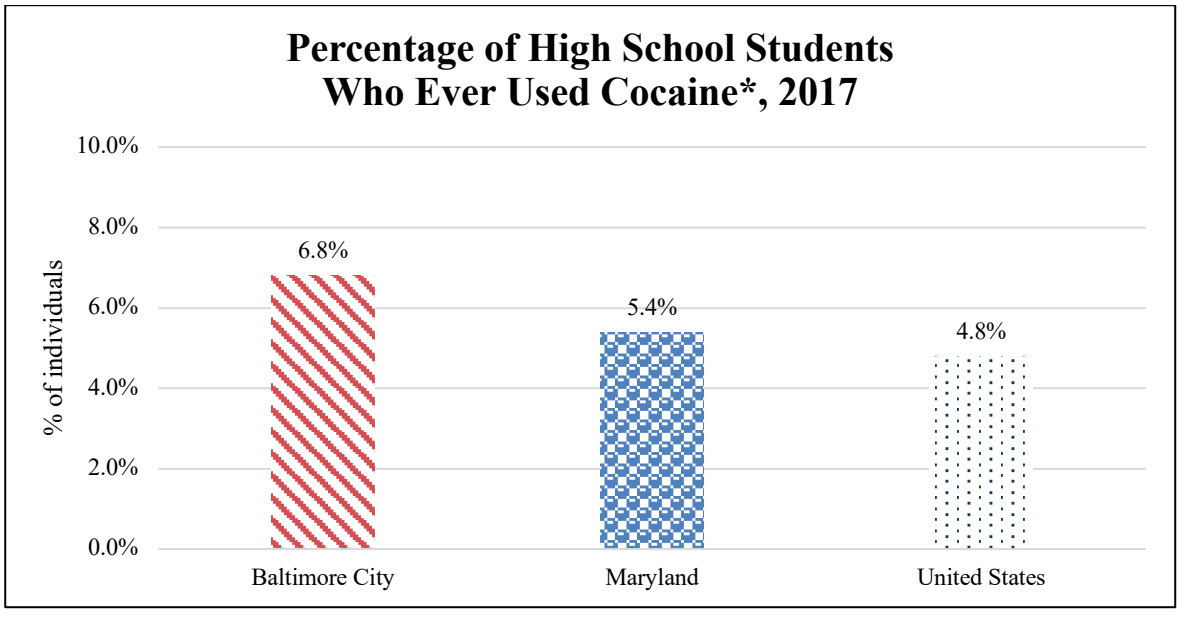
Prevalence of Substance Use Disorders

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 this substance, 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.

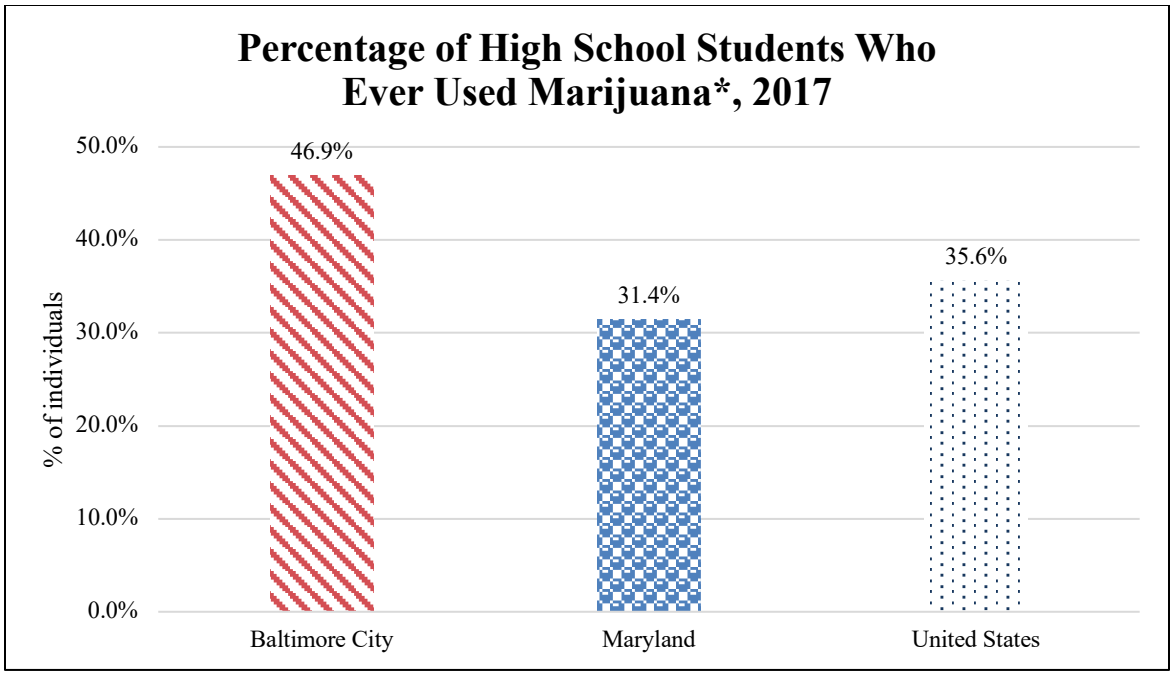


Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017



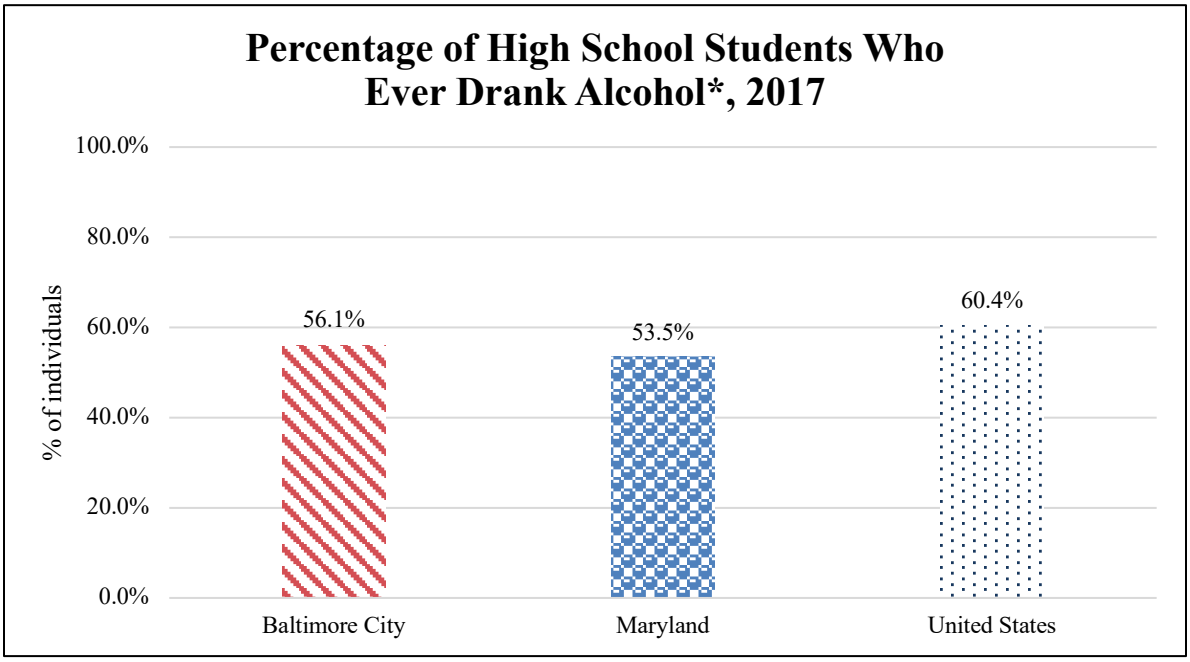
Source: CDC Youth Risk Behavior Surveillance System (YRBSS), 2017

*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

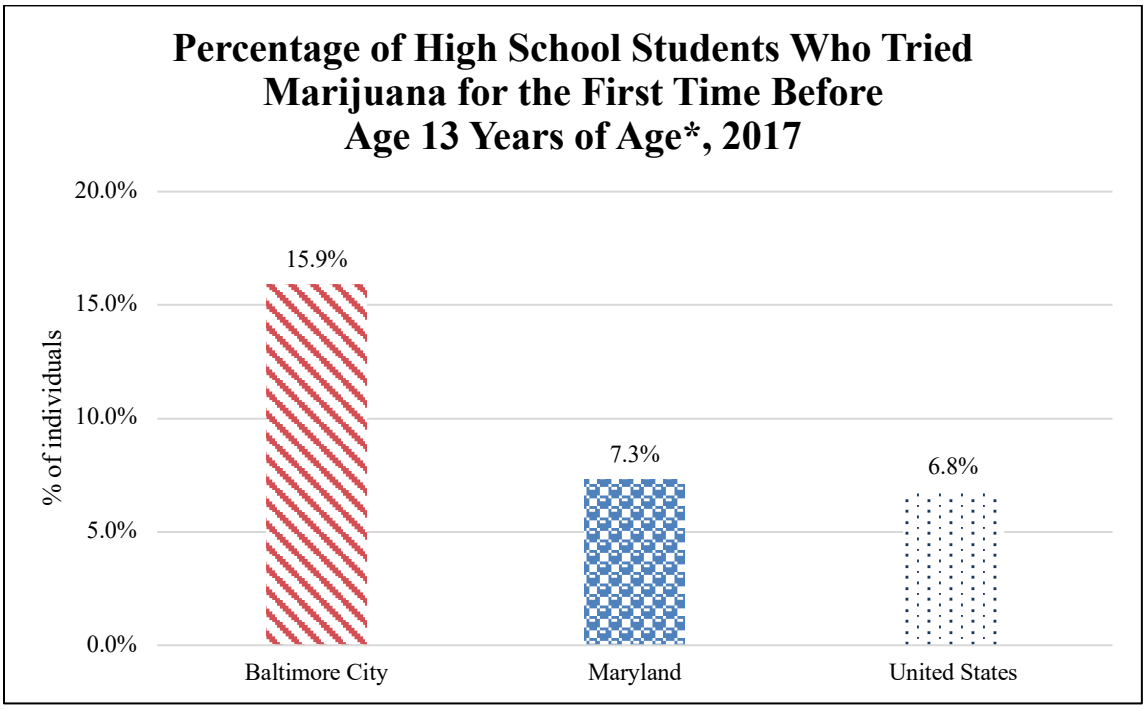
*One or more times during their life



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

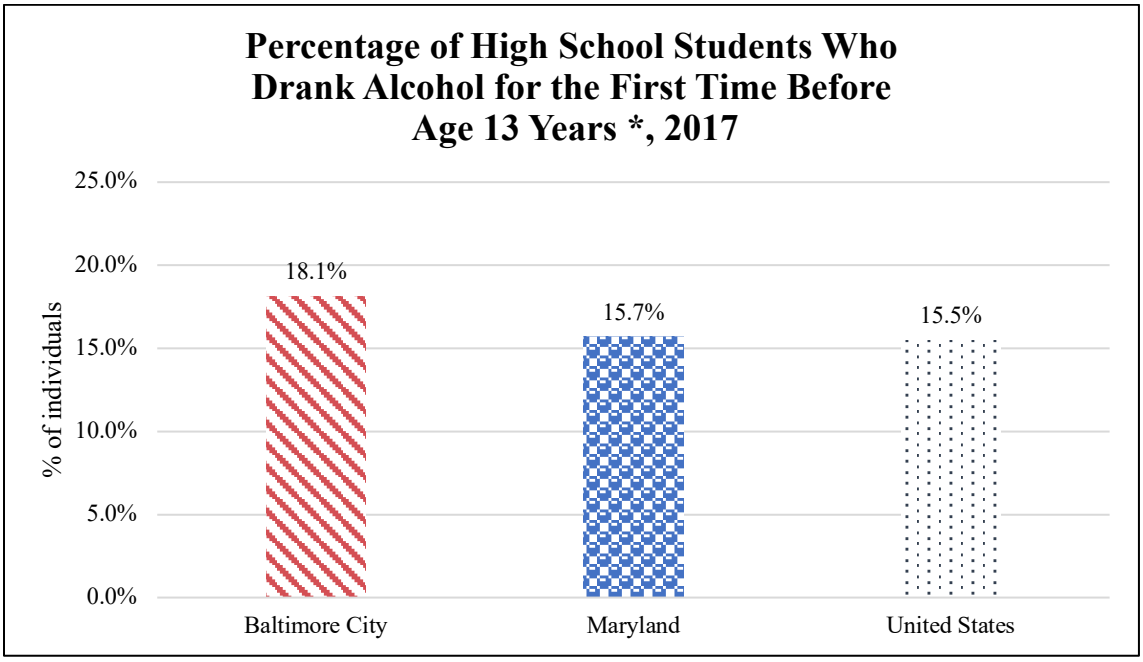
*Had at least one drink of alcohol on at least 1 day during their life

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

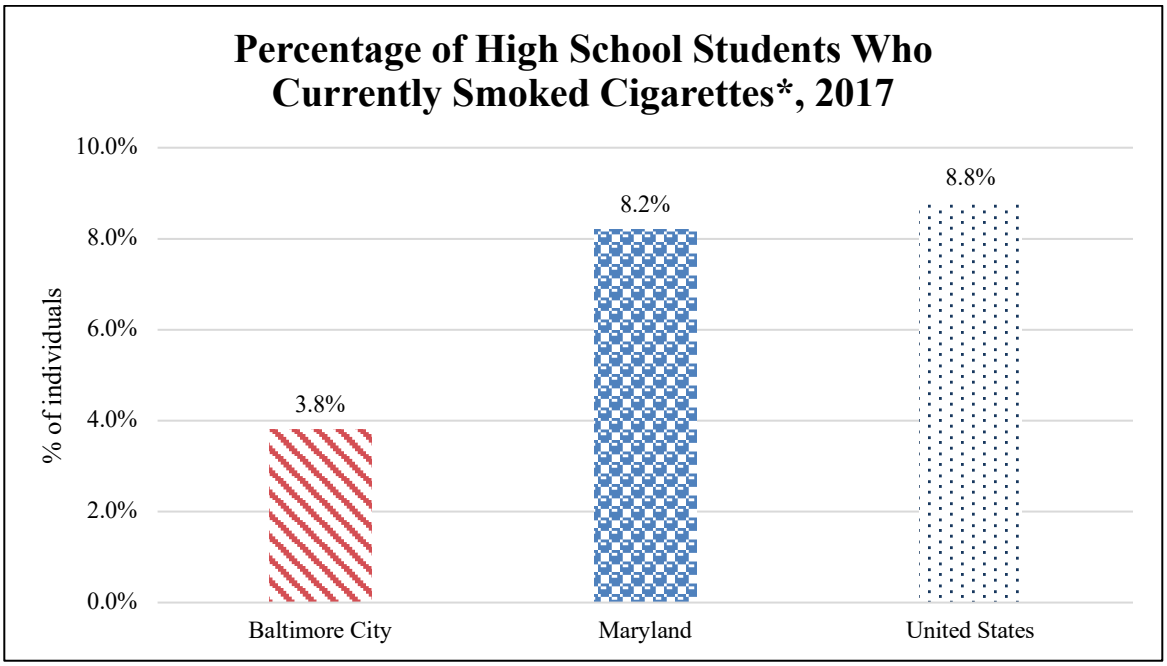
*One or more times during their life



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

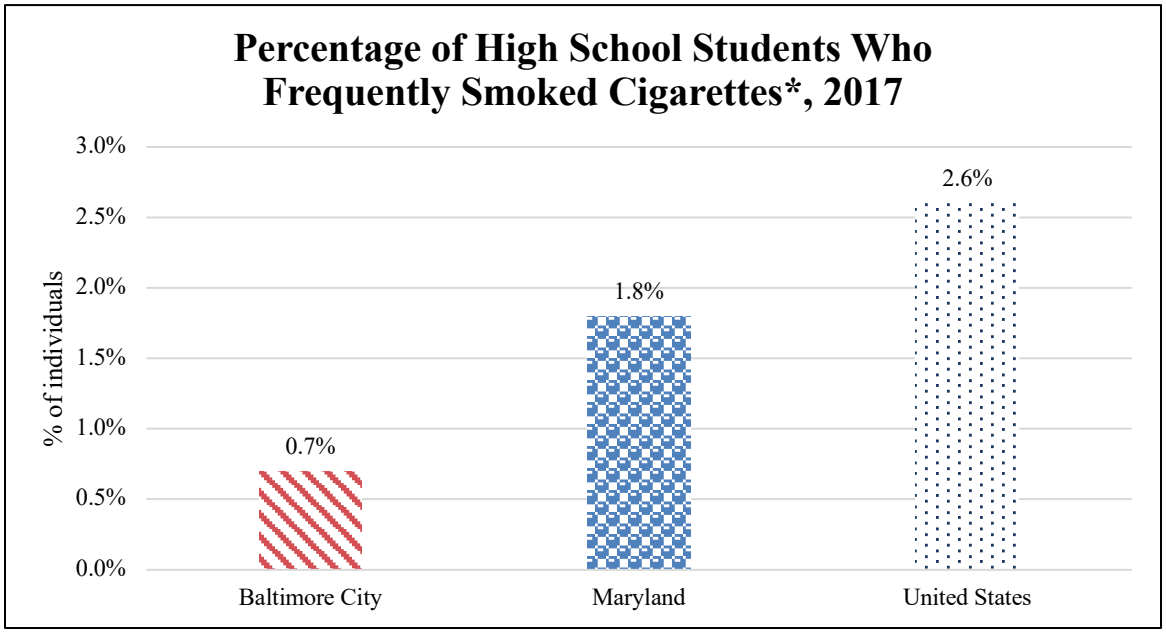
*Had at least one drink of alcohol on at least 1 day during their life

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

*Smoked cigarettes on 20 or more of the past 30 days

Additionally, the percentage of high school students who have ever used e-cigarettes in Baltimore City (32.4%) is lower than both the state (35.3%) and the nation (42.2%). Fewer high school students in Baltimore City use e-cigarettes (4.8%) compared with the state (13.3%) and the country (13.2%).

