

BALTIMORE MENTAL HEALTH SYSTEMS, INC.

(BMHS)

<http://www.bmhsi.org>

Annual Report

Fiscal Year 2004

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STEPHEN T. BARON, LCSW-C
PRESIDENT

PETER BEILENSON, M.D.
BOARD CHAIRMAN

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PREFACE

FY'04 presented a number of challenges for the Public Mental Health System (PMHS) in both the city and the state. Faced with a several year budget deficit and possible threats to the mental health carve-out, the Mental Hygiene Administration (MHA) initiated several changes in the reimbursement structure through the PMHS with the goal of reducing expenditures by 10%. The reimbursement for Psychiatric Rehabilitation Programs (PRPs) was changed from a per encounter payment to a monthly case rate. Several Baltimore City providers experienced revenue losses of greater than 10%, a few child PRP programs ceased operations, and the long-term effects on PRP program participants is as yet unknown. In addition, reimbursement for uninsured individuals to hospital-based providers for outpatient services was eliminated as hospital reimbursement rates factor in uncompensated care.

Despite these financial pressures, BMHS continued its efforts to improve access to care, ensure quality of care and expand collaboration between various agencies. In FY'04, with funding from the Governor's Office of Crime Control and support from the Blaustein Foundation and Open Society Institute (OSI) BMHS initiated in collaboration with the Baltimore Police Department and the National Alliance for the Mentally Ill-Metropolitan Baltimore, the Behavioral Emergency Services Team (BEST) project; continued its evidence-based project on Assertive Community Treatment; in collaboration with the Baltimore City Public Schools began plans to expand school-based services; in collaboration with Baltimore Substance Abuse Systems, Inc. (BSAS) initiated an integrated care project for substance abuse providers; in conjunction with the District Courts implemented a mental health court located at Southern District; worked with its housing development subsidiary, Community Housing Associates, Inc. (CHA) to acquire additional project-based Section 8 certificates; and, supported its newest subsidiary the Mental Health Policy Institute for Leadership and Training (MHPILT) in developing training and services for juvenile sex offenders and a separate initiative on poverty and depression; and, continued to make improvements in the BMHS contracting process.

During this past year, BMHS assumed greater responsibility for authorizing services for individuals seeking Residential Rehabilitation Programs (RRP) and for non Medicaid recipients seeking PRP services. These additional tasks required the development of a number of new protocols to meet these demands. At the end of the year, BMHS made a decision to outsource its finance office to the accounting firm of Butler-Lochte. This decision was made for both efficiency and cost saving reasons.

The tables below depict the utilization of the Public Mental Health System (PMHS) by Baltimore City residents. They capture data on individuals whose claims were paid by Maryland Health Partners (MHP) the state's Administrative Service Organization for the PMHS. The data is as of July 31, 2004 and since providers have nine months to submit claims we expect the numbers reported will grow between 5-8% before FY'04 is closed. Baltimore City residents have consistently accounted for about 30% of the state's total number of clients served and total state expenditures.

1, Unduplicated consumer count						
	FY'02	FY'03	FY'04	Change from FY'02 - FY'04	% Change	
Medicaid recipients in the waiver	23,005	25,729	25,882	2,877	12.51%	
Gray zone (uninsured) individuals	4,661	3,779	4,125	-536	-11.50%	
Medicaid individuals not waiver eligible	1,513	1,412	873	-640	-42.30%	
TOTAL	29,179	30,920	30,880	1,701	5.83%	
The reduction of uninsured individuals is most likely reflective of new criteria for eligibility implemented in '03.						
2. Breakdown of users by age groups						
Age Group	FY'02	%	FY'03	%	FY'04	%
0-12	8,759	30.02%	9,693	31.35%	10,219	33.09%
13-17	4,247	14.55%	4,994	16.15%	5,692	18.43%
18-21	1,106	3.79%	1,182	3.82%	1,195	3.87%
22-64	13,934	47.75%	14,037	45.40%	13,376	43.32%
65 +	1,133	3.88%	1,014	3.28%	398	1.29%
Total	29,179		30,920		30,880	
From '02 through '04 the under 17 population increased from almost 45% of those served to almost 52% of individuals served by the Public Mental Health System.						
3. Expenditures by coverage						
Year	Medicaid indiv.	Uninsured	Total	Avg/per user		
FY'02	\$114,286,615	\$13,717,807	\$128,004,422	\$4,387		
FY'03	\$133,937,500	\$11,649,267	\$145,586,767	\$4,708		
FY'04	\$129,354,615	\$12,501,464	\$141,856,079	\$4,594		
While the total costs of expenditures have increased the cost/user has remained relatively consistent.						
4. Expenditures by age group						
Under 17						
Year	MA	Uninsured	Total	# of users	Avg/user	
FY'02	\$54,335,542	\$1,649,780	\$55,985,322	13,006	\$4,305	
FY'03	\$71,102,559	\$1,473,601	\$72,576,160	14,687	\$4,942	
FY'04	\$71,139,870	\$1,279,349	\$72,419,219	15,911	\$4,552	
While there has been tremendous growth in the number of youth services and the corresponding expenditures, the average cost per youth is very similar to the average of all age groups.						
5. Use and expenditures of psychiatric rehabilitation programs (PRP)						
In February of '04 new case rate went into effect for this service.						
Year	Exp. Under 18	Users under 18	Avg cost/user	Exp. Over 18	Users over 18	Avg cost/users
FY'02	\$8,495,570.00	2,619	\$3,243.82	\$19,191,573.00	2,519	\$7,618.73
FY'03*	\$18,086,684.00	4,279	\$4,226.85	\$17,876,678.00	2,124	\$8,416.52
FY'04	\$11,666,717.00	4,543	\$2,568.06	\$17,376,830.00	2,480	\$7,006.79
does not include uninsured individuals who were paid through grants						

GOALS & PROGRESS REPORTS

GOAL #1: Ensure that a wide range of services are available and accessible to meet the diverse needs of Baltimore City residents.

ADULT SERVICES

Objective 1A: Monitor access to services in targeted programs of the fee-for-service Public Mental Health System (PMHS).

Indicator: Report on utilization rates at emergency rooms (ER), outpatient mental health clinics (OMHC), and inpatient units using MHP data as compared to prior years and experiences and perceptions reported by drop-in center members.

Strategies:

1. Use MHP data on services provided by ERs, OMHCs, and in-patient units.
2. Survey drop-in center members and report on their perceived access to care within the PMHS.

PROGRESS: This objective was partially met.

During this year the Baltimore City residents experienced increasing difficulty in obtaining access to State Mental Health inpatient services for all levels of care: emergency, intermediate and long-term. It was not unusual for individuals to wait for days in emergency rooms and months on in-patient units of general hospitals for transfer to a State facility. (this was a state-wide problem) BMHS participated with a MHA task group to look at this issue but no resolution was developed as plans for closure of Crownsville Hospital took precedence.

The following is a review of the use of outpatient and primarily general hospital and private inpatient services over the past three years. As the chart describes, outpatient has gone up while inpatient has been reduced. This is the preferred direction. Unfortunately, data is not available for emergency room utilization.

Service	FY'02		FY'03		FY'04		Change from FY'02 - FY'04	% change
	Clients	Dollars spent	Clients	Dollars spent	Clients	Dollars spent		
Outpatient	28,359	\$44,135,848	29,971	\$50,734,216	29,590	\$55,961,023	\$11,825,175	27%
Inpatient	3,192	\$32,450,680	3,010	\$32,471,027	2,716	\$29,352,140	-\$3,098,540	-10%

Adult Services staff was unable to develop and implement a survey of consumers who utilize our City drop-in centers. This was due to the additional authorization duty that we began February 1, 2004. This new duties included authorizing consumers for Residential Rehabilitation Programs (RRP) and for Psychiatric Rehabilitation Programs (PRP) for non Medicaid individuals.

However, in early FY'05 we began this process by meeting with the directors of the three Baltimore City consumer drop-in centers, On Our Own, Helping Other People Through Empowerment, and Hearts and Ears to plan the survey.

