Behavioral Health System Baltimore

FY 2021 Activities, Data, and Planning

March 2022

A. Introduction

Behavioral Health System Baltimore (BHSB) is a leading expert and resource in advancing behavioral health and wellness in Baltimore City and the state of Maryland. As a nonprofit organization, BHSB manages and oversees a full range of quality public mental health and substance use services. BHSB has a unique role within the public behavioral health system, as the lead entity responsible for ensuring there is coordination and connections to other public service systems—like law enforcement, hospitals, and schools—to promote access to behavioral health care and address social determinants of health. To do this, BHSB partners with a range of public, private, faith-based, and philanthropic partners, as well as community-based organizations, people with lived experience and their families, and other advocates. Our goal is to make Baltimore healthier by improving our system of care for individuals, families, and communities impacted by mental illness and substance use (collectively referred to as "behavioral health").

Organizational Structure

BHSB is led by Crista M. Taylor, a clinical social worker and 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 supports a growing scope of work. It ensures responsiveness to the needs within the changing system, and it establishes the organization as a leader in the new, integrated healthcare landscape.

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, human resources and procurement are 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.

- 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.

- 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 support, compliance audits, and the facilitation of consumer quality improvement activities. The team also manages the investigation of provider complaints and critical incidents.

- Operations
  Operations works to increase BHSB's capacity to be nimble, efficient, and adaptive to change. Specifically, the goal of the department is to ensure that BHSB is effectively meeting its mission by strategically implementing and supporting processes that align resources and decision making across the organization. The department facilitates cross-organizational processes, maintains a secure electronic network, facilitates a data-driven approach to BHSB's work with analytics and other data products, advances a harm reduction philosophy and practices, collaborates with community stakeholders to implement activities designed to prevent substance misuse and reduce its health and social consequences, and provides medical consultation to support the clinical work of various teams. In addition, Operations oversees the organization-wide implementation of the strategic plan.

- Finance
  Finance manages the financial and contracting operations of the organization. The department provides oversight of private and public grant or funding awards,

contracts issued to sub-vendors, grants accounting, general accounting, and payroll for organizational-wide work. Activities include contracts issuance, tracking of contract deliverables, payroll processing, tax reporting, managing organizational risk, preparing organizational and sub-vendor budgets including assurance that all funds are properly utilized and expended, financial statement preparation, and oversight of audits.

B. New Developments and Challenges

Systemic racism, oppression and childhood trauma are major drivers of the disproportionally high rates of mental illness and substance use disorders in Baltimore City. Our behavioral health care system contributes to systemic oppression through policies and approaches that create barriers to accessing services and resources. One of BHSB's core values is equity. With this value, we remain committed to understanding the impact of systemic racism within our organization and the behavioral health system and to deconstructing the structures of oppression that still exist within our system of care and the communities we serve. We understand that to advance our vision of a city where people and communities thrive, we must prioritize supporting the health and wellness of Black, Indigenous and People of Color lives.

Based on preliminary data provided by the Maryland Department of Health's Vital Statistics Administration, there were 1,358 unintentional intoxication deaths involving all types of drugs and alcohol in Maryland through the second calendar quarter of 2021. This represents a 0.5 percent increase from the first six months of 2020, when there were 1,351 such fatalities. There were 1,217 opioid-related fatal overdoses in this time frame, an increase of 1.1 percent from the same period in 2020. Of these, 1,129 deaths involved fentanyl, an increase of 1.2 percent from the first six months of 2020. There were 250 prescription opioid-related deaths during the same time frame, an increase of 15.7 percent, while heroin-related deaths decreased by 34.4 percent, falling from 294 in the first half of 2020 to 193 in the first half of this 2021.

In response to this continued public health emergency, BHSB collaborates with external local partners such as Peers in Drug Treatment Courts, which supports people in navigating the public behavioral health system through the support of clinical care coordinators and peer recovery specialists. BHSB also addresses this public health emergency through its harm reduction programs, one of which is the Maryland Harm Reduction Training Institute (MaHRTI). MaHRTI offers leadership training series to staff of harm reduction programs statewide. Additionally, Bmore Power (Peers Offering Wellness Education and Resources) canvasses areas with overdose spikes, connects with people in that area, provides tips for safe drug use, trains to use naloxone, connects people to treatment, and collects data on overdose reversals.

The age-adjusted suicide rate for the United States in 2020 (13.2 per 100,000) was higher than the rate for the state of Maryland (9.5 per 100,000), which in turn was higher than the rate for the city of Baltimore (8.7 per 100,000). Both the United States and Maryland display a significant trend of an increasing suicide rate over the past twenty years. The same pattern is not evident in Baltimore City; however, since suicide is a rare event, changes in rates are difficult to determine over a population as small as a single city. BHSB is working to integrate suicide prevention into its overall prevention strategies.

Administrative Service Organization Transition

Maryland's transition to a new Administrative Service Organization (ASO) in January 2020 has been enormously challenging for the public behavioral health system. Ongoing efforts to reconcile claims requires a substantial commitment of time and resources on the part of providers. This reconciliation process also raises questions about the accuracy and reliability of the data that is reported through the ASO.

High-cost user reports and real-time high inpatient utilizer notifications from the ASO were lost in the transition. This information is essential for local behavioral health authorities (LBHAs) to actualize the role of managing the local system of care more fully, which includes identifying individuals and families who would benefit from increased system-level care coordination to identify unmet needs and the services and supports that are needed to address those needs. In addition, LBHAs have not had access to the weekly detailed paid claims reports.

Integrated Service Delivery

In the fall of 2021, BHSB completed a tool to self-assess its 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; and workforce.

Based on the criteria in the tool, BHSB assessed itself at level three for each domain except for quality, which was a level two. Of the seven domains, quality is the one that lists the direct client experience in the description of the domain. While BHSB is organizationally structured to perform its training, complaint investigation, and performance improvement activities in an integrated manner, the impact of integration to the individual, family and/or community in the quality domain is not fully realized. Full realization of a more integrated experience at the service recipient level is dependent on activities to advance integration that are outside the scope of authority currently granted to the local behavioral health administration (LBHA) to align with the intent of this domain, BHSB rated itself at level 2 until some of the challenges identified above can be addressed.

Housing

BHSB regularly receives complaints from consumers, families, and behavioral health providers about housing for individuals who have behavioral health disorders. Some programs promote themselves as providing supportive housing or recovery housing. While identifying as a supportive housing program suggests that the provider offers supportive services within the home and linkage to other community resources, complaints often indicate these supports are not integrated within the program. Other programs that promote themselves as being recovery residences are not certified by the State of Maryland, Maryland Certification of Recovery Residences (MCORR) certification, which means they operate with no oversight. Unfortunately, neither the BHA nor BHSB has the authority to investigate recovery residences that are not certified. A comprehensive approach at the state level that creates a mechanism to monitor non-certified programs is essential.

Additional Challenges

Some of the other barriers to expanding the depth and reach of the public behavioral health system (PBHS) in Baltimore City include:

- Maryland's public behavioral health system does not have a reimbursement structure for integrated service delivery.
- There is not authority at the local level to require specific system-wide programmatic components, such as integrated service delivery, outcome measures, or evidenced-based screening tools or assessments.
- There is limited authority at the local level to enforce quality and provide sanctions for poor service delivery.
- The workforce shortage is at a crisis level in the behavioral health system. It is difficult for non-profit, community-based organizations to compete with large health systems when recruiting for direct care, administrative, and leadership positions
- There are not enough bilingual, behavioral health practitioners, and those who exist are in high demand.
- The delayed pace of funding awards and receipt of cash from the Behavioral Health Administration is an ongoing and difficult challenge. This is compounded by unclear and complicated processes.
- Funding and infrastructure is limited relative to the broad scope of responsibilities and workload assigned to BHSB in its role as the LBHA for Baltimore City.

C. FY 2021 Highlights and Achievements

Key FY 2021 Highlights

- Nearly 66,000 consumers received mental health services and over 35,000 received substance use services through the public behavioral health system in Baltimore City in FY 2021 with annual expenditures of over $580 million.
- In FY 2021, BHSB awarded $43 million in grant funds, with 289 contracts issues to 179 organizations and consultants.
- 98,115 people called the Here2Help Hotline line for assistance.
- 7,176 children and youth received individual treatment services through the Expanded School Mental Health program.
- 483 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 address the behavioral health requirements of the Consent Decree between Baltimore City, the Baltimore Police Department, and the Department of Justice.
- BHSB released nine competitive procurements resulting in 10 contracts with 10 unique organizations, 4 of which were new to BHSB. Total funding awarded is over $1.1 million.

Antiracism

BHSB has developed an Antiracist Framework that delineates responsibilities within each department to help shape this work for the organization and is working to operationalize the Framework now. Our commitment to antiracism and our work toward becoming antiracist is a part of communications with all staff and our community partners through emails, all-staff meetings, and our website and other communications platforms. In addition, BHSB's work toward becoming antiracist is a part of every job interview, and BHSB is committed to hiring people that share the same values.

Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership

BHSB provides project management for the Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership, which includes 17 hospitals, four local behavioral health authorities, and leaders in Baltimore City, Baltimore County, Carroll County, and Howard County. Its overall goal is to reduce unnecessary emergency department use and police interaction for people in behavioral health crisis.

The GBRICS *Policy Agenda* has been adopted. The priority for 2022 is to establish a 988 trust fund and allocate an initial $10 million to support crisis call centers and other crisis services. BHSB contracted with Behavioral Health Link for state-of-the-art call center software. A regional Call Center is being planned for a 2022 launch.

Here2HelpHotline

The Here2 Help Hotline is Baltimore City's 24/7 crisis hotline, offering callers access to confidential advice and emotional support. BHSB increased awareness of the hotline through a door knocking campaign and targeted faith community outreach. Canvassers gave out information door-to-door and left door tags for at-home residents, knocking on 7,000 doors in Cherry Hill, Curtis Bay/Brooklyn, Park Heights, Upton, Violetville, McElderry Park, and Four by Four in Northeast Baltimore. A church bulletin insert was also created and disseminated during church services throughout Baltimore.

COVID-19

Since March 2020, BSHB has conducted routine online provider COVID-19 update meetings. During FY 21, the focus of these meetings gradually shifted from addressing immediate provider needs for personal protective equipment, service delivery barriers, and testing and response to COVID-19 outbreaks to expanding education and access to vaccines.

Maryland Crisis Stabilization Center

The Maryland Crisis Stabilization Center provides safe, short-term sobering services for adults under the influence of drugs and/or alcohol or who were recently revived from an overdose. In June 2021, the Baltimore City Health Department approved an increase in the bed capacity for the Stabilization Center from 17 beds to 30. Referrals from community-based provider organizations continue to be the largest referral source.

Trauma-Informed and Resilience Training in Head Start Centers

The Early Childhood Mental Health program began its third iteration of the Conscious Discipline training, which aims to help early childhood providers and educators better interact with students by using a trauma-informed and resilience-based approach. Much like the prior year, it included methods that acknowledge the current challenges the pandemic has posed for these settings.

Medication Assisted Treatment

BHSB partnered with the University of Maryland Opioid Treatment Program to implement Emocha for methadone and buprenorphine medication treatment. Emocha is a mobile health platform designed to improve medication adherence using video technology and human engagement using a CDC-endorsed model in which healthcare workers watch patients take every dose of medication, monitor side effects, and provide support. This intervention has been implemented with four individuals to date, with the goal of serving 35 over the next year. This pilot will be evaluated to determine whether it should be promoted for wider use.

Collaborative Planning & Implementation Committee (CPIC)

BHSB works 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. BHSB co-chairs the Collaborative Planning and Implementation Committee (CPIC), which has a central aim of decreasing interactions between people with behavioral health disorders and police.

CPIC implemented a newly re-designed 40-hour Crisis Intervention Team (CIT) Certification course for Baltimore Police Department officers in 2021. Four classes were held with 69 officers successfully completing the process to become CIT-certified. BHSB plays a critical role in the ongoing training of police officers, with a full-time staff person assigned to partner with the police department on training implementation.

Supporting Discharge Plans from Inpatient Hospital Units

BHSB provided several educational sessions with hospitals across the city on available community-based resources and services. These efforts have directly connected inpatient units with community providers to best support youth and their families transitioning back to the community with a warm handoff.

BHSB is also encouraging coordination organizations (CCOs) to maintain and strengthen their relationships with the inpatient hospitals. BHSB reached out to BHA during the fall of 2021 with questions related to the billing capability for targeted case management (TCM) programs to provide supportive services to families with children who are transitioning children back to the community. BHA discussed this issue with providers during one of BHSB's recent quarterly convenings of the CCOs and is working with Medicaid to confirm the appropriate billing code.

Additionally, BHSB is working with Baltimore City Department of Social Services (BCDSS) to improve the education on CCO services and referrals of BCDSS-involved youth for CCO services.

Harm Reduction/Outreach

BHSB's Maryland Harm Reduction Training Institute (MaHRTI) helps to develop the Maryland harm reduction workforce and support Maryland programs in providing optimal services to people who use drugs. MaHRTI launched a new website, www.mahrti.thinkific.com, in June 2021. The website hosts on-demand and live trainings for staff of harm reduction programs statewide.

Bmore POWER (Peers Offering Wellness Education and Resources) is a team of people with lived experience related to drug use. It works to address the continuing high rates of overdose in Baltimore City. During FY 2021:

- 18,045 naloxone kits were distributed, and
- 2,559 overdose reversals were reported.

Staff from Bmore POWER and MaHRTI were selected through a competitive process to present at the ACCESS Harm Reduction Conference hosted by the Maryland Department of Health. BHSB staff presented on restorative justice and harm reduction, structuring harm reduction programs to support staff well-being, and music therapy.

Capitation Project and Residential Rehabilitation Program (RRP)

The Capitation Project is a pilot project developed to meet the needs of those with severe and persistent mental illness and is considered the highest level of outpatient community level care offered in the city. 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. In FY 21, there were 54 new enrollments in Capitation. Of those, 29 (54%), came directly from the state hospitals.

There are eight Residential Rehabilitation Program (RRP) providers located throughout Baltimore City, two of which are programs dedicated to serving the transitional age youth (TAY) population. Baltimore City was awarded 12 additional RRP beds, which is the first expansion of this service line in many years. Four of the expansion beds are currently online. BHSB is working with the other RRP providers to initiate the process of adding the remaining 8 beds to their program. These beds will be prioritized for Baltimore City residents being discharged from State Hospitals, serving as an additional resource to expedite the transition of individuals back to the community.