3. 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 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 youth and adults in FY 2019. Data reports include claims submitted through September 30, 2019 (three months after the end of FY 2019).

The substance related disorders (SRD) utilization data describe the use of SRD services and associated expenditures for youth and adults in FY 2019. Data reports include claims submitted through September 30, 2019 (three months after the end of FY 2019). It is important to note that the data includes only SRD ambulatory services (outpatient, intensive outpatient and opioid maintenance therapy) for 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 provides 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 3.7WM. The ASAM level of care 3.1 was reimbursed through the ASO beginning in January 2019.

Mental Health Utilization

As in previous years, the most recent data reported (FY 2019) is incomplete, as claims may be submitted up to 12 months after the date of service delivery. Therefore, the data for FY 2019 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 2019 data to FY 2018 and FY 2017 data for trends over time. When comparisons with previous years show increases in FY 2019, it is likely that the actual increase is somewhat greater. Conversely, decreases in FY 2019 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.

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 fiscal years prior to FY 2019 has been updated to include claims that were paid after September 30th of the respective fiscal year and may, therefore, differ from data reported in previous BHSB annual reports.

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 2019 data on mental health service utilization in the PBHS:

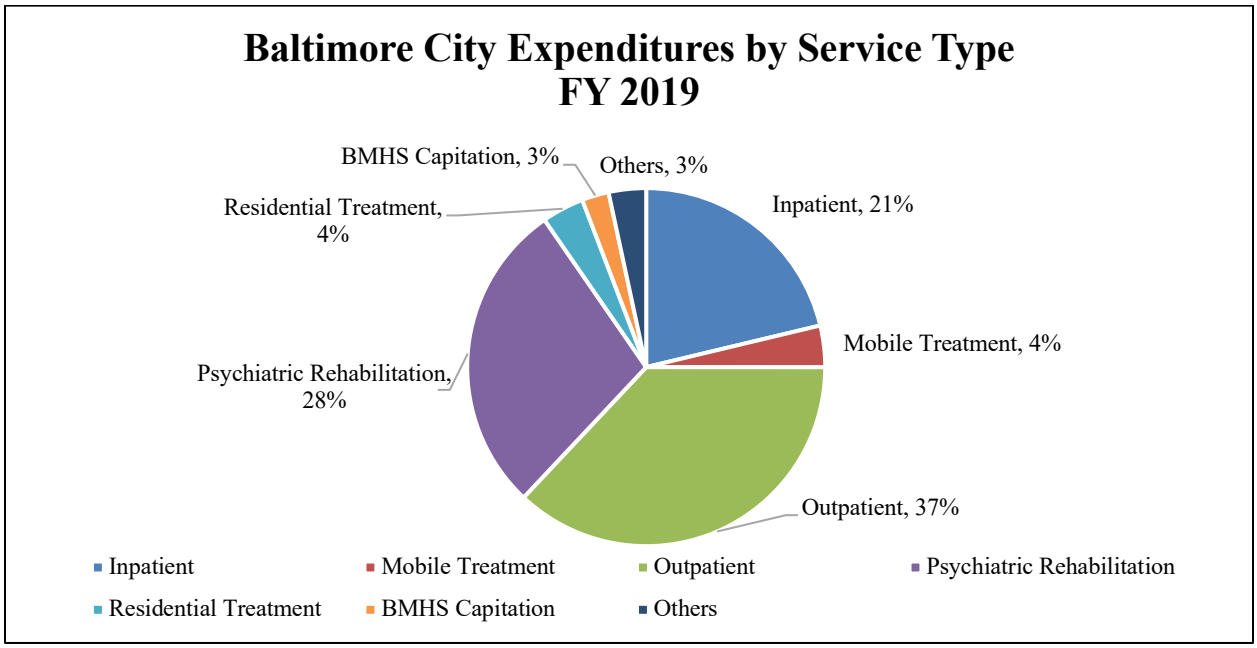
- The mental health system continues to serve a significant number of individuals in Baltimore City: 58,567 people in the last year (representing almost 1 out 10 city residents), and 26.0% of the total people served in Maryland.
- Expenditures totaled $335,128,082, representing 30.6% of the state's expenditures.
- It served a full age-continuum of the population, with the majority (61.5%) being adults.
- Outpatient is the most common service type, with more than 53,000 consumers served in the past year.
- There has been a total of 23,338 people identified as dually diagnosed, representing 39.8% of the total people served in FY 2019.
- The average expenditure per consumer in Baltimore City was $5,722.
- The most expensive service type per person served was residential treatment ($63,538).
- The average cost per person from Baltimore City served for residential treatment was substantially less ($63,538) than for the state ($83,449).

Consumers Served & Expenditures

While Baltimore City represents 10.2% of the state's population and 18.5% of the state's Medicaid-eligible population, it represented 26.0% of those who utilized mental health services in FY 2019. Total expenditures of $335,128,081 for Baltimore City accounted for 30.6% of the state's total expenditures on public mental health services in FY 2019. 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] Additionally, as noted in the "Population in Poverty (%), 2018" table, Baltimore City has the second highest percentage of the population living in poverty among Maryland counties, which equates to the highest number of people living in poverty by nearly 30,000 people over the next highest county.[36]

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 12.6% and 18.1%, respectively, in the past fiscal year. This is a positive change that may indicate increased engagement among populations who typically have less engagement with the PBHS.



Source: Beacon Health Options
Based on claims paid through September 30, 2019
Others: Case Management, Crisis, Residential Rehabilitation, Respite Care, Supported Employment, BMHS Capitation, Emergency Petition, Purchase of Care, PRTF Waiver

In the last fiscal year, the city experienced an increase of nearly $30 million in mental health services expenditures (9.1%). This increase is largely due to variations associated with the following service types: psychiatric rehabilitation program ($19.4 million), outpatient services ($4.7 million), and residential treatment ($3.5 million), all of which also showed increases in consumers served. The increase in outpatient services, while a large dollar amount, represents

[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] Small Area Income and Poverty Estimates (2018). https://www.census.gov/data-tools/demo/saipe

less than a 4% increase in expenses and consumers served, as the service line serves the highest number of consumers and has the highest expenditures. Worth noting is the fact that though the psychiatric rehabilitation program (PRP) and Residential Treatment Center (RTC) numbers increased in Baltimore City, they still made up a lower percentage of total expenditures for the city than for the state.

The increase in PRP services is likely related to PRP expansion under "any willing provider," which resulted in several new providers being added in FY 2019. Providers that are new to PRP could be identifying individuals among different populations or through different referral sources than those historically used by longer-standing PRPs, resulting in an increased number of individuals served within this level of care.

For RTCs, this increase in consumers is more complicated. The number of RTCs statewide has decreased over the past several years, with the closure of Good Shepherd and other RTC programs. The state has worked to address this reduction in capacity by adding capacity to RICA Baltimore. However, these "beds" have generally not be accessible to Baltimore City youth for a variety of reasons.

As a result, placement agencies such as Department of Juvenile Services and Department of Social Services have had to rely on out of state placements more frequently. This could mean that with more youth being placed out of state, there has been greater opportunity for other youth to access in-state beds. An alternative explanation could also be that youth are moving through RTC placement at a quicker rate for shorter stays, resulting in a higher number of consumers due to turnover of beds.

The average cost per person served during FY 2019 was $5,722, with the adolescents having the highest cost per person at $7,405. The cost per person among adolescents seems largely driven by inpatient and PRP claims. PRP is discussed above, and inpatient will be discussed below with the difference between the state and city costs per person.

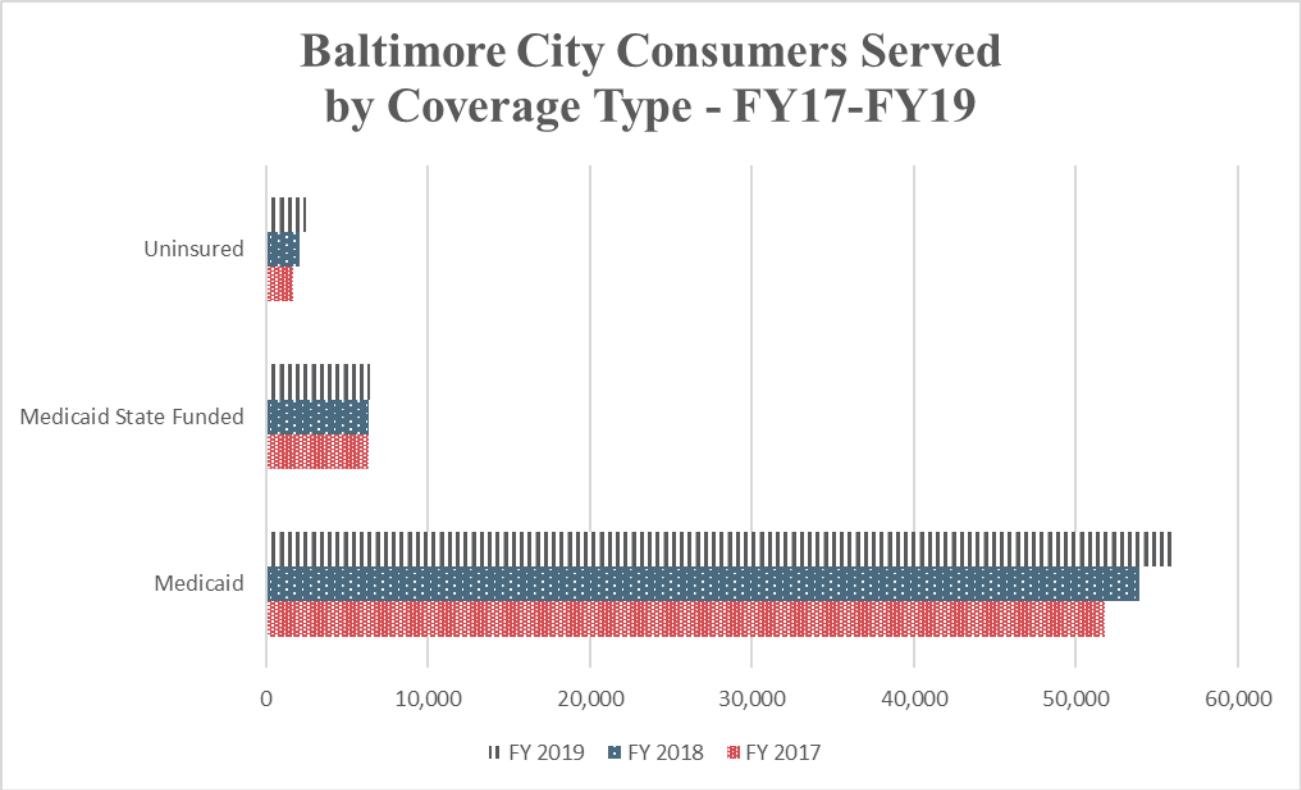
Insurance Coverage

The main source of health insurance coverage for public mental health services is Medicaid, including Medicaid State-funded.[37] Between FY 2018 and FY 2019, Medicaid consumers served and expenditures increased on par with the overall increases in utilization, which is expected, as Medicaid-covered consumers made up 95.7% of the Baltimore City public mental health consumers.[38] Of particular note is the increase from FY 2017 to FY 2019 of nearly 800 uninsured

[37] 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.

[38] 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%.

consumers, in addition to an extra $1.2 million spent on the uninsured. This is likely due to statewide communication from BHA clarifying to providers which services for the uninsured are reimbursable. 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.



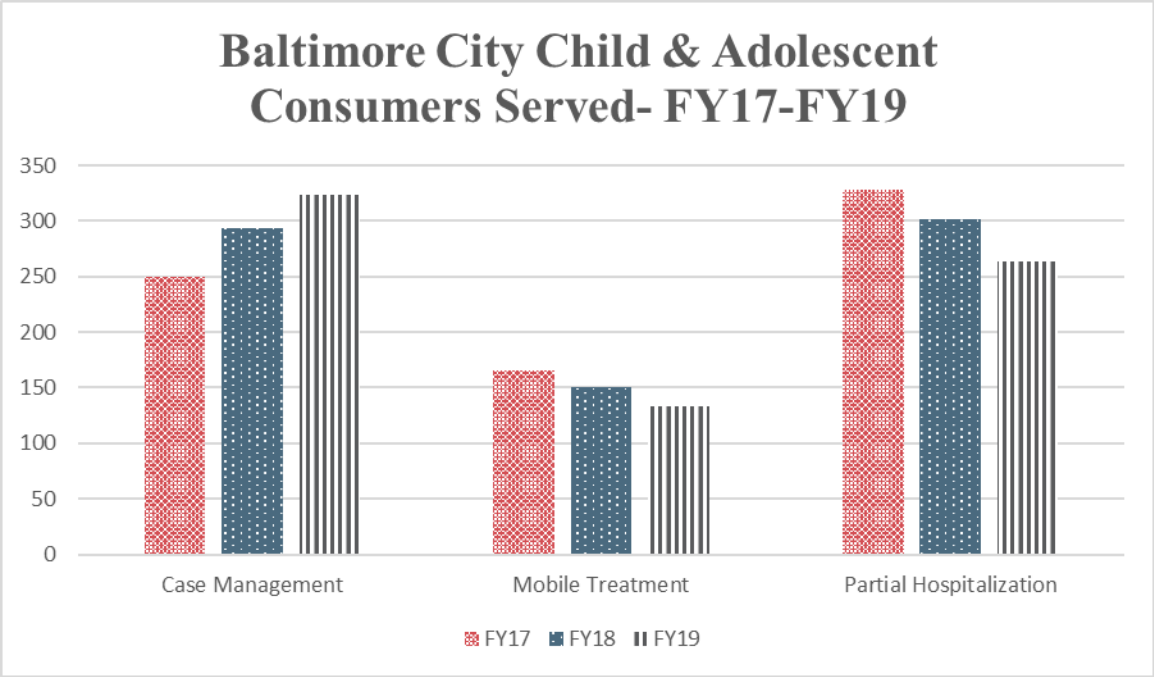
Source: Beacon Health Options
Based on claims paid through September 30, 2019

Adult versus Youth

The proportion of adult and youth consumers receiving public mental health services is consistent from FY 2017 thru FY 2019, as roughly two out of three consumers are adults, and one out of three are children or adolescents. Maryland's PBHS 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.