The responsibility for review and authorization of all Residential Rehabilitation (RRP) services and all Psychiatric Rehabilitation Program (PRP) requests for non-Medicaid participants was a major shift in duties for staff. During FY'03 we had approved 37 new RRP placements, which was similar to the number (38) this year. However this year we were responsible for approving concurrent review and performed an additional 218 concurrent reviews. The PRP monthly volumes ranged from a high of 114 requests for authorization in June to lows of 32 in April and May. 30% of the PRP requests were not authorized on their first submission necessitating the return of the application for correction and a second review by BMHS staff. Returns initially were for client signatures on plans and diagnosis not meeting criteria.

Objective 1B: Provide 170 eligible consumers with funding through special initiatives.

Indicator: Number of loans and grants provided to individuals moving to independent living; number of consumers supported to remain in the community; number of individuals leaving Patuxent Institution.

- Strategies:
1. Provide 100 consumers moving into independent housing with a start-up loan or grant.
 2. Assist 50 consumers to return and remain in the community from state hospital centers.
 3. Assure that 25 individuals with serious mental illness are identified 3 months prior to mandatory discharge from the Patuxent Institution and are referred for community placement services.

PROGRESS: This objective was partially met.

126 individuals received a grant or loan used primarily for start-up costs associated with moving to independent housing. Uses included security deposits, first month's rent, furniture and assistance with repayment of old BGE bills. Another 25 applications were received, but the requestor either did not follow through with completion of the application the applicant or did not qualify under the policy guidelines. An additional \$11,000 grant to provide BGE assistance was received from the Baltimore City Community Foundation late in the year.

Adult Services Staff participated with MHA, Springfield and Spring Grove to assist with the development of community living plans for four individuals with special needs. Twenty-six individuals moved from the state hospital to the community with support from BMHS and the service providers, 13 individuals entered through the Capitation programs and 13 individuals through Residential Rehabilitation Programs (RRP). Funding for rental subsidy or special accommodations to sustain an additional 15 individuals to remain in the community was provided. An additional 22 people received a one time only monetary assistance primarily for a first month's rent coupled with an enhanced service plan which enabled them to remain in the community.

The budget for the Patuxent Initiative was reduced for FY'04 requiring a decrease of the expected number of individuals to be assisted from 25 to 11. Using the Initiative nine (9) men were provided case management to develop a community services plan prior to their mandatory release from Patuxent. This number is below the target amount by two (2). As there was a halt on referrals due to possible further budget constraints.

Objective 1C: Ensure that the Ageless Learning Project (community support for seniors) offered at senior centers are in place.

Indicator: Number of sites (senior centers) at which the project is presented and the number of services provided.

- Strategies:
1. Identify an OMHC that will assume responsibility for the program.
 2. Assist the OMHC in identifying geriatric mental health educators to provide the service and support the training.
 3. Link new educators with staff at Baltimore City senior sites to provide programs at each identified site.

PROGRESS: This objective was partially met.

During the first half of the year Jewish Family Services continued to provide Community Education & Support to seniors through their educational programs and senior sites in the community. Approximately 100 hours of services were provided to this population. By August BMHS had identified an OMHC with the experience, capacity and willingness to assume responsibility for the program. Two clinical social workers with extensive geriatric experience had been identified to provide the service. Discussions were in progress with the Mental Health Association of Maryland to develop a budget and time line for training the social workers to provide this program, based on the previous Ageless Learning project. However, in November the Mental Hygiene Administration announced that funding for Community Support & Prevention initiatives would be eliminated by 1/1/04. Without funding to support this program the project was discontinued.

Objective 1D: Develop opportunities to expand the Baltimore Capitation Project in conjunction with MHA.

Indicator: Program expanded to serve more than 311 individuals.

- Strategies:
1. Identify a funding structure to expand the project.
 2. Identify new provider(s) through a request for proposal process, if expansion merits.

PROGRESS: This objective was partially met.

The Baltimore Project was expanded to 353 individuals; 40 slots were added for state hospital referrals, and 2 slots were converted from residential rehabilitation (RRP) to capitation as a result of reimbursement changes to RRP.

No new providers were added in fiscal year 2004, but the capacities of the current providers were increased. Consultation was given to Montgomery County regarding their proposal for a case rate project, but their project has not yet been funded.

Objective 1E: Assist current capitation project providers in meeting quality of care standards and obtain positive clinical outcomes.

Indicators: Number of meetings with cap program providers, grades obtained in the yearly independent review, performance on new outcome measures devised.

- Strategies:
1. Provide in-service training at least quarterly on best practices and vision and goals of the capitation project.
 2. Attend meetings at least quarterly with providers to discuss issues and troubleshoot problems as they arise.
 3. Do statistical analysis of new outcome measures to determine their usefulness in measuring care, and adjust outcome measures as needed.

PROGRESS: This objective was met.

Site visits were completed at both sites during fiscal year 2004 to assess quality of care and record keeping. Both sites performed well, and Chesapeake Connections made significant improvements to their record keeping and after hours procedures. Meetings were held 9 times during the year with capitation providers, mostly to troubleshoot new billing and collections procedures with the state's administrative service organization (ASO).

Six in-service trainings were conducted with providers during the year; four with Chesapeake Connections and two with Creative Alternatives. The goal for fiscal year 2005 will be to increase these trainings to Creative Alternatives and maintain the same frequency or increase it with Chesapeake Connections. Trainings will focus on case conferences, basic counseling and empathy techniques, as well as the recovery model popularized by Patricia Deegan.

New outcome measures on employment, independent living, and training and education were implemented for fiscal year 2004. The independent evaluation is currently underway.

Objective 1F: Train Department of Social Services (DSS) workers under the Temporary Assistance to Needy Families (TANF) Grant to recognize mental illness and substance abuse and make appropriate referrals for service.

Indicator: Number of training sessions completed and the number of consultations offered to DSS workers.

- Strategies:
1. Schedule and complete training sessions for DSS case managers on recognizing the signs and symptoms of mental illness, substance abuse, and learning disabilities that may impede the individuals' progress in obtaining and maintaining employment.
 2. Schedule and complete training sessions for BSAS substance abuse counselors in best practices for co-occurring disorders and in screening for mental illness.
 3. Attend case conferences and discussions with DSS workers to crystallize learning and improve skills in working with dually diagnosed individuals.

PROGRESS: **This objective was partially met.**

The State Department of Human Resources agreed to the funding request submitted by BMHS in collaboration with our local Department of Social Services (DSS) to improve the identification and treatment of Temporary Aid for Needy Families (TANF) recipients with mental health needs. A contract was given to Universal Counseling to accomplish this goal. Licensed mental health providers were assigned to each of the 11 DSS offices and provided 38 presentations to the staff of their center. As a result 1165 DSS customers were referred for services; 670 completed a mental health/psycho-social assessment resulting in 505 referrals to mental health services. 302 customers were provided brief therapy during the referral process.

Objective 1G: **Implement the Minkoff/Cline Continuous Comprehensive Integrated System of Care (CCISC) model in Baltimore to increase expectations of the provision of integrated care by Baltimore providers of mental health and substance abuse services.**

Indicator: Number of meetings with providers and consumers to build consensus, number attended, number of new policies and outcome measures instituted to track progress in the CCISC model.

- Strategies:
1. Schedule and complete consensus-building meetings with consumers and providers to discuss the model and choose outcome measures and policy changes from the CCISC model.
 2. Choose two or three outcome measures from the CCISC model with which to measure progress in implementing integrated care.
 3. Review progress made using the new outcome measures and policies and make adjustments.

PROGRESS: **This objective was partially met.**

The BMHS/BSAS Integrated Care Committee reconvened in November 2003. It has met monthly since then, and has been attended by several key providers of substance abuse and mental health services, most of whom are actively providing some form of integrated services. The process of building consensus and determining outcome measures has taken longer than anticipated. The first several months of the Integrated Care Committee meetings were used to educate providers on the consensus best practices on integrated care, discuss barriers to providing

integrated care within the system, and beginning to hear from providers about the programming they offer and the approaches they are using. This committee is continuing to hear from providers regarding their programs, and the next steps will include strategic planning for collecting outcome measures.

