

Baltimore Mental Health Systems, Inc.

(BMHS)

<http://www.bmhsi.org>

Core Service Agency

One-Year Comprehensive Mental Health Plan

Fiscal Year 2004

July 1, 2003 to June 30, 2004

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Baltimore Mental Health Systems, Inc. One Year Comprehensive Plan Fiscal Year 2004

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SECTION I - PROGRAM PLAN

A. Description of the Mental Health Service System

1. Executive Summary

Baltimore Mental Health Systems, Inc. (BMHS), the Core Service Agency (CSA) for Baltimore City is committed to developing and managing a comprehensive community based mental health system for high quality care. The fiscal year (FY) '04 Strategic Plan reflects this commitment. BMHS' mission, values, and principles guided the development of the plan. To develop its needs assessment, BMHS used a variety of methods to collect information, including but not limited to analysis of Maryland Health Partners (MHP) data, State hospital data, input from the BMHS Board of Directors through its committees, and feedback from providers and key stakeholders.

The topics and population identified in the needs assessment attempt to ensure that Baltimore City residents are receiving a full range of services. The budget and the corresponding information support the need for the services, specify outcomes, and address the need for contract dollars. All funding requests are within BMHS' allocation with the inclusion of expected revenue from interest income. It is important to note that due to the drop in interest rates there is a reduction of \$100,000 of anticipated interest revenue.

2. Introduction and Program Narrative

BMHS' plan, while providing background on current activities, attempts to identify areas of focus for FY'04. In doing so, we identify strengths and needs of the current Baltimore City PMHS as well as identifying specific funding requests for FY '04. For the readers convenience we have organized the Introduction into four major sections. They are as follows:

- % Board Structure and Development
- % Ongoing Service Initiatives
- % Interagency Collaborations, and
- % Systems Development and Support.

a) Board of Directors Structure and Development

In FY'02, the BMHS Board of Directors established five committees with the goal of improving the involvement of Board members in governance issues of the Public Mental Health System (PMHS). The committees are chaired by BMHS Board members and staffed by BMHS personnel. They are augmented by community representation such as consumers, providers and other interested parties. We have completed the first full year of working with the committee structure. The committees met regularly during the year and participated in the review of the goals and objectives prior to presentation to the full Board.

b) Ongoing Service Initiatives

1) Development of Affordable Housing

BMHS' housing subsidiary, Community Housing Associates, Inc. (CHA), provides access to affordable, community-based housing. These include 400 Section 8 certificates which have expired. Upon their expiration, the Baltimore City Housing Authority returned the certificates to their central allocation pool. We are continuing discussions with the City to preserve the certificates for individuals with psychiatric disabilities.

CHA is unique in the State of Maryland and has served as a model for other jurisdictions developing affordable housing for individuals with psychiatric disabilities. There are very few mental health systems that have specifically established entities to create affordable housing opportunities for individuals with psychiatric disabilities. CHA has proven to be a valuable resource for individuals with mental illness as well as to the overall

mental health system. Access to affordable housing is a key component of an individual's recovery.

For FY'04, we are in the process of developing a CHA owned property to serve as the City's second Safe Haven for 20 individuals who are homeless and have a psychiatric disability. Funding for the development of the second Safe Haven has been received from the Department of Housing and Urban and Development (HUD), the Department of Health and Mental Hygiene's (DHMH) Community Bond Program, HOME funds, and the Baltimore City Office of Homeless Services (OHS). Service dollars will be a combination of HUD and State funds.

Currently, CHA is focusing its efforts on improving its property management functions and its financial situation. BMHS, through State funds, provides an annual grant to CHA and has routinely identified additional one-time-only dollars. However, CHA is often presented with additional costs related to turnover, property damage or unforeseen increases in insurance costs or other essential areas which create a fiscal challenge.