Case management services among children and adolescents, more specifically referred to as Mental Health Case Management: Care Coordination, had an increase in the number of persons served, while mobile treatment and partial hospitalization had a decrease. The complementary

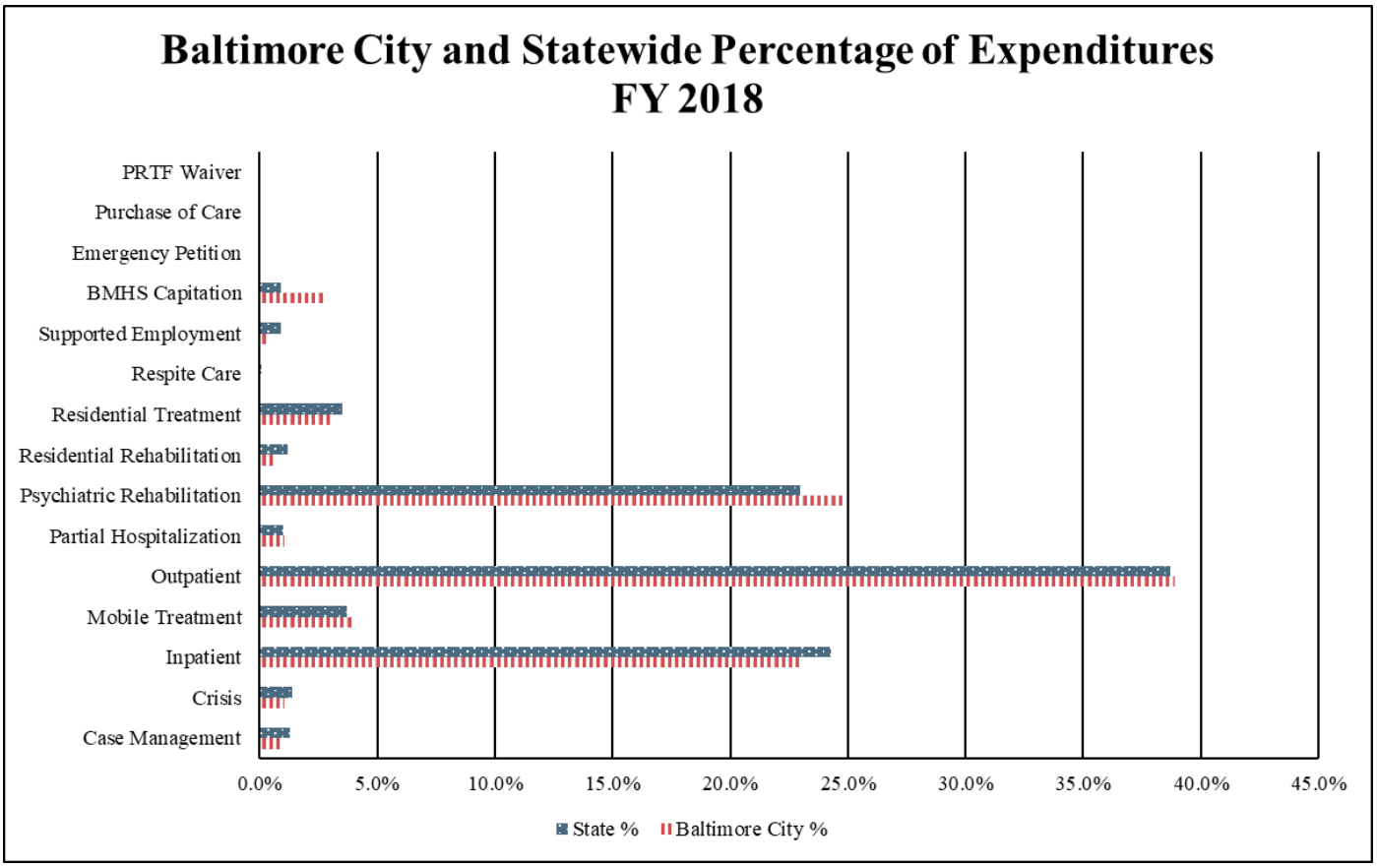
changes likely occurred because consumers may only be served in both case management and either mobile treatment or partial hospitalization with an exception request from the ASO. These exceptions are reserved for the most complex cases requiring creative treatment planning across the system of care. Mental health case management: care coordination is expanding appropriately to meet the needs of the community. Also, among children and adolescents, mental health case management: care coordination expenditures increased, both because of an increase in consumers served and due to a large increase in the case management reimbursement rate statewide.



Source: Beacon Health Options
Based on claims paid through September 30, 2019

City versus State

A higher percentage of Baltimore City residents (9.3% of the city population) utilized public mental health services during FY 2019, compared to the state (3.6% of the population). A larger percentage of the city population (43.2%) is eligible for Medicaid than the state population (23.3%), so a larger percentage of the overall population participating in services is expected. The greater percentage of eligible consumers needing and receiving behavioral health care 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. Behavioral health services may also be more available in the city than in the rest of the state.



Source: Beacon Health Options
Based on claims paid through September 30, 2019

Both Baltimore City and the state saw an increase (9.1% and 3.8%, respectively), in the average cost per consumer between FY 2017 thru FY 2019. For the last three years, Baltimore City has had a higher overall cost per consumer than the state. While the reasons for this are likely multifactorial and relate to underlying social determinants of health, two specific factors may contribute to the differences.

First, the average cost per veteran consumer in Baltimore City was $8,212 per year in FY 2019. This cost is around 1.4 times higher than for non-veterans, with a minimal cost variation over a three-year comparison from FY 2017-2019 ($129). Though the average cost per veteran consumer was slightly higher for the state ($8,310) than for the city, one-third of the veterans utilizing public mental health services reside in the city. The large number of veterans in the city utilizing public mental health services and their higher cost per consumer than the general population may contribute to the higher cost per consumer in Baltimore City as a whole.

Additionally, a large driver of the cost per consumer is inpatient claims. A 2019 study sponsored by the Maryland Hospital Association investigated discharge delays (time spent in an inpatient setting after discharge was clinically indicated) among behavioral health consumers. The study

found that discharge delays occurred in 7% of inpatient behavioral health hospital stays and lasted an average of 13 days. Such delays, even in a small percent of the population, can drive up costs. The largest proportion of discharge delay cases in the state occurred in Baltimore City (29%), and 83% of the cases across the state occurred among the publicly insured or uninsured.[39] Often the reason for delayed discharges across the state involved consumers being unable to transfer to another facility, indicating that though the capacity and utilization in Baltimore City and the state are increasing, the needs of the consumers may not always be met in a timely manner.

Medicaid Penetration – Mental Health Services Utilization

Over the last three years, the number of Medicaid consumers receiving mental health services has increased by 8.2% in the city and 11.1% in the state.

This number has increased significantly since the passage of the Affordable Care Act (ACA) in 2014. Since FY 2014, there has been a 20% increase in the number of individuals covered by Medicaid who utilized public mental health services, from 46,861 (FY 2014) to 56,061 (FY 2019).

Persons Served by Coverage Type*							
	FY 2014	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**% Change from FY 2018 - FY 2019**
Medicaid	46,861	51,082	51,283	51,818	53,929	56,061	4.00%
Medicaid State Funded	5,582	5,458	5,585	6,294	6,333	6,389	0.90%
Uninsured	2,274	3,456	3,185	1,670	2,082	2,452	17.80%

*Based on claims paid through September 30, 2019

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

[39] Dillon, K. & Thompson, D. Delays in hospital discharges of behavioral health patients: Results from the Maryland Hospital Association Behavioral Health Data Collection, 2019. https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf

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.[40] Individuals experiencing mental health disorders often face multiple barriers to care and have low incomes, in part because the disorders frequently impact the individuals' work and functional capacities.[41] 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.[42]

The Baltimore City penetration rate is 21.6%, and the state rate 15.3%. According to the Substance Abuse and Mental Health Services Administration, approximately 19.1% of adults experienced mental illness in 2018,[43] indicating that the Baltimore City penetration rate more closely represents the number of likely mental health cases in the jurisdiction. However, given the information discussed in the social determinants of health section, the number of individuals with underlying behavioral health conditions among Medicaid recipients and uninsured persons in Baltimore City likely exceeds the national average.

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 26.0% of all consumers served in Maryland and 30.6% of state expenditures.

[40] 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/

[41] 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.

[42] 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.

[43] Key Substance Use and Mental Health Indicators: Results from the 2018 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/ cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	Persons Served By Age Group*				
	FY 2017	FY 2018	% Change	FY 2019	% Change
Early Child (0-5)	2,026	2,025	0.0%	2,142	5.8%
Child (6-12)	9,238	9,809	6.2%	9,881	0.7%
Adolescent (13-17)	6,024	6,172	2.5%	6,361	3.1%
Transitional (18-21)	2,524	2,778	10.1%	3,129	12.6%
Adult (22 to 64)	33,354	34,586	3.7%	36,028	4.2%
Elderly (65 and over)	791	869	9.9%	1,026	18.1%
TOTAL	**53,957**	**56,239**	**4.2%**	**58,567**	4.1%

**Based on claims paid through September 30, 2019*

	Persons Served By Service Type*				
	FY 2017	FY 2018	% Change	FY 2019	% Change
Case Management	1,231	1,318	7.1%	1,256	-4.7%
Crisis	660	768	16.4%	698	-9.1%
Inpatient	4,890	4,768	-2.5%	4,471	-6.2%
Mobile Treatment	1,224	1,280	4.6%	1,243	-2.9%
Outpatient	50,251	51,899	3.3%	53,557	3.2%
Partial Hospitalization	661	628	-5.0%	519	-17.4%
Psychiatric Rehabilitation	12,899	15,498	20.1%	19,379	25.0%
Residential Rehabilitation	1,089	1,180	8.4%	1,099	-6.9%
Residential Treatment	137	155	13.1%	201	29.7%
Respite Care	40	36	-10.0%	28	-22.2%
Supported Employment	523	454	-13.2%	462	1.8%
BMHS Capitation	342	330	-3.5%	327	-0.9%
Emergency Petition					
Purchase of Care					
PRTF Waiver					
****TOTAL**	**53,957**	**56,239**	**4.2%**	**58,567**	**4.1%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Persons Served By Coverage Type*				
	FY 2017	FY 2018	% Change	FY 2019	% Change
Medicaid	51,818	53,929	4.1%	56,061	4.0%
Medicaid State Funded	6,294	6,333	0.6%	6,389	0.9%
Uninsured	1,670	2,082	24.7%	2,452	17.8%
****TOTAL**	**53,957**	**56,239**	**4.2%**	**58,567**	**4.1%**
Dually Diagnosed	**21,765**	**23,027**	**5.8%**	**23,338**	**1.4%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	Expenditures By Age Group*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Early Child (0-5)	$6,247,104	$5,938,708	-4.9%	$6,331,272	6.6%
Child (6-12)	$48,838,813	$51,751,353	6.0%	$55,415,100	7.1%
Adolescent (13-17)	$37,849,291	$39,562,564	4.5%	$47,100,968	19.1%
Transitional (18-21)	$13,170,223	$14,993,837	13.8%	$15,607,542	4.1%
Adult (22 to 64)	$173,303,935	$188,826,437	9.0%	$203,779,435	7.9%
Elderly (65 and over)	$5,232,982	$6,085,587	16.3%	$6,893,765	13.3%
TOTAL	**$284,642,348**	**$307,158,486**	**7.9%**	**$335,128,082**	**9.1%**

**Based on claims paid through September 30, 2019*

	Expenditures By Service Type*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Case Management	$2,469,107	$2,666,012	8.0%	$2,812,195	5.5%
Crisis	$2,563,085	$3,145,249	22.7%	$3,040,389	-3.3%
Inpatient	$67,128,206	$71,132,243	6.0%	$71,254,022	0.2%
Mobile Treatment	$11,298,647	$11,881,005	5.2%	$12,561,657	5.7%
Outpatient	$115,365,808	$119,307,991	3.4%	$123,998,228	3.9%
Partial Hospitalization	$4,285,991	$3,226,381	-24.7%	$2,689,670	-16.6%
Psychiatric Rehabilitation	$62,666,061	$75,709,119	20.8%	$95,070,766	25.6%
Residential Rehabilitation	$1,695,140	$1,700,096	0.3%	$1,746,754	2.7%
Residential Treatment	$7,900,368	$9,275,642	17.4%	$12,771,169	37.7%
Respite Care	$52,185	$40,013	-23.3%	$35,439	-11.4%
Supported Employment	$850,279	$884,102	4.0%	$947,832	7.2%
BMHS Capitation	$8,289,686	$8,149,640	-1.7%	$8,152,491	0.0%
Emergency Petition					
Purchase of Care					
PRTF Waiver					
****TOTAL**	**$284,642,348**	**$307,158,487**	**7.9%**	**$335,128,081**	**9.1%**

**Based on claims paid through September 30, 2019*

	Expenditures By Coverage Group*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Medicaid	$258,459,068	$278,837,636	7.9%	$306,140,792	9.8%
Medicaid State Funded	$23,579,341	$25,087,362	6.4%	$25,123,846	0.1%
Uninsured	$2,603,939	$3,233,487	24.2%	$3,863,444	19.5%
****TOTAL**	**$284,642,348**	**$307,158,485**	**7.9%**	**$335,128,082**	**9.1%**
Dually Diagnosed	**$147,393,858**	**$170,474,964**	**15.7%**	**$179,167,181**	**5.1%**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	Persons Served: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Case Management	250	293	17.2%	324	10.6%
Crisis					
Inpatient	907	877	-3.3%	888	1.3%
Mobile Treatment	166	151	-9.0%	133	-11.9%
Outpatient	16,734	17,274	3.2%	17,398	0.7%
Partial Hospitalization	328	302	-7.9%	263	-12.9%
Psychiatric Rehabilitation	5,396	6,032	11.8%	7,223	19.7%
Residential Rehabilitation					
Residential Treatment	130	147	13.1%	196	33.3%
Respite Care	40	36	-10.0%	28	-22.2%
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					
****TOTAL**	**17,288**	**18,006**	**4.2%**	**18,384**	**2.1%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Case Management	$626,463	$608,958	-2.8%	$751,364	23.4%
Crisis					
Inpatient	$14,377,865	$14,098,892	-1.9%	$16,735,376	18.7%
Mobile Treatment	$978,504	$973,290	-0.5%	$1,003,989	3.2%
Outpatient	$49,706,377	$50,965,873	2.5%	$51,995,935	2.0%
Partial Hospitalization	$2,410,414	$1,710,532	-29.0%	$1,540,702	-9.9%
Psychiatric Rehabilitation	$17,321,437	$19,917,904	15.0%	$24,167,076	21.3%
Residential Rehabilitation					
Residential Treatment	$7,391,697	$8,894,789	20.3%	$12,606,150	41.7%
Respite Care	$52,185	$40,013	-23.3%	$35,439	-11.4%
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					
****TOTAL**	**$92,935,206**	**$97,252,624**	**4.6%**	**$108,847,341**	**11.9%**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	Persons Served: Adult (Age 18+ Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Case Management	981	1,025	4.5%	932	-9.1%
Crisis	656	767	16.9%	697	-9.1%
Inpatient	3,983	3,891	-2.3%	3,583	-7.9%
Mobile Treatment	1,058	1,129	6.7%	1,110	-1.7%
Outpatient	33,517	34,625	3.3%	36,159	4.4%
Partial Hospitalization	333	326	-2.1%	256	-21.5%
Psychiatric Rehabilitation	7,503	9,466	26.2%	12,156	28.4%
Residential Rehabilitation	1,085	1,178	8.6%	1,097	-6.9%
Residential Treatment					
Respite Care	0	0	#DIV/0!	0	#DIV/0!
Supported Employment	517	450	-13.0%	461	2.4%
BMHS Capitation	342	330	-3.5%	327	-0.9%
Emergency Petition					
Purchase of Care					
PRTF Waiver	0			0	
****TOTAL**	**36,669**	**38,233**	**4.3%**	**40,183**	**5.1%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Adult (Age 18+ Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Case Management	$1,842,645	$2,057,054	11.6%	$2,060,832	0.2%
Crisis	$2,551,832	$3,140,429	23.1%	$3,036,907	-3.3%
Inpatient	$52,750,341	$57,033,351	8.1%	$54,518,646	-4.4%
Mobile Treatment	$10,320,143	$10,907,715	5.7%	$11,557,668	6.0%
Outpatient	$65,659,431	$68,342,118	4.1%	$72,002,293	5.4%
Partial Hospitalization	$1,875,577	$1,515,849	-19.2%	$1,148,968	-24.2%
Psychiatric Rehabilitation	$45,344,625	$55,791,215	23.0%	$70,903,690	27.1%
Residential Rehabilitation	$1,694,433	$1,698,225	0.2%	$1,743,482	2.7%
Residential Treatment					
Respite Care	$0	$0	#DIV/0!	$0	#DIV/0!
Supported Employment	$842,305	$881,108	4.6%	$947,384	7.5%
BMHS Capitation	$8,289,686	$8,149,640	-1.7%	$8,152,491	0.0%
Emergency Petition					
Purchase of Care					
PRTF Waiver	$0			$0	
****TOTAL**	**$191,707,144**	**$209,906,163**	**9.5%**	**$226,280,740**	**7.8%**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	State and County Comparisons Persons Served*			
	STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	7,965	3.5%	2,142	3.7%
Child	41,251	18.3%	9,881	16.9%
Adolescent	29,719	13.2%	6,361	10.9%
Transitional	13,769	6.1%	3,129	5.3%
Adult	129,591	57.5%	36,028	61.5%
Elderly	2,965	1.3%	1,026	1.8%
TOTAL	**225,260**	**100.0%**	**58,567**	**100.0%**
SERVICE TYPE				
Case Management	6,581	2.9%	1,256	2.1%
Crisis	2,808	1.2%	698	1.2%
Inpatient	18,775	8.3%	4,471	7.6%
Mobile Treatment	4,409	2.0%	1,243	2.1%
Outpatient	210,766	93.6%	53,557	91.4%
Partial Hospitalization	2,162	1.0%	519	0.9%
Psychiatric Rehabilitation	45,053	20.0%	19,379	33.1%
Residential Rehabilitation	5,317	2.4%	1,099	1.9%
Residential Treatment	452	0.2%	201	0.3%
Respite Care	437	0.2%	28	0.0%
Supported Employment	3,791	1.7%	462	0.8%
BMHS Capitation	367	0.2%	327	0.6%
Emergency Petition	424	0.2%		
Purchase of Care	23	0.01%		
PRTF Waiver	31	0.01%		
TOTAL	**225,260**	**100.0%**	**58,567**	**100.0%**
COVERAGE TYPE				
Medicaid	215,660	95.7%	56,061	95.7%
Medicaid State Funded	30,324	13.5%	6,389	10.9%
Uninsured	9,496	4.2%	2,452	4.2%
TOTAL	**225,260**	**100.0%**	**58,567**	**100.0%**
DUALLY DIAGNOSED INDIVIDUALS				
All with DD #	**73,908**	**32.8%**	**23,338**	**39.8%**