Another parallel activity has been in process since March 2004. BMHS and BSAS received a grant from the Open Society Institute (OSI) to further systems change within the Baltimore substance abuse treatment community. The goals of this grant include implementation of universal screening for mental illnesses within all grant-funded substance abuse service providers in Baltimore, and provision of training to the providers on best practices for individuals with co-occurring disorders. Following a forum for all BSAS providers in March 2004, an advisory committee of interested BSAS providers was convened to assist BMHS and BSAS in implementing the grant. This committee has also been meeting monthly, and has chosen a screening tool. The tool will be rolled out at a second provider forum in October 2004. Along with the screening tool, the forum will also be used to educate providers on eligibility criteria for the public mental health system and on how to gain this eligibility for their clients.

One of the system goals for fiscal year 2005 will be to work with all publicly funded mental health and substance abuse service providers to complete the COMPASS assessment tool at least once, and then to complete it every 6 months. If this initiative is successful, the COMPASS will serve as a useful service improvement outcome measure for providers.

CHILD AND ADOLESCENT SERVICES

Objective 1H: Ensure the availability of mental health services in 6 Baltimore City Head Start Programs and the implementation of Safe Start Program services in two Baltimore City communities in collaboration with the Head Start Program and the Family League of Baltimore City (FLBC).

Indicator: Completion of service contracts with providers and the number of children/families served.

Strategy: Contract with providers to provide early childhood services for the Head Start and Safe Start initiatives.

PROGRESS: This objective was met.

Mental health services were provided in six Baltimore City Head Start programs, through DHMH contract funding. During FY04 additional funding was also received from Baltimore City Head Start, which allowed the project to expand to six other Head Start programs, for a total of 12 Head Start sites served by five mental health programs. The chart below provides composite information on mental health services provided in the Head Start programs through BMHS contracts with Johns Hopkins Bayview Medical Center, Kennedy Krieger Family Center, UMB-Center for Infant Studies, Urban Behavioral Associates, and Villa Maria.

ACTIVITY	YTD TOTAL
Referrals Received	353
Number of children on caseload	306
Child Prevention Activities	762
Observations	778
Family Consultations:	
Total (Child behavior/mental health)	260
Of the total above, the number of children who received 3 or more (Child behavior or mental health)	32
Other	92
Family Workshops/Groups	77
Staff Consultations:	
Total (Child behavior/mental health)	749
Of total number of children who received 3 or more (Child behavior or mental health)	106
Other	317
Program Meetings	372
# of children discussed	445
Staff Development Sessions	93
Total Head Start Funded Enrollment = 2596	
Total Number of Programs Served = 12	
Total Number of FTEs = 9*	(*1 FTE position was unfilled in the 3 rd and 4 th quarters)

The Baltimore City Safe Start Initiative expanded to city wide service. A total of 33 referrals have been received. Six families received mental health treatment, and service linkages were provided to five families. Child Development Community Policing responded to 83 trauma responses in which 21 children under six were present.

Objective 1I: Provide purchase of care and transition services to 20-30 children/young adults.

Indicator: Number of children and youth served.

- Strategies:
1. Maintain TAY initiative capacity to serve 20 youth.
 2. Provide resource coordination and purchase of care support to children/families with needs that cannot be readily met through the fee-for-service system.

PROGRESS: This objective was met.

1) During FY04, a total of 29 Youth were served by the TAY project. The TAY program did maintain a capacity to serve up to 20 youth at any given time. 2) BMHS provided funding from DHMH Purchase of Care for 12 families with needs that could not be met through the Public Mental Health fee-for-service system. Funding was provided for one youngster's placement in an intensive respite setting; one in a Therapeutic group home; one-to-one support services were provided to prevent out of home placement for one youth; and 9 families were helped with transportation. These DHMH funds are limited and the BMHS Resource Coordination staff has done an excellent job of appropriately involving other systems to provide funding for a variety of

needed services.

Objective 1J: Maintain the capacity of school-based mental health programs to provide mental health prevention and treatment services in Baltimore City Public Schools (BCPSS).

- Indicators:
1. Number of schools with school-based clinicians.
 2. Number of children receiving mental health services in BCPSS.
- Strategies:
1. Provide technical assistance and training support to schools in providing Skill Streaming initiatives.
 2. In collaboration with the FLBC fully implement the truancy initiative in three schools.
 3. Ensure the presence of mental health services in two Judy Centers.

PROGRESS: This objective was met.

During FY 04, eighty-three (83) schools were served by school-based mental health programs. The total number of unduplicated students receiving mental health services was 5,473. Consistent with our commitment to partner with key adults in the lives of children, over 9,500 consultations were provided to participating parents/families and 9,100 consultations were offered to teachers. Consistent with past years, outcome data available for academic year 2003-2004 reveals the positive impact of school-based mental health services. The Outcome data below is based on students seen four or more times by a mental health clinician; total sample = 1309.

- ? 93% of students served had no suspensions after beginning mental health services
- ? 93% of students served were not referred to Child Study Team (CST) for Special Education assessment or services
- ? 80% of students served attended 90+% of school days

Through the BMHS School Mental Health Violence Prevention project, for which DHMH funding was partially restored beginning in January, 2004, 351 Skillstreaming pro-social skills development group sessions were provided in fourteen schools. In past years, School-Based programs had made good use of the Community Prevention and Support reimbursement for pre-approved prevention / mental health education activities, however, that method of reimbursement was discontinued as of February, 2004. Programs participating in the School Mental Health Violence Prevention project were required to continue delivering other prevention group activities in addition to Skillstreaming; 485 prevention group sessions were provided during the second half of FY04 in the 14 participating schools.

BMHS has continued to work cooperatively with the Family League of Baltimore City (FLBC) on the Truancy Prevention Initiative. Funding from this Initiative supports School-Based Clinicians in three schools, where in addition to the typical School-Based Mental Health treatment and early intervention services, prevention and intervention services are being developed to address school truancy issues.

Blended funding from Early Childhood Initiative and School Based Services helped support a part time mental health professional at the Judy Center at John Eager Howard

Elementary School. In FY 04, a total of 760 consultative hours (average of 20 hours/week for 38 weeks) were provided to teaching staff. In addition, 36 hours of staff development were provided.

Objective 1K: Continue to collaborate with city and state agencies on the development of a high-end/high-cost service initiative by developing a program model, identifying funding approaches, and issuing an RFP.

Indicator: Documentation of program model development, funding mechanisms, and creation of an RFP.

- Strategies:
1. Hold regular state and local stakeholder meetings to develop program model, funding approaches, and an RFP.
 2. Seek funding from state and other sources.

PROGRESS: This objective was partially met.

BMHS and the Family League of Baltimore City (FLBC) the Local Management Board (LMB) for Baltimore City have been working together for several years to develop a wrap-around case rate service for a specific cohort of youth with serious emotional disturbance (SED). These children have needs which are complex, distinctive and varied over time thus necessitating flexible and fluid services. During this past year while not making as much progress as we anticipated there has been progress in several areas. Deputy secretaries of the various child serving state agencies have developed a state-wide focus on wrap-around services for which our initiative is seen as a pilot for the state; MHA has worked with BMHS to develop a financing strategy; and BMHS has revised the program design to include the following items.

Current Funding Plan

The goal of the financing strategy is to maximize funding participation from all relevant parties in Baltimore City. FLBC is currently spending approximately \$2 million in State General funds to support 60 youngsters in their Community Services Initiative (CSI). These youth have been returned or diverted from Residential Treatment Centers (RTCs). We are proposing, contingent on OCYF approval, to use FLBC's CSI funds to serve as the state match for Medicaid reimbursement in the city's wraparound initiative. In doing so, we expect that we can increase the enrollment from 60 youth to 100 individuals. Since all or almost all of the CSI youth are MA eligible, by using these funds as the state match we can operate a \$4 million program at no additional cost to MHA. The actual case rate would be developed based upon actuarial work of UMBC.

The ultimate goal is to establish a case rate that is inclusive of the cost of community residential placements e.g. therapeutic group homes and therapeutic foster care. Therefore, the case rate would need to be increased and the increase would be supported by funding from DJS and DHR. In early August, 2005, under the auspices of the Sub-Cabinet for Children Youth and Families, VandenBerg and Associates, national experts in wrap-around services and funding, will be providing on-site consultation over several consecutive days to help the state implement wrap-around services. VandenBerg and Associates have been requested to provide consultation on how to ensure maximum funding participation by all relevant state agencies.