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 who are 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 2021, 22 unique consumers were served in outpatient mental health treatment, 11 in PRP, 11 in RRP, and 0 in SEP.

Women With Children (WWC)

BHSB, in partnership with the BHA Gender Specific Unit, contracts with two Recovery Residence sub-vendors that provide services to WWC who have a substance use disorder. The target population is women who are early in recovery and have custody of their child/children or will have custody within 60 days of enrollment. Women receive case management services and care coordination while in the program, including linkage to community resources such as recovery support, entitlements, permanent housing resources, education, and employment. During FY 2021, 16 families (WWC) were served, which consisted of 16 mothers and a total of 26 children.

BHSB continued to actively participate in the Child Fatality Review and Fetal Infant Mortality Review teams. This process entails providing behavioral health treatment histories for the case reviews and contributing to the systems recommendations that are formulated to prevent premature deaths. Acting on a recommendation that resulted from this process, BHSB added a deliverable to all direct service contracts to require that sub-vendors implement practices to

increase knowledge about and reduce the occurrence of sleep-related deaths among their consumers and staff.

Healing Us Together (HUT) Project

In June 2021 BHSB began collaborating with the Ministers Conference Empowerment Center CDC to plan the HUT (Healing Us Together) project, in which faith-based and other community leaders across 14 council districts use the *S.E.L.F. Community Conversations* curriculum to facilitate healing-centered conversations. The project name (Healing Us Together) represents family and community, and its acronym (HUT) symbolizes the process of recognizing the unique experiences and perspectives of individuals and families. Its goal is to engage communities that have been adversely affected by COVID-19 and racial trauma and begin a process of self-healing from toxic stress and trauma to wellness and recovery.

BHSB, in partnership with the community, educated and continues to coach three cohorts of clergy and other community leaders from across the city's 14 council districts. A total of 75 individuals have participated in HUT, including 47 facilitators and 28 participants.

Consistent with HUT's philosophy, equitable compensation for participation is a vital component of culturally competent initiatives aimed at engaging vulnerable communities and people of marginalized groups. HUT provides payment incentives in the form of honorariums to participants to lower the barriers to program participation experienced by these individuals and promote parity in accessing behavioral health services. In 2022, HUT was able to acquire funding from the Starvos Niarchos Foundation and Kreiger Foundation. Funds were expensed as equitable compensation in the form of direct payments totaling $17,902 to HUT participants to reduce barriers to program participation.

Interdisciplinary Street Outreach

The Interdisciplinary Street Outreach team leverages local, state, and federal funds to provide integrated, street-based services to people who are not otherwise able to access care. Services include peer support, crisis de-escalation, harm reduction interventions, buprenorphine prescriptions, clinical mental health and addiction assessments and counseling, and expert housing and benefits systems navigation.

In FY 2021, the team played a critical role in ensuring access and continuity to essential services and supplies, particularly buprenorphine, amidst the chaos of COVID-19. Many of the people served were abruptly disconnected from shelter or other living arrangements as they or living companions needed to isolate or socially distance. Many also experienced interruptions or barriers to accessing behavioral health care as heath care facilities suspended or altered their service offerings. As a result, the team created new partnerships with behavioral health providers based on consumers' needs to address barriers created by the pandemic. The team

continues to work closely with Emergency Medical Services to increase the number of referrals and develop a real-time referral mechanism for overdose survivors who refuse transportation to a hospital.

During FY 2021, the team achieved the following deliverables:

- Number of persons served: 1,673

  Of this group, at the time of enrollment:

  - 1,068 (64%) had a known mental health condition,
  - 702 (42%) had a known "drug abuse" or "alcohol abuse"[1] condition,
  - 875 (52%) had two or more chronic conditions (defined as a chronic mental health, addiction, developmental disability, or health condition), and
  - 1,375 (82%) were living in a place not meant for human habitation.

- Of the persons whose enrollment ended during FY 2021 (930):
  - 197 (21%) exited to "positive" (non-street) destinations and
  - 89 (9.6%) gained or increased their income between start and exit.

Critical Incident/Complaint Investigations and Compliance Audits

BHSB has authority designated by the state to provide local oversight of programs and services within the public behavioral health system and to investigate *critical incidents* and *complaints*.

A critical incident is an unexpected, adverse, or unfavorable event that harms a consumer or staff – or has the potential to harm these individuals. Reporting of critical incidents refers to collecting targeted incident data with the goal of improving consumer safety and quality of care. Collecting incident data is the initial step in the incident management process. *Critical Incident Reports* facilitate the identification of individual and system-level factors along with root causes contributing to challenges being experienced by a cross-section of stakeholders. The discovery of root causes leads to quality improvement actions based on real-time insights regarding risks and trends.

BHSB has a mechanism for anyone – consumers, family members, provider staff, and/or the general public - to submit a complaint. A complaint is a concern or grievance expressed after a threshold of dissatisfaction has been reached. Frequently, complaints are made by consumers or family members. To resolve complaints, BHSB gathers relevant information, investigates, and offers guidance to all parties involved. Generally, complaints tend to represent individual experiences rather than widespread systematic failures. Notably, this leads to a focus on

[1] Language in data collection tool mandated by federal standards.

subjective impressions and less on standardized practices and procedures. An emphasis on consumer satisfaction drives BHSB to seek and respond to feedback from stakeholders as important components of risk management, quality, and satisfaction. The process of investigating critical incidents and complaints cultivates a continuous quality improvement culture and demonstrates a commitment to advancing a person-centered or consumer-centered care first approach.

To determine compliance and adherence to applicable regulations among providers, BHSB regularly conducts audits. Auditing is a systematic and objective assessment designed to evaluate and improve the quality of behavioral health services. In partnership with BHA and the designated ASO, BHSB participates in select audits associated with all levels of behavioral health services. Additionally, BHSB conducts audits on contracts issued by the organization.

During FY 2021, there were:

- 163 Critical Incidents reported (all of which have been closed)
- 63 Complaints reported (all of which have been resolved and closed)
- 164 Accountability Compliance Audits conducted

Community and Stakeholder Engagement

BHSB is in the second year of operating with a dedicated Community Engagement Coordinator, who works to build relationships between BHSB and community members. The Community Engagement Coordinator connects community members with resources, facilitates workshops in pioneering spaces like Bible studies and community association meetings, and participates in resource fairs throughout Baltimore City. The Community Engagement Coordinator has also worked with umbrella organizations that cover several neighborhoods or business districts. She has collaborated with The Greenmount Life Opportunity & Wellness (GLOW) initiative in Barclay, East Baltimore Midway, Greenmount West, and Hardwood to ensure that residents have access to behavioral health programs. Market Center Baltimore is another broad-based organization that covers the 27 blocks surrounding the historic Lexington Market.

To learn what is needed in community the Community Engagement Coordinator has begun to co-facilitate listening sessions. Two listening sessions have taken place with a group of older adults and participants from Turnaround Tuesday, a jobs movement that primarily serves returning citizens and persons who face obstacles in gaining employment. Future listening sessions will take place with young adults, the immigrant community, and persons from the LGBTQ community. To date, there have been:

- 21 meetings with providers and the community members and
- 40 community meetings, which include resource fairs and festivals.

Moreover, the community has reached out in increased numbers directly to the Community Engagement Coordinator indicating that they need behavioral health services.

Behavioral Health Disaster Plan Activities

BHSB coordinates with the Baltimore City Health Department (BCHD) and the City of Baltimore in the event of a public emergency. BHSB updated the Baltimore City Behavioral Health Disaster Preparedness Plan during FY 21 to include revised contact information at BSHB and provider organizations, the new name of Baltimore's 24-hour Here2Help Hotline, a brief description of BSHB's COVID-19 related activities, and other minor edits.

Sub-Grantee Monitoring

BHSB utilizes a team-based approach, comprised of Program Leads, Grants Accountants, Contract Administrators, and Quality Coordinators, to manage, monitor, and audit contracts. BHSB's Contract Management System (CMS), which is a web-based, electronic application for contract management, monitoring, and reporting, supports the work of the contract team. It provides each team member with the opportunity to manage, review, approve and monitor contracting workflow, including letters of award, deliverables, budgets, program reports, fiscal reports and invoices, and approval of payments. BHSB completes a retrospective audit of each sub-vendor at the end of the fiscal year.

Contract Documentation

The Contract Administrator 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 also ensures that BHSB contracts are issued and executed within the appropriate timeframe.

Program Reports

A program report form is created from the contract deliverables in CMS at the beginning of each contract execution. Sub-vendors are required to submit program reports throughout the contract period, and the Program Lead reviews these reports to monitor progress on deliverables. If the Program Lead determines, based upon the review of program reports, that the sub-vendor is meeting all deliverables, the Program Lead will approve the program reports. If the Program Lead determines that the sub-vendor is not meeting its programmatic deliverables without a satisfactory explanation outlining the contributing factors and how the sub-vendor intends to course correct, the Program Lead, in collaboration with the contract team, will collaborate with the sub-vendor to identify the challenges and solutions. If the sub-vendor is unable or unwilling to address the concerns, the contract team will consider other approaches, such as a site visit, requiring a corrective action plan, training, and/or a more sustained process of technical assistance.

Sub-vendor Fiscal Reports/Budgets/Invoices

The Grants Accountant 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 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.

Sub-vendor Audit Report

Sub-vendors who are required to submit an annual independent audit must do so within nine months following the contract fiscal year. The Accounting Monitor will ensure that audits are collected and will document compliance with this requirement. The Accounting Monitor will review audits for findings that may affect contract performance and follow up on findings to collect management responses. The Accounting Monitor will also review audits to ensure that the contract amount listed in the audit reconciles to the final reporting submitted to BHSB.

The BHSB contract team will document sub-vendor compliance throughout the year to determine if conditions may require an onsite or desk financial audit. These conditions could include non-compliance in contracting, performance, financial reporting, or audit submission, as well as a determination of high risk from sub-vendor risk assessments and/or audit findings.

Accountability Compliance Audits

All contracts are audited on an annual basis to review if service delivery meets contractual requirements and relevant federal, state, and local regulations. The Accountability Compliance Audit structure varies depending on the total annual contract award:

- $99,999 or less: annual desk audit
- $100,000 or greater: annual audit alternates every other year between a desk audit and an onsite audit at the location where services are provided.

A site visit may occur if a problem is identified that requires further investigation. Site visits are scheduled with sub-vendors in advance unless there are concerns that warrant an unscheduled visit.

The Quality Coordinator will verify many aspects of the contract during the site visit, such as evidence that services were delivered as reported in their Program Report, that employees have the credentials needed to perform services, that required policies are posted or otherwise available to consumers. The Quality Coordinator will also review consumer charts for best practice standards, such as the progress notes reflecting consumer goals, etc.

The Quality Coordinator documents the results of the audit in the *Accountability Compliance Audit Report*, which is shared with the sub-vendor. This report will include any quality

improvement recommendations made and whether a program improvement plan is required as a result of non-compliance.

E. Data and Planning

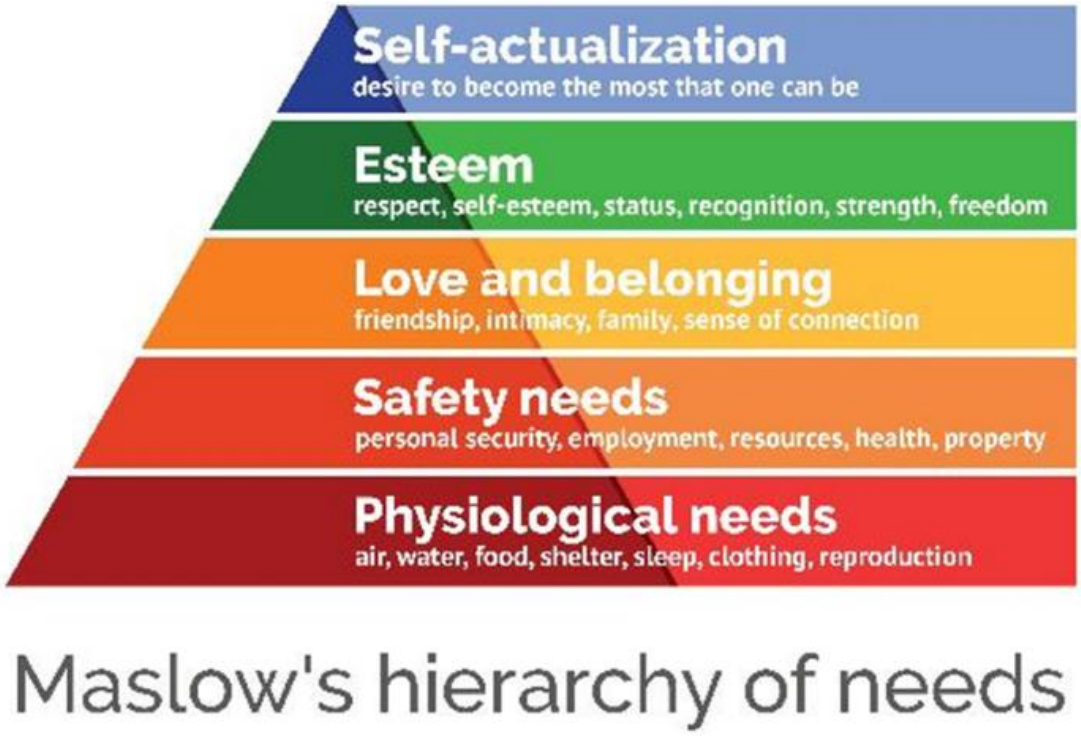
Methodology

As part of BHSB's strategic planning process, we investigated qualitative data gathered from communities in Baltimore City, specifically the 32 respondents to BHSB's 2022-2023 Policy Priorities Stakeholder Input Survey. The respondents were community members and providers in Baltimore City who offered opinions on subjects such as racial inequities, service gaps, and interactions with law enforcement. While this qualitative data is limited in scope, we have also had discussions about how to incorporate more qualitative data into our data-driven decision making as one strategy to center community voices. We will continue to expand on these efforts in the coming year. The quotes in italics throughout this section reflect qualitative data from that survey.

When using a mixed methods design, the qualitative and quantitative data inform each other. In this report, we focused on the qualitative data first for the reasons described above, then used quantitative data from public sources and data internal to BHSB to inform and provide a broader picture around the qualitative data. These data are provided as graphs in the narrative below. Worth noting is that the quantitative data supported the qualitative data community members provided.