**Based on claims paid through September 30, 2019*

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

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	State and County Comparisons Expenditures*			
	STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	$20,190,165	1.8%	$6,331,272	1.9%
Child	$193,269,229	17.6%	$55,415,100	16.5%
Adolescent	$163,147,281	14.9%	$47,100,968	14.1%
Transitional	$56,845,853	5.2%	$15,607,542	4.7%
Adult	$638,416,123	58.3%	$203,779,435	60.8%
Elderly	$23,160,689	2.1%	$6,893,765	2.1%
TOTAL	**$1,095,029,340**	**100.0%**	**$335,128,082**	**100.0%**
SERVICE TYPE				
Case Management	$16,202,610	1.5%	$2,812,195	0.8%
Crisis	$14,852,172	1.4%	$3,040,389	0.9%
Inpatient	$253,559,133	23.2%	$71,254,022	21.3%
Mobile Treatment	$41,187,110	3.8%	$12,561,657	3.7%
Outpatient	$419,037,021	38.3%	$123,998,228	37.0%
Partial Hospitalization	$9,660,214	0.9%	$2,689,670	0.8%
Psychiatric Rehabilitation	$270,117,173	24.7%	$95,070,766	28.4%
Residential Rehabilitation	$12,277,663	1.1%	$1,746,754	0.5%
Residential Treatment	$37,718,724	3.4%	$12,771,169	3.8%
Respite Care	$1,136,928	0.1%	$35,439	0.0%
Supported Employment	$9,714,050	0.9%	$947,832	0.3%
BMHS Capitation	$9,099,972	0.8%	$8,152,491	2.4%
Emergency Petition	$152,275	0.014%		
Purchase of Care	$220,649	0.020%		
PRTF Waiver	$93,646	0.009%		
TOTAL	**$1,095,029,340**	**100.0%**	**$335,128,081**	**100.0%**
COVERAGE TYPE				
Medicaid	$985,970,664	90.0%	$306,140,792	91.4%
Medicaid State Funded	$91,355,423	8.3%	$25,123,846	7.5%
Uninsured	$17,703,253	1.6%	$3,863,444	1.2%
TOTAL	**$1,095,029,340**	**100.0%**	**$335,128,082**	**100.0%**
DUALLY DIAGNOSED INDIVIDUALS				
All with DD #	**$505,174,207**	**46.1%**	**$179,167,181**	**53.5%**

**Based on claims paid through September 30, 2019*

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

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

	State and County Comparisons Cost Per Person Served*			
	State	**County**	**Difference**	**Index^**
AGE				
Early Child	$2,535	$2,956	$421	116.6
Child	$4,685	$5,608	$923	119.7
Adolescent	$5,490	$7,405	$1,915	134.9
Transitional	$4,129	$4,988	$859	120.8
Adult	$4,926	$5,656	$730	114.8
Elderly	$7,811	$6,719	-$1,092	86.0
TOTAL	**$4,861**	**$5,722**	**$861**	**117.7**
SERVICE TYPE				
Case Management	$2,462	$2,239	-$223	90.9
Crisis	$5,289	$4,356	-$933	82.4
Inpatient	$13,505	$15,937	$2,432	118.0
Mobile Treatment	$9,342	$10,106	$764	108.2
Outpatient	$1,988	$2,315	$327	116.5
Partial Hospitalization	$4,468	$5,182	$714	116.0
Psychiatric Rehabilitation	$5,996	$4,906	-$1,090	81.8
Residential Rehabilitation	$2,309	$1,589	-$720	68.8
Residential Treatment	$83,449	$63,538	-$19,910	76.1
Respite Care	$2,602	$1,266	-$1,336	48.6
Supported Employment	$2,562	$2,052	-$511	80.1
BMHS Capitation	$24,796	$24,931	$136	100.5
Emergency Petition	$359			
Purchase of Care	$9,593			
PRTF Waiver	$3,021			
TOTAL	**$4,861**	**$5,722**	**$861**	**117.7**
COVERAGE TYPE				
Medicaid	$4,572	$5,461	$889	119.4
Medicaid State Funded	$3,013	$3,932	$920	130.5
Uninsured	$1,864	$1,576	-$289	84.5
TOTAL	**$4,861**	**$5,722**	**$861**	**117.7**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM
UTILIZATION FY 2019

VETERANS RECEIVING MENTAL HEALTH SERVICES IN FY 2017-2019
(PERSONS SERVED)

COUNTY	FY 2017	FY 2018	FY 2019
Allegany	156	147	144
Anne Arundel	266	285	272
Baltimore City	1,493	1,420	1,424
Baltimore County	568	563	538
Calvert	73	68	64
Caroline	57	50	40
Carroll	101	100	100
Cecil	113	109	101
Charles	88	86	73
Dorchester	52	58	55
Frederick	154	162	148
Garrett	29	31	35
Harford	166	155	160
Howard	117	96	99
Kent	17	17	17
Montgomery	312	314	293
Prince George's	306	292	283
Queen Anne's	34	32	29
St. Mary's	65	69	85
Somerset	37	34	38
Talbot	36	33	31
Washington	243	241	230
Wicomico	146	141	160
Worcester	77	69	59
Statewide	**4,517**	**4,374**	**4,303**

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 2019

VETERANS RECEIVING MENTAL HEALTH SERVICES IN FY 2017-2019 (EXPENDITURES)

COUNTY	FY 2017	FY 2018	FY 2019
Allegany	$809,734	$846,251	$743,546
Anne Arundel	$2,503,040	$2,622,192	$2,194,823
Baltimore City	$12,068,180	$11,443,688	$11,694,107
Baltimore County	$5,363,827	$4,780,111	$4,310,801
Calvert	$331,795	$279,364	$235,899
Caroline	$356,207	$376,321	$263,427
Carroll	$991,279	$617,776	$687,935
Cecil	$889,849	$498,404	$384,741
Charles	$553,316	$481,947	$330,206
Dorchester	$451,845	$367,153	$451,833
Frederick	$1,574,746	$1,798,488	$1,357,610
Garrett	$184,374	$162,267	$103,343
Harford	$1,421,611	$892,786	$1,107,272
Howard	$1,153,382	$1,011,087	$1,075,682
Kent	$87,857	$81,732	$78,011
Montgomery	$3,257,766	$3,452,172	$3,609,940
Prince George's	$3,675,302	$3,931,726	$3,327,293
Queen Anne's	$124,142	$161,603	$125,181
St. Mary's	$543,516	$627,119	$506,296
Somerset	$212,778	$204,536	$390,843
Talbot	$178,414	$101,617	$118,825
Washington	$1,345,147	$1,408,084	$1,265,068
Wicomico	$987,427	$1,167,388	$1,096,114
Worcester	$161,828	$164,256	$300,273
Statewide	**$39,227,362**	**$37,478,068**	**$35,759,069**

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

FY 2019 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	70,975	21,989	31.0%	4,790	**21.8%**
Anne Arundel	576,031	95,723	16.6%	16,793	**17.5%**
Baltimore County	828,431	199,989	24.1%	32,874	**16.4%**
Calvert	92,003	14,398	15.6%	2,889	**20.1%**
Caroline	33,304	12,054	36.2%	1,842	**15.3%**
Carroll	168,429	23,283	13.8%	4,465	**19.2%**
Cecil	102,826	26,460	25.7%	5,024	**19.0%**
Charles	161,503	32,251	20.0%	3,944	**12.2%**
Dorchester	31,998	12,936	40.4%	2,541	**19.6%**
Frederick	255,648	41,098	16.1%	7,214	**17.6%**
Garrett	29,163	8,636	29.6%	1,254	**14.5%**
Harford	253,956	45,349	17.9%	8,589	**18.9%**
Howard	323,196	46,201	14.3%	5,996	**13.0%**
Kent	19,383	5,003	25.8%	953	**19.0%**
Montgomery	1,052,567	188,515	17.9%	18,618	**9.9%**
Prince George's	909,308	228,609	25.1%	21,855	**9.6%**
Queen Anne's	50,251	8,428	16.8%	1,426	**16.9%**
St. Mary's	112,664	22,781	20.2%	3,372	**14.8%**
Somerset	25,675	8,835	34.4%	1,849	**20.9%**
Talbot	36,968	8,589	23.2%	1,583	**18.4%**
Washington	150,926	44,326	29.4%	8,772	**19.8%**
Wicomico	103,195	34,759	33.7%	5,904	**17.0%**
Worcester	51,823	13,468	26.0%	2,848	**21.1%**
Baltimore City	602,495	260,054	43.2%	56,061	**21.6%**
Statewide	**6,042,718**	**1,405,552**	**23.3%**	**215,660**	**15.3%**

* Maryland Vital Statistics Est. Md. Population July 1, 2018

Data Source: Average MA Eligible supplied by UMBC Hilltop Institute. Data through September 2019.

BALTIMORE CITY PUBLIC MENTAL HEALTH SYSTEM UTILIZATION FY 2019

POPULATION IN POVERTY (%), 2018

Jurisdiction	All (%)	Children 0-17 (%)	Ranking Total Population in Poverty (%)
United States	13.1	18.0	
Allegany	16.7	21.3	3
Anne Arundel	7.0	9.6	17
Baltimore	9.9	13.0	11
Baltimore City	18.9	26.1	2
Calvert	5.4	6.6	23
Caroline	13.2	19.9	6
Carroll	6.0	6.1	22
Cecil	8.3	12.8	14
Charles	6.6	9.3	19
Dorchester	15.4	27.0	4
Frederick	6.2	7.4	21
Garrett	12.2	18.4	8
Harford	7.0	9.7	16
Howard	5.2	6.2	24
Kent	12.9	19.2	7
Montgomery	6.9	8.4	18
Prince George's	8.3	12.0	13
Queen Anne's	6.5	8.6	20
Somerset	23.4	31.4	1
St. Mary's	8.0	10.6	15
Talbot	9.2	14.6	12
Washington	11.1	16.5	9
Wicomico	14.6	20.1	5
Worcester	10.4	17.7	10
Statewide	9.1	12.1	

https://www.census.gov/data-tools/demo/saipe

Substance Related Disorder (SRD) Utilization

Claims may be submitted up to 12 months after the date of service delivery, so the data for FY 2019 does not reflect all the claims for services rendered to Baltimore City individuals. Grant-funded residential SRD services for all ASAM levels of care except 3.1 transitioned to the ASO starting on July 1, 2017, and 3.1 transitioned to the ASO on January 1, 2019. This is important to note when comparing FY 2017 data to FY 2018 and FY 2019 data.

The SRD service utilization tables present summary data from the past three fiscal years for Baltimore City and the past fiscal year for Maryland.

Overall, there are several striking observations from the FY 2019 data on SRD service utilization in Baltimore City:

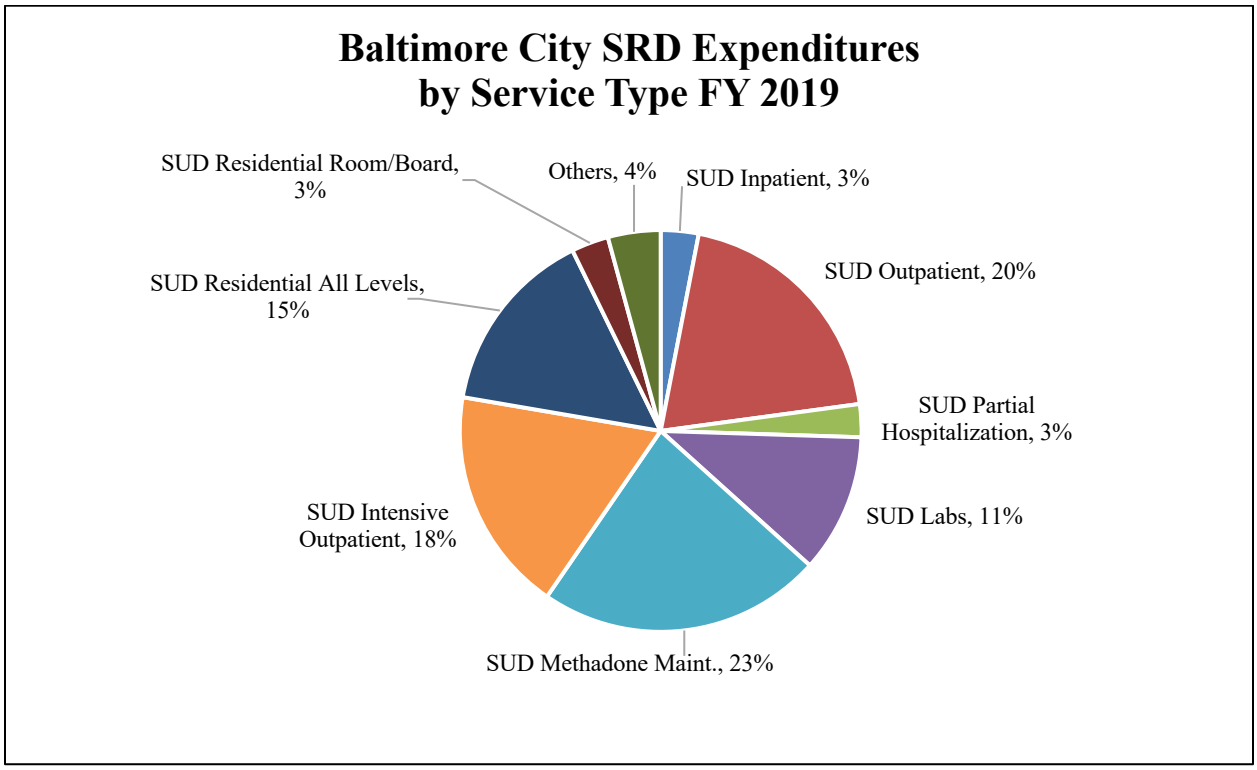
- The public SRD system served 34,964 individuals.
- Expenditures totaled $175,719,829.
- The most frequently utilized levels of care were the ambulatory services: outpatient, methadone maintenance, and intensive outpatient.
- The substance use disorder (SUD) residential levels of care (3.1, 3.3, 3.5, 3.7 and 3.7.D) served 4,107 people during the second year that these services were reimbursed by the ASO, reflecting a 37% increase in consumers served over the first year.
- Labs represented 11.2% of the total expenditures, representing a decrease from FY 2018.
- Uninsured individuals represented 10.6% of those served.
- The average expenditure per consumer in Baltimore City was $5,026.
- The most expensive service types per person served were SUD Court Ordered Placement - Residential ($19,840) and SUD Women with Children/Pregnancy – Residential ($17,618). Both reflect increases in costs per person served but are also lower than the state cost per person served for each service.
- Two of the ambulatory services (intensive outpatient and outpatient) were above the state's average cost per consumer.
- Medicaid costs per person in Baltimore City were above the state average ($5,026 vs. $3,961).