Services

A broad provider network which offers creative and individualized services is essential. Thus, the model includes the provision of a broad array combining both traditional and non-traditional formal services as well as informal services.

Examples of traditional formal services:

- | | | | |
|---|----------------------------|---|-----------------------|
| ? | Case management | ? | After school programs |
| ? | In-home support | ? | Respite |
| ? | Therapy/clinic and in-home | ? | Medication Services |
| ? | Day treatment | | |

Examples of non-traditional services/supports:

- ? Community camps
- ? Big Brother/Big Sister
- ? Art opportunities in the community such as music lessons
- ? Mentoring and tutoring in the community
- ? Family support activities and educational programs
- ? Family partners who assist enrolled families
- ? Recreation and participation in athletics and sports leagues
- ? Community conferencing and other dispute resolution mechanisms

Informal services might be such things as:

- ? Support in working as a volunteer
- ? Building natural neighborhood support groups
- ? Rites of passage programs

Length of Stay

Since this is an individualized and flexible approach, there will be those who need more formal support for a longer period, especially those children who may have a serious and persistent mental illness that will require high support as they grow into adulthood. The structure must allow for independent variations within the ideal. In other wraparound models nationally, families are typically enrolled for an average of 15 to 18 months.

Quality Management

Quality will be managed by a combination of training, ongoing management and evaluation of outcomes. First, there will be initial and continuous intensive training in the system of care and wraparound values and methods for implementing these values and family-professional partnerships. Second, there will be standards of care or thresholds relating to the time frames for the meeting of child/family teams, development and review of plans of care. These standards will be used to ensure that there is fidelity to the wraparound framework and that services are family-driven. Third, there will be individual benchmarks for each child to be measured periodically for aggregated profiles for review by family members, lawmakers, advocates, family and community organizations and the public. Fourth, there will be a series of

outcomes that will be evaluated on an annual basis and the scores on these outcomes will be directly related to incentive funds and retention of any savings.

Family members, as well as family and community organizations will be involved in quality improvement and quality assurance. Their efforts will be critical in creating a feedback mechanism focusing on ensuring quality, and in linking data to social marketing strategies (e.g., testifying before legislative bodies, media advocacy, development of newsletters and websites).

Outcome domains will include an increase or improvement in civic participation and community involvement, family access to community care for target population, child functioning, emotional/behavioral functioning (including decreased use of detention, substance use etc.), social/peer relationships, satisfaction of other agencies/providers, cost effectiveness, availability and use of culturally and linguistically appropriate resources, family empowerment, family satisfaction, use of alternative and mainstream community resources, family functioning, success in school, physical health, financial stability for families, child satisfaction/happiness, and safety for kids.

GOAL #2: Improve continuity of care.

ADULT SERVICES

Objective 2A: Collaborate with the Office of Homeless Services (OHS) to provide services to homeless individuals.

Indicator: Report on funding (grants) received and services rendered

- Strategies:
1. Acquire and monitor funding for mental health homeless services.
 2. Coordinate with OHS and its Rise Again Project to provide mental health outreach services to engage homeless consumers and refer them to the appropriate services.

PROGRESS: This objective was met.

In February the Office of Homeless Services (OHS) restored funding for four outreach programs, the SSI Presumptive Eligibility Program and Safe Haven 1 with an award from HUD. BMHS and the providers had developed a creative strategy to ensure that these programs continued from July 1, 2003-January 31, 2004. Baltimore City Department of Housing provided interim funding for Safe Haven 1, while each of the other providers – Bon Secours, Johns Hopkins, North Baltimore Center, People Encouraging People, and University of Maryland Medical Systems – were able to maintain their programs until the funding was restored. Other funding for services to homeless persons with mental illness was received from Mental Hygiene Administration and PATH funding.

In May we were notified that our application for a grant from Baltimore Community Foundation had been approved. The grant will provide \$11,000 to be used to assist with payment of BGE bills for those meeting the grant's requirements. Unpaid BGE bills are the single most frequent obstacle experienced by our homeless population to enter into leases for independent housing.

The Hands in Partnership (HIP) collaboration between the BMHS, the outreach teams, the Downtown Partnership, police, Health Care for the Homeless, Adult Protective Services and DSS' Rise Again Outreach Project continued to meet regularly and coordinate their efforts to engage the street homeless population. BMHS and Community Housing Associates, Inc. (CHA) developed and opened The Ethel Elan Safe Haven to provide an additional 19 homeless individuals with mental illness with housing. This program, named for CHA's former Executive Director, Ethel Elan, who passed away in February, 2003 was funded with DHMH Community Bond Funds as well as funding from the City, State, and HUD.

BHMS worked with Baltimore City Health Department (BCHD) to provide mental health services during the 22 Code Blue nights. Code Blue is a designation in Baltimore City when due to extreme cold and harsh weather conditions a designated emergency shelter is opened. Adult Services solicited volunteers from its list of mental health clinicians augmented by the BMHS HUD Homeless Outreach Teams to work at the shelter and to be on both the morning and evening buses. BCRI was available to provide crisis response as needed.

Objective 2B: Continue to provide leadership to develop service linkages to address the community-based mental health needs of individuals involved in the criminal justice system.

Indicator: Mental health staff stationed at Southern District Court and the development and implementation of special court proceedings

- Strategies:
1. Collaborate with providers in the criminal justice system to develop a mental health court.
 2. Collaborate with the Department of Public Safety and Corrections to sustain and improve services with appropriate discharge planning.

PROGRESS: The objective was met.

During the year BMHS convened regular meetings with all of the interested parties to continue to reduce incarceration of the mentally ill. As a result the Baltimore City Mental Health Court was expanded. The September 2004 publication of the Maryland judiciary Justice Matters described the progress of our Mental Health Court. Below are aspects from that article.

“In Baltimore City, where the mentally ill offender population is large and the problems are extreme, a partnership was formed in 2002 to create a Mental Health Court pilot program. The goal of the program is to improve outcomes for this special population, while increasing public safety. The program began with the consolidation of all cases in which a competency evaluation was ordered-approximately 250 each year.

Previously, these cases were scattered among nine different criminal courts and multiple judges, prosecutors and defense attorneys, said Judge Cooksey, who heads the program.

Consolidating these cases onto a single docket allows for case processing by a dedicated team of individuals, trained in mental health law, who follow each case throughout the process.

A key role in the project is played by FAST (Forensic Alternative Services Team) staff, master's-level clinicians who assist with the identification, assessment, planning and, in some cases, monitoring of the defendants. FAST facilitates the coordination needed to assure that all parties are included in the proceeding as needed. Police departments from Baltimore City and Baltimore County also participate in the effort by agreeing to expedite the execution of any warrants that are issued.

In order to enroll in the program, the defendant must be a Baltimore City resident who is eligible for public mental health services. There must be a diagnosis of an Axis I serious mental illness and/or a trauma related disorder. The charge may not be a domestic violence related offense, and the defendant may not have any prior convictions of a crime of violence. Defendants may be referred to the program from a variety of sources. Defendants who remain in custody are often referred by court commissioners, Pretrial Detention and Services investigators or jail medical staff. Police, attorneys, family members, advocacy groups, clinicians and probation offices are also potential referral sources, in addition to District Court judges." The Court is in session every Thursday afternoon at the John R. Hargrove Court House Part II.

BMHS initiated its Behavioral Emergency Services Team (BEST) project in collaboration with the Baltimore Police Department (BPD)/National Alliance for the Mentally Ill-Metropolitan Baltimore (NAMI). The initiative has started in the Central police district and has provided trainings to BPD police officers, members of the Sheriff's Department and the Downtown Partnership to respond to individuals who are having a psychiatric crisis that require police intervention. BEST hopes to increase the ability of the mental health system to support the police and has the following goals:

1. Decrease police "down time"
2. Decrease arrests and increase linkages to mental health services for individuals who previously would have previously been arrested
3. Decrease police and citizen injury
4. Decrease use of deadly force

In addition to BMHS, BPD and NAMI the other partners for the BEST project are the University of Maryland Medical Systems, Inc. (UMMS) and Baltimore Crisis Response Inc. (BCRI).