BHSB appreciates the commitment of the Behavioral Health Administration to supporting a data-driven approach to strategic planning at the local level. BHSB is in the third year of its three-year strategic plan, and we have been engaged in a planning process for the FY 2023-2025 strategic plan since January. The data that follows was prepared to inform the strategic planning process. While it does not include every data source suggested for this report, it offers a thorough look into the unique needs of Baltimore City, which helped facilitate the planning process. In addition, the FY 20 - 22 service utilization data did not arrive in a timely enough manner to allow for the thorough consideration it required. However, this data was added as an addendum to the report along with recommendations for data needed for ongoing management of the public behavioral health system. Any data regarding public behavioral health system utilization in the main body of the report comes from a report sent to BHSB on September 27, 2021 that included claims paid through September 19, 2021.

Basic Needs

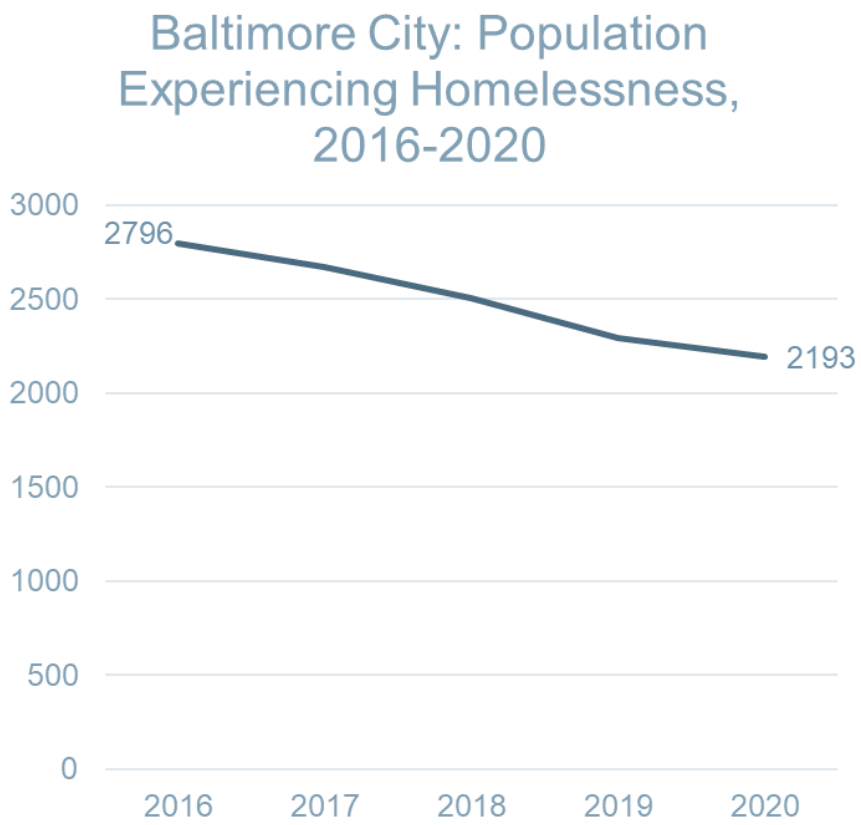


To fully understand the behavioral health needs of the residents of Baltimore City, one must understand Maslow's Hierarchy of Needs.[2] This widely accepted theory posits that needs lower down on the pyramid must be met before the higher up needs.[3] Behavioral health care often falls into the "Safety needs" or "Love and belonging" categories, and residents of Baltimore City, where the 21.2% of residents live in poverty, according to the 2019 American Community Survey 5-year estimates, often require assistance meeting the more basic "Physiological needs" of food and shelter.

<u>Homelessness</u>

"Many of our consumers are at risk for becoming street homeless and many more are living in conditions that are unfit for humans."

[2] Image source: https://www.thoughtco.com/maslows-hierarchy-of-needs-4582571
[3]: https://www.simplypsychology.org/maslow.html

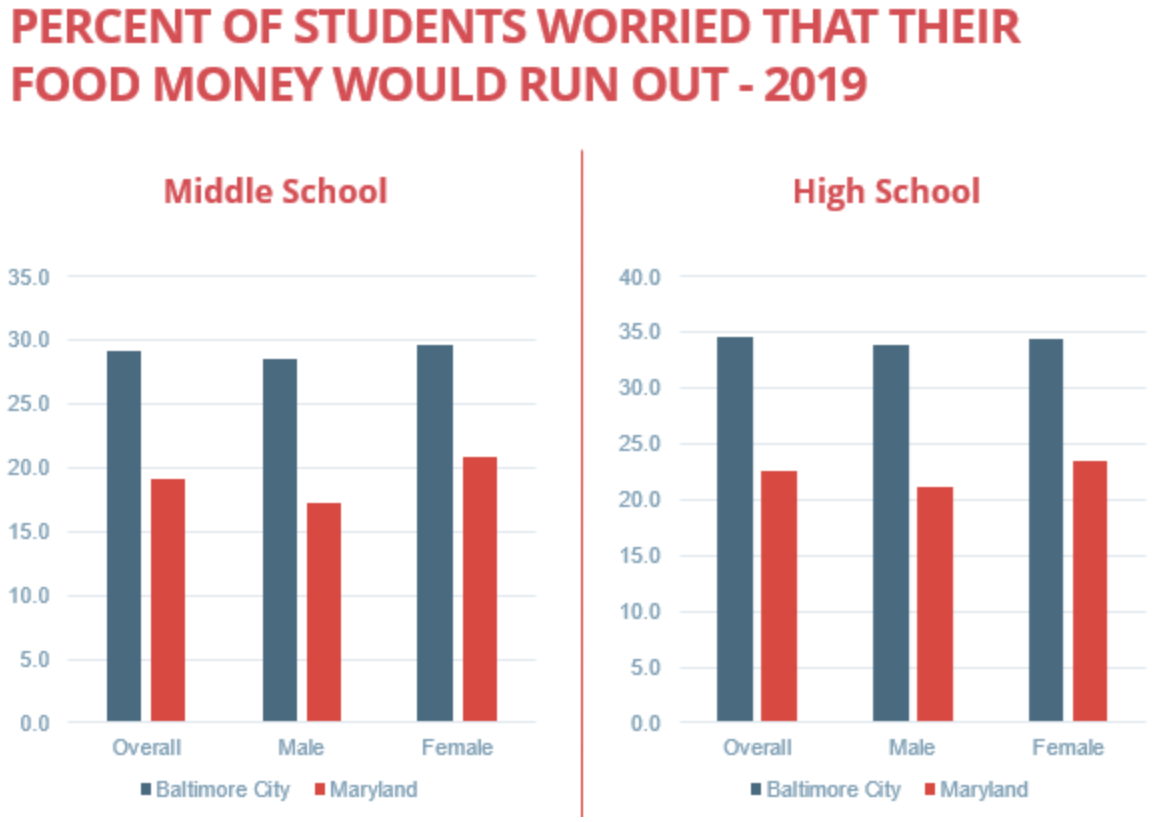


Baltimore City's population experiencing homelessness had been decreasing from 2016 to 2020 according to the Point-in-Time estimate,[4] though the last count was taken in January of 2020, before the COVID-19 pandemic was in full-force in Maryland. The data for the 2022 point-in-time estimate in February 2022 were not available at the time of this report; however, Mayor Brandon M. Scott has indicated an expectation that the pandemic had increased homelessness in the city.[5] Even among those not experiencing homelessness, adequate housing can be difficult for lower-income families to find. An analysis by the National Low Income Housing Coalition determined that a Baltimore City renter would need to work 91 hours at minimum wage to afford a two-bedroom apartment at fair market rent.[6]

Food Desert

According to the most recent Youth Risk Behavior Survey (YRBS) in 2019, approximately 30% of middle school students and 35% of high school students worried that their family's food money would run out, compared to around 20% of both middle and high school students in Maryland as a whole.

[4] Baltimore City Mayor's Office of Homeless Services Point in Time Estimate
[5] City Announces Point-In-Time Count of People Experiencing Homelessness in Baltimore | Mayor's Office of Homeless Services (baltimorecity.gov)
[6] National Low Income Housing Coalition. Out of Reach 2021

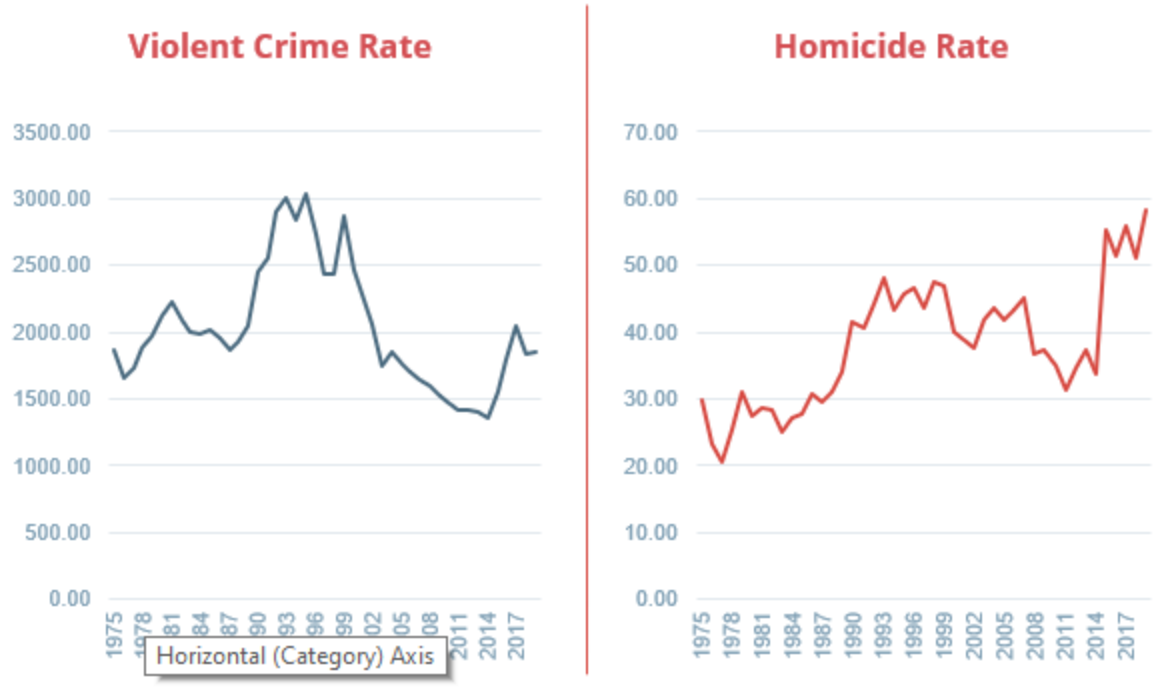


Safety Needs

Violent Crime and Homicide

The violent crime rate in Baltimore City, which includes murder, rape, robbery, and aggravated assault, peaked in the 1990s and steadily declined through 2014. However, beginning in 2015---a year that coincides with the death of Freddie Gray while in police custody---the violent crime rate began to rise through 2019. The data are not yet available to determine how the COVID-19 pandemic has influenced this statistic. When the homicide rate is taken separately and analyzed on its own, the data show a rise in homicides in the city from 1975 through 2019.[7]

[7] Governor's Office on Crime Control & Prevention, 1975-2017, FBI Crime in the United States, 2018 & 2019.



Police Involvement in Behavioral Health

"Promote reciprocal relationships between providers and the police so that both sides understand the needs of the population being served."

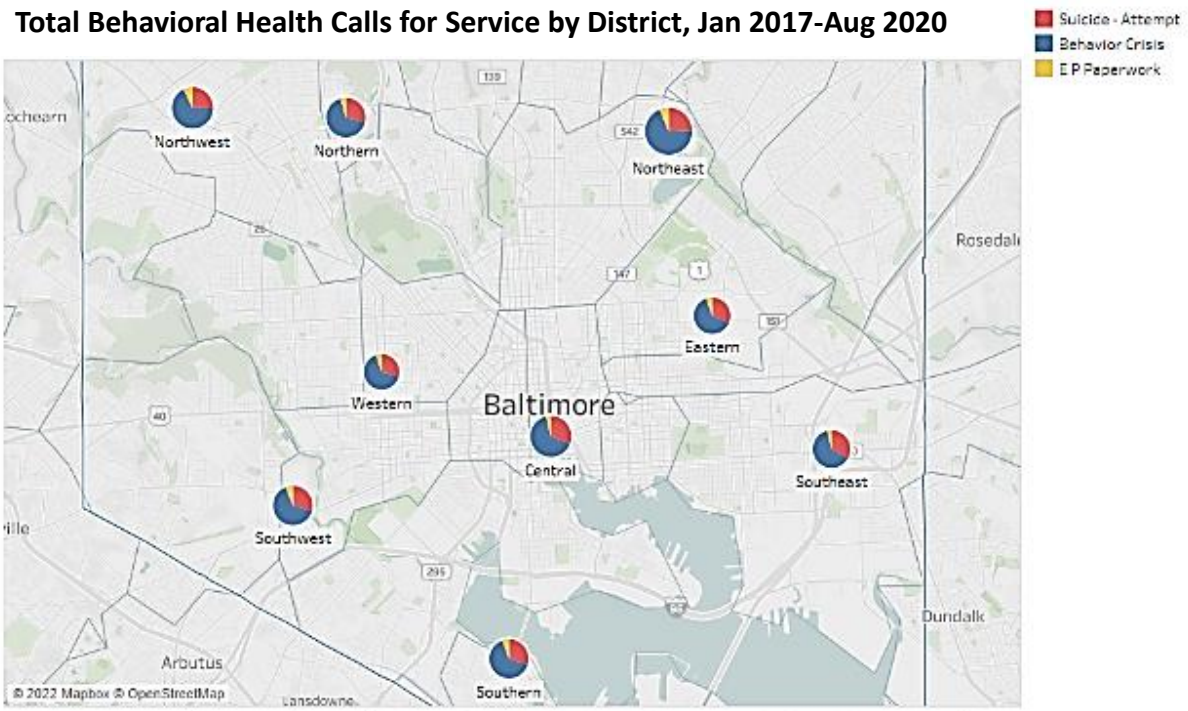
"[E]stablish a mobile crisis response and stabilization system that does not include police responders"

BHSB co-leads 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. CPIC envisions a police force in which

- diversion is routine,
- all officers are trained at a basic level to respond to behavioral health emergencies,
- there is a humane response to people in crisis,
- there is a sufficient number of specially trained Crisis Intervention Team (CIT) officers to be dispatched to calls for service involving people experiencing a behavioral health crisis, and
- there is a process for police to respond in partnership with the behavioral health system to allow for more complex diversion opportunities.