Consumers Served & Expenditures

While Baltimore City represents 10.2% of the state's population and 18.5% of the city's Medicaid-eligible population, it represented 30.0% of those who utilized public SRD services and 38.1% of the state's total expenditures in FY 2019, with a total of 34,964 consumers served and total expenditures of $175,719,829. Research shows that a high proportion of individuals

receiving SUD treatment services have a history of high ACE scores and trauma exposure.[44] The prevalence of high ACE scores and other social, economic and educational structures, including poverty, racism, and community violence, increases the likelihood of chronic illnesses, including behavioral health conditions. [45]

From FY 2018 to FY 2019, children consumers aged 6-12 showed a decrease in the number of persons served but a sharp increase in expenditures. This change in spending appears to be a return to usual levels after particularly low expenditures in FY 2018. Both persons served and expenditures increased among the elderly in FY 2019.

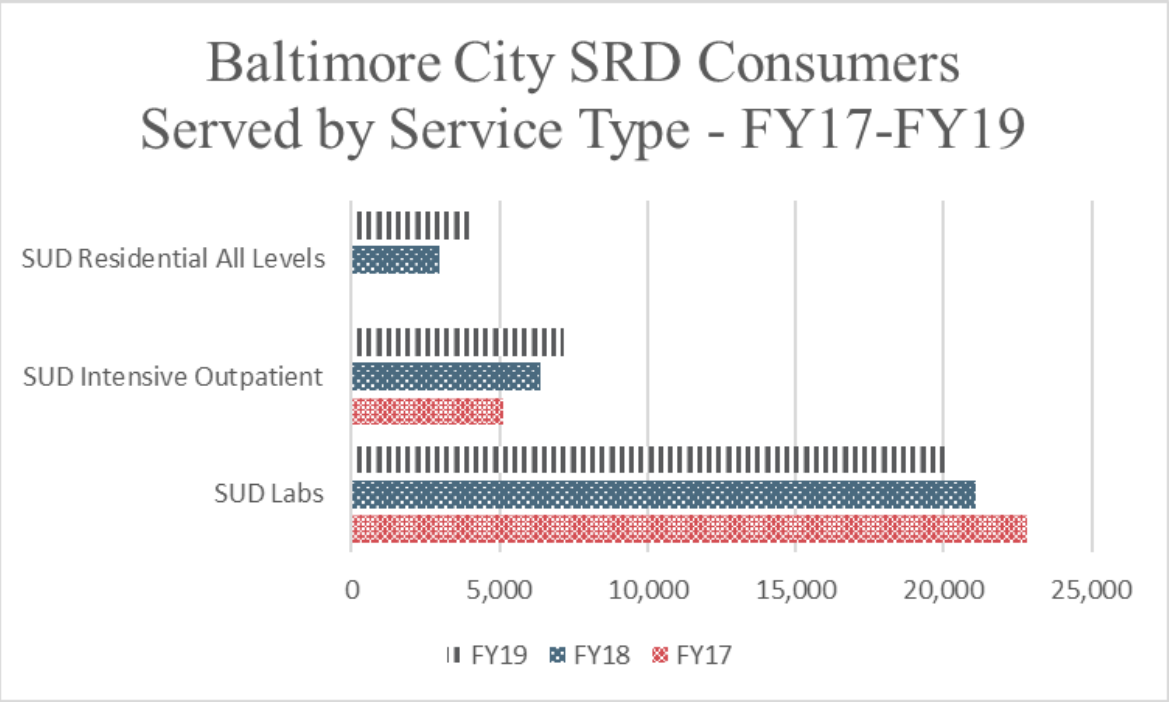


Source: Beacon Health Options
Based on claims paid through September 30, 2019

FY 2019 saw marked increases in persons served and expenditures for all types of residential care, primarily because it represents the second year of data with residential reimbursement and the first half-year with the 3.1 level of care reimbursed. SUD Intensive Outpatient showed

[44] 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.
[45] 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

an increase in persons served and expenditures across the three-year period, likely at least in part because prescribers were able to bill for buprenorphine services under medication management sessions. SUD Labs showed a decrease in both persons served and expenditures across the three-year time period after messaging from the state encouraging more appropriate use of labs.



Insurance Coverage

The main source of health insurance coverage for public SRD services was Medicaid, including Medicaid State-funded.[46] After a substantial increase in State-Funded Medicaid in FY 2018, due to the transition away from grant funding, the increase in FY 2019 was more modest. In FY 2019 the number of uninsured individuals represented 10.6% of the Baltimore City residents utilizing public SRD services. The total number of uninsured consumers served in Baltimore City increased by 74.9% between FY 2016 and FY 2019. 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	FY 2018	FY 2016 – 2018	FY 2019	FY 2016 – 2019

[46] 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.

		Percent Change		Percent Change		Percent Change
2,387	3,178	33.1%	3,793	58.9%	4,175	74.9%

Youth versus Adult

The gap between adult and youth consumers receiving public SRD services continues from FY 2017 thru FY 2019. 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. This has included embedding SRD treatment and prevention services in fifteen Baltimore City Public Schools.

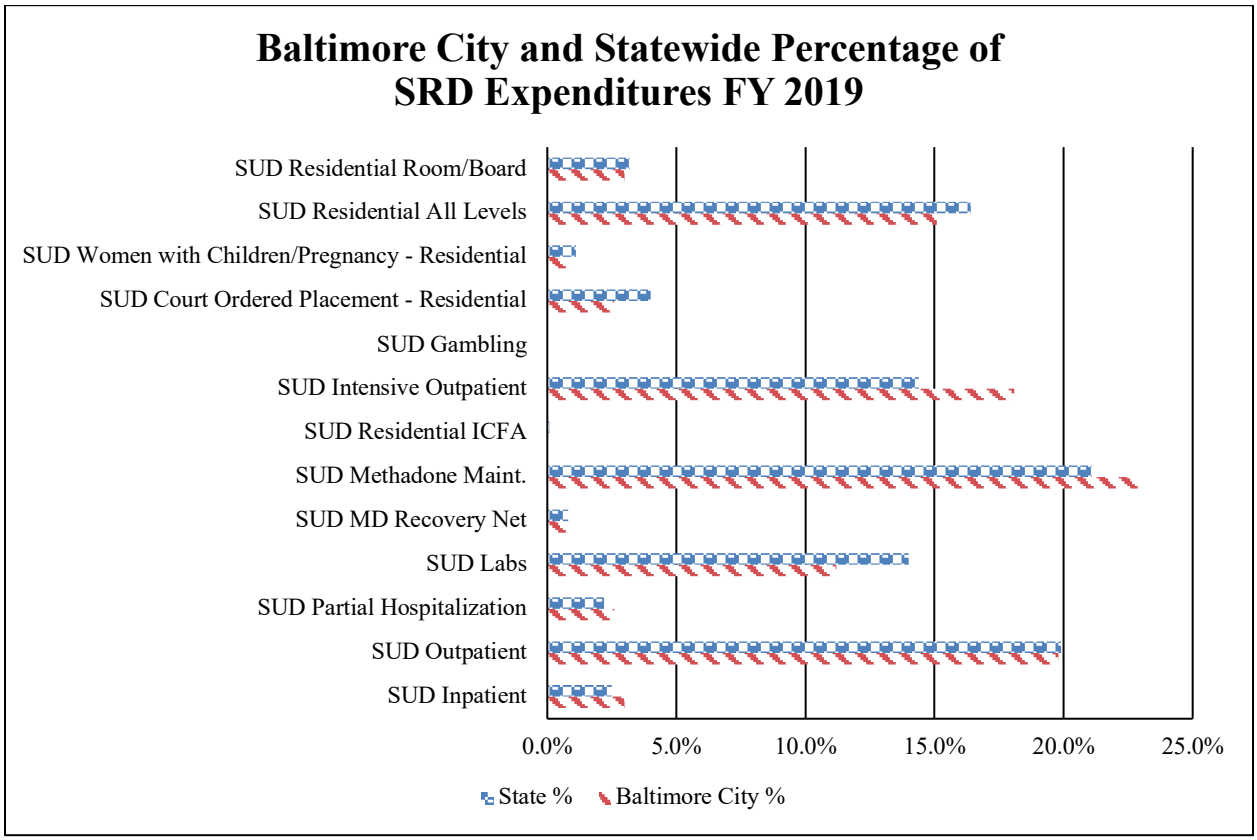
Though children showed a decrease in persons served, they showed an increase in expenditures, which seems to be a return to typical expenditure levels after a particularly low year in FY 2018. Historic barriers to the engagement of youth in SRD treatment include the inability to suppress Explanation of Benefits (EOBs) from caregivers for youth who wish to access treatment without caregiver knowledge and a lack of residential SRD treatment in Maryland. The last residential SRD program serving youth, Catoctin Summit, closed during the summer of 2019.

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.

City versus State

Baltimore City residents utilized SRD services during FY 2019 at a higher rate (5.7% of the city population) than the state (1.9%). For the last three years, Baltimore City has had a higher SRD overall cost per consumer than the state. The average cost per person for the city in FY 2019 was $5,026, which is higher than the statewide cost per person, $3,961. Both Baltimore City and the state saw an increase (27.1% and 31.3%, respectively) in the overall cost per consumer between FY 2017 thru FY 2019. As discussed in the mental health section, the higher cost per person in the city versus the state could be due to the high percentage of veterans in the city, as well as the number and length of delayed discharges.

Baltimore City has higher utilization of methadone maintenance compared with the state, which is on par with the utilization in FY 2018. The difference is possibly explained by 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 MAT programs in the city, as compared to other jurisdictions, and could reflect a cultural tendency to use methadone to treat opioid use disorders.



Source: Beacon Health Options
Based on claims paid through September 30, 2019

Primary Substance at Admission (All Ages)

The number of SRD admissions has decreased in both the city (by 23.3%) and the state (by 16.2%) over the three-year period. This change is largely accounted for by decreases in opiate admissions. 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. Heroin is the most common substance among the opiates, representing 85% of the total opiates as primary substance in FY 2019. The number of heroin admissions, both as a percentage of opiate admission and as a percentage of total admissions is higher in the city than the state. From FY 2017 to FY 2019, Baltimore City residents represented between 44% to 41% of the total admissions in Maryland for which heroin was the primary substance (All Ages).

The second most common primary substance is alcohol, representing around 17% of total admissions in FY 2019. The third and fourth most common are marijuana and cocaine, representing 7.6% and 7.1%, respectively. Admissions for both alcohol and cocaine seem to be on the rise in both the city and the state, while marijuana admissions seem to be on the decline.

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 30% of all consumers served in Maryland and 38% of state expenditures.

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	Persons Served by Age Group*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Early Child (0-5)		15			
Child (6-12)	84	54	-35.7%	42	-22.2%
Adolescent (13-17)	812	773	-4.8%	664	-14.1%
Transitional (18-21)	1,103	1,128	2.3%	1,004	-11.0%
Adult (22 to 64)	30,513	32,237	5.7%	32,225	0.0%
Elderly (65 and over)	593	799	34.7%	1,021	27.8%
TOTAL	**33,113**	**35,006**	**5.7%**	**34,964**	**-0.1%**

**Based on claims paid through September 30, 2019*

	Persons Served by Service Type*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
SUD Inpatient	1,506	1,239	-17.7%	1,344	8.5%
SUD Outpatient	21,278	23,644	11.1%	24,239	2.5%
SUD Partial Hospitalization	1,538	1,592	3.5%	1,629	2.3%
SUD Labs	22,796	21,085	-7.5%	20,101	-4.7%
SUD MD Recovery Net	1,619	1,754	8.3%	1,747	-0.4%
SUD Methadone Maint.	13,698	13,908	1.5%	14,206	2.1%
SUD Residential ICFA	132	52	-60.6%	11	-78.8%
SUD Intensive Outpatient	5,141	6,385	24.2%	7,160	12.1%
SUD Gambling	0	12	#DIV/0!	34	183.3%
SUD Invitation for Bid	195	98	-49.7%	0	-100.0%
SUD Court Ordered Placement - Residential	0	111	#DIV/0!	233	109.9%
SUD Women with Children/Pregnancy - Residential	0	37	#DIV/0!	76	105.4%
SUD Residential All Levels	0	3,000	#DIV/0!	4,107	36.9%
SUD Residential Room/Board	0	2,967	#DIV/0!	4,096	38.1%
****TOTAL**	**33,113**	**35,006**	**5.7%**	**34,964**	**-0.1%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Persons Served by Coverage Type*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Medicaid	31,147	32,716	5.0%	32,160	-1.7%
Medicaid State Funded	1,160	5,513	375.3%	7,034	27.6%
Uninsured	3,178	3,775	18.8%	4,175	10.6%
****TOTAL**	**33,113**	**35,006**	5.7%	**34,964**	**-0.1%**
DUALLY Dx^			**#DIV/0!**		**#DIV/0!**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	Expenditures by Age Group*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Early Child (0-5)		$3,993			
Child (6-12)	$32,799	$18,788	-42.7%	$31,838	69.5%
Adolescent (13-17)	$1,200,276	$731,013	-39.1%	$531,897	-27.2%
Transitional (18-21)	$1,749,890	$2,046,526	17.0%	$1,763,261	-13.8%
Adult (22 to 64)	$125,971,608	$150,594,207	19.5%	$168,821,207	12.1%
Elderly (65 and over)	$1,959,397	$3,229,678	64.8%	$4,569,192	41.5%
TOTAL	**$130,918,740**	**$156,624,205**	**19.6%**	**$175,719,829**	**12.2%**

**Based on claims paid through September 30, 2019*

	Expenditures by Service Type*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
SUD Inpatient	$5,421,772	$5,499,561	1.4%	$5,349,954	-2.7%
SUD Outpatient	$23,631,120	$32,662,239	38.2%	$34,807,577	6.6%
SUD Partial Hospitalization	$3,505,745	$3,804,468	8.5%	$4,656,438	22.4%
SUD Labs	$32,105,865	$22,849,639	-28.8%	$19,634,426	-14.1%
SUD MD Recovery Net	$1,156,558	$1,367,643	18.3%	$1,405,620	2.8%
SUD Methadone Maint.	$42,253,044	$37,134,672	-12.1%	$40,237,822	8.4%
SUD Residential ICFA	$791,227	$312,971	-60.4%	$58,262	-81.4%
SUD Intensive Outpatient	$19,347,087	$26,852,457	38.8%	$31,839,505	18.6%
SUD Gambling	$0	$8,169	#DIV/0!	$19,902	143.6%
SUD Invitation for Bid	$2,706,321	$1,416,783	-47.6%	$0	-100.0%
SUD Court Ordered Placement - Residential	$0	$1,316,848	#DIV/0!	$4,622,808	251.1%
SUD Women with Children/Pregnancy - Residential	$0	$395,984	#DIV/0!	$1,338,961	#DIV/0!
SUD Residential All Levels	$0	$19,591,731	#DIV/0!	$26,484,459	#DIV/0!
SUD Residential Room/Board	$0	$3,411,041	#DIV/0!	$5,264,097	#DIV/0!
****TOTAL**	**$130,918,739**	**$156,624,206**	**19.6%**	**$175,719,831**	**12.2%**

**Based on claims paid through September 30, 2019*

	Expenditures by Coverage Group*				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
Medicaid	$122,536,984	$135,856,954	10.9%	$145,554,384	7.1%
Medicaid State Funded	$2,211,510	$13,259,575	499.6%	$22,150,748	67.1%
Uninsured	$6,170,245	$7,507,677	21.7%	$8,014,697	6.8%
****TOTAL**	**$130,918,739**	**$156,624,206**	**19.6%**	**$175,719,829**	**12.2%**
DUALLY Dx^			**#DIV/0!**		