To ensure the financial viability of the organization, we have begun a concerted effort to develop additional funding sources and the CHA Board of Directors has developed a subcommittee to guide and monitor these efforts.

2) School-Based Mental Health Initiatives

BMHS oversees a network of school-based providers which provide mental health services in 87 or 50% of the city public schools. The services are jointly funded by the Baltimore City Public School System (BCPSS), the Baltimore City Health Department (BCHD) and BMHS. Services funded through these sources are not billable through the current fee-for-service structure. The school-based services are designed to promote healthy development, and to limit deeper involvement in special education, juvenile justice or more deep-end mental health services. As an additional component to our school-based initiative services program, BMHS supports a variety of services designed to support children's access to entitled services funded through the individualized educational plan (IEP) process, and ensure early access to drop out prevention for seriously emotionally children (SED).

3) Department of Juvenile Justice (DJJ) Initiatives

In collaboration with DJJ and MHA, BMHS has developed several service initiatives to address the needs of Baltimore City children and adolescents involved in the juvenile justice system. In FY'02 as in FY'01, more than 550 males were screened to identify the need for mental health services. Eighty percent of those screened were positive for a need for mental health services. This percentage is consistent with our findings in FY'01. The assessments were done using the Massachusetts Adolescent and Youth Screening Inventory (MAYSI). Current views of the MAYSI suggest that it overestimates the need for mental health services. Despite this, the prevalence of mental health service needs in the Juvenile Justice system is estimated to be above 60%.

Working with DJJ, and the Johns Hopkins University, BMHS provided oversight and supported the development of an expanded facility-based mental health initiative designed to provide more indepth mental health evaluation and services to youth in both Waxter and Cheltenham. The goal in FY'04 is to move the core of this service to the DJJ facility in Baltimore City once it has opened. This will ensure rapid access to mental health services for all detained Baltimore City youth.

Additionally, with DJJ/MHA funding, BMHS continued efforts to provide mental health services to the DJJ aftercare initiative. Universal Counseling and the East Baltimore Mental Health Partnership are the providers for this initiative which began in FY'02.

4) Special Initiative Between BMHS and State Facilities

During the latter half of FY'01, BMHS began an initiative with Springfield Hospital Center to continue the progress that had been initiated with the Community Enhancement Initiative (CEI). The program, known as Transitional Service Partnership requires Baltimore City community programs (especially the Intensive Case Management Programs) to collaborate with staff and patients at Springfield to develop a community placement that is acceptable to the patient. The service time required for the development of a relationship by the patient with community providers and the ensuing transition services are reimbursed through the use of monies that were saved from previous initiatives. The program was continued in FY'03 but with disappointing results during the first half

of the year as there have been very few referrals. Those who were referred were either scheduled for admission to a residential rehabilitation program or were withdrawn as “not ready for discharge”. BMHS will be exploring at both Springfield and Spring Grove the efficacy of continuing this program or whether a design change needs to be made.

The Baltimore Capitation Program for adults continues to work closely with State facilities in helping individuals move into the community and will continue doing so as they have available capacity. In FY'04, we would like to expand the capitation project and continue with the inclusion of individuals leaving State hospitals. Eighteen persons referred by State facilities were admitted to the project in FY'02.

In FY'04, BMHS will continue to interact with MHP and MHA facilities to assure that community services for individuals are promoted prior to hospitalization in a State facility. Support for alternative community plans will be provided through individual consultation with Baltimore Crisis Response, Inc. (BCRI), general hospital psychiatric units and other providers as requested. For patients in general hospitals awaiting transfer to a State facility, BMHS continues to review the referral to explore the possibility of a less restrictive discharge plan.

In an effort to promote more effective treatment in child residential treatment centers (RTC) BMHS in conjunction with the Mental Hygiene Administration and the Johns Hopkins School of Medicine formed an ongoing work group to develop and train RTC providers on “best practice protocols.”