The data below indicate the calls for service for behavioral health purposes received by BPD from January 2017-August 2020.

Total Behavioral Health Calls for Service by District, Jan 2017-Aug 2020

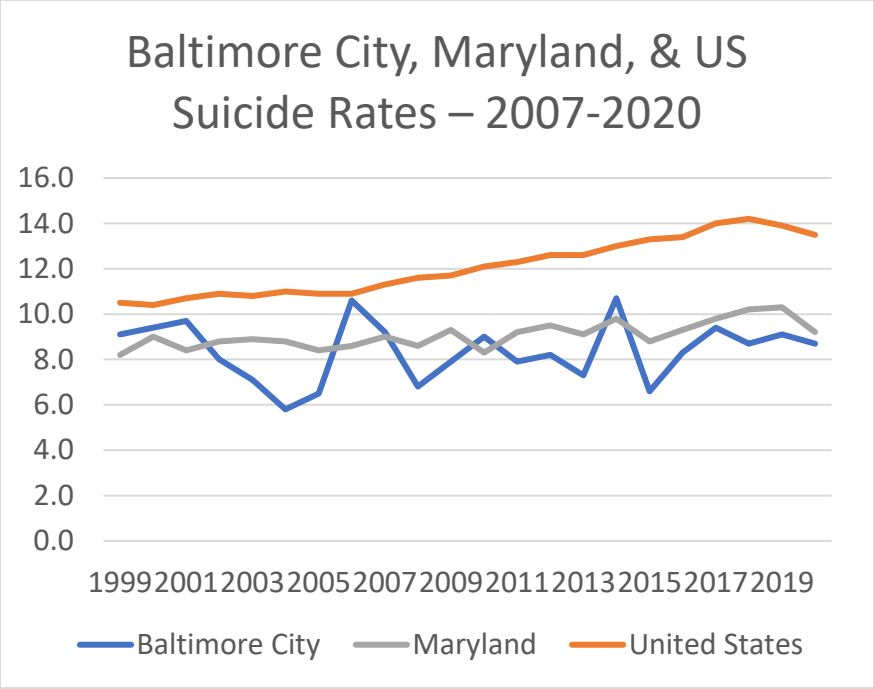


	Central	Eastern	Northeast	Northern	Northwest	Southeast	Southern	Southwest	Western
Suicide - Attempt	1,741	1,394	1,792	1,505	1,457	1,584	1,529	1,549	1,225
Behavior Crisis	3,702	2,838	5,140	3,479	3,846	2,992	3,325	3,392	2,772
E P Paperwork	212	242	470	240	417	182	290	322	223
Total	5,655	4,474	7,402	5,224	5,720	4,758	5,144	5,253	4,220

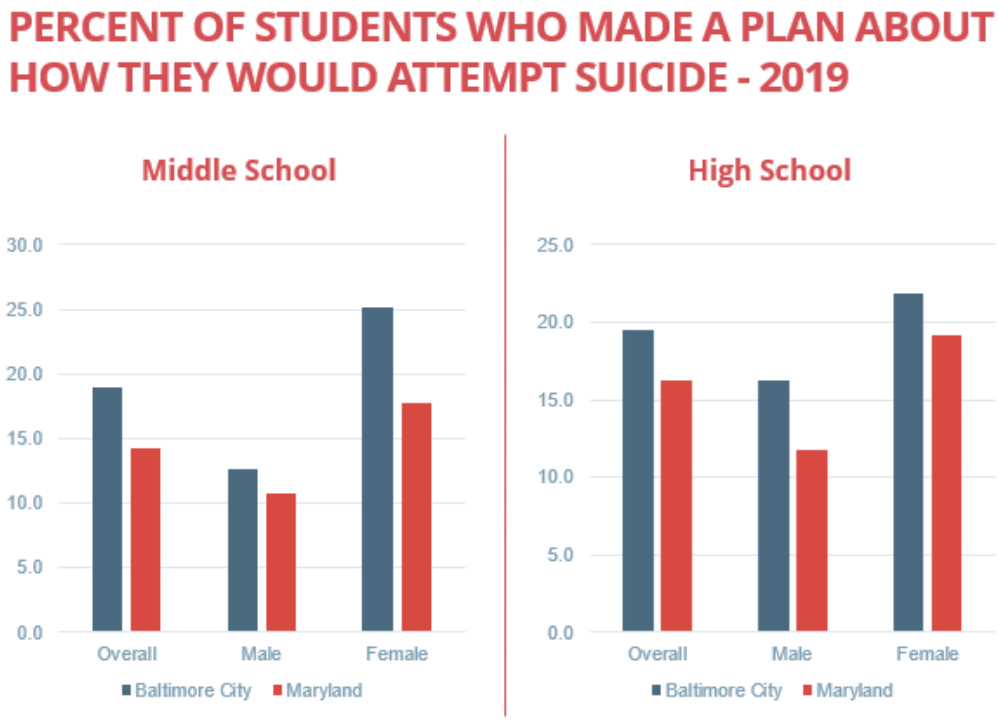
Suicidal Behavior

The suicide rate in both Maryland and the United States as a whole has been on the rise over the last twenty years. A similar pattern has not been found in Baltimore City data; however, suicide is a rare event, and over a small population such as a city, rates are unstable, and trends can be difficult to identify.[8] Despite the rarity of suicide, each death by suicide creates a cascading effect of trauma on loved ones and associates.[9]

[8] CDC Wonder Underlying Cause of Death Database
[9] CDC Suicide Fact Sheet



Moreover, though suicide rates may not differ significantly between Baltimore City and the state of Maryland, data from the YRBS indicate that Baltimore City children and youth are significantly more likely to have made a plan about how they would attempt suicide. This difference is especially striking among middle school girls and high school boys.

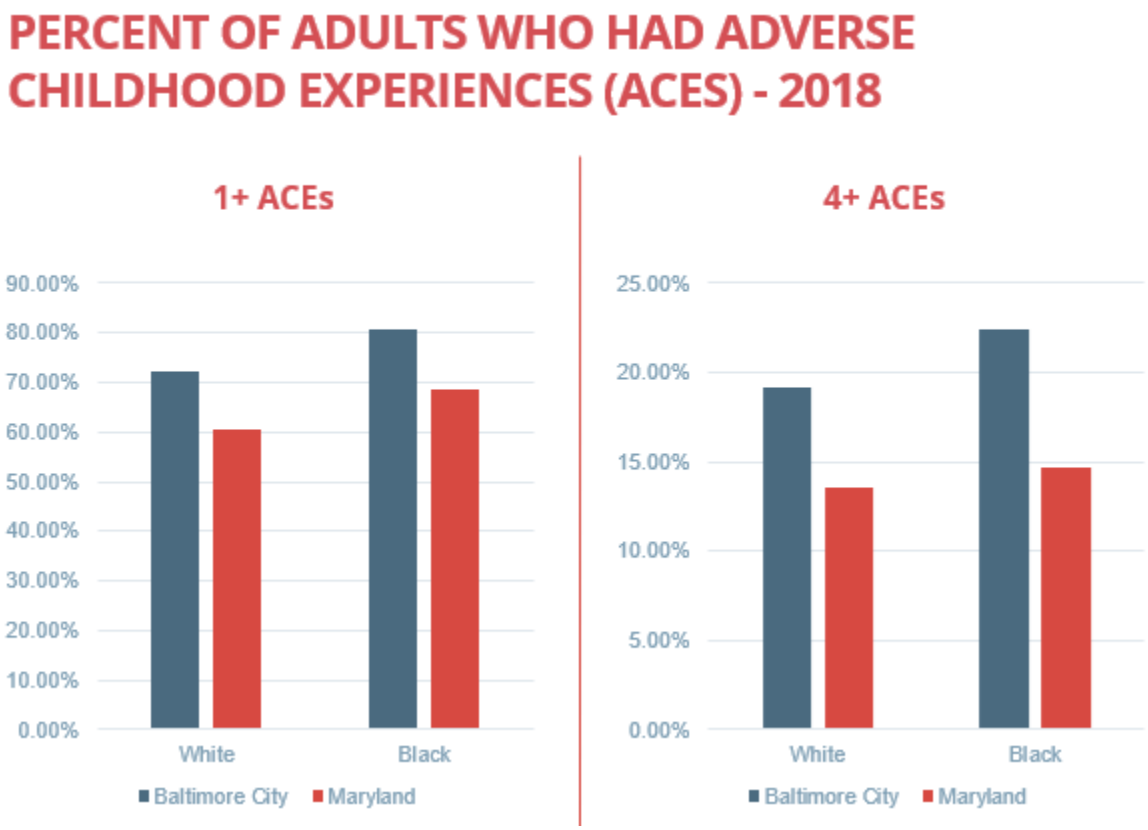


Adverse Childhood Experiences (ACEs)

"There is a clear need for more services and education in schools and child care programs. More parent education focusing on the children's development."

"intensive in-home services and evidence-based practices for children and youth at-risk of foster care or juvenile justice involvement."

During the mid-1990s, Kaiser Permanente and the Centers for Disease Control and Prevention conducted a survey of over 17,000 Kaiser Permanente members. The study demonstrated an association between adverse childhood experiences (ACEs) and health and social problems across the lifespan. It revealed that ACEs are very common and linked to every major chronic illness, costing billions of dollars each year. Adults in Baltimore City are more likely to have experienced ACEs in their youth than residents in Maryland as a whole, and this difference is especially notable in Black adults who have experienced four or more ACEs.[10] These data point to a need to focus prevention efforts on children and youth and to ensure that communities have the resources needed by families to prevent and mitigate the impact of traumatic and toxic adverse experiences.



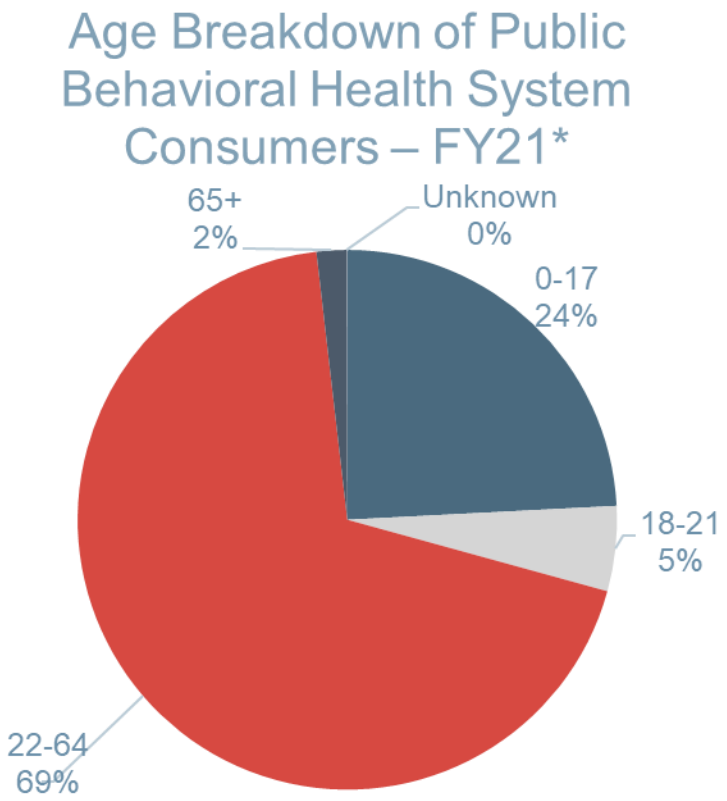
[10] MD-IBIS - Query Builder - Maryland Behavioral Risk Factor Surveillance System (BRFSS) Data - Adverse Childhood Experiences Score, 2018

"Family based centers for both outpatient and residential centers that provide a holistic approach for the entire family that includes prevention, health and referral services."

"Elder care is on the mind, especially as COVID has specifically targeted elders. What is the role of support of elders as members of families?"

Nearly one-quarter of consumers who had FY 21 claims paid through 9/19/21 in the Baltimore City public behavioral health system were under eighteen years of age. A further 5% were transitional age youth (age 18-21), emphasizing the need for treatment services for youth and their caregivers.

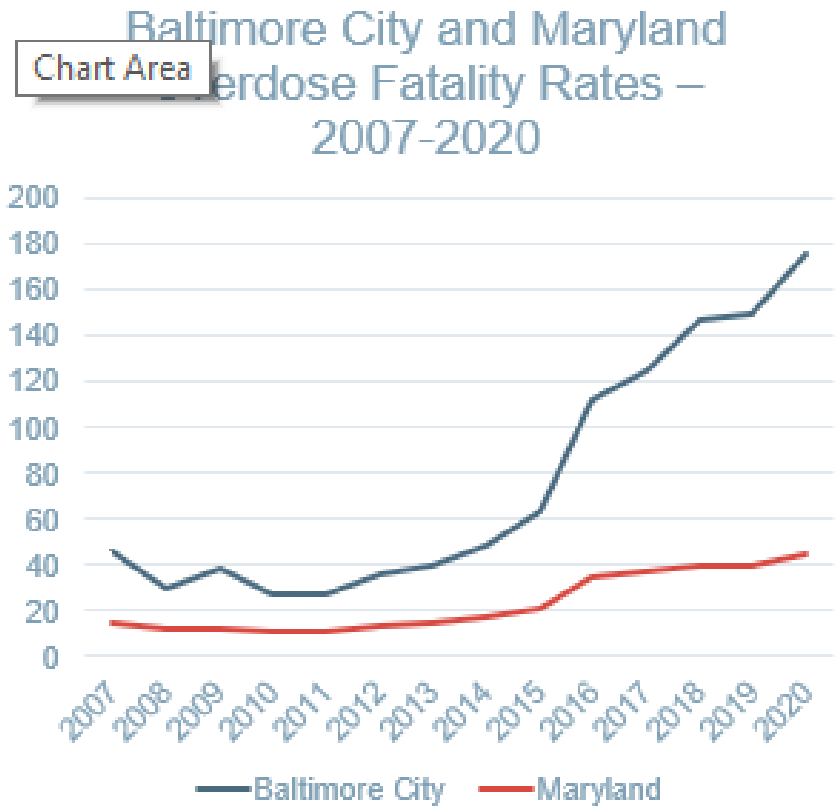
While only 2% of the same set of consumers were aged sixty-five or older, this is largely because people in that age group have their claims covered by Medicare and are thus not part of the public behavioral health system. However, their needs and the roles they play in families are important considerations.