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	Persons Served: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
SUD Inpatient	12				
SUD Outpatient	446	372	-16.6%	329	-11.6%
SUD Partial Hospitalization					
SUD Labs	693	668	-3.6%	513	-23.2%
SUD MD Recovery Net	0				
SUD Methadone Maint.		0			
SUD Residential ICFA	94	33	-64.9%		
SUD Intensive Outpatient	134	91	-32.1%	55	-39.6%
SUD Gambling	0				
SUD Invitation for Bid	0	0	#DIV/0!	0	#DIV/0!
SUD Court Ordered Placement - Residential	0	0	#DIV/0!	0	#DIV/0!
SUD Women with Children/Pregnancy - Residential	0	0	#DIV/0!	0	#DIV/0!
SUD Residential All Levels	0			0	
SUD Residential Room/Board	0			0	
****TOTAL**	**904**	**842**	**-6.9%**	**714**	**-15.2%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Child / Adolescent (Age 0 – 17 Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
SUD Inpatient	$32,266				
SUD Outpatient	$209,694	$186,665	-11.0%	$234,702	25.7%
SUD Partial Hospitalization					
SUD Labs	$245,044	$203,090	-17.1%	$162,108	-20.2%
SUD MD Recovery Net	$0				
SUD Methadone Maint.		$0			
SUD Residential ICFA	$539,126	$211,171	-60.8%		
SUD Intensive Outpatient	$185,120	$137,018	-26.0%	$117,108	-14.5%
SUD Gambling	$0				
SUD Invitation for Bid	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Court Ordered Placement - Residential	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Women with Children/Pregnancy - Residential	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Residential All Levels	$0			$0	
SUD Residential Room/Board	$0			$0	
****TOTAL**	**$1,237,845**	**$753,796**	**-39.1%**	**$566,167**	**-24.9%**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	Persons Served: Adults (Age 18+ Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
SUD Inpatient	1,494	1,232	-17.5%	1,334	8.3%
SUD Outpatient	20,832	23,272	11.7%	23,910	2.7%
SUD Partial Hospitalization	1,531	1,591	3.9%	1,628	2.3%
SUD Labs	22,103	20,417	-7.6%	19,588	-4.1%
SUD MD Recovery Net	1,619	1,753	8.3%	1,746	-0.4%
SUD Methadone Maint.	13,696	13,908	1.5%	14,203	2.1%
SUD Residential ICFA	38	19	-50.0%		-47.4%
SUD Intensive Outpatient	5,007	6,294	25.7%	7,105	12.9%
SUD Gambling	0	11	#DIV/0!	32	190.9%
SUD Invitation for Bid	195	98	-49.7%	0	-100.0%
SUD Court Ordered Placement - Residential	0	111	#DIV/0!	233	109.9%
SUD Women with Children/Pregnancy - Residential	0	37	#DIV/0!	76	105.4%
SUD Residential All Levels	0	2,999	#DIV/0!	4,107	36.9%
SUD Residential Room/Board	0	2,966	#DIV/0!	4,096	38.1%
****TOTAL**	**32,209**	**34,164**	**6.1%**	**34,250**	**0.3%**

**Based on claims paid through September 30, 2019*
***Note: Totals represent unduplicated counts and may not equal the sum of the individual lines*

	Expenditures: Adults (Age 18+ Years) *				
	FY 2017	**FY 2018**	**% Change**	**FY 2019**	**% Change**
SUD Inpatient	$5,389,506	$5,495,979	2.0%	$5,307,021	-3.4%
SUD Outpatient	$23,421,426	$32,475,575	38.7%	$34,572,875	6.5%
SUD Partial Hospitalization	$3,483,135	$3,794,936	9.0%	$4,655,619	22.7%
SUD Labs	$31,860,822	$22,646,549	-28.9%	$19,472,318	-14.0%
SUD MD Recovery Net	$1,156,558	$1,367,488	18.2%	$1,405,548	2.8%
SUD Methadone Maint.	$42,249,060	$37,134,672	-12.1%	$40,235,515	8.4%
SUD Residential ICFA	$252,101	$101,800	-59.6%		-48.6%
SUD Intensive Outpatient	$19,161,967	$26,715,439	39.4%	$31,722,397	18.7%
SUD Gambling	$0	$7,989	#DIV/0!	$19,671	146.2%
SUD Invitation for Bid	$2,706,321	$1,416,783	-47.6%	$0	-100.0%
SUD Court Ordered Placement - Residential	$0	$1,316,848	#DIV/0!	$4,622,808	251.1%
SUD Women with Children/Pregnancy - Residential	$0	$395,984	#DIV/0!	$1,338,961	238.1%
SUD Residential All Levels	$0	$19,589,603	#DIV/0!	$26,484,459	35.2%
SUD Residential Room/Board	$0	$3,410,766	#DIV/0!	$5,264,097	54.3%
****TOTAL**	**$129,680,896**	**$155,870,411**	**20.2%**	**$175,153,662**	**12.4%**

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	State and County Comparisons Persons Served *			
	STATE		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	34	0.0%		
Child	334	0.3%	42	0.1%
Adolescent	3,221	2.8%	664	1.9%
Transitional	4,748	4.1%	1,004	2.9%
Adult	106,527	91.4%	32,225	92.2%
Elderly	1,646	1.4%	1,021	2.9%
TOTAL	**116,510**	**100.0%**	**34,964**	**100.0%**
SERVICE TYPE				
SUD Inpatient	3,350	2.9%	1,344	3.8%
SUD Outpatient	74,905	64.3%	24,239	69.3%
SUD Partial Hospitalization	3,329	2.9%	1,629	4.7%
SUD Labs	75,387	64.7%	20,101	57.5%
SUD MD Recovery Net	4,751	4.1%	1,747	5.0%
SUD Methadone Maint.	33,867	29.1%	14,206	40.6%
SUD Residential ICFA	55	0.0%	11	0.0%
SUD Intensive Outpatient	16,757	14.4%	7,160	20.5%
SUD Gambling	236	0.2%	34	0.1%
SUD Invitation for Bid	N/A	N/A	N/A	N/A
SUD Court Ordered Placement - Residential	767	0.7%	233	0.7%
SUD Women with Children/Pregnancy - Residential	238	0.2%	76	0.2%
SUD Residential All Levels	11,548	9.9%	4,107	11.7%
SUD Residential Room/Board	11,520	9.9%	4,096	11.7%
****TOTAL**	**116,510**	**100.0%**	**34,964**	**100%**
COVERAGE TYPE				
Medicaid	109,717	94.2%	32,160	92.0%
Medicaid State Funded	19,708	16.9%	7,034	20.1%
Uninsured	11,068	9.5%	4,175	11.9%
TOTAL	**116,510**	**100.0%**	**34,964**	**100.0%**
DUALLY DIAGNOSED INDIVIDUALS				
All with DD ^		0.0%		0.0%

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	State and County Comparisons Expenditures *			
	STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	$8,967	0.00%		
Child	$138,261	0.03%	$31,838	0.0%
Adolescent	$2,830,381	0.61%	$531,897	0.3%
Transitional	$8,791,942	1.91%	$1,763,261	1.0%
Adult	$443,000,220	96.00%	$168,821,207	96.1%
Elderly	$6,681,053	1.45%	$4,569,192	2.6%
TOTAL	**$461,450,824**	**100.0%**	**$175,719,829**	**100.0%**
SERVICE TYPE				
SUD Inpatient	$11,617,108	2.52%	$5,349,954	3.0%
SUD Outpatient	$91,942,709	19.92%	$34,807,577	19.8%
SUD Partial Hospitalization	$10,382,133	2.25%	$4,656,438	2.6%
SUD Labs	$64,588,292	14.00%	$19,634,426	11.2%
SUD MD Recovery Net	$3,810,446	0.83%	$1,405,620	0.8%
SUD Methadone Maint.	$97,752,416	21.18%	$40,237,822	22.9%
SUD Residential ICFA	$361,324	0.08%	$58,262	0.0%
SUD Intensive Outpatient	$66,409,755	14.39%	$31,839,505	18.1%
SUD Gambling	$155,447	0.03%	$19,902	0.0%
SUD Invitation for Bid	N/A	N/A	N/A	N/A
SUD Court Ordered Placement - Residential	$18,440,606	4.00%	$4,622,808	2.6%
SUD Women with Children/Pregnancy - Residential	$5,252,978	1.14%	$1,338,961	0.8%
SUD Residential All Levels	$75,928,530	16.45%	$26,484,459	15.1%
SUD Residential Room/Board	$14,809,080	3.21%	$5,264,097	3.0%
****TOTAL**	**$461,450,824**	**100.0%**	**$175,719,831**	**100.0%**
COVERAGE TYPE				
Medicaid	$382,453,269	82.9%	$145,554,384	82.8%
Medicaid State Funded	$60,749,134	13.2%	$22,150,748	12.6%
Uninsured	$18,248,421	4.0%	$8,014,697	4.6%
TOTAL	**$461,450,824**	**100.0%**	**$175,719,829**	**100.0%**
DUALLY DIAGNOSED INDIVIDUALS				
All with DD ^		0.0%		0.0%

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

	State and County Comparisons Cost per Person Served *			
	State	**County**	**Difference**	**Index^**
AGE				
Early Child	$264			
Child	$414	$758	$344	183.1
Adolescent	$879	$801	-$78	91.2
Transitional	$1,852	$1,756	-$95	94.8
Adult	$4,159	$5,239	$1,080	126.0
Elderly	$4,059	$4,475	$416	110.3
TOTAL	**$3,961**	**$5,026**	**$1,065**	**126.9**
SERVICE TYPE				
SUD Inpatient	$3,468	$3,981	$513	114.8
SUD Outpatient	$1,227	$1,436	$209	117.0
SUD Partial Hospitalization	$3,119	$2,858	-$260	91.7
SUD Labs	$857	$977	$120	114.0
SUD MD Recovery Net	$802	$805	$3	100.3
SUD Methadone Maint.	$2,886	$2,832	-$54	98.1
SUD Residential ICFA	$6,570	$5,297	-$1,273	80.6
SUD Intensive Outpatient	$3,963	$4,447	$484	112.2
SUD Gambling	$659	$585	-$73	88.9
SUD Invitation for Bid	N/A	N/A	N/A	N/A
SUD Court Ordered Placement - Residential	$24,043	$19,840	-$4,202	82.5
SUD Women with Children/Pregnancy - Residential	$22,071	$17,618	-$4,453	79.8
SUD Residential All Levels	$6,575	$6,449	-$126	98.1
SUD Residential Room/Board	$1,286	$1,285	$0	100.0
****TOTAL**	**$3,961**	**$5,026**	**$1,065**	**126.9**
COVERAGE TYPE				
Medicaid	$3,486	$4,526	$1,040	129.8
Medicaid State Funded	$3,082	$3,149	$67	102.2
Uninsured	$1,649	$1,920	$271	116.4
TOTAL	**$3,961**	**$5,026**	**$1,065**	**126.9**
DUALLY DIAGNOSED INDIVIDUALS				
All with DD ^		0.0%		0.0%

**Based on claims paid through September 30, 2019*

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

PRIMARY SUBSTANCE AT ADMISSION (ALL AGES) STATEWIDE VS COUNTY
FY 2017-2019

	FY 2017		FY 2018		FY 2019	
	State	**County**	**State**	**County**	**State**	**County**
Alcohol	9,056	2,206	10,405	2,631	11,184	2,724
Amphetamines	169	32	205	31	251	42
Barbiturates				0		
Benzodiazepines	445	148	527	172	526	145
Cocaine	2,615	1,005	3,161	1,118	3,546	1,167
Diphenylhydantoin (Dilantin)		0		0		0
GHB/GBL	0	0	0	0	0	0
Hallucinogens	72	12	92	22	84	26
Inhalants	11					
Ketamine	24		13		17	
Marijuana/Hashish	4,886	1,412	5,102	1,482	4,516	1,248
Meprobamate						
Opiates	40,640	15,719	27,224	9,674	27,688	10,532
Over the Counter	46	14	40		42	
PCP	294	12	259		292	11
Sedatives	30		36	11	29	
Stimulants	67	14	84	27	123	36
Tranquilizers						
Synthetic Cannabinoids	110	29	85	15	86	11
Other Substance	4,239	300	4,248	336	4,953	373
^None	986	393	17		122	22
TOTAL	**63,700**	**21,314**	**50,426**	**15,551**	**53,394**	**16,362**
Heroin (Opiates subset)	**31,563**	**13,861**	**20,541**	**8,439**	**20,837**	**8,980**

**Based on claims paid through September 30, 2019.*

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 2019

VETERANS RECEIVING SUBSTANCE RELATED DISORDER TREATMENT SERVICES
FY 2017-2019 (PERSONS SERVED)

COUNTY	FY 2017	FY 2018	FY 2019
Allegany	139	129	129
Anne Arundel	223	254	275
Baltimore City	1,579	1,595	1,670
Baltimore County	465	485	507
Calvert	57	64	64
Caroline	28	35	28
Carroll	94	85	82
Cecil	110	94	94
Charles	58	55	59
Dorchester	41	44	59
Frederick	105	122	135
Garrett	26	21	27
Harford	143	148	145
Howard	67	57	54
Kent	16	18	18
Montgomery	139	136	125
Prince George's	101	115	125
Queen Anne's	21	24	23
St. Mary's	42	48	54
Somerset	18	23	28
Talbot	23	26	25
Washington	169	187	172
Wicomico	122	111	147
Worcester	57	64	61
Statewide Total	**3,683**	**3,765**	**3,915**

**Based on claims paid through September 30, 2019.*

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 2019

VETERANS RECEIVING SUBSTANCE RELATED DISORDER TREATMENT SERVICES
FY 2017-2019 (EXPENDITURES)

COUNTY	FY 2017	FY 2018	FY 2019
Allegany	$312,156	$379,688	$365,629
Anne Arundel	$775,754	$1,244,759	$1,544,491
Baltimore City	$7,434,517	$9,095,466	$10,699,379
Baltimore County	$1,639,866	$2,205,231	$2,704,481
Calvert	$116,698	$255,224	$212,509
Caroline	$66,223	$96,370	$149,626
Carroll	$337,301	$355,074	$424,447
Cecil	$264,322	$360,813	$407,761
Charles	$130,663	$288,793	$266,002
Dorchester	$159,215	$231,229	$309,481
Frederick	$490,514	$725,130	$758,000
Garrett	$39,483	$58,306	$113,770
Harford	$418,772	$484,997	$528,251
Howard	$292,908	$291,532	$334,383
Kent	$89,469	$75,047	$46,385
Montgomery	$518,408	$735,343	$758,666
Prince George's	$232,774	$476,794	$672,853
Queen Anne's	$64,063	$113,466	$59,601
St. Mary's	$101,486	$184,029	$243,266
Somerset	$59,589	$137,249	$123,438
Talbot	$85,417	$111,618	$88,517
Washington	$652,061	$823,619	$872,897
Wicomico	$433,346	$554,096	$615,056
Worcester	$112,003	$183,997	$205,920
Statewide Total	**$14,827,008**	**$19,467,870**	**$22,504,809**

**Based on claims paid through September 30, 2019.*

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 2019

NUMBER OF OPIOID RELATED OVERDOSE DEATHS BY COUNTY

COUNTY	CY 2017	CY 2018	CY 2019	% Change CY17-18	% Change CY18-19
Allegany	37	27	14	**-27.0%**	**-48.1%**
Anne Arundel	220	233	164	**5.9%**	**-29.6%**
Baltimore City	514	615	477	**19.6%**	**-22.4%**
Baltimore County	379	400	254	**5.5%**	**-36.5%**
Calvert	29	32	19	**10.3%**	**-40.6%**
Caroline			15	**20.0%**	**88.0%**
Carroll	51	70	39	**37.3%**	**-44.3%**
Cecil	57	56	39	**-1.8%**	**-30.4%**
Charles	40	25	25	**-37.5%**	**0.0%**
Dorchester				**-25.0%**	**66.7%**
Frederick	70	66	42	**-5.7%**	**-36.4%**
Garrett				**-57.1%**	**66.7%**
Harford	101	93	61	**-7.9%**	**-34.4%**
Howard	54	36	24	**-33.3%**	**-33.3%**
Kent				**-50.0%**	**400.0%**
Montgomery	93	66	68	**-29.0%**	**3.0%**
Prince George's	108	82	62	**-24.1%**	**-24.4%**
Queen Anne's		22	16	**175.0%**	**-27.3%**
St. Mary's	36	26	19	**-27.8%**	**-26.9%**
Somerset				**100.0%**	**-50.0%**
Talbot				**42.9%**	**-10.0%**
Washington	47	78	50	**66.0%**	**-35.9%**
Wicomico	26	26	22	**0.0%**	**-15.4%**
Worcester	13	12		**-7.7%**	**-25.0%**
Out of State	81	141	82	**74.1%**	**-41.8%**
Unknown				**0.0%**	**400.0%**
Statewide Total	**2,009**	**2,143**	**1,539**	**6.7%**	**-28.2%**

These are overdose deaths where one or more opioid was found to contribute to the cause of death.