5) Specialized Service Needs Populations

Baltimore City has contracted for residential services for individuals with special needs for many years. The speciality groups include individuals with mental illness and developmental or neurological problems and those who have experienced head trauma, and formerly homeless individuals with mental illness who have moved to transitional housing programs. Demand for outpatient services for Spanish speaking undocumented immigrants are increasing. The individuals receiving these services have been able to remain in the community over many years. In FY'02, a change in provider relative to residential services for individuals with traumatic brain injury was initiated by BMHS. This program will expand the number of individuals served from 10 to 11. Jail mental health services continue to be offered in Baltimore City's Central Booking Facility, and the Detention Center. In addition, competency screening for the State is offered by contract by the Medical Service of the Circuit Court in Baltimore. This office also participates with the University of Maryland and Clifton T. Perkins in the training of forensic psychiatrists and other mental health professionals.

Special population initiatives for Baltimore City's children, adolescents and families have been developed to meet a variety of identified needs. Client support services are designed to address unique, short term out-of-home placement and non-billable supports that promote clinical stability and support to the family. Placement services have included long term support for out-of-State placements for high-need children, and vocational support for children in residential treatment center (RTC) placement. Given the growing numbers of homeless families and children, BMHS provides outreach and therapeutic nursery services to homeless families and children. In conjunction with MHA, BMHS provides support for respite services to families with seriously emotionally disturbed (SED) children. Finally, in conjunction with MHA, BMHS has implemented a service initiative to address the needs of Transitional Age Youth (TAY) as they age out of the child mental health system.

Access to entitlements continues to be important for both consumers and providers. With the need to reduce grey zone services, providers are being asked to assist consumers with applications for Medicaid, Social Services, Social Security Disability and Supplemental Security Income. Assistance is provided by case management providers, Psychiatric Rehabilitation providers and specially funded entitlement coordinators.

Funding for an agency to develop and provide pro bono mental health services continues. This agency reports an increase in requests for mental health counseling services since July 1,2002 when State supported services for the non-Medicaid population became less easily accessible.

Through an initiative developed by the Metropolitan Mental Health Association, Project Praise reaches out to Baltimore City residents through local churches to develop an awareness of mental illness and the availability of treatment.

One consumer run peer support program, Hearts and Ears has begun to attract national recognition in its programming for gay, lesbian, bisexual and transgendered persons with mental illness. Over 130 persons from across Maryland, the Mid-Atlantic region, and as far away as Michigan and Canada attended their conference held in early FY'03.

BMHS has a long history of assisting consumers to transition from the hospital to the community living as independently as possible. This has been achieved through the use of set aside funding to assist the individuals with both ongoing living expenses (for those moving from State hospital inpatient care) and one time only assistance for emergency services and goods such as shelter, food, dental work, medication or pharmacy, costs related to enabling a consumer to establish a residence such as, rent, security deposit and basic furnishings.

At the request of MHA, BMHS has assisted a community group to develop a program to support individuals seeking assistance for issues of pedophilia.

6) Mobile Crisis and Hotline

BMHS developed the State's first mobile crisis team and 24 hour hotline in 1993 by establishing and contracting with Baltimore Crisis Response, Inc. (BCRI). During FY'02 BCRI has grown in both the number of services and the types of service it provides. The hotline now provides response to persons or agencies requesting assistance with shelter or outreach to homeless individuals thought to have a mental disorder. By bringing all of these calls to a central location, BMHS expects to be able to more clearly identify types of services needed, location for those services and to collaborate with other agencies to provide the resources to meet the need. The addition of substance abuse residential treatment for detoxification developed in this way with the addition of 10 beds for substance abuse detox to the existing 12 BCRI crisis beds provided for individuals with acute psychiatric needs. BMHS also supports consultation to area emergency rooms to conduct assessments and to develop client disposition plans.