The Governor's Office of Crime Control and Prevention awarded a \$149,000 grant for the project. Matching funds have been received the Morton and Jane Blaustein Foundation and Open Society Institute (OSI). Two training classes were held in FY'04 with over 35 participants. T additional training classes are scheduled for the first half of FY'05.

CHILD AND ADOLESCENT SERVICES

Objective 2C: Maintain a crisis/trauma response system that promotes effective transitions between crisis services and long term service programs.

- Indicators:
1. Execution of contracts with the Baltimore Child Development Community Policing Program (CDCP) and the Baltimore Child and Adolescent Response System (B-CARS).
 2. Documentation of the numbers of children/families served.
 3. Document requests that could not be responded to due to a lack of resources.
- Strategies:
1. Maintain and promote the growth of B-CARS and the CDCP programs
 2. Identify unmet needs.

PROGRESS: This objective was met.

During FY04 B-CARS received 1377 requests for psychiatric crisis services, of which 721 were assessed (a 30% increase from number assessed in FY03). Of those assessed, 599 children and their families received up to two weeks of intensive services, which represents a 38% increase from FY03 to FY04 in total number served. The charts below reflect the increase in children and adolescents served and the sources of referrals:

	FY02	FY03	% change compared to FY02	FY04	% change compared to FY03
# children assessed	506	555	+ 9.7%	721	+29.9%
# children served	425	434	+2.1%	599	+38.0%

FY04 B-CARS Referral Sources	% of Total Referrals
Family Members	59%
Baltimore City Public Schools	12%
Hospital ERs	7.5%
Hospital - Other	7.2%
Mental Health Agencies	6.6%
Baltimore City Police	3.8%
Baltimore City DSS	2.6%
Department of Juvenile Services	1.3%
FY04 TOTALS:	100%

Child Development Community Policing (CDCP) responded to 107 calls from the community requesting on site assistance to children exposed to violence. Additional funding from Baltimore City Safe Start has supported CDCP's efforts to provide trauma response services to children under age six, however this funding will end in December 2005. CDCP has developed

an excellent working relationship with the Baltimore City Police, and as a result requests for CDCP services are around the clock. Given that no funding is currently available for after-hours pay differential, and because many calls are received in the middle of the night, an immediate response may be delayed due to the unavailability of trauma response team members. In addition to direct trauma response intervention CDCP also provides a number of training opportunities to community members, police staff, and mental health professionals. In FY 04 CDCP provided three 20-hour Fellows training sessions with a total of 32 participants, 6 community youth for a total of 408 participants, and 9 Police Academy trainings with 87 participants.

Objective 2D: Provide training/orientation sessions to providers on developmental and transition age issues.

- Indicators:
1. Documentation of completion of training sessions and numbers of persons attending.
 2. Summaries of participant evaluations.

- Strategies:
1. Provide a multi-session training series on early childhood development and mental health issues.
 2. Provide two orientation sessions on transition age youth issues.

PROGRESS: This objective was met.

Through the Baltimore City Safe Start Initiative, the third Early Childhood Mental Health Series was offered in the Fall of 2003 and a fourth series began in the Spring of 2004. A total of 189 mental health professionals attended training between September 11, 2003 - June 9, 2004.

During BMHS site visits to Residential Treatment Centers that serve Baltimore City children and adolescents, BMHS staff provided orientation /information to the clinical teams on not only the Transition Age Youth (TAY) initiative, but also on the Local Coordinating Council (LCC) process, Community Services Initiatives (CSI), and Inter-Agency Review Panel services. Residential Treatment Centers visited by BMHS staff are provided in the following chart:

FY'04 RTC # of Visits Serving Baltimore City Children & Adolescents

RICA-Baltimore	2
Sheppard Pratt-Ellicott City	1
Sheppard Pratt-Mann Center	1
Good Sheppard Center	0
Potomac Ridge-Rockville	2
Woodbourne Inc.	2
Potomac Ridge-Crownsville	2
Edgemeade-Upper Marlboro	0
The Jefferson School, RTC	1
New Directions	2
Chesapeake Youth Center	0
Villa Maria	1
Advo-Serv (Bear, Delaware)	*6

*Finalized plans to return Baltimore City resident from out of state residential treatment center early in FY05.

Objective 2E: Continue development and support of programs targeted to address the community-based needs of youth involved in the juvenile justice and court systems.

Indicator: Documentation of numbers of children/families served in facility, community and court-based programs.

- Strategies:
1. Collaborate with MHA and the Department of Juvenile Services (DJS) in the continued implementation of facility-based mental health and intensive aftercare mental health service programs.
 2. Continue to collaborate with the juvenile court through the (LINKS) initiative.

PROGRESS: This objective was met.

Through BMHS' involvement with the Baltimore City Circuit Court's LINKS initiative, 166 court-involved children were served. Mental Health assessments, case coordination, and brief individual and family therapy services were provided to 60 court-involved youth. Through the Family Intervention Specialist project (FIS), 188 youth have been helped to make the transition back to the community from Department of Juvenile Services (DJS) facilities.

In FY'04, BMHS through funding from MHA, hired three psychologist to work at the new DJS detention center in Baltimore City. The staff include a mental health director who oversees the mental health services at the detention center and supervises DJS staff who are on-site. One of the three BMHS staff provided services at DJS' Schaeffer House and Maryland Youth Resource Facility which are residential programs for court-ordered youth.

<p>GOAL #3: Ensure that affordable, safe, and comfortable housing is available.</p>
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Objective 3A: Inspect 100% of housing operated by residential rehabilitation programs(RRP) to ensure compliance with Code of Maryland Regulations (COMAR).

Indicators: Number of RRP units, number/percent inspected, type of approvals

PROGRESS: This objective was met.

Baltimore City has ten Residential Rehabilitation Programs (RRP) and one Residential Crisis Services (RCS) that provide housing for 386 adults. Quality improvement staff inspected 100% RRP/RCS programs and two additional housing units operated by contractual providers. Programs were found to be in compliance with the physical site requirements in COMAR

10.21.22., these regulations that outline Maryland's requirements for these programs. In general, most residences were located in decent neighborhoods, all had access to public transportation and the physical environments were comfortably furnished and clean. The most common violations found were structural repairs needed and routine maintenance (e.g. painting, carpet, gutters, holes in walls usually punched by clients in crisis, etc.).

QI staff conducted 209 housing inspections. The majority (142) were annual inspections as required by the Department of Health and Mental Hygiene. Providers received a general approval if there were no violations. Provisional approvals were given if violations were found. Providers had 30 days to make corrections. QI follow up inspections found corrections completed within the 30 day time frame at 39/51 units (77%). The table below summarizes FY04 housing inspections.

Provider	# of Units	# of Beds	Initial Inspections (New addresses)	Annual Inspections # of units		Each Units Follow Up Inspections
				Compliance (General approval)	Violations (Provisional approval)	
Alliance	15	46		9	6	6
BCRI	6	14		5	1	1
Dulaney Station	1	5			1	1
Fellowship House	1	16			1	1
Harbor City	20	53	1	10	10	18
Harford/Belair	15	46	2	12	3	3
Key Point	20	49	1	10	10	10
NBC	17	34			17	21
New Phases	10	23		10		
PEP	31	72		30	1	1
VOA	6	28		5	1	1
*JHBMC Capitation	1	3		1		
*Progressive Horizon	1	3		1		
Total	142 (*144)	386 (*392)	4	91 (*93)	51	63

*The two residential programs that are inspected through contractual or special relationships.

Objective 3B: Interview 50% of consumers in RRP housing in Baltimore City to evaluate satisfaction with housing conditions.

Indicators: Number of consumers in RRP housing; number/percent interviewed; level of satisfaction reported

PROGRESS: This objective was met.

The residential specialist interviewed 203 (57%) of the 358 consumers living in RRP's at
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time of annual inspection. Overall, consumers were satisfied with their homes and the services staff provide. Sample questions/results from the consumer satisfaction survey are shown below. Full report available on request.