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

CY19 data is not final and is subject to change.

Data Source: Maryland Office of the Chief Medical Examiner (OCME)/ Vital Statistics Administration (VSA)

BALTIMORE CITY PUBLIC SUBSTANCE RELATED DISORDERS UTILIZATION
FY 2019

Medicaid Substance Related Disorders 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	70,975	21,989	31.0%	3,088	**14.0%**
Anne Arundel	576,031	95,723	16.6%	10,288	**10.7%**
Baltimore County	828,431	199,989	24.1%	15,916	**8.0%**
Calvert	92,003	14,398	15.6%	2,106	**14.6%**
Caroline	33,304	12,054	36.2%	1,011	**8.4%**
Carroll	168,429	23,283	13.8%	2,566	**11.0%**
Cecil	102,826	26,460	25.7%	3,966	**15.0%**
Charles	161,503	32,251	20.0%	2,310	**7.2%**
Dorchester	31,998	12,936	40.4%	1,401	**10.8%**
Frederick	255,648	41,098	16.1%	3,624	**8.8%**
Garrett	29,163	8,636	29.6%	720	**8.3%**
Harford	253,956	45,349	17.9%	5,170	**11.4%**
Howard	323,196	46,201	14.3%	2,098	**4.5%**
Kent	19,383	5,003	25.8%	625	**12.5%**
Montgomery	1,052,567	188,515	17.9%	4,922	**2.6%**
Prince George's	909,308	228,609	25.1%	5,765	**2.5%**
Queen Anne's	50,251	8,428	16.8%	852	**10.1%**
St. Mary's	112,664	22,781	20.2%	2,484	**10.9%**
Somerset	25,675	8,835	34.4%	931	**10.5%**
Talbot	36,968	8,589	23.2%	768	**8.9%**
Washington	150,926	44,326	29.4%	5,608	**12.7%**
Wicomico	103,195	34,759	33.7%	3,299	**9.5%**
Worcester	51,823	13,468	26.0%	1,368	**10.2%**
Baltimore City	602,495	260,054	43.2%	32,160	**12.4%**
Statewide	**6,042,718**	**1,405,552**	**23.3%**	**109,717**	**7.8%**

* Maryland Vital Statistics Est. Md. Population July 1, 2018
Data Source: Average MA Eligible supplied by UMBC Hilltop Institute. Data through September 2019.

I. FY 2021 Goals

BHSB's Board of Directors serves in a governing role, guiding the strategic vision for the organization. In addition, it serves as the local mental health advisory council and the local drug and alcohol council as defined by the State of Maryland. BHSB's Board of Directors, along with staff, engaged in a strategic planning process during FY 2016 that resulted in a strategic plan to guide the organization through the next few years (2017 - 2020). It included 13 goals, 42 objectives, and 155 action steps. The board assigned oversight of the strategic plan implementation to the Operations and Oversight Committee.

During the fall of 2018, Operations and Oversight Committee advised staff that the plan should be reframed to reduce its scope and focus the work of the organization on a smaller number of broad, strategic goals. During the winter and spring of 2019, staff collaborated with the committee members to develop a revised plan. One of the primary data sources that informed this work was the *Baltimore Public Behavioral Health System Gap Analysis* report, which involved significant stakeholder involvement, including 166 individuals who participated in key informant interviews or focus groups, including at least 48 consumers or family members.

The resultant *Three-Year Strategic Plan: FY 2020-2022* serves as a guide to drive BHSB's day-to-day work.

Behavioral Health System Baltimore, Inc. (BHSB)
Three-Year Strategic Plan: FY 2020-2022

The public behavioral health system operates within a highly complex construct of federal, state and city policies, payment models and priorities. To be responsive to system partners and the needs of the community, BHSB must set a strategic direction that supports ongoing, adaptive learning and agility. To this end, the three-year strategic plan sets forth action steps that will guide implementation activities during the first year. BHSB will review progress, assess changing conditions, and adjust action steps for subsequent years of this plan.

Goal 1: Increase access to high-quality, integrated behavioral health services for Baltimore City.

Strategy 1: *Partner with the Baltimore Police Department (BPD) and the Mayor's Office of Human Services to meet the behavioral health requirements of the Consent Decree between Baltimore City, BPD and the Department of Justice by preventing people from having unnecessary contact with police and diverting people away from the criminal justice system into services that will meet their needs.*

Action Steps:

- Complete a gap analysis of the behavioral health system in Baltimore City.
- Implement key recommendations from the gap analysis as prioritized by the Collaborative Planning and Implementation Committee (CPIC).
- Plan for the integration of the BPD's Crisis Response, Law Enforcement Assisted Diversion and Homeless Outreach Teams.
- Develop capacity to use available data to track the number of people arrested who have contact with the public behavioral health system.
- Support the development of standards of care and outcome-based performance measurement in Drug Courts and Mental Health Courts.

Strategy 2: *Enhance access points within the system of care in Baltimore City.*

Action Steps:

- Increase utilization of the Maryland Crisis Stabilization Center by working with partners (including fire, police, hospitals, etc.) to expand the number of pathways to enter the center, i.e. revised protocol, walk-ins, etc.
- Fully integrate and increase the scope of street outreach services available to engage and educate people about services in the public behavioral health system.
- Finalize and release the BHSB plan to strengthen and expand the behavioral health crisis response system in Baltimore City.

- Assess the need for dedicated staff to systemically manage access within the system of care.
- Develop capacity and procedures to work with a broader population of individuals with frequent acute health needs who need a higher level of care management.
- Develop standards of care and a competitive funding process that incentivizes community-based Wellness and Recovery Centers to function as low-barrier access points within the system of care.
- Continue implementing a hub and spoke model for buprenorphine treatment by creating one additional "hub" for on-demand buprenorphine treatment along with a network of "spokes" for ongoing care after an individual stabilizes.
- Advocate for Medicaid reimbursement for additional crisis response services.

Strategy 3: *Support the development of the behavioral health work force in the city.*

Action Steps:

- Promote the value and roles of peer recovery specialists by sponsoring high-quality continuing education and creating opportunities to impact policy and system design.
- Develop a training plan that addresses the identified needs within the system of care and articulates a process for continual reassessment and revision of the plan.
- Expand the capacity of the Maryland Harm Reduction Training Institute by hiring a second staff person.
- Expand BHSB's capacity to supervise student interns.

Strategy 4: *Plan for and implement approaches that are designed to meet the unique behavioral health needs of youth and young adults in Baltimore City.*

Action Steps:

- Review local, regional, and national data and feedback from community stakeholders, including directly from youth, to increase understanding of the ways in which the existing system of care could be designed to better meet the unique needs of youth and young adults.
- Strategically partner with youth advocacy organizations to ensure youth have a voice in the behavioral health system.
- Develop community and youth-driven priorities to guide BHSB's programmatic planning and advocacy work as related to the needs of children and youth.

Strategy 5: *Expand methods to assess quality within the provider network.*

Action Steps:

- Define the meaning of a provider "in good standing" and create a plan for how to utilize the standard within BHSB's monitoring activities.
- Assess the frequency and process for monitoring and verifying contractual compliance of sub-contractors and develop operating procedures that are consistent and transparent to these organizations.

Goal 2: Ensure Baltimore City's public behavioral health system remains strong within a changing health care context.

Strategy 1: *Enhance BHSB's capacity to be nimble and responsive within the shifting health care landscape by reviewing and revising internal policies and practices to ensure a high level of customer service with internal and external partners.*

Action Steps:

- Review, revise and clearly document procurement and contracting procedures to increase the efficiency and effectiveness of the procurement and contracting processes.
- Develop and implement proactive processes that facilitate communication between the Finance and Administration teams and other teams within the organization to increase collective understanding and collaboration in managing organizational risk, compliance and financial management.
- Implement a new payroll and timekeeping system to streamline the process of allocating and certifying time charged to grants.
- Develop and implement a provider relations plan that includes a cohesive strategy for provider meetings, newsletters, trainings, and customer service.
- Develop and implement a community relations plan that outlines proactive strategies to engage communities in BHSB's work, including those communities that are underserved and emerging.

Strategy 2: *Ensure that a local understanding of Baltimore City's unique strengths and challenges informs system management, planning, integration and advocacy.*

Action Steps:

- As the financing model for health care shifts to value-based payment models, educate BHSB leadership and initiate a planning process with the provider network.
- Implement an advisory board to inform BHSB's decision making regarding priorities and practices, including system integration activities.

- Increase capacity to use data to engage in strategic planning, advocacy and quality improvement activities.
- Integrate data as a standing agenda item in provider and workgroup meetings.
- Support Bmore POWER in growing and developing as a group by undertaking a strategic planning and organizational development process.

Strategy 3: *Ensure that BHSB staff have the support needed to be successful in their roles.*

Action Steps:

- Create and implement an employee development plan.
- Create and implement a training plan for supervisors.
- Create and implement a plan to solicit, review and respond to regular feedback from staff.
- Create and implement a plan to integrate restorative practices within the organization.
- Create more opportunities for staff at all levels to engage in strategy, policy, and process development.

Goal 3: Increase health equity in Baltimore City by collaborating with other partners to address adverse childhood experiences (ACEs) and the social determinants of health.

Strategy 1: Promote educational opportunities to understand, prevent and mitigate the impact of systemic racism, toxic stress and trauma.

Action Steps:

- Sponsor another Undoing Racism workshop for staff and partners.
- Sponsor an annual conference and other trainings that promote resilience and wellness and mitigate the impact of toxic stress and trauma.
- Implement a primary prevention strategy that promotes behavioral health and wellness and mitigates the impact of toxic stress.

Strategy 2: Collaborate with other system partners to increase access to safe and affordable housing opportunities.

Action Steps:

- Partner with the Behavioral Health Administration and other stakeholders to implement lower-barrier housing options in communities of choice, such as the Rapid Re-housing pilot.

Impact

Individuals, families and communities impacted by mental illness and substance use are served by a complex system of publicly funded services. BHSB must collaborate with stakeholders in other systems, such as criminal justice, schools, housing, social services, etc., to achieve positive outcomes. While BHSB cannot shift population-level outcomes alone, it is our responsibility to track key indicators in which improved behavioral health in Baltimore City is a critical factor.

Annual Outcomes:

- Reduction in suicide deaths *(data source: Maryland Department of Health (MDH)*
- Reduction in overdose deaths *(data source: MDH)*
- Reduction in homelessness *(data source: Mayor's Office of Human Services)*
- Reduction in overall psychiatric symptoms *(data source: Outcomes Measurement System; difference between initial and follow up interviews)*
- Improvement in quality of life indicators *(data source: Outcomes Measurement System: Recovery & Functioning Indicators; difference between initial and follow up interviews)*

BHSB uses dashboards to track a wide range of outputs that serve as indicators of system performance. Some key dashboards that will be created and/or monitored during FY 2020 include:

- System Utilization
- Crisis Services
- Access to Care
- Quality and Performance
- Behavioral Health Workforce Development
- Outreach

Addendum A: Organization Chart


Behavioral Health System Baltimore
DRAFT: Updated January 20, 2020
Crista Taylor President & CEO
Jennifer Glassman Special Projects Coordinator
Shanna Borell Special Projects Manager
Lee Irving Special Assistant
Gayle Jordan-Randolph Medical Director
Ayelet Gincel Director Human Resources
Shanice Petion Human Resources Specialist
Kathi Ruffin Vice President Finance / CFO
Adrienne Breidenstine Vice President Policy & Communications
Lynn Mumma Vice President Operations / COO
Denise Wheatley-Rowe Vice President Accountability
Steve Johnson Vice President Programs
Beata Siakowska Director Grants Accounting
VACANT Controller
Keisha Tatum Director Contracting Operations
Lanre Alonge Director Information Technology
Candace Duval Grants Accountant
Valerie Bowling Grants Accountant
Philip Engler Grants Accountant
Wanda Rohlehr Grants Accountant
Kristen Johnson Grants Accountant
Amy Vasbinder Accounting Manager
Cindy Liu Senior Staff Accountant
VACANT Fiscal Coordinator
Lakeisha Hendricks Senior Contract Administrator
Arielle Cartwright Contract Administrator
Nató Jeffress Contract Administrator
Xavier Fuller CMS Specialist
VACANT Administration Manager
Tiffiney Hairston Administrative Specialist
Karen Wade Administrative Specialist
Dorothy Jenkins Receptionist
Kristen Emerson Administrative Specialist
Stacey Jefferson Associate Director, Policy and Community Engagement
POSTED Community Engagement Coordinator
Barry Waters Provider Relations Manager
Elizabeth Unger Communications Manager
Carolyn Jefferson-Leach Director Prevention
Latosha Brooks Prevention Services Coordinator
VACANT Prevention Coordinator
Tiffinee Scott Youth Engagement & CTC Coordinator
VACANT MSPF I/OMPP Coordinator
Mrugesh Patel Database Administrator
Elizabeth Corrigan Data Analyst and Epidemiology
VACANT Data Manager
Emily Heinlein Director Public Health Strategic Initiatives
VACANT Harm Reduction Training Institute Manager
Miera Corey Harm Reduction Training Institute Coordinator
Montressa Tripps Program Assistant
William Miller, Jr. Bmore POWER Coordinator
Darryl Burrell Bmore POWER Coordinator
Nathan Fields Outreach Coach
Bonnie Campbell Director Special Projects
Patricia Cobb-Richardson Director Community Resilience
Terri Alexander U-TURNS Project Manager
Bmore POWER
VACANT Director Quality Initiatives
Tyrone Fleming Associate Director Quality
Jacquelyn Camper Quality Coordinator
Romona Dixon-Smith Quality Coordinator
VACANT Quality Coordinator
VACANT Quality Coordinator
Diana Long Incident Management & Investigations Manager
Kwante Carter Compliance Coordinator
Mark Slater Director Rehabilitation & Treatment
Kisha Winston-Watkins Associate Director Adult Services
Elizabeth Wexler C.I.T. Coordinator
Shira Cavalieri Rehabilitation & Treatment Coordinator
Tasha Pope Rehabilitation & Treatment Coordinator
Tyesha Hill Rehabilitation & Treatment Coordinator
Heather Dewey Associate Director Child & Family
Ashley Collins Rehabilitation & Treatment Coordinator
Talliesha Abeokuto Rehabilitation & Treatment Coordinator
Anish Narayen Stabilization Center Project Manager
VACANT Associate Director Clinical Services
Alicia Torres Referrals Coordinator
Alex Wykowski Clinical Services Coordinator
POSTED OCC Project Monitor
Gabby Knighton Director Special Populations
Tamara Andreson Associate Director Recovery Support Services
Mark Sine Recovery Services Coordinator
POSTED Recovery Services Coordinator
Julvette Price Consumer Inclusion Coordinator
Georgia Stevens Long Term Care Coordinator
VACANT LEAD Project Manager
Daniel Jarvis Associate Director Special Populations
Jerry Jackson Criminal Justice Care Coordinator
David Taylor Criminal Justice Care Coordinator
Kola Bakre Older Adults Behavioral Health Coordinator
BHSB Leadership
President's Office
Finance and Operations
Policy and Communications
Operations
Accountability
Programs
Vacant / Posted Position

Addendum B: BHSB 2020 Policy Priorities

Behavioral Health System
Baltimore

2020 POLICY PRIORITIES

Advancing Behavioral Health and Wellness

STRENGTHEN AND EXPAND BEHAVIORAL HEALTH CRISIS SERVICES

A broader investment in behavioral health crisis response services is essential to divert people from ED visits and interactions with law enforcement. A comprehensive, integrated crisis response system serves as a critical access point to help individuals in crisis, while reducing harm and overall costs for the health care system. Baltimore City is fortunate to have some key behavioral health crisis response services; however, there are still gaps in services. This results in uncessary Emergency Department visits and hospitalizations and interactions with law enforcement for people with mental health and substance use disorders. Baltimore City is under a consent decree with the US Department of Justice, which has important implications for behavioral health crisis response in the city.

SUPPORT FUNDING COMMITMENTS FOR BEHAVIORAL HEALTH

The Fiscal Year 2021 budget and beyond must include the 4 percent rate increase for behavioral health providers to ensure access to mental health and substance use treatment and recovery support services. Behavioral health programs provide a range of behavioral health care including therapeutic clinical treatment and recovery support services to assist individuals and families achieve stability and recovery. The HOPE Act of 2017 and the subsequent minimum wage legislation of 2019 provide multi-year reimbursement rate increases for behavioral health services. The rate increases support the infrastructure for public behavioral health system and increase access to life-saving services for vulnerable individuals in our community.