In 1999, BMHS expanded its crisis services to meet the needs of children. Baltimore Child and Adolescent Response Services (BCARS) provides mobile treatment, crisis residential, and in-home supports to prevent unnecessary emergency room contacts, reduce inpatient hospitalizations and shorten lengths of inpatient stays.

c) Interagency Collaborations

A major focus of BMHS continues to be its collaborations with other agencies that serve individuals with mental illness. BMHS staff are involved in over 45 committees or workgroups that have an interagency focus. Listed below are some of the highlights of the interagency collaborations.

1) BMHS/National Alliance for the Mentally Ill-Metropolitan Baltimore (NAMI)/Baltimore City Police Department (BPD)

In FY'02, representatives of BMHS/BPD and NAMI-Metropolitan Baltimore began working together to develop a mental health/police initiative with the goal of improving outcomes of police interactions with mentally ill citizens. In December of 2001, BMHS, BPD and NAMI established a committee which has met for the past year. The committee consists of BMHS staff, police, NAMI members, mental health providers and consumers representatives. The police department has identified a coordinator and the current plan is to establish a pilot project in the Central District in late FY'03. We expect the pilot project to be fully operational in FY'04.

In FY'99, BMHS in collaboration with BPD and Johns Hopkins School of Public Health initiated a joint effort to address the mental health needs of children, families and communities that have been the victims of violent trauma. The Child Development Community Policing Program (CDCP) was developed to cross-train police, mental health professionals and community members on the impacts of violence, and to develop cross-discipline and community trauma response teams.

2) BMHS/Family League of Baltimore City (FLBC)

The Family League of Baltimore City (FLBC) is the Local Management Board (LMB) for Baltimore City.

In this role, they are responsible for planning, monitoring and ensuring that children and adolescent serving agencies are working together. BMHS collaborates with the FLBC in several areas. One of the major areas is that the leaders of both organizations sit on the others' Board of Directors. For FY'04, there are several primary projects that will benefit children and adolescents who have complex emotional needs. These projects are as follows:

(a) Demonstration Capitation Project

BMHS and FLBC identified the need for a program to better serve children and adolescents with SED. The project will identify children and adolescents who are in a restrictive level of care, are not stable in their community tenure, are having bad outcomes and are high-cost users in the PMHS. Since beginning the initial planning, BMHS and the FLBC have been joined by representatives of the Montgomery County CSA, representatives of Montgomery County's Collaboration Council for Children, Youth and Families, Montgomery County's LMB, DHMH, MHA, and family members to further develop this initiative. This group is serving as the planning committee for this project with the goal of developing a pilot project to be implemented no later than FY'04, in Baltimore City and Montgomery County.

Also in FY'03, the FLBC took the lead in initiating a pilot project to serve 25 youth detained in DJJ facilities. The project is an effort to replicate the Milwaukee wraparound community-based service model and will be incorporated in the larger project.

(b) Truancy Initiative

The Baltimore City Public School System (BCPSS) reports that 10% - 15% of children in grades kindergarten - 5 are absent on any given day. BMHS, as a part of the FLBC Community Partnership has received funding to target three elementary schools with high truancy rates and to develop an intervention to lower absentee rates. The project was fully implemented in FY'03 at the start of the school year. We are working with FLBC to develop a truancy prevention model that can be replicated in other schools across Baltimore City.

(c) Reduction of Violent and Aggressive Behavior in Elementary Schools

BMHS is a recent recipient of a federal grant developed in partnership with the BCPSS, which targets 50 youngsters in grades kindergarten - 5 who have been expelled from school. Data from the last school report indicate that in FY'01 590 children in grades kindergarten - 5 were expelled from school. This is a large number of children who are experiencing failure at an early age. Using the resources of our current school-based services and the new resources of the federal grant, an assertive intervention was implemented in FY'03 to target children who are at risk for expulsion.