Overdose

"Given the ever increasing overdose rates, two areas stick out: prevention and robust harm reduction services as being underfunded, underresourced, and in need of much more attention and integration into the rest of the BH system and beyond."

The Baltimore City overdose fatality rate has increased in Maryland over the past five years; however, the Baltimore City rate has increased to a far greater degree,[11] pointing to an increased need for prevention and harm reduction techniques, as observed in the above quote. The continued presence of fentanyl, as well as the introduction of non-opioid xylazine in recent years, contribute to this increased rate.

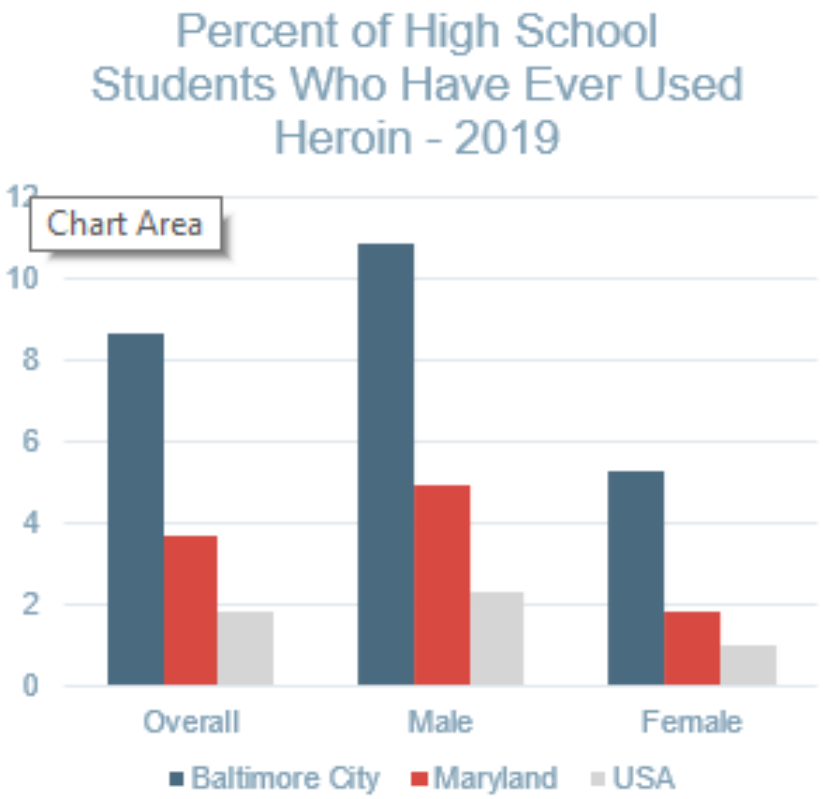


"Support medication assisted treatment for youth under 18 years old in community behavioral health treatment settings."

"There are barely any 'youth-friendly' or youth-focused behavioral health providers, esp. for substance use services. Also need more treatment and recovery options that can keep family units together (parents + kids of all ages)."

The data from the YRBS indicate that Baltimore City high school students are much more likely to have tried heroin than their counterparts in Maryland and the United States, indicating that the need for substance use prevention and treatment in Baltimore children and youth is high.

[11] Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2020 Annual Report, Maryland Department of Health, June 2021



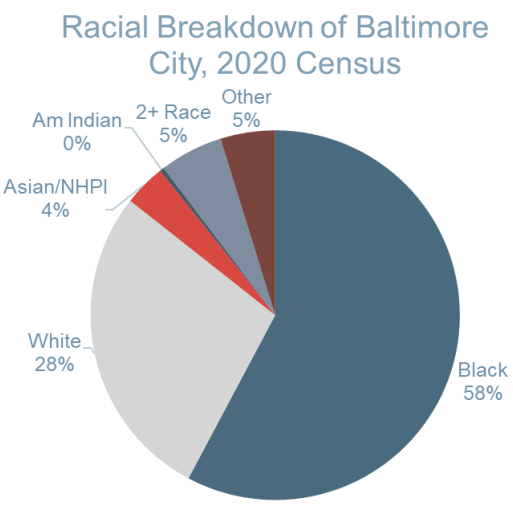
Race and Equity

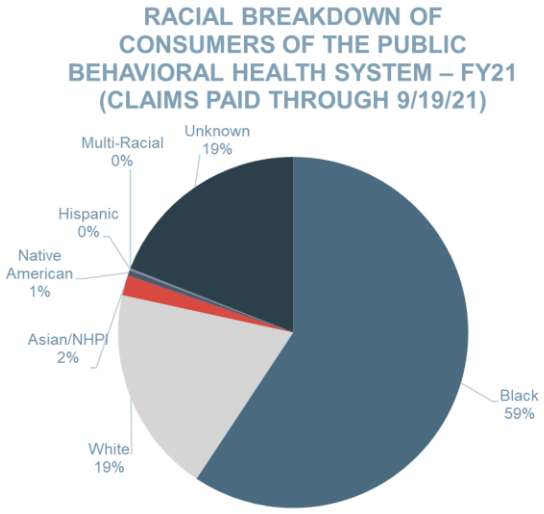
"Directly acknowledge the history of racist medical practices as a root cause of distrust of medical systems in general, including a distrust of behavioral health."

"[R]ecruitment of diverse population of behavioral health providers"

According to the 2020 Census and historical data, Baltimore City has long had a majority Black population, and a longer history of perpetuating systemic racism and other forms of racial injustice. The city has been deeply impacted by the public health crisis of systemic racism for its entire history. Due to many abuses of Black people by the medical system,[12] as well as evidence-based practices normed around a white population, there is a deep distrust of the healthcare system in Black communities. BHSB works to address these injustices by investing in training for the peer support workforce, many of whom are Black, Indigenous, and people of color (BIPOC), and advocating to increase employment opportunities for peers. Additionally, BHSB works to bolster the skills and capacity of front-line, non-traditional behavioral health providers such as clergy members, many of whom are BIPOC.

[12] Byrd, W.M. & Clayton, L.A. (1992). An American dilemma: A history of Blacks in the healthcare system. *Journal of the National Medical Association*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2637749





"All data related to behavioral health, especially that reported out by the state and city, needs to be disaggregated by race"

"[We] need data on the racial make up of leadership, staff, and people being served across the behavioral health system so that it is clear where inequities lie and how to address them in meaningful ways including in leadership positions."

BHSB is committed to becoming an antiracist organization. To that end, we are beginning to employ Results-Based Accountability, a framework for measuring the impact of our actions, to be the measurement arm of our antiracist framework. We have also begun to develop processes to collect data on the racial demographics of the organizations with whom we contract and will hopefully have this data to share in coming years.

"The larger agencies are allowed to continue to receive large contracts while smaller agencies continue to struggle."

"I also think it will be important to reach out to faith communities to have increased acceptance of helping people access care."

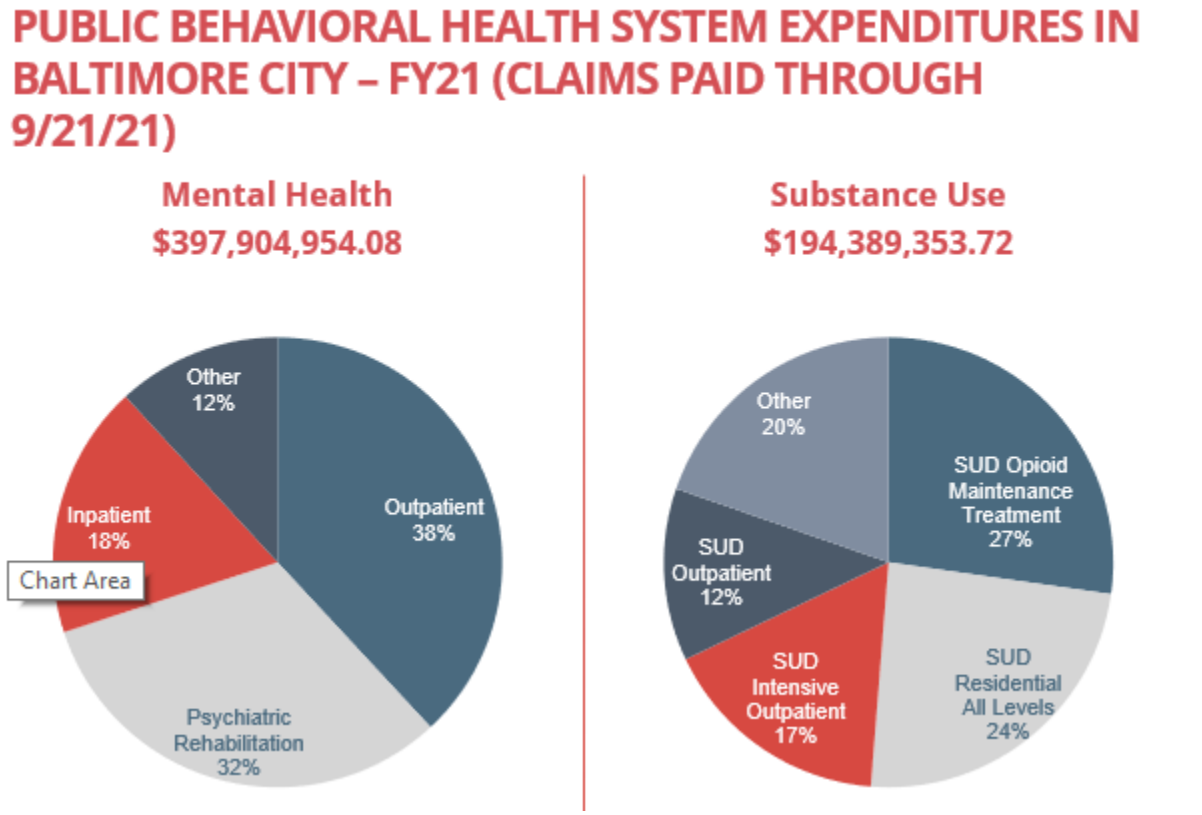
The qualitative data indicate that there is some perception that BHSB's practices regarding funding of larger versus smaller organizations lack equity. This is a significant challenge, as many smaller organizations that are closer to communities lack the knowledge and/or resources necessary to manage the requirements of publicly funded contracts. BHSB is considering possible opportunities within its organizational capacity and scope to help address this long-standing challenge. One approach is a growing partnership with community and non-traditional providers such as clergy to advance behavioral health and wellness across Baltimore City.

Quality of Care

"There needs to be better oversight of service providers, actually looking at the quality of care being provided and closing down those providers that are not actually providing care, but are billing the heck out of Medicaid."

One of the core components of Results-Based Accountability is to look at whether anyone is better off because of the services they receive. In this non-punitive framework, BHSB and providers can work together to choose measures and monitor if efforts are making a difference or if adjustments need to be made to better serve the consumers.

A review of the data for FY 21 reflects that almost 1/3 of all fee-for-service public behavioral health system (PBHS) mental health service utilization expenditures, as collected by the Administrative Service Organization (ASO), were for mental health Psychiatric Rehabilitation Program (PRP) services. As the public behavioral health system is a state-driven system, BHSB partners with the Behavioral Health Administration (BHA) and the ASO to audit for adherence to applicable regulations and standards that govern this area of work. In its role as the local behavioral health authority (LBHA), BHSB will advance the partnership with BHA to collaboratively develop an audit tool that reflects quality metrics and fosters an understanding of PRP services and feasible ways to confirm service delivery.



"The criteria to qualify for higher levels of care should not be so strict that it eliminates most of the people that need that level of care. The expectation of substance abuse programs should not be to force their patients into mental health therapy while they are still adjusting to life without

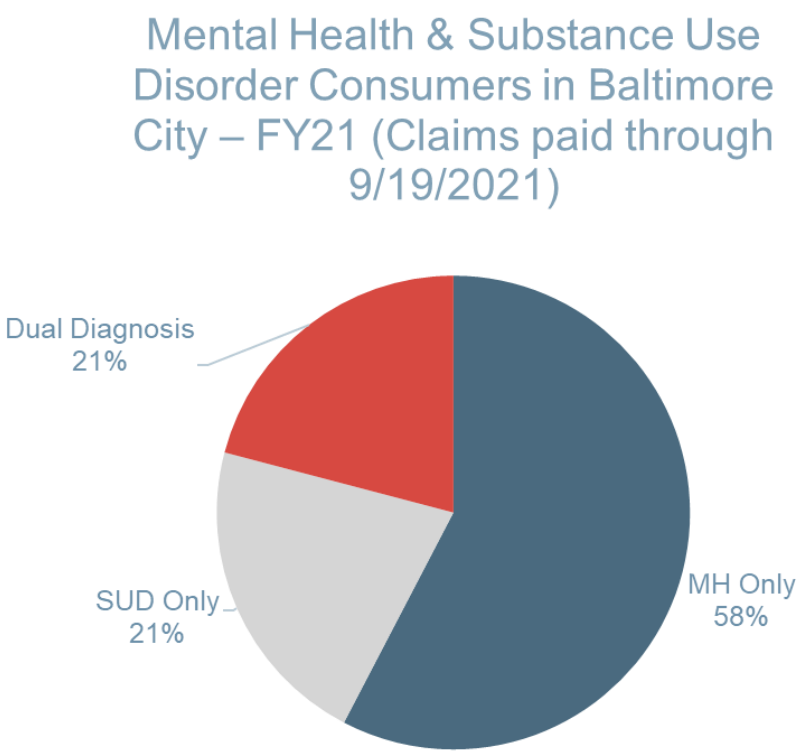
drugs because they don't know what to do with their clients or how to help them. There are so few long-term programs available that support individuals to stay well early on after their illness."

Part of quality care is ensuring that consumers have care options that meet their needs. BHSB advances a harm reduction philosophy and approach that involves meeting people where they are and helping people who use drugs live in the safest way possible, regardless of their willingness to seek treatment. When people who use drugs or people with mental health conditions seek treatment, they should be able to do so in a way that reflects their personal and cultural needs, rather than being forced into a program that requires them to make choices or enact changes they do not want or are not ready to make.

Care Integration, Care Coordination, & Choice of Care

"Help MH providers understand SUD and vise [sic] versa (but I see that it is mostly needed in MH). Attack the stigma still in the mental health provider community about SUD. I've heard several times from MH only providers "I don't know anything about addiction". How can that be?"