Sample Questions/Results from Consumer Satisfaction Survey				
	N	Agree	Neutral	Disagree
I am satisfied with my household furniture.	203	199 (98%)	4 (2%)	0
I am satisfied with the time fix things/quality of repairs.	203	200 (99%)	0	3 (1%)
My family is supportive of me.	203	173 (85%)	10 (5%)	20 (10%)
I feel staff treat me the same as others in the program	203	186 (92%)	0	17 (8%)
The services I receive are helpful to me.	203	199 (98%)	1 (.5%)	3(1.5%)
I have a job and earn a pay check.	203	45 (22%)	1(.5)	157 (77%)
I feel safe in this neighborhood.	203	192 (95%)	2 (1%)	8 (4%)
My religious/spiritual beliefs help me cope with problems	203	168 (83%)	6 (3%)	29 (14%)

Community Housing Associates, Inc.

Objective 3C: Ensure the availability of affordable housing for individuals with psychiatric disabilities.

Indicator: Number of available housing units and number of units leased.

- Strategies:
1. Maintain current housing stock as attractive affordable housing units.
 2. Develop new units when opportunities become available .

PROGRESS: This objective was met.

CHA and its subsidiaries continue to lease the 88 owned units, and administer the 171 Shelter Plus Care (S+C) certificates, for individuals who are both very-low income and diagnosed with a chronic psychiatric disability. During FY04, CHA housed 271 individuals and their families, against 261 individuals the prior year.

In December 2003, CHA oversaw the completion and opening of its second Safe Haven facility, located on Belair Road. This nineteen-bed facility is operated by Helping Other People through Empowerment (HOPE), and houses individuals who have been particularly difficult to bring into treatment for mental illnesses, and difficult to house. The house operates at full capacity.

Objective 3D: Ensure that all housing units are in compliance with Housing Quality Standards (HQS).

Indicator: Number of housing units that fail inspections.

Strategy: Ensure that all housing units are inspected routinely and that all deficiencies are corrected.

PROGRESS: This objective was met.

Last year, CHA developed a process of sequential inspections (90, 60, and 30 days preceding annual inspections) to assure that all units are meeting housing quality standards on an annual basis.

During this year, CHA developed a tracking system to monitor the pass/success rate of units at the point of 60-day inspection. In data collected since January 2004, 78% of units passed either the 90 or 60 day inspection. The remaining 22% also passed the 60 or 30 day inspection, but outside of the internal standard of timeliness. No units failed HQS standards at annual inspection.

GOAL #4: Ensure efficient and accountable financial management.

FINANCE OFFICE

Objective 4A: Set up appropriate accounting records for all new sources of funding.

Indicator: Submit quarterly financial reports to BMHS division directors for monitoring.

Strategy: Develop a system to ensure that all necessary information is received in order to generate accurate reports.

PROGRESS: This objective was partially met.

There was improvement in the setting up of the financially records but there no reports generated. At the end of March BMHS' Chief Financial Officer (CFO) of 16 years retired . BMHS contracted with the accounting firm of Butler-Lochte to perform the functions of the CFO for the period of April 1, 2004- June 30, 2004. In June a decision was made by the Board of Directors that effective July 1, 2004, BMHS would contract with Butler Lochte to operate the entire fiscal office. One of the major reasons for this change was to improve our ability to generate regular and accurate financial reports.

Objective 4B: Maintain appropriate accounting record keeping for ongoing BMHS administration and sub-vendor contracts to meet external funding source requirements and internal monitoring.

Indicator: Sustain the scrutiny of an annual (A-133) single audit and the oversight of the BMHS Finance Committee and CHA Finance Committee at regularly scheduled meetings.

Strategy: Ensure that records are properly organized and reported on in a timely manner.

PROGRESS: This objective was partially met.

The oversight of the BMHS and CHA finance committee as well as the audit review raised concerns and supported the decision to initiate a major change in the operation of the fiscal office.

Objective 4C: Ensure that BMHS operates with a balanced budget.

Indicator: Year-end report indicates that the budget is balanced.

- Strategies:
1. Financial information is reviewed by BMHS Finance Committee on a quarterly basis.
 2. Appropriate adjustments are made.

PROGRESS: This objective was partially met.

While BMHS' budget was monitored there were no regular quarterly reports. Early indications anticipate a balanced but this may be negatively influenced by the severance pay expenditures related to the transition of the fiscal office.

GOAL #5: Maintain a quality management program to continuously evaluate and improve BMHS' activities.

ADULT SERVICES

Objective 5A: Collect and monitor the outcome measures for COMAR licensed service providers in Baltimore City.

Indicator: Quarterly reports received from COMAR licensed Baltimore City providers.

- Strategies:
1. Continue to collect quarterly reports from Psychiatric Rehabilitation Programs, Mobile Treatment Providers, and Supported Employment Programs.
 2. Develop outcome measures for OMHCs with the providers.

PROGRESS: This objective was met.

BMHS has implemented Outcome Measure tracking to SEP services Citywide. Working with a consultant, meetings were held with SEP providers to select data that would be measured and tracked on a quarterly basis. Starting with clients currently receiving services from the previous

quarter, each SEP reported on how many individuals were in pre-placement, DORS job coaching or the extended service phase of work. For those individuals who were working, the number of hours of support provided, salaries, hours worked and length of job retention were selected to be monitored. These same measures were taken for those who have left jobs, with the added measure for the reason why the employment ended. It is too early to have an analysis of the data which will be available next year.

The data collection process continued for Adult PRP and Mobile treatment programs. A process was not developed for collecting data for outpatient clinics.

CHILD AND ADOLESCENT SERVICES

Objective 5A: Collect and monitor the outcome measures for COMAR licensed service providers in Baltimore City.

Indicator: Quarterly reports received from COMAR licensed Baltimore City providers.

Strategies 1. Continue to collect quarterly reports from Psychiatric Rehabilitation Programs.

PROGRESS: This objective was partially met.

During the first four months of FY04, a Child PRP Data Workgroup met to develop a Data reporting form that could provide a sense of change in the client population served. Beginning with the second quarter of FY04, Psychiatric Rehabilitation Programs (PRPs) serving Baltimore city children and adolescents, were required to submit data. During the 2nd Quarter 18 PRPs submitted data; 12 PRPs submitted for 3rd Quarter; 11 submitted for 4th Quarter. Several reminders about data requirements / due dates were sent each quarter, however due to limited staff resources, no follow-up telephone calls were made to specific agencies that did not comply with data submission. Although participation was limited, the 2nd Quarter data did reflect a decrease in emergency room visits and in psychiatric hospitalizations from the 3 months prior to obtaining PRP services.

During the third quarter of FY04, the reimbursement structure for PRP services changed along with a tightening of Medical Necessity Criteria for this service, resulting in decreased numbers of PRP clients served. Several of the programs that were consistent in submitting data had very few clients on which to report. The decrease in compliance with data submission may have been related to the PRP focus on maintaining financial viability and adjusting to the new method of submitting reimbursement claims, as well as the submission of data to MHP on all PRP services delivered. A process was not developed for collecting data for outpatient clinics.

Objective 5B: Provide clinical reviews at 80% of RRP Programs in Baltimore City to review rehabilitation plans of high cost users and those residents either discharged or receiving a level change.

Indicator: Number of providers; number of charts reviewed, and report of findings.

Strategies: 1. Develop a form to track outcomes for high cost users and individuals leaving RRP or receiving a level change.

2. Conduct clinical reviews with RRP providers to review charts.
3. Provide report of findings.

PROGRESS: The objective was partially met.

Approved referrals for RRP services more than doubled this year from 66 applications in FY'03 to 148 in FY'04. Yet the number of vacancies remained at the '03 level which allowed for only 38 new placements. The lack of Section 8 vouchers and/or special initiatives and the increased cost of Assisted Living residences may account in part for the lack of movement from RRP.

As described earlier Adult Services staff became responsible for RRP and non-Medicaid PRP authorizations. This new responsibility and the absence of staff due to illness resulted in only one RRP clinical site visit being accomplished. The clinical review was conducted at the North Baltimore Center's Residential Rehabilitation Program. A Program Improvement Plan (PIP) was submitted but overall improvement in charting was noted by the survey team.

QUALITY IMPROVEMENT/OPERATIONS DIVISION

Implement comprehensive contract management processes that ensures increased accountability and effective monitoring of local state and federally funded contracts.

Timeliness of contract execution: number of contracts, number/percent executed before start date, number progress reports due, number reports submitted, ratings assigned, number of QI site visits, number of performance improvement plans required.