(d) Expanded School-based Services and Violence Prevention

Through the collaborative efforts of the FLBC and BMHS staff, additional State funding has been received to expand school-based services and develop strategies to reduce violence in the public schools. These funds will support activities in 25 of the 87 schools that have mental health services. In FY'03, all participating schools in this initiative have continued to use the Skills Streaming Pro-Social Model which has been proven to be an effective intervention in public schools. For FY'04, we will continue to work to maintain the program in all of the participating schools.

(e) Early Childhood Mental Health Services

In FY'03, BMHS continued its commitment to serve the 0-6 year-old population by joining forces with FLBC to establish a coordinated mental health system to serve families with young children who have been exposed to or are victims of violence. The Safe Start Initiative will be implemented in two communities in mid FY'03 and will continue in FY'04. This initiative expands on BMHS' existing early childhood collaborations with BCPSS and Baltimore City Head Start which provides access to mental health services in Judy Centers and selected Head Start programs.

3) BMHS/ Baltimore Substance Abuse Systems (BSAS)

Since a significant number of individuals receiving services in the PMHS have a co-occurring substance abuse problem, BMHS has developed a strategic plan with the Baltimore City's substance authority, Baltimore Substance Abuse Systems, Inc. The goal of the plan is to improve services for individuals with co-occurring disorders. BSAS contracts with BMHS to provide leadership on co-occurring disorders and this will hopefully continue in FY'04. In addition, funding for a special program at University of Maryland which serves non-Medicaid eligible clients has continued.

In collaboration with BSAS and the Baltimore City Department of Social Services (DSS) BMHS continues to focus on the following initiatives:

(a) Training to staff of both mental health, social services and substance abuse treatment providers. In addition, we hope to expand ongoing training to staff of parole and probation.

(b) Joint coordination and planning meetings with senior staff of BSAS and BMHS as well as an annual meeting between the Boards of both organizations.

(c) Continuation of an annual conference on dual diagnosis for all Baltimore City mental health and substance abuse providers.

4) Baltimore City Health Department (BCHD) on Domestic Preparedness

BMHS has worked closely with the BCHD to ensure that Baltimore City is prepared to provide mental health support in the event of a critical incident. Domestic Preparedness has been a focal point within the Health Department for a number of years. A BMHS staff member has been trained in weapons of mass destruction response and has organized training of volunteers to be available to offer mental health services as secondary responders. Trained volunteers were available to travel to New York, Washington, D.C., and Pennsylvania in September, 2001 and mental health teams aided the Baltimore City Health Department during the Anthrax scare of October. This is an ongoing collaboration which has been extended to MHA to assist with the development of their disaster preparedness plan.

During FY'04, BMHS will continue to collaborate with BCHD to improve the Baltimore City's ability to respond to real or possible incidents of domestic disaster. Additional training for volunteers will be offered to assure that mental health counseling and supports are available as needed.

5) Baltimore City Department of Housing Office of Homeless Services

In late December 2002, BMHS learned that its funding from HUD for our outreach services, the SSI Project and Safe Haven was not renewed. As of this writing, we are working with the providers and the Baltimore City Department of Housing and Community Development to extend the present funding and operations until renewal grants can be submitted for start in January 2004.

In prior years, BMHS has received grants for services for homeless persons with mental illness and one hundred and seventy Shelter Plus Care rental assistance housing certificates from HUD. These service grants provide funding for mental health outreach, a twenty-bed Safe Haven, a Social Security Income (SSI) Presumptive Eligibility Program and a consumer run drop in center all targeted to homeless persons with mental illness. This collaboration is extended to a nationally acclaimed project known as Hands in Partnership (HIP). HIP brings together the outreach teams, BMHS, BCRI, BPD, DSS, BSAS, OHS and Health Care for the Homeless. Together, these agencies focus their outreach activities and support each other in their efforts to house homeless persons. HIP utilizes monthly meetings of the administrators and twice monthly meetings of the service providers to achieve the goals of creating and actualizing policies and procedures necessary to engage homeless individuals.