It has been nearly a decade since Maryland integrated its mental health and substance use services, but the separation of the two is still experienced at the local level by providers and consumers. Despite the fact that more than one-fifth of consumers receive both mental health and substance use services, the services are often provided separately, and most data from the state is reported separately. Further integration is necessary to serve consumers in a holistic manner.



"[A]doption of interoperable EHRs with meaningful use standards across the BH system is a significant gap and barrier to adequate understanding of what is happening in the system, including who is being served, outcomes, and how to improve care through the use of measurement-based care."

"I have found that we sometimes have clients whose mental health is severe and they require supportive services such as a group home where they are monitored by clinical staff and supports, but we do not know where to find these services for our clients."

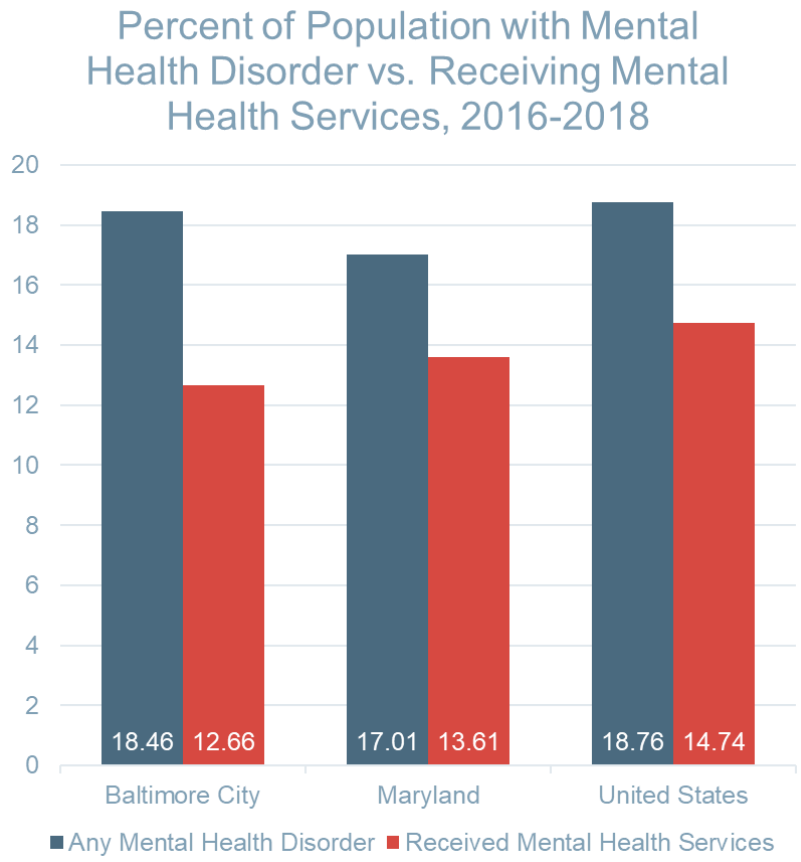
The size and complexity of the behavioral health system, as well as the bifurcation of mental health and substance use services, creates significant challenges in meeting the full spectrum of consumers' needs. Having access to information about services consumers have received or are receiving from other programs would increase opportunities to effectively coordinate care.

"Integrate into Primary Care and Urgent Care settings"

"Normailze [sic] the fact that humans face challenges and assist them to acquire problem solving skills."

Furthermore, consumers and providers in who responded to BHSB's survey expressed a need for behavioral health care to be more accessible to the consumers who need it. The National Survey on Drug Use and Health estimated approximately 18.5% of the Baltimore City population had a mental health disorder, but only 12.7% were seeking treatment in 2016-2018. A great deal of stigma still exists around people who seek help for mental health disorders and

even more so for substance use disorders. One suggestion that arose through the survey is to integrate behavioral health treatment into primary care settings, though the challenges of primary care physician capacity and of educating primary care providers about the complete biopsychosocial treatment of behavioral health disorders would need to be addressed.



Workforce Needs

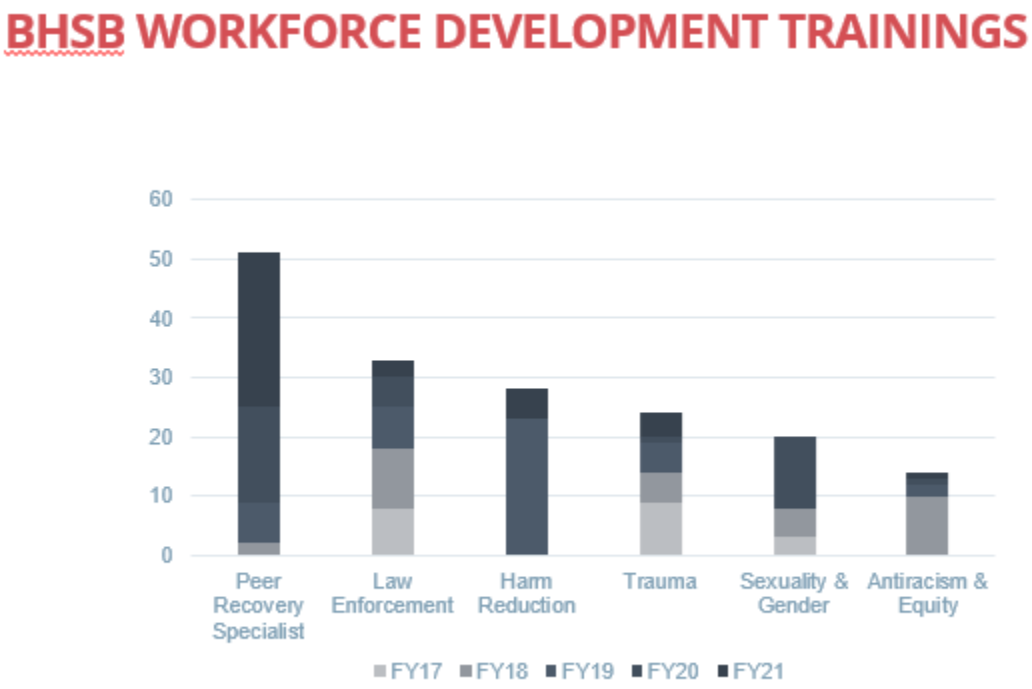
"Workforce does not receive ongoing coaching and support to continue to implement evidence-based and promising practices. Reimbursement rates are insufficient to pay living wages and to support the ongoing workforce and CQI costs."

"Many therapists at OMHCs are unwilling to receive training because they need to pay for it out of pocket. This forces clients/patients to attend substance-abuse specific programs outside of their 'originating' program, and it is not always successful."

Providers have reported that due to low wages and lack of funding, they have inadequate resources to keep up with advancements in treatment practices. BHSB has significantly increased its efforts around providing trainings for the behavioral health workforce, including trainings for Peer Recovery Specialists, law enforcement, clinicians, and people engaged in harm reduction activities. While these are important topics, they might not be meeting providers' basic needs around keeping up to date with the latest treatment modalities.

The current imbalance between workload and funding is the biggest obstacle preventing BHSB from devoting more attention and resources to the many opportunities to expand its work and the system of care in the city. This imbalance might worsen if funding is cut, which is always a possibility in a tight budget landscape both at the state and city levels.

To advance its capacity to support this work, BHBS standardized and streamlined its practices related to identifying and selecting trainers to reduce the administrative burden both internally and for potential trainers. A standard rate was set, a new contract was developed, and an application process was developed that allows trainers to submit applications on a rolling basis.



"Development of and training to support programs specific to working with youth on the Autism Spectrum and Intellectual and Developmental Disabilities. There are not nearly enough services and quality trainings available to address working with these groups."

"Substance use services for youth and Autism Spectrum and IDD/DD services are severely lacking."

While autism and intellectual & developmental disabilities (IDD) treatment is not covered under the public behavioral health system, the fact remains that there is a high amount of comorbidity between autism/IDD and behavioral health conditions. According to the Autism Research Institute, 84% of individuals with autism suffer from anxiety, and 26% suffer from depression. Additionally, persons with autism but without IDD are twice as likely as someone without autism to suffer from a substance use disorder. Similarly, the National Association for the Dually Diagnosed reports that approximately 35% of individuals with IDD also suffer from

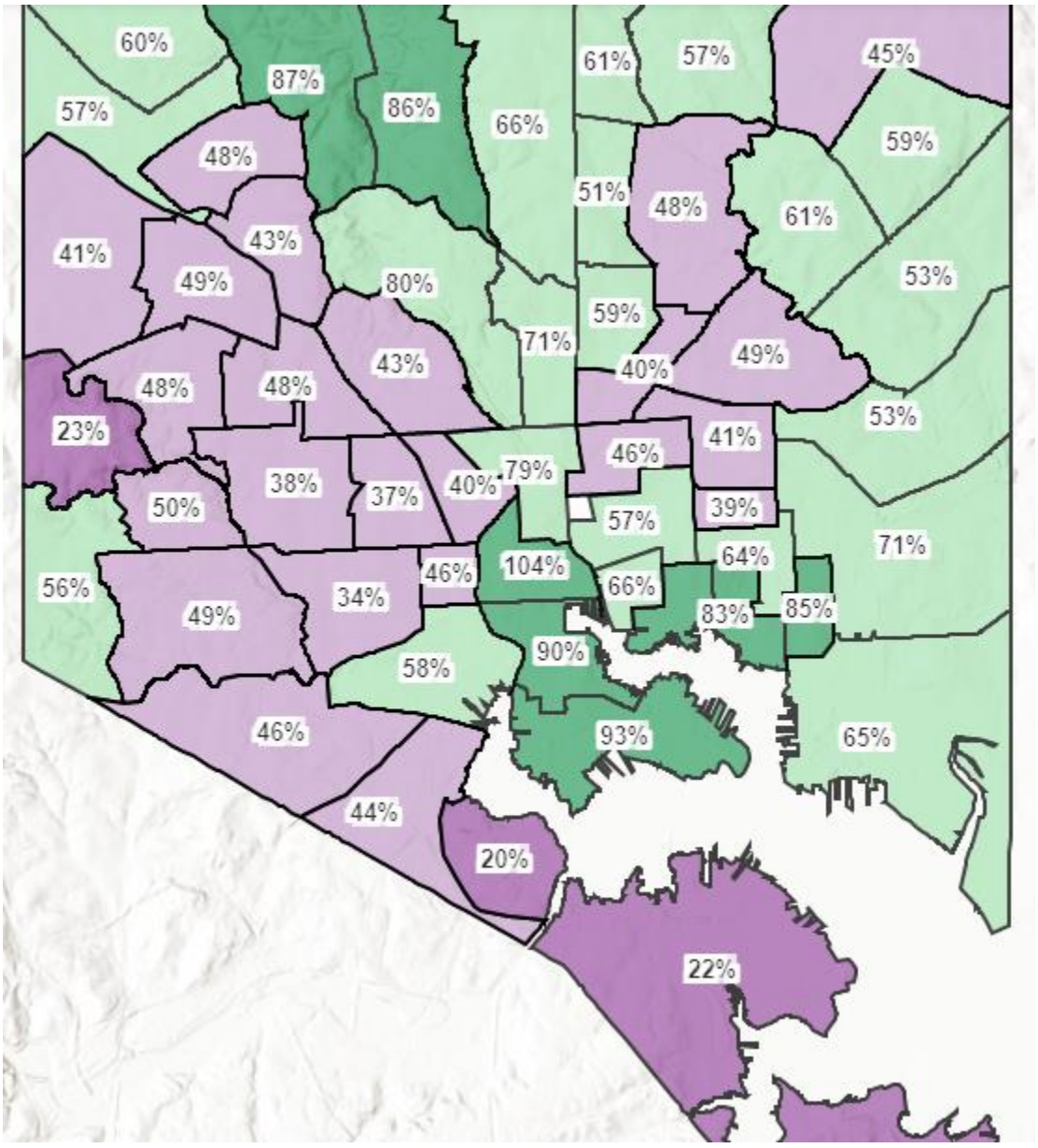
mental illness. The result is that providers are often tasked with treating one of these conditions without having sufficient knowledge about the other, which limits their capacity to offer holistic treatment.

COVID-19

BHSB has been working with providers since the start of the COVID-19 pandemic to ensure that Baltimore City residents continue to receive high quality behavioral health care. BHSB hosted weekly provider meetings to share resources and problem-solve and maintained a website with centralized access to information and resources. We also provided personal protective equipment to providers, including over 12,000 masks (4,000 of which were N95s), over 13,400 pairs of gloves, and over 2,000 face shields.

The focus in FY 21 around the pandemic expanded to include ensuring consumers had access to COVID-19 vaccinations. As the map below from the Baltimore City Health Department's (BCHD) Baltimore City COVID-19 Vaccination Dashboard indicates, the pattern of individuals who are less likely to have received at least one dose of a COVID-19 vaccination aligns with the "Black Butterfly" region of the city, where over a century of racially-motivated policies have had a devastating impact on the health and wellness of majority Black communities. The behavioral health network has encountered the same barriers to providing vaccines to consumers as it has in providing behavioral health services--a general lack of trust in the healthcare system and need for more culturally competent care. Nonetheless, BHSB has engaged in several steps to increase the vaccination rate: reaching out to providers who serve a large number of unvaccinated consumers, partnering with BCHD to create vaccine clinics, and assisting providers who wanted to become licensed to distribute vaccines.

Baltimore City Resident COVID-19 First or Single Dose Vaccination Coverage by Community Statistical Area (CSA) (all ages) (updated 11/30/2021)



Data Section Addendum: Public Behavioral Health System Administrative Data

BALTIMORE CITY Consumer Count, Expenditure and Units
Mental Health
Fiscal Years 2020 and 2022
Claims Paid Through 10/31/2021

FY	Consumers	Expenditure	Units
2020	68,908	$373,304,801.49	2,443,253
2021	65,805	$397,022,849.77	2,479,068
2022	48,037	$106,229,654.45	671,984

Data for FY 2021/22 are not complete as providers have 12 months from the time of service in which to submit a claim for payment.

BALTIMORE CITY Consumer Count, Expenditure and Units
Substance Use
Fiscal Years 2020 and 2022
Claims Paid Through 10/31/2021

FY	Consumers	Expenditure	Units
2020	41,137	$187,965,145.41	2,731,376
2021	35,603	$186,308,239.08	2,450,379
2022	22,845	$61,698,892.95	757,221

Data for FY 2021/22 are not complete as providers have 12 months from the time of service in which to submit a claim for payment.