INCREASE SCHOOL BEHAVIORAL HEALTH SUPPORTS

To support academic achievement, full funding of the recommendations of the Kirwan Commission is needed to ensure equitable access to early intervention and school-based behavioral health services. Early intervention and access to behavioral health services in Baltimore schools can provide many students with the necessary resources to thrive in the classroom and achieve academic success. The Kirwan Commission released an interim report in January 2019 that adopted a set of recommendations to address students behavioral health needs, such as increased training for school personnel, the scaling of school behavioral health services in all jurisdictions, systemic screening and identification of student needs, and a statewide system of accountability and outcome measurement.

IMPROVE MARYLAND'S PUBLIC BEHAVIORAL HEALTH SYSTEM

Efforts to improve the system should promote integration and define and clarify the role and authority for local system management agencies to ensure there is active and consistent oversight of behavioral health services and access to a full range of behavioral health services in the community. Maryland's public behavioral health system (PBHS) is a nationally recognized model, however, there is opportunity to improve the system to ensure cost-effectiveness and quality of care. Local system management and planning agencies (LBHAs, CSAs, LAAs) play a key role in Maryland's PBHS, overseeing and coordinating access to behavioral health services and supports to address the particular needs and gaps in their community. Unfortunately, the lines of authority and responsibility for system oversight are unclear between local authorities and the state.

SUPPORT A COORDINATED RESPONSE TO ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs) must be incorporated into State policies and procurement so that funding is targeted directly to communities and interventions that mitigate the effects of childhood trauma. Adverse Childhood Experiences (ACEs) are traumatic events that can have a profound impact on a child's health and well-being lasting into adulthood. Communities play a big role in supporting a child's healthy development and buffering the impact of childhood trauma and ACEs.

PROMOTE HARM REDUCTION STRATEGIES

Policies that support harm reduction interventions and promote inclusion of people who use drugs improve the health and safety of our communities must be incorporated and advanced in public policy making. Harm reduction is an approach that utilizes practical strategies to reduce negative consequences associated with drug use. Harm reduction interventions, such as naloxone distribution and overdose prevention sites provide innovative and effective ways to engage people who use drugs around safer drug use and link them to treatment and support services.

Addendum C: Cultural and Linguistic Competency Self-Assessment & Strategies

Cultural and Linguistic Competency Self-Assessment & Strategies

One of BHSB's key priorities is to increase the capacity of the public behavioral health system (PBHS) in Baltimore City to promote equity, undo racism and increase inclusiveness. This requires structures and practices that address stigma, bias and discrimination. The U.S. Department of Health and Human Services (HHS) developed the National Culturally and Linguistically Appropriate Services (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.

BHSB is committed to advancing the capacity of Baltimore City's PBHS to deliver integrated services with cultural and linguistic competency. To guide this work, BHSB conducted a CLAS self-assessment, which informed planning to advance this work during FY 2021.

FY 2021 CULTURAL AND LINGUISTIC COMPETENCY STRATEGIES

TEMPLATE

Instructions: *CSAs, LAAs and LHBAs receiving funding from the MDH/BHA are required to submit Cultural and Linguistic Competency (CLC) Strategies as part of their FY 2021 Plan Submissions. The following template should be used to list your strategies to advance CLC efforts in your jurisdiction.*

COVER PAGE

(a) **Name of Agency/Organization:**
Behavioral Health System Baltimore, Inc.

(b) **Address:**
100 S. Charles St, Tower 2, 8th Floor
Baltimore, MD 21201

(c) **Region (MDH/BHA designated region):**

Baltimore City

(d) **Name of contact person (Agency/Organization Lead or Designee):**
Lynn Mumma
E-mail: lynn.mumma@bhsbaltimore.org
Telephone #: 443-615-7848

(e) **Brief overview of services provided by agency/organization (***no more than 95 words***):**

BHSB is a nonprofit organization that serves as the local behavioral health authority for Baltimore City. In this role, BHSB is tasked by the State of Maryland with a range of activities to plan, manage, and monitor the public behavioral health system at the local level.

BHSB works to build an efficient and responsive system that addresses the needs of individuals, their families, and communities impacted by mental illness and substance use. We do this by providing local leadership in overseeing prevention, early intervention, treatment, and recovery support services as well as developing innovative services.

(f) **Agency/organization mission statement:**
We work to develop, implement and align resources, programs and policies that support the behavioral health and wellness of individuals, families and communities.

Organizational Values:
- Integrity
- Equity
- Innovation
- Collaboration

- Quality

(g) **Agency/organization vision statement:**
We envision a city where people thrive in communities that promote and support behavioral health and wellness.

PART 1: CLAS SELF- ASSESSMENT

Instructions: Attach a copy of the completed CLAS Self-Assessment Tool for the agency.

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)	X			
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)	X			
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			

PART 2: OVERARCHING GOALS AND SELECTED STANDARDS FOR PRIORITY FOCUS

Instructions: *For each of the overarching goals below list the (a) Associated standard that is prioritized for focus, then, include the following information for each overarching goal in the space provided: (b) Strategies to build competency for the selected standard, (c) Performance Measures for achieving competency for the selected standard, and,(d) Intended impact for addressing the selected standard.*

*Refer to your completed CLAS Self-Assessment Tool to identify the prioritized standard that has been selected for focus under each of the overarching goals. Refer to the CLCSP Guidelines for additional information.(*https://bha.health.maryland.gov/Documents/CLCSP%20final%20document%20-%20TA%2004.25.19%20(1).pdf)

ORGANIZATIONAL CONTEXT

One of BHSB's core values is *Equity*, and a key organizational priority is to increase the capacity of the public behavioral health system in Baltimore City to promote equity, undo racism and increase inclusiveness. Public policy across many sectors, including health care and behavioral health, has played a pivotal role in building structural and institutional barriers that have disproportionately and negatively impacted marginalized groups. To advance BHSB's vision of a city where people thrive in communities that promote and support behavioral health and wellness, these barriers must be dismantled.

BHSB does this work at both the organizational and systemic levels. BHSB is an organization and has internal work to do. As the local behavioral health authority (LBHA) for Baltimore City, BHSB is responsible for overseeing hundreds of providers within Baltimore's public behavioral health system (PBHS). In this role, BHSB provides leadership to advance the system's capacity to provide integrated services that are equitable, inclusive and culturally responsive.

BHSB's Equity and Inclusion Workgroup, which is comprised of BHSB employees at all levels of the organization with representation from every department and most teams, supports and promotes this work internally, with the goal of building capacity for BHSB to advance the work at the system level. During the summer of 2019, the Equity and Inclusion Workgroup formed a subgroup tasked with completing the CLAS Self-Assessment Tool and developing strategies to increase cultural and linguistic responsiveness, equity and inclusion within BHSB and across the system of care.

In establishing goals for FY 2021, BHSB considered the complexity and size of the system it oversees and framed its approach with the recognition that equity, inclusion and cultural humility are not endpoints that are achieved so much as long-term, ongoing processes. The goals that follow are based on a realistic assessment of what can be accomplished in the next fiscal year.

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES
Selected a standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):* Standard 2: Our organizational governance and leadership promote and use CLAS standards in policies, practices and allocation of resources.
Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):* 1. Build capacity of the internal Equity & Inclusion workgroup to impact BHSB's culture and practices and sustain this impact over time. 2. Build on progress BHSB has made to create a resource guide for behavioral providers to understand regulations regarding serving consumers with limited English proficiency (LEP) by expanding technical assistance to ensure implementation across the provider network.
Performance Measures *(How will success be measured):* 1. # of staff participating in the work of the Equity & Inclusion workgroup 2. # of trainings for the provider network to increase knowledge and skills in providing services to individuals with LEP 3. # of participant evaluations that rate the training as having advanced their LEP capacity. 4. # of service line meetings in which relevant, updated resources regarding serving individuals with LEP are shared
Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):* Educate BHSB staff and provider network about relevant regulations and promote policies and practices within BHSB and across the behavioral health network that increase access to services that are equitable, inclusive and linguistically responsive to individuals with LEP.

GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS BEHAVIORAL HEALTH SERVICES

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*

Standard 8: We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community.

Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):*

1. Translate behavioral health and other resource materials into the 5 languages most commonly spoken in Baltimore City, which include Spanish, Chinese, French, Korean and Arabic.[47]
2. Contract for telephonic interpretation services and communicate to populations that have limited English proficiency that this service is available for consumers who contact BHSB's clinical services team.

Performance Measures *(How will success be measured):*

1. Number of materials translated.
2. Number of languages materials are translated into.
3. Number of times interpretation services are utilized.

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*

Increase access to and utilization of BHSB and the public behavioral health system.

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

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*

Standard 11: 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.

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

Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):*

1. Analyze claims utilization data by race to identify trends and gaps to inform about potential disparate utilization of services.
2. Identify contracts for which data could be broken down by race and ethnic group and require this breakdown for FY 2021 contract deliverables.

Performance Measures *(How will success be measured):*

- # of contracts for which deliverables require racial and ethnic group breakdown
- # meetings with sub-vendors to review data and discuss policy and practice implications
- # of service line meetings during which utilization data broken down by race, ethnicity and primary language is presented and discussed to identify potential policy and practice changes

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*

Increase the capacity of BHSB and the provider network to analyze data to understand the needs of specific populations and use it to inform policy and practice changes that increase cultural and linguistical responsiveness, equity and inclusion.

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

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*

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

Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):*

- Develop a shared understanding within BHSB regarding the effectiveness of EBPs related to the populations served in Baltimore City and increase knowledge of culturally relevant and community-informed sources of evidence.
- Partner with community-based organizations that are implementing evaluation approaches that incorporate an anti-racist lens and community engagement.

Performance Measures *(How will success be measured):*

- # meetings with community-based organizations
- # partnerships with community-based organizations

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*

Increase capacity to identify and promote practices that have a culturally relevant evidence base.

GOAL 5: ADVOCATE FOR AND INSTITUTE ONGOING WORKFORCE DEVELOPMENT PROGRAMS IN CULTURAL AND LINGUISTIC COMPETENCE REFLECTIVE OF MARYLAND'S DIVERSE POPULATION

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*

Standard 4: 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.

Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):*

- Sponsor trainings that educate BHSB staff and the provider network about culturally and linguistically responsive, equitable, antiracist and inclusive practices.

Performance Measures *(How will success be measured):*

- # trainings
- # participants in trainings
- # participants who indicate in training evaluation that it provided at least one tool that they can use in their work

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*

A workforce that has education and tools to increase its capacity to provide culturally and linguistically responsive, equitable and inclusive services.

Addendum D: Board of Directors

2019-2020 BOARD OF DIRECTORS

Board Term October 1, 2019-September 30, 2020

Terms of Office

Letitia Dzirasa, MD, BHSB Board Chair Ex-officio, No term limit
Commissioner of Health, Baltimore City Health Department
1001 East Fayette Street, Baltimore, MD 21202
410-396-4387

Reverend S. Todd Yeary, PhD, Vice Chair 3rd term: 2018-2019, 2019-2020, 2020-2021
Member, Executive & Governance Committees
Senior Pastor, Douglas Memorial Community Church
1325 Madison Avenue, Baltimore, MD 21217
410-523-1700

Ryan Hemminger, Treasurer 1st term: 2019-2019, 2019-2020, 2020-2021
Member, Executive Committee; Chair, Audit and Finance Committee
5618 St. Albans Way, Baltimore, MD 21212
443-536-9930

Nancy Rosen-Cohen, PhD, Secretary 3rd term: 2018-2019, 2019-2020, 2020-2021
Member, Executive Committee; Co-Chair, Communications, Advocacy and Policy Committee
Executive Director, NCADD-Maryland
28 E. Ostend Street, Suite 303, Baltimore, MD 21230
410-625-6482

John T. Bullock, PhD 1st term: 2019-2019, 2019-2020, 2020-2021
Member, Communications, Advocacy and Policy Committee
1405 Hollins Street, Baltimore, MD 21223
410-953-9575

David Olawuyi Fakunle, PhD 1st term: 2019-2020, 2020-2021, 2021-2022
Member, Communications, Advocacy and Policy Committee
CEO, DiscoverME/RecoverME: Enrichment Through the African Oral Tradition
4208 Cottman Ave, Baltimore, MD 21206
410-440-8142

Kevin C. Lindamood, MSW 2nd term: 2018-2019, 2019-2020, 2020-2021
Co-Chair, Communications, Advocacy and Policy Committee
President & CEO, Health Care for the Homeless, Inc.
6602 Charlesway, Baltimore, MD 21204
410-837-5533

Nalini Negi, PhD, MSW 1st term: 2019-2020, 2020-2021, 2021-2022
Associate Professor, School of Social Work, University of Maryland, Baltimore
525 W. Redwood Street, Baltimore, MD 21201
410-706-3024

Frederick G. Savage, Esq. 3rd term: 2017-2018, 2018-2019, 2019-2020
Chair, Operations and Oversight Committee; Member, Governance Committee
5702 Stony Run Drive, Baltimore, Md. 21210
410-733-1040

Steven Sharfstein, MD 2nd term: 2019-2020, 2020-2021, 2021-2022
Member, Operations and Oversight Committee
President Emeritus, Sheppard Pratt Health System
6501 N. Charles Street, Baltimore, MD 21202
410- 938-4200

Howard C. Sigler, Esq. 3rd term: 2017-2018, 2018-2019, 2019-2020
Co-Chair, Criminal Justice Committee
4100 N. Charles St. # 806, Baltimore MD 21218
443-759-5420

Alan C. Woods III, Esq. 3rd term: 2017-2018, 2018-2019, 2019-2020
Member, Audit and Finance Committee
4504 Keswick Road, Baltimore, MD 21210
410-491-5448

Tony A. Wright 3rd term: 2017-2018, 2018-2019, 2019-2020
Member, Governance & Communications, Advocacy and Policy Committees
Executive Director, On Our Own, Inc.
6301 Harford Road, Baltimore, MD 21214
410-444-4500

Addendum E: Sub-grantee Monitoring Procedures

Sub-grantee Monitoring Procedures

BHSB employs various processes to monitor administrative, fiscal and programmatic contractual performance. Each contract is assigned a Program Lead, Grants Accountant Lead, Contract Administrator Lead and Quality Coordinator Lead. Each Lead performs assigned oversight functions:

- Program Lead: Reviews and approves the budget and proposed staffing in accordance with the scope of services, as well as the program reports that are submitted on a schedule as required in the contract. If deliverables are not being met or there are concerns about the quality of service delivery, the Program Lead collaborates with the sub-vendor throughout the contract term to ensure that issues are addressed on an ongoing basis. Fee-for-service and consultant contracts require the submission of an invoice, which is reviewed and approved by the Program Lead in accordance with the scope of services. The Program Lead maintains communication with the sub-vendor throughout the contract term and provides collaborative support to manage challenges and resolve problems as they arise. Technical assistance is provided if indicated.

- Grants Accountant Lead: Reviews and approves budgets, invoices, and fiscal reports along with any supporting detail documentation, if applicable, that are submitted by sub-vendors on a schedule as required in the contract. If budgets or fiscal reports include unallowable expenses or other errors, the Grants Accountant Lead explains the issues to the sub-vendor and requests that they make the corrections and resubmit an accurate budget or fiscal report. Mathematical errors can be corrected by the Grants Accountant.

- Contract Administrator Lead: Reviews and ensures all required documentation is submitted by sub-vendors on a schedule as required in the contract. This includes the Risk Assessment Form, W-9, insurance documentation, and independent financial audit(s). The Contract Administrator ensures that BHSB contracts are issued and executed within the appropriate timeframe.

- Quality Coordinator Lead: Conducts an annual audit of all sub-grantees at the conclusion of the contract term to review if service delivery met contractual requirements and relevant federal, state and local regulations. The audit structure varies depending on the total annual contract award:

    - $99,999 or less: there is an annual *desk audit*. Sub-vendors are required to submit documentation electronically, and the review is completed remotely.

- $100,000 or greater: there is an annual audit that alternates every other year between a *desk audit* and an *onsite audit*. *Desk audits* are conducted remotely, as described above, and *onsite audits* are conducted at the location where services are provided.

Based upon funder or other requirements, the schedule of audits may be conducted outside of these parameters.

BHSB's Chief Financial Officer (CFO) ensures that all financial audits are reviewed to determine if conditions exist that may prevent sub-vendors from delivering services and/or fulfilling the terms and conditions of the contract.

Addendum F: Behavioral Health Disaster Preparedness Plan