The implementation of a second Safe Haven for which an award was recently received should take place at the end of FY'03 and be fully operational in early FY'04.

Planning is underway to develop a data base to be in operation in FY'03 to be utilized by all HUD grant programs. The data base will be used to improve HUD service reporting to connect with the OHS ROSIE reporting program and improving BMHS' ability to monitor Baltimore City's population of homeless persons with mental illness.

6) Geriatric Partnerships

BMHS represents the PMHS on the Interagency Aging Committee (IAC), chaired by the Commission on Aging. This is a unique activity for a CSA, as in all other jurisdiction the Health Department rather than the CSA represents mental health concerns on the local IAC. In Baltimore City, the IAC's primary activities have included:

- Triad Committee which seeks to improve collaboration with the BPD and the Sheriff's Department and providers in the aging service network.

% A Clinical Subcommittee which includes private social service agencies who come together to review and plan for individuals who present complex problems that involve multiple agencies. Recommendations are made to the client's care provider team with one agency assuming lead responsibility.

- Consultation on mental health issues to the Guardianship and Case Management Units at the Commission on Aging.

BMHS' working with CHA led to the opening of an eight-unit residential rehabilitation program (Glenmore Manor) for older individuals with mental illness. The residence has been fully occupied with nursing services provided in addition to standard rehabilitation. This is a community enhancement initiative.

During FY'04, BMHS will continue to participate with the Commission on Aging to provide education on mental illness in the elderly population to assisted living providers, senior centers and adult medical day care programs. Our Director of Geriatric Services and our psychogeriatric nurse will work closely with MHA facilities, other providers of mental health services and nursing homes to assure that individuals are receiving care in the least restrictive setting.

BMHS continues to fund three programs designed to alleviate the barriers to services experienced by the elderly. Two of these service programs provide outreach and in-home services in the community or in Baltimore City's senior housing projects. The other provides a mental health professional at one of our local hospitals to provide support to elderly individuals by improving access to a full continuum of care through the reduction of fragmentation in services and improving linkages throughout the hospital. As a result of convening interdisciplinary case conferences and providing training, over 400 persons have benefitted from specialized psychiatric services.

BMHS received funding from the Department of Human Resources (DHR) through DSS to provide case management for vulnerable adults identified by DSS Adult Protective Services. By collaborating with DSS vulnerable adults will receive mental health assessments and services as needed.

7) Criminal Justice System - Courts and Corrections

BMHS continues to have a strong presence in the criminal justice arena. Monthly forensic liaison meetings bring together the courts, the Office of the Public Defender, the State Attorney's Office, the Detention Center, the Medical Service of the Circuit Court's Forensic Assessment Services Team (FAST), community providers, the Carter Center, Office of Forensic Aftercare, BSAS, BCRI and BPD. The meetings focus on problem solving issues that develop between agencies or impede rapid appropriate service planning and delivery for arrested individuals. These have included issues arising in the implementation of Emergency Petitions, competency evaluations and dispositions and medication for incarcerated individuals.

We continue to focus our efforts through the Forensic Alternative Service Team (FAST) and the Baltimore City Detention Center on trauma and its effects on incarcerated women.

In the Fall of 1999, BMHS began its initiative with Patuxent Institution to work with the Department of Public Safety and Corrections (DOC) for discharge planning for persons with a diagnosed mental illness who are leaving incarceration on mandatory release. This initiative has continued and it is anticipated that this initiative will assist 25 Baltimore City individuals in the coming year and should form the ground work for better cooperation between these two State administrations especially in the area of planning for return to the community. This is especially important for Baltimore City as Baltimore City residents comprise 70% of the population of DOC facilities.