BHSB was unable to further analyze the FY 20-22 paid claims data further due to the late receipt of the report. In light of the many challenges encountered in the current ASO data system and the ongoing efforts to reconcile claims, for future analysis it would be helpful if the data supplied included comments from BHA addressing the best estimation of the accuracy of the data and its reliability for basing analyses and drawing conclusions. In addition, lack of complete data from prior years makes it hard to track change over time and conduct year-to-year comparisons.

BHSB would also benefit from receipt of the weekly claims detail data report. Prior to the change in the ASO, BHSB had set up an automated process to download, analyze, and visualize the weekly claims detail files. This automated process increased BHSB's capacity to perform our duties as the local system manager.

Lastly, standard reports historically provided to LBHAs would be helpful. High-cost user reports and real-time high inpatient utilizer notifications from the ASO were also lost in the transition to the new ASO. This information is essential for LBHAs to actualize the role of managing the local system of care more fully and identify individuals and families who would benefit from increased system-level care coordination to identify unmet needs and the services and supports that are needed to address those needs.

F. Strategic Goals and Objectives

BHSB's *Three-Year Strategic Plan: FY 2020-2022* was created with the support and partnership of the BHSB Board of Directors, which serves in a governing role, guiding the strategic vision for the organization. The strategic plan serves as a guide to drive BHSB's day-to-day work and set a strategic direction that is responsive to system partners and the needs of the community. It supports ongoing, adaptive learning and agility, with a focus on broad, overarching goals to build out the system of care and develop BHSB's organizational capacity to effectively lead this work. This approach represents a significant shift from the structure of prior plans, which were much more granular.

The plan is structured to have static goals and strategies over the three-year span, with action steps being updated annually by staff. To this end, each year BHSB reviews progress, assesses changing conditions, and adjusts action steps that will guide implementation activities for the subsequent year of this plan. The FY 2022 planning process built in opportunities for leadership and shared decision making at all levels of the organization, which advanced BHSB's core value of *Equity*. The lessons learned informed the planning process that is being conducted during the winter and spring of 2022 to create BHSB's FY 2023-2025 strategic plan.

Analysis: FY 2021 Action Steps Implementation

Of the 31 action steps that were established for FY 2021, 16 (52%) were completed, 14 (45%) were partially completed, and 1 (3%) was not completed. Some action steps were not fully completed because the work is ongoing beyond the boundaries of a single year, and others because BHSB adapted the work in response to shifting conditions and ongoing learning. BHSB values the learning that happened, as well as the collaborative efforts within and across teams to integrate new knowledge by adapting implementation activities.

BHSB's core values serve as important lenses through which BHSB analyzes its progress in implementing FY 2021 action steps. One core value is *Innovation*, which requires building an inclusive culture that promotes growth and learning, fosters the generation of creative solutions, and supports employees to take chances and learn from mistakes. Setting challenging action steps that require a reasonable amount of "stretch" is one tool that can help create conditions that yield innovative thinking. Partial completion of 45% of action steps, with just one that was not partially completed, indicates that we set an appropriate amount of "stretch" for ourselves. *Collaboration* is another of BHSB's core values. Implementing each of the FY 2021 action steps required effective information-sharing, problem-solving, and communication within and across teams and with external partners.

One of the learning points from the first year (FY 2020) of implementing BHSB's three-year strategic plan was that there was inconsistency in the degree to which action steps were specific, measurable, and designed to be completed within the year timeframe. BHSB adopted the SMART (Specific, Measurable, Attainable, Relevant, and Time-based) framework to guide the development of FY 2021 action steps, thereby uplifting another core value: *Quality*.

During the winter of 2021, BHSB's leadership team developed a process for planning FY 2022 action steps that incorporated lessons learned from prior years:

- Integrate the implementation of the strategic plan into organizational processes in a way that advances BHSB's core value of *Equity*.
- Engage staff in planning action steps.
- Structure the planning process in a way that increases leadership and decision making at all levels of the organization.

BHSB's FY 2021 Implementation Report is included as Appendix B. FY 2022 Action Steps are below.

Three-Year Strategic Plan: FY 2020-2022

FY 2021 Action Steps

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, each year BHSB will review progress, assess changing conditions, and adjust action steps that will guide implementation activities for the subsequent year 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:

- Implement several key tasks for of the GBRICS Partnership: 1) develop and test the Care Traffic Control software technology, 2) release a Request for Proposals (RFP) to identify a provider for the Regional Call Center; 3) develop mobile crisis team (MCT) standards and incorporate them into a MCT RFP and contract(s).
- Facilitate meetings and information sessions that address secondary trauma and resilience among BPD and provide resources guides to residents that offer various services and programs.

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

Action Steps:

- Collaborate with the Administrative Services Organization to develop a mechanism for receiving regular reports on individuals identified as high utilizers of behavioral health services and implement process for follow-up to coordinate services for these individuals.
- Ensure full implementation of two overnight mobile crisis teams operating between the hours of 11PM and 7AM and responding to requests for service from both hospitals and community referrals.
- Collaborate with the Baltimore City Health Department and other partners to develop a plan to increase capacity of the Maryland Stabilization Center to thirty-five (35) beds.

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

Action Steps:

- Develop a curriculum for individuals who are currently unable to become certified peer recovery specialists, using a harm reduction approach.
- Offer on-demand harm reduction trainings on the online Thinkific training platform.
- Build capacity in Baltimore City to ensure peers have access to Intentional Peer Support training by ensuring that staff from at least 10 providers participate in a Train the Trainer training.

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:

- Increase utilization of Care Coordination services by at least 50 youth, employing a family-focused, team-based approach.
- Implement Communities That Care and provide life skills and SELF training to reduce risk factors that lead to unhealthy behaviors in youth and build protective factors around them using the social development strategy.

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

Action Steps:

- Incorporate the definition and associated elements of a sub-vendor "in good standing" into the Quality Review that is part of BHSB's procurement process.
- Establish the compliance rate of FY 21 audited contracts.
- Complete pre-readiness steps to prepare for implementing a Contract Compliance Policy.

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:

- Streamline procedures and clarify functions, roles, and timelines for 3 internal processes (training, GBRICS, and service line meetings).
- Develop Finance Library in SharePoint with procedures by area and function with FAQ.
- Develop and implement a Financial Monitoring plan for sub-vendor contracts to ensure compliance with funding agencies.

- Continue to enhance upgrades to BHSB's Contract Management System by refining administrative and budgeting procedures and developing integrations for Chart of Accounts and Accounts Payable.
- Develop accounting procedures and financial reporting for tracking and communicating contract spending and guidelines for reallocation of funds.
- Develop and release purchasing policy updates with accompanying accounting procedures and forms.

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

Action Steps:

- Partner with Mental Health Association of Maryland (MHAMD) to bring Mental Health First Aid training to three target communities (TBD) in Baltimore City.
- Partner with MHAMD to create a dashboard reflecting Consumer Quality Team (CQT) feedback and results.
- Implement a cross-organizational workgroup tasked with developing strategies to strengthen connections between Bmore POWER and BHSB's other teams.
- Document feedback from community engagement activities and its impact on programming decisions. Identify creative ways to share this information internally and externally.
- Partner with Baltimore City Health Department to leverage existing resources and collaborate on projects and campaigns to disseminate information to our target youth population on substance use prevention and opioid misuse in an effort to report a 50% increase in knowledge of substance misuse prevention and opioid misuse prevention strategies by June 2022.
- Host a local community forum with funded partners and potential partners to present data and outcome measures that derived from the prevention work.

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

Action Steps:

- Update monthly internal dashboard to include at least 5 areas of interest to the entire organization and implement a strategy to educate staff in multiple forums about what data is included and what it means for BHSB's work.
- Work with a third-party vendor to implement a compensation plan that positions BHSB within the non-profit sector to equitably recruit and retain employees and ensures an ongoing strategy for fair and equitable compensation for all staff.
- Create and implement a process to review and update the employee handbook that incorporates feedback from employees throughout the organization.
- Review and update the hiring and the onboarding process to ensure each new employee feels welcomed and receives the information needed to be successful in their work.

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:

- Educate and coach 25 faith leaders and members of the community to facilitate Healing Us Together groups using the SELF Community Conversations model.
- Advance organizational-level change within the provider network by sponsoring a learning community that provides technical assistance and coaching to implement anti-racist, inclusive, and trauma-informed policies and practices.
- Implement the Results-Based Accountability framework as a system of measurement for BHSB's anti-racism work as defined in the One Organizational Framework.

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

Action Steps:

- Partner with the Housing Authority of Baltimore City and the Mayor's Office of Homeless Services (MOHS) to establish a small pilot project offering housing opportunities to those enrolling in the Outpatient Civil Commitment project.
- Develop a dashboard to track housing outcomes for consumers served by the Interdisciplinary Street Outreach team.

Three-Year Strategic Plan: FY 2023-2025

The FY 2023-2025 strategic plan will use the Results Based Accountability (RBA) framework. RBA is a disciplined way of thinking and acting to improve entrenched and complex social problems. It uses data-driven decision-making processes to help communities and organizations get beyond talking about problems to taking action to solve problems.

BHSB has been building capacity over the past couple years to operationalize RBA. A group of staff members from each department committed during December 2020 to engage in an intensive process to become RBA-certified. They are now working together to prepare BHSB to operationalize the framework. The strategic planning process is an opportunity to engage the entire organization – including the Board of Directors and staff – in learning and applying RBA.

BHSB began the planning process for the FY 2023-2025 strategic plan in December 2021 by forming the Strategic Planning Workgroup (SPW), which is composed of representatives of the Board of Directors and each of BHSB's departments. The data presented in the *Data and Planning* section of this report was prepared to inform the strategic planning process, which is ongoing through the winter and spring of 2022. It includes structured exercises using RBA tools and iterative feedback loops between the SPW and BHSB's Leadership team. BHSB anticipates finalizing its *Three-Year Strategic Plan: FY 2023-2025* in June 2022.

Appendix A: CLC Strategies Template and the CLAS Self-assessment Tool

One of BHSB's core values is Equity, and our strategic plan includes a goal of increasing health equity in Baltimore City. To build capacity to advance this goal, BHSB is actively engaged in becoming an antiracist organization. This work is enormously challenging and can only happen with deep commitment across the organization. BHSB's Equity and Inclusion workgroup, which is comprised of employees representing every department and all levels of the organization, serves as a champion. It functions in the role of change agent to promote a more equitable and inclusive workplace and citywide system of care.

One component of this work is to build 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 public behavioral health system to deliver integrated services with cultural and linguistic competency. To guide this work, BHSB conducted a CLAS self-assessment during the fall of 2019, which informed planning to advance this work during FY 2021. However, it is important to note that the CLAS standards are geared to providers of direct services. As a local behavioral health authority, BHSB oversees providers that are part of a statewide network of care. While BHSB offers education and support at the local level, it is outside the scope of its authority to set benchmarks or requirements for providers that it does not directly fund.

In establishing its CLAS 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. Below is an update on the implementation of the strategies that were identified during FY 2021.

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.

BHSB included the CLAS Self-Assessment in its FY 2021 Annual Plan as required by BHA.

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)

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.

Update on implementation:

- 27 BHSB employees are members of the Equity & Inclusion workgroup
- The Equity & Inclusion workgroup is co-facilitated by a small group of participants that works together to plan and facilitate meetings. The co-facilitation team rotates annually. This structure was created to provide leadership opportunities to interested staff.
- BHSB created a Language Access Resource Guide that is posted to its website.

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.[13]

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

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.

Update on implementation:

- BHSB translated 3 documents into the 5 languages most commonly spoken in Baltimore City, which include Spanish, Chinese, French, Korean, and Arabic.
- While BHSB receives limited direct calls from consumers, we opened an account with Language Line to utilize their interpretation services when a consumer calls and has limited English proficiency. Prior to implementation, BHSB conducted internal trainings to increase competencies in using interpretation services. The services have not yet been utilized.

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.

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 linguistic responsiveness, equity, and inclusion.

Update on implementation:

- BHSB created tools in Tableau to analyze claims utilization data by race; however, claims utilization data has not been available since the transition to the current ASO.
- The other strategies were not implemented to date due to various challenges, including disruptions due to COVID-19 and the unavailability claims utilization data through the ASO.

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 antiracist 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.

Update on implementation:

- BHSB facilitated two community listening meetings to obtain feedback from Baltimore City residents and community stakeholders. The feedback is informing BHSB's planning to assure decisions are made through an equity lens that ameliorates racial disparities and increases collaboration with Black, Indigenous, and People of Color (BIPOC).

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.

Update on implementation:

- BHSB sponsored the below trainings and professional development opportunities for all staff during FY 2021. To support staff's ability to attend, BHSB's operations were closed during the facilitated staff discussions and REELL sessions.
  - Series of staff discussions about personal and professional experiences of racism facilitated by BHSB's Medical Director
  - *Language as an Equalizer*
  - *How to Use An Interpreter*
  - 4-part training series *Racism Education with Engagement of Leaders into Liberation (REELL).*
- BHSB did not conduct an evaluation of the specific trainings. An annual racial justice organizational assessment collects data from staff regarding BHSB's antiracism work at the organizational level.

Appendix B: Three-Year Strategic Plan: FY 2020-2022, FY 2021 Implementation Report

Behavioral Health System Baltimore

Three-Year Strategic Plan: FY 2020-2022
FY 2021 Implementation Report

Background

The *Three-Year Strategic Plan: FY 2020-2022* serves as a guide to drive BHSB's day-to-day work and set a strategic direction that is responsive to system partners and the needs of the community. It supports ongoing, adaptive learning and agility, with a focus on broad, overarching goals to build out the system of care and develop BHSB's organizational capacity to effectively lead this work. This approach represents a significant shift from the structure of prior plans, which were much more granular.

The current three-year plan was created with the support and partnership of the BHSB Board of Directors and is structured to have static goals and strategies over the three-year span, with action steps being updated annually by staff. To this end, each year BHSB reviews progress, assesses changing conditions, and adjusts action steps that will guide implementation activities for the subsequent year of this plan.

This document reports on progress in implementing BHSB's strategic plan during FY 2021, which is the second year of the three-year plan. It includes population-level outcome measures that serve as indicators of behavioral health and wellness across Baltimore City, as well as the status of each FY 2021 action step and an analysis of our implementation progress.