1. Execute 100% of BMHS contracts on or before the date services are started.
 2. Staff responsible for managing contracts will follow up in a timely manner when contract requests have not been initiated or providers have not returned documents.
 3. Vendor contract committee will meet regularly to monitor the execution of contracts, provider submission of progress reports, staff ratings of progress reports, and quality improvement site visit results.
 4. Quality improvement and fiscal staff will conduct an annual training on contract management procedures.
 5. Quality improvement staff will conduct annual and bi-annual contract site visits to evaluate services and to provide technical assistance to providers.
 6. The Board of Directors Quality Improvement Committee will meet regularly and review quality improvement activities.

This objective was met.

BMHS awarded 206 contracts during FY04. Management of contracts was coordinated between fiscal, program and quality improvement divisions. The vendor contract committee met regularly to oversee the process. Appropriate procedures were followed to ensure the necessary checks and balances were in place. Program staff selected vendors and established contract deliverables. Quality improvement staff provided annual training on contract procedures. Quality improvement staff coordinated site visits to evaluate compliance. The Department of Health and Mental Hygiene (DHMH) funded approximately 60% (132) of BMHS contracts. The majority (90) of these contracts were to be executed by July 1, 2003. While 66 (73%) were executed by the due date, it was still short of the target. BMHS received funding for the remaining 84 contracts from local, state, federal, and private institutions. The following table lists agencies providing funding to BMHS.

FY04 FUNDING SOURCES			
LOCAL	STATE	FEDERAL	PRIVATE
? Baltimore City Public Schools	? Mental Hygiene Administration Department of Human Resources	? Housing Urban Development	? Abell Foundation
? The Family League Department of Social Services	? Governor's Office of Crime Control and Prevention	? Substance Abuse and Mental Health Services Admin.	? Straus Foundation
			? Open Society Institute
			? Morton and Jane Blaustein Foundation

BMHS continued to manage quality by conducting ongoing monitoring, regular meetings with providers, technical assistance to providers and training. All vendors were required to submit documentation that demonstrated the type and number of services delivered. Documentation consisted of monthly data reports, receipts for equipment/supplies, invoices, etc. In addition, QI conducted 57 contract site visits to vendor programs. The purpose of the visits were to compare progress reports/invoices, etc. submitted previously to BMHS to actual records at the program site. Interviews were conducted with program staff, consumers and family members as a part of the evaluation process. The majority of the vendors funded by BMHS were found to be providing services consistent with their contract. QI required performance improvement plans from 21 contracts. Most corrections were related to clarification of expectations between vendor and BMHS or record keeping.

There was only one contract where serious concerns were raised that resulted in a delay in issuing the contract. BMHS increased monitoring and provided additional technical assistance to the provider. Slightly more than half (53%) of the contracts required submission of a standardized progress report/rating system, completed by the vendor and BMHS. Program staff assigned a rating of "Met" for contracts ending June 30, 2004 if, staff determined the vendor complied overall with contract and delivered quality services based on reporting and site visits. Similarly, contracts with end dates after June 30th were rated "On Target" if they were in compliance by close of FY04. Improvements in reporting were noted this year with 87% of contracts submitting 100% of progress reports by the end of the year. The table below summarizes provider's performance at years end.

APPENDIX A PROGRESS REPORTING AS OF JUNE 30TH	
Contracts Required to Submit Reports	109 (53%)
Contracts Submitting <u>All</u> Reports	95 (87%)
Contracts Submitting <u>All</u> Reports -Rated as Met or On Target to Meet as of 6/30/04	94 (99%)
Contracts with Incomplete Reporting	14 (13%)

Objective 5D: Assist community mental health providers in Baltimore City in complying with Code of Maryland Regulations (COMAR).

Indicators: Number new applications, number OHCQ site visits, number OHCQ visits attended, number performance improvement plans required, number of workshops.

- Strategies:
1. Provide technical assistance to providers submitting applications for new services in Baltimore City and submit recommendations to OHCQ.
 2. Attend 90% of site visits in Baltimore City conducted by OHCQ to evaluate provider compliance with COMAR. regulations.
 3. Review provider performance improvement plans (PIP) and provide technical assistance as needed.
 4. Monitor providers continued compliance with conditions of deemed status awards granted by MHA.
 5. Conduct a workshop on Medical Assistance regulations (COMAR 10.02.59) to support providers' efforts to obtain reimbursements.
 6. Conduct a workshop on medical records documentation in compliance with COMAR regulations.

PROGRESS: This objective was met.

QI staff received numerous calls requesting technical assistance on the application process, clarification of COMAR requirements for documentation and staffing, and technical assistance with the development of performance improvement plans.. QI joined with Mental Hygiene Administration's Office of Managed Care Compliance in conducting site visits to providers who experienced large growth in billing and claims over the last fiscal year or who BMHS received complaints. For the first time we began to see incidents of potential fraud and abuse that were reported to Maryland's Office of Inspector General and criminal charges were filed in some instances. CSA's will soon be expected to conduct ongoing site visits of providers to ensure quality of care, implementation of proper billing procedures, and compliance with state/federal regulations to identify possible false billing, fraud and abuse. The QI staff attended

state wide training conducted by MHA and the OIG in preparation for these changes.

The QI division received 37 applications for new or expanded services (14 Outpatient Mental Health Clinics (OMHC), 17 Psychiatric Rehabilitation Programs (PRP) , 2 Residential Crisis Services, 1 Group Home and 1 Mental Health Vocational Program). All applications were reviewed within the required time frame. As the number of child PRP providers continued to increase along with costs, Mental Hygiene took steps to control spending by implementing several policy changes. As a result of the changes, Baltimore City saw an increase in the number of PRPs submitting applications to provide outpatient mental health services as a means to coordinate services to children and adolescents. There are currently 91 community mental health service providers located in Baltimore city, (a 25% increase over FY03's 69 providers) offering 178 services (a 16% increase since FY03. The table below summarizes Baltimore City programs.

Number of Community Mental Health Programs by Type	
Adult Group Homes (GH)	6
Children Therapeutic Group Homes (TGH)	2
Mobile Treatment Services (MTS)	7
Outpatient Mental Health Clinics (OMHC)	47
Psychiatric Rehabilitation Programs (PRP)	76
Residential Rehabilitation Programs (RRP)	8
Residential Crisis Services (RCS)	3
Respite Care Services (RC)	2
Mental Health Vocational Programs (MHVP)	11
Targeted Case Management (TCM)	6
Partial Hospitalization Program (PHP)	10
Total	178 Increase of 16%

The Office of Health Care Quality (OHCQ) and Mental Hygiene Administration conducted 51 site visits to city providers. BMHS staff attended most of the on-site reviews. As a result of deficiencies sited during the reviews, providers submitted 28 performance improvement plans to the QI division for review and technical assistance before final submission to OHCQ. QI division conducted on site training and technical assistance with providers on a as needed basis. **Monitor and report on sentinel events (deaths, complaints, unusual incidents).**

Number of deaths reported; number/type of complaints, number of help calls.

Compile data on MHA death reports, complaints, help calls and unusual incidents upon receipt from staff.

This objective was met.

BMHS received 60 report of deaths forms from COMAR providers. These reports reflect known deaths of consumers actively enrolled in the program. We suspect actual numbers may be higher than reported. In some instances, providers are notified by third parties months after the death occurred.

FY04 Summary of Consumer Death Reports					
Consumer Deaths	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Total Reported	16	10	20	14	60
Males	9	8	11	7	35
Females	7	2	9	7	25
Cause of Death Known	9	9	7	11	36
Cause of Death Unknown	7	1	13	3	24
Mean Age	52	54	45	65	54 years

FY04 Summary of Complaints Received	
1st Quarter	14
2nd Quarter	6
3rd Quarter	6
4th Quarter	8
Total	34
Type of Complaints	Customer service, inadequate treatment, poor housing conditions, personnel complaint, right violation, finance

A total of 34 complaints were received. Complaints are handled by all divisions. QI staff often negotiates with consumers and providers to resolve consumer concerns that are not satisfactorily resolved through the programs' grievance procedure.