BMHS in conjunction with the judges, State Attorney's Office, the Medical Services of the Circuit Court and the Office of the Public Defender continued working on the development of an initiative to provide a comprehensive program for individuals who have a mental illness coming before the court. The first step toward a mental health court was established as The Competency Court located in Southern District Court. All cases of individuals for whom a competency screening is requested have their cases transferred to Southern. This creates an opportunity for FAST, the mental health evaluators and the Court to collaborate on an appropriate disposition for the individual. The participants of the Competency Court joined in a grant application to the Bureau of Justice for funding to more fully develop a mental health court.

BMHS' Child and Adolescent (C&A) Division in collaboration with Baltimore City Juvenile Court established the LINKS Program to identify and address the mental health needs of children who come before the court. BMHS has placed a Resource Coordinator on-site at the court for 2.5 days per week. The Resource Coordinator provides consultation to Juvenile Court justices, works with families and children to identify and establish linkages to needed services, and represents BMHS on cases involving DHMH committed children.

d) Systems Development and Support

1) Outcomes for the Public Mental Health System

In FY'02, BMHS began a process to develop and track outcomes that can help us determine the effectiveness of a service and provider. BMHS collaborated with Psychiatric Rehabilitation Programs (PRP) and Mobile Treatment programs to develop measurable outcomes that are to be reviewed quarterly. The goal has been to identify outcomes that provide meaningful information to BMHS and the provider while attempting to use information that is easily attainable. During FY'03, BMHS met on a quarterly basis with adult and child PRP providers and mobile treatment providers to review their performance based on selected outcomes. These meetings are also used to revise the outcomes as needed. A copy of the outcomes reports are included as Appendix #1. In FY'04, our goal is to collect outcomes on Supported Employment Programs and develop a tool for outcomes for outpatient mental health clinics.

2) Cultural Competence

Noting both the changes in demographics of Baltimore City, and the Surgeon General's report on the disparities in access and appropriateness of mental health services to persons of color, BMHS conducted its first Cultural Competence Assessment. The assessment was conducted by having providers respond to a survey which was a requirement of their FY'02 contract. The survey was modeled on a similar national assessment conducted by Georgetown University, and sought to determine the provider community's knowledge regarding the diversity of the Baltimore City Service population, and their capacity to serve various populations in terms of linguistic and cultural competency.

3) Evidence-Based Practices

BMHS has been involved in the national project to implement evidence-based mental health interventions for individuals with serious mental illness. Currently the North Baltimore Center's Chesapeake Connections is involved with the Supported Employment practice. Through funding from the Veterans Administration (VA) and the Blaustein Foundation, four Baltimore City sites are participating in the Assertive Community Treatment (ACT)

initiative. By the end of FY'04 we will be able to examine the outcomes of the mobile treatment providers who participated in the evidence-based practice initiative as compared to those that did not have the special training.

4) Serving Individuals with Depression in High Poverty Areas

There has been a recognition that individuals who live in poverty have a higher rate of depression and often do not receive treatment. Therefore, a barrier to employment and other skills needed to improve an individual's economic condition may be related to untreated depression. BMHS has begun working with the Abell Foundation about doing further work in this area and we will continue this focus in FY'04. This will build on an existing contract with the DSS which places mental health professionals in two local DSS sites to assess the mental health needs of DSS customers.

5) Training Institute

In the early part of this year, BMHS convened a number of leaders in the academic community to address the issue of the dearth of training and post graduate experiences creating a crisis in workforce development in public psychiatry and a parallel gap between research and practice. We have been able to attract the participation of many of the leading academic institutions in the Baltimore area. A full listing of the participants is attached as Appendix #2. The group meets regularly and has established the Institute for Mental Health Leadership and Policy.

The overall mission of the Institute is to establish an ongoing link with and between the academic centers, governing bodies, payers and providers for the purpose of initiating, facilitating and coordinating training and education at all levels. The Institute's goal is to promote new leadership in the field of community mental health to significantly improve the delivery and quality of public mental health services in the community. In FY'04 we will be working to identify a funding base for the Institute.