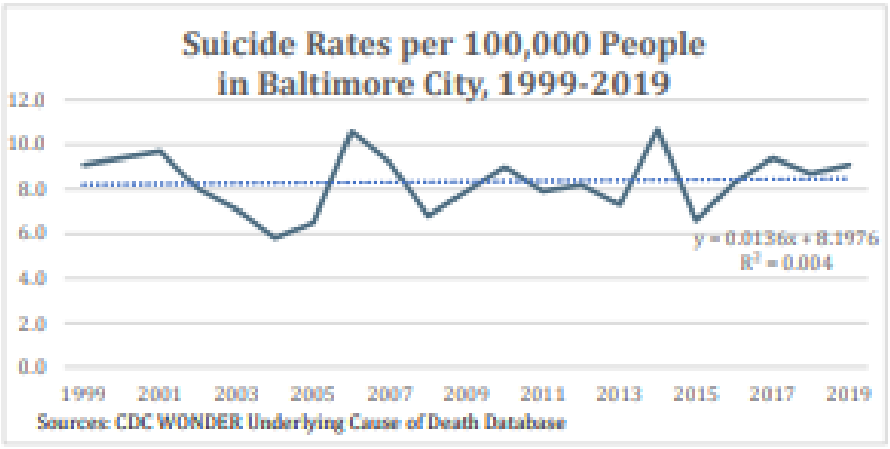
Indicators

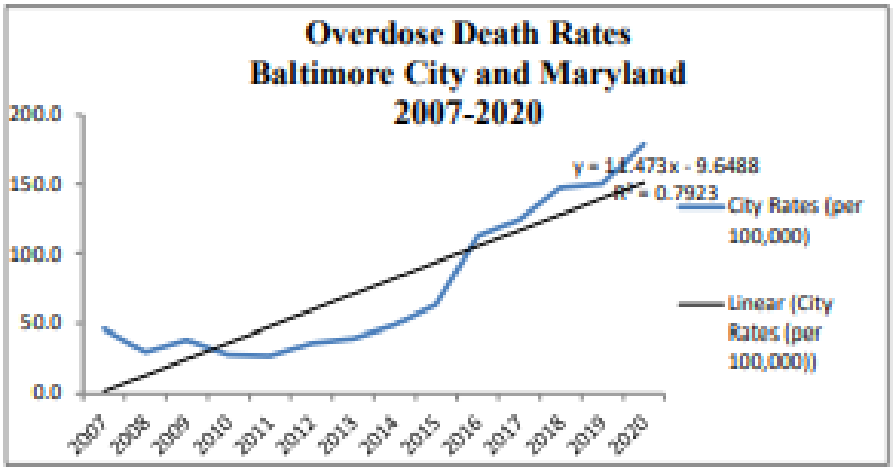
Individuals, families, and communities impacted by mental illness and substance use are served by a complex system of publicly funded services. BHSB collaborates with stakeholders in other systems, such as schools, housing, criminal justice, and social services, to achieve positive outcomes.

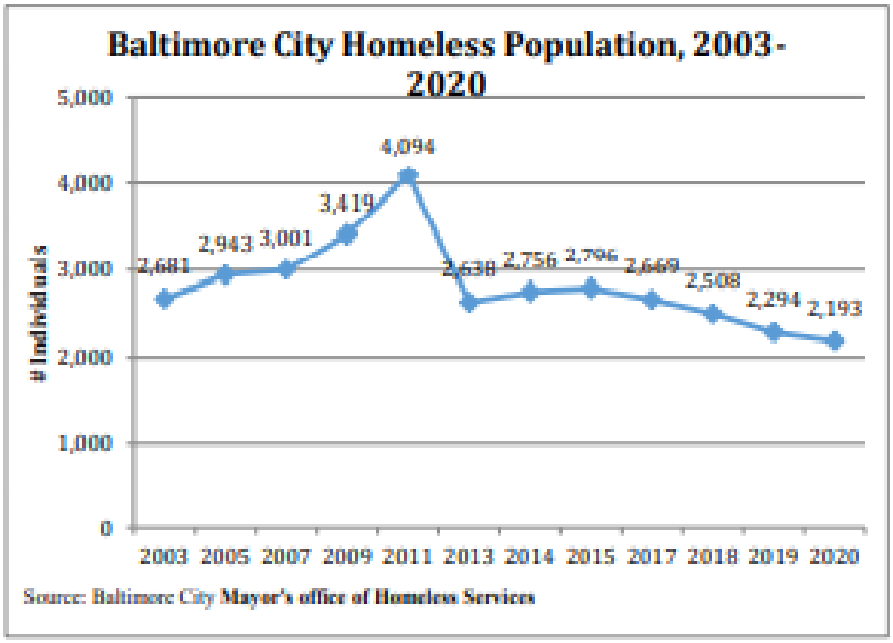
The *Three-Year Strategic Plan: FY 2020-2022* establishes five population-level metrics that serve as indicators of Baltimore City's behavioral health and wellness. Unfortunately, the data source for two of the five outcome measures is no longer available. The Maryland Department of Health has discontinued the use of the Outcomes Measurement System to gather data for the public behavioral health system (PBHS). It is unclear at this time if a new system will be implemented to measure outcomes for the PBHS. For this reason, BHSB is not able to report on two measures: reduction in overall psychiatric symptoms and improvement in quality of life.

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)
- (*Note: data no longer available*) Reduction in overall psychiatric symptoms (data source: Outcomes Measurement System; difference between initial and follow up interviews)
- (*Note: data no longer available*) Improvement in quality of life indicators (data source: Outcomes Measurement System: Recovery & Functioning Indicators; difference between initial and follow up interviews)


Suicide Rates per 100,000 People in Baltimore City, 1999-2019
12.0
10.0
8.0
6.0
4.0
2.0
0.0
1999 2001 2003 2005 2007 2009 2011 2013 2015 2017 2019
y = 0.0136x + 8.1976
R² = 0.004
Sources: CDC WONDER Underlying Cause of Death Database


Overdose Death Rates
Baltimore City and Maryland
2007-2020
200.0
150.0
100.0
50.0
0.0
2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
y = 11.473x - 9.6488
R² = 0.7923
City Rates (per 100,000)
Linear (City Rates (per 100,000))


Baltimore City Homeless Population, 2003-2020
5,000
4,000
3,000
2,000
1,000
0
Individuals
2,681
2,943
3,001
3,419
4,094
2,638
2,756
2,796
2,669
2,508
2,294
2,193
2003 2005 2007 2009 2011 2013 2014 2015 2017 2018 2019 2020
Source: Baltimore City Mayor's office of Homeless Services

FY 2021 Action Steps Implementation Status

The implementation status of FY 2021 action steps is below. Each action step is marked as completed (green), partially completed (yellow), or not completed (red). Some action steps were not fully completed because they reflect work that is ongoing beyond the boundaries of a single year, and others because BHSB has adapted the work in response to shifting conditions.

Goal 2 Action Steps and Status

Strategy 1	Complete an internal Contracting Manual that clearly documents contracting procedures.	
	Develop accounting procedures and financial reporting for tracking and communicating contract spending and guidelines for reallocation of funds.	
	Develop and implement a Financial Monitoring plan for sub-vendor contracts to ensure compliance with funding agencies.	
	Develop and release a Customer Service Survey to sub-vendors for the purpose of guiding data-driven decision-making related to one of BMSB's key functions.	
	Develop and release purchasing policy updates with accompanying accounting procedures and forms.	
	Develop Guidelines for BHA Quarterly Monitoring	
	Enhance Finance Sharepoint Site By Function with FAQs	
	Implement a new or update existing Contracting System to increase efficiency, collaboration, and transparency in pre and post award contracting processes.	
	Implement a process to monitor and recapture underspending earlier in the fiscal year.	
Strategy 2	Implement the Encore POWER strategic plan that was developed in FY 20.	
	Increase capacity to use data by adding more detailed analyses to 2 existing dashboards.	
	Increase capacity to use data by implementing 3 new dashboards.	
Strategy 3	Create and communicate to all staff expectations and standardized procedures for one-on-one meetings.	
	Standardize all job descriptions and upload into UltiPro.	

Goal 3 Action Steps and Status

Strategy 1	Create an organizational framework that presents BMSB's commitment to anti-racism and the measures by which we will hold ourselves accountable.	
	Partner with the Healing Us Together (HUT) collaborative to implement SELF Community Conversations in each of Baltimore City's 14 districts	
	Sponsor a learning community for behavioral health providers to operationalize trauma-informed care.	
Strategy 2	Issue an RFP that includes Rapid Rehousing and encourage behavioral health providers to integrate this service into their model.	

Analysis: FY 2021 Action Steps Implementation

Of the 31 action steps that were established for FY 2021, 16 (52%) were completed, 14 (45%) were partially completed, and 1 (3%) was not completed. Some action steps were not fully completed because the work is ongoing beyond the boundaries of a single year, and others because BHSB adapted the work in response to shifting conditions and ongoing learning. BHSB values the learning that happened, as well as the collaborative efforts within and across teams to integrate new knowledge by adapting implementation activities.

BHSB's core values serve as important lenses through which BHSB analyzes its progress in implementing FY 2021 action steps, one of which is **Innovation.** Innovation requires building an inclusive culture that promotes growth and learning, fosters the generation of creative solutions, and supports employees to take chances and learn from mistakes. Setting challenging action steps that require a reasonable amount of "stretch" is one tool that can help create conditions that yield innovative thinking. Partial completion of 45% of action steps, with just one that was not partially completed, indicates that we set an appropriate amount of "stretch" for ourselves.

Collaboration is another of BHSB's core values. Implementing each of the FY 2021 action steps required effective information-sharing, problem-solving, and communication within and across teams and with external partners.

One of the learning points from the first year (FY 2020) of implementing BHSB's three-year strategic plan was that there was inconsistency in the degree to which action steps were specific, measurable, and designed to be completed within the year timeframe. BHSB adopted the SMART (Specific, Measurable, Attainable, Relevant, and Time-based) framework to guide the development of FY 2021 action steps, thereby uplifting another core value: **Quality**.

During the winter of 2021, BHSB's leadership team developed a process for planning FY 2022 action steps that incorporated lessons learned from prior years:

- Integrate the implementation of the strategic plan into organizational processes in a way that advances BHSB's core value of **Equity**.
- Engage staff in planning action steps.
- Structure the planning process in a way that increases leadership and decision making at all levels of the organization.

The structure for the action step planning process included:

1) materials to educate staff about the strategic plan and the SMART framework so that they could participate in planning in a meaningful way,
2) questions to guide teams' discussions, and
3) an iterative process in which the leadership team reviewed proposed action steps, made recommendations to strengthen or combine them, and collaborated to coordinate and align the work across the organization.

Next Steps

The FY 2022 planning process built in opportunities for leadership and shared decision making at all levels of the organization, which advanced BHSB's core value of **Equity**. The lessons learned will inform the planning process that will be conducted this winter and spring to create BHSB's next strategic plan, which will set a strategic direction for BHSB's day-to-day work beginning with FY 2023.

Appendix C: BHSB 2020-2021 Policy Priorities

Behavioral Health System Baltimore

POLICY PRIORITIES, 2022-2023

Advancing Behavioral Health and Wellness for All

The need for behavioral health services and emotional support is more important than ever to support individuals, families, and communities in the aftermath the COVID pandemic. We must build upon the strengths of our behavioral health system to make reforms that ensure all residents have access to effective and culturally relevant mental health and substance use services. Toward that end, BHSB supports the following policies to advance behavioral health and wellness in Baltimore City:

1. **Build a stable behavioral health workforce to ensure equitable and reliable access to prevention, early intervention, treatment and rehabilitation, and support services**
   Maryland's Public Behavioral Health System (PBHS) is a nationally recognized model; however, many communities, in particular black and brown communities, still face barriers to accessing care due to the lack of available providers in their community. With increasing demand for services, people are experiencing long delays for receiving care due to the lack of available and culturally diverse behavioral health providers. The reasons behind the behavioral health workforce shortage vary from having too few people entering the profession to comparatively low salaries and service reimbursement rates, making it difficult for providers to recruit and maintain qualified professionals. *Maryland must address the behavioral health workforce shortage, and increase racial, ethnic and gender diversity in the behavioral health field through continuing to increase the reimbursement rates for community behavioral health services, investing in peer support services, and by providing compensation incentives (eg. loan repayment, comprehensive benefits) and professional licensing reform.*

2. **Strengthen and expand community-based behavioral health crisis services**
   A comprehensive and well-resourced behavioral health crisis response system reduces unnecessary use of hospital emergency rooms and law enforcement response for people experiencing a behavioral health emergency. Maryland currently does not provide 24/7 crisis services in all communities, and investments are needed to build out the 988 call centers and other crisis response services, such as mobile crisis teams and crisis stabilization centers. National efforts to launch the new 988 suicide prevention and behavioral health crisis hotline will increase access to behavioral health services but only if the state invests in the community services and infrastructure needed to respond dependably to those who need help. *Maryland should promote 988 as the statewide number for access to behavioral health services and allocate funds to support the continuum of behavioral health crisis services and further integrate crisis services with the broader public behavioral health system.*

3. **Invest in co-designed mental health and support services for youth and families**
   Early intervention emotional support and mental health services for youth are fragmented, inequitably available, and not easily accessible. Youth and families navigating these services are experts on their unique needs and should not only be a recipient of services, but partners in all elements of the design including implementation, evaluation, and evolution of services. Co-designing services is a research-informed and authentically collaborative approach to developing and providing services to youth and families. The partnerships between system managers, service providers, and youth and families are vital to ensure that the services provided are equitable, accessible and appropriate. *Maryland should examine how to support communities to develop and implement co-designed programs and provide sustainable funding to support the growth of these models across the state.*

4. **Establish Overdose Prevention Sites and 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 and reduce the harm caused by the War on Drugs, which disproportionately impacts communities of black, indigenous, and people of color (BIPOC). Overdose deaths continue to increase in Baltimore City, even more so during the COVID pandemic. Harm reduction interventions, such as Overdose Prevention Sites (OPS) provide innovative and effective ways to engage people who use drugs around safer drug use and link them to treatment and support services. There are no OPS in the United States, but more than 100 worldwide and none have ever experienced an overdose death. *Maryland should establish OPS to prevent deaths, reduce harm associated with drug use (eg. HIV, Hepatitis B and C, skin infections, etc.), and connect people using drugs to treatment and support services in the community.*