FY04 Number of Help Calls Received				
1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
346	388	490	530	1754

FY04 Summary of III Level Grievances Received					
	Grievances Received	Compliance with timeliness	Grievance Upheld	Grievance Denied	Other (Partial authorization or Pending decision)
1 st Quarter	0	0	0	0	0
2 nd Quarter	20	10	6	2	12
3 rd Quarter	30	11	7	8	15
4 th Quarter	77	2	23	42	12
Total	127	23	20	30	77
Services Frequently Requested	Psychiatric Rehabilitation Programs (66), Inpatient Services (36) and Targeted Case Management (20).				

During FY04 BMHS processed 127 non-urgent level III grievances filed by mental health service providers on behalf of their clients. These grievances are filed with BMHS appealing services that are denied by Maryland Health Partners (MHP). Majority of the grievances during this period were filed by Johns Hopkins Bayview Medical Center; Johns Hopkins East Baltimore Mental Health Partnership; Johns Hopkins Hospital inpatient services; North Baltimore Center and Harford-Belair Community Mental Health Center. Services that were frequently requested in the grievances were Psychiatric Rehabilitation, inpatient services and Targeted Case Management. BMHS is required to respond to a non-urgent level III grievance within ten business days and an emergency/urgent care: inpatient admission grievance within five business days.

We were in compliance with timeliness for 23/127 grievances processed. This low number was due to the lack of a Psychiatrist that would make the final clinical decision. Dr Marta Hopkinson initially took on an added responsibility to review these grievances, but it quickly became apparent that Dr Hopkinson needed help reviewing the rapidly growing number of grievances that were coming in to us. BMHS contracted with two outside psychiatrists in June 2004 to review grievances which should make for improvements.

Community Education

ADULT SERVICES

Objective 6A: Provide training for 60% of assisted living providers who are Medicaid waiver approved.

Indicator: Number of providers trained.

Strategies: 1. Develop a curriculum to address mental health issues and behavioral interventions for assisted living providers.

2. Collaborate with the Commission on Aging to identify all Medicaid waiver approved assisted living providers in Baltimore City.
3. Offer a minimum of 1 workshop for identified providers with 60% participation.

PROGRESS: This objective was met.

In June '03 the Office of Health Care Quality (OHCQ) convened a workgroup to review the assisted living regulations and make recommendations to the Legislature to refine and reform the existing regulations which have been difficult to implement and monitor. BMHS represented the agency and the Mental Hygiene Administration on that work group. In addition BMHS participated on a subcommittee, which was charged with revising the client assessment tool, to better reflect the care needs of residents, including mental health and behavioral problems. The first legislative report made recommendations primarily for changes in the operation of those homes with 17 or more residents. The workgroup continues to meet and is working on the more difficult issues facing the smaller homes—those that serve our population, an SSI recipient with a mental illness disability rather than frail elderly.

The Office of Health Care Quality (OHCQ) is no longer offering training for Assisted Living providers; however all training curricula offered by outside groups must be approved by OHCQ. There are several mental health, behavioral health and dementia curricula, including the one proposed by BMHS in a grant proposal submitted to the Maryland Department on Aging. BMHS has supported the efforts of Mental Health Association of Maryland's Coalition on Mental Health and Aging along with the Alzheimer's Association to require through legislation, education on these issues for providers state-wide. For the past 15 months the Baltimore City Commission on Aging (CARE) has been re-structuring the organization and re-establishing its priorities. Recently, The Interagency Aging Committee (IAC) has been re-convened and will resume many of its former activities. CARE may be in a better position to collaborate with BMHS on city training in FY'05. The Clinical Subcommittee will be re-established under the leadership of BMHS.

Objective 6B: Maintain an active and available mental health response team as an integral part of the Baltimore City Health Department (BCHD) response plan.

Indicator: Number of individuals trained and list or those willing to receive training when available.

- Strategies:
1. Continue to coordinate mental health training with the BCHD.
 2. Provide information and education on domestic preparedness to interested individuals.

PROGRESS: This objective was met.

The mental health subcommittee meetings were held at BCHD-Field Health Services (FHS) three times this year with its last meeting in May that developed the response phase plan training. This third adjunct training included response scenarios, grief counseling, and crisis pastoral counseling and how they fit with the mental health response. BMHS was actively involved with BCHD in a state-wide mock event. BCRI played a critical role as it staffed the

city's receiving site in that event.

Domestic Preparedness information was provided to interested parties including MHA. BMHS received FEMA funding to outreach to families and individuals in Baltimore City- especially in the Fells Point area to identify and assist those needing additional services as a result of Hurricane Isabel. Eight individuals, recruited from our outreach and mental health service agencies, provided 590 hours of outreach. They were able to provide information and linkage where appropriate to support services.

Objective 6C: Educate public mental health system (PMHS) providers in Baltimore City on a range of mental health issues and topics.

Indicator: Number of PMHS provider staff who receive training and the number of training opportunities provided.

- Strategies:
1. Provide workshops to case management providers and community acute psychiatric hospitals about the role of BMHS in Baltimore's PMHS.
 2. Provide workshops to PMHS providers on trauma and crisis response.
 3. Coordinate a forensic conference.

PROGRESS: This objective was partially met.

Training for Case Managers was provided by Adult Services Staff in collaboration with CHA. 47 case managers representing the seven (7) intensive case management programs and five (5) Psychiatric Rehabilitation Programs (PRP) attended. The training focused on the tenant landlord relationship, the responsibilities and expectation of case managers and the assistance available from BMHS. Six (6) meetings were held at BMHS for providers focusing on services to the homeless. These meetings concentrated on expansion of resources, collaboration between agencies and training on opportunities for special assistance from BMHS including the use of emergency petitions.

In May BMHS Adult Staff met with 16 outreach workers and case managers from our HUD programs to review with them their mission and responsibilities. As a result of this meeting a number of training issues were identified. BMHS agreed to provide training sessions on these issues beginning with understanding mental illness in FY05.

Training for the command staff from all nine Police Districts was provided on the changes in the law relating to their role in the Emergency Petition process. The trainers included Judge Charlotte Cooksey of the District Court, Richard Ortega, Ph.D. from MHA and Sue Diehl from BMHS. BCRI and BCARS have continued this training for police officers on a weekly basis as a component of the in-service required for all officers each year.

Three support groups were provided to those clinicians who participated in the FY'03 training on the identification and treatment for individuals who have experienced trauma.

Because of the new responsibility to authorize PRP and RRP services and the absence of staff due to illness, there was no forensic conference this year. Plans are underway to hold the conference in early spring 2005.

CHILD AND ADOLESCENT SERVICES

Objective 6D: Provide and/or support a series of ongoing children's mental health training activities targeted to providers, consumers and the Baltimore City community.

- Indicators:
1. Documentation of training/orientation sessions held.
 2. Documentation of providers participating in training/orientation sessions.
 3. Completion of contract with Families Involved Together (FIT).
 4. Summary of participant evaluations where applicable.
- Strategies:
1. Provide a mental health training series on early childhood mental health needs.
 2. Conduct informational meetings with providers on the Baltimore City child and adolescent PMHS.
 3. Hold ongoing informational and training sessions for school-based mental health service providers.
 4. Provide training sessions on cultural competency.
 5. Support FIT in providing training/educational opportunities for the public on children's mental health issues.

PROGRESS: See also 2D.

Professional Development Training Opportunities focused on the School-Based Mental Health clinicians in FY04 included the following:

“Domestic Violence: Clinical Interventions for Children and Adolescents” - August 29, 2003
Approximately 75 school based mental health clinicians attended.

“A Commitment to Excellence: Improving & Sustaining School Mental Health Programs Through Research and Evaluation” - November 14, 2003; Approximately 80 school based mental health clinicians attended.

“Effective Use of the DSM-IV in Expanded School Mental Health “ - January 9, 2004
Approximately 60 school based mental health clinicians attended.

“Engaging Parents In Authentic Partnerships” - March 5 & March 9, 2004
Approximately 15 school based mental health clinicians and 15 school employed personnel attended.

“Truancy: Working Together To Win Our Children Back!” - May 14, 2004

Approximately 350 representatives from school, community, and faith based organizations attended. This conference was done in collaboration with BCPSS, Family League of Baltimore, Inc., March Funeral Homes, Inc., Coppin State University, and Baltimore City Community College.

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