6) Advocacy Education and Training

Among the contracts awarded and monitored by BMHS are those to providers who advocate for services for persons with mental illness, for the reduction of stigma, for self help and peer support, and family support and education and training through presentations to the public, special interest groups and providers on mental health issues. These providers include:

- Consumer run drop-in centers (On Our Own, HOPE and Hearts & Ears)
- State wide consumer advocate programs which provide programs for the community and technical assistance for small local affiliates
- Local affiliates of national groups, e.g. NAMI and Mental Health Association
- Black Mental Health Alliance
- University based training centers
- City-wide child and family advocates, and
- Youth job-readiness and location providers.

BMHS has long supported a specialized educational program that trains consumers to provide direct mental health support services. Graduates of this program frequently are hired as staff by peer support programs, case management and outreach programs and residential providers.

Other training initiatives include a yearly forensic conference, training for case managers in the City, and training for clinicians working with individuals who are survivors of trauma especially those with severe mental illness.

Funding to support scholarships for six undergraduates at Coppin State College continues to encourage students to choose careers in mental health service delivery.

3. System Mission, Vision, and Values

Mission Statement

The mission of Baltimore Mental Health Systems (BMHS) is to develop and manage a system of care in which Baltimore City residents have access to high quality public mental health services.

Vision Statement

Baltimore City seeks to be a national leader in the development of high quality, innovative and effective public mental health services. Services are developed to meet the needs of the community based on input received during ongoing planning processes. BMHS will be a model for other local mental health authorities throughout the country because of effective leadership, collaboration with the community, efficient management of costs, and a comprehensive data-driven quality management program.

Value StatementBMHS Values:

- % To design a continuum of services specifically to meet the mental health needs of the citizens of Baltimore City,
- % To include the opinions and participation of staff, consumers, families, mental health providers, and other key stakeholders in developing and improving systems of care,
- % To recognize the rights of consumers and families to participate in care decisions and to be treated with dignity and respect,
- % To support individuals in their efforts to maximize their full potential,
- % To offer effective mental health services,
- % To ensure a cost-effective delivery of services,
- % To ensure a delivery of services in the least restrictive environment appropriate to the needs of consumers,
- % To have available a culturally competent system of care that respects the differences among individuals,
- % To educate, train and promote research,
- % To offer appropriate and affordable housing for persons with mental illness that is comfortable, attractive and safe,
- % To maximize all potential resources for the purpose of delivering high quality care.

BMHS' Roles & Responsibilities in the Public Mental Health System

- % Leadership
- % Policy and planning
- % Systems development/program development
- % Facilitated access to appropriate levels of care
- % Procurement
- % Collaboration
- % Education, technical assistance and training
- % Quality improvement
- % Fiscal management
- % Collection and management of information
- % Research and evaluation
- % Development of a range of housing opportunities

4. Demographics of Baltimore City

Over the past 40 years, Baltimore similar to other urban areas in the U.S. has experienced a decline in population. Once the largest political jurisdiction in the State of Maryland, with 939,024 or 25% of the State's population, Baltimore is currently the fourth largest subdivision in the State with a population of 635,210 according to the U.S. Census Bureau estimate for 2001. This is approximately 12% of the State's population according to the same source. The majority of the individuals residing in Baltimore City are African-American (64%) with Caucasians making up 32% and other races the additional 4%.

In 1999, almost 23% of the residents of the city were below poverty and the per capita income was \$16,978 as compared to the State of Maryland's \$25,616.

The elderly (65 years of age) and older comprise up 13.2% of the City's population.

5. Description of Process and Needs Assessment

In preparing our needs assessment we met with the various BMHS Board committees, provider groups, reviewed data from MHP, State hospitals and the Maryland Health Care Commission.

The findings of this process are the following:

During the past month discussions were held with the Adult Services Committee of the BMHS Board of Directors and with Adult Services providers. Both groups unanimously agreed that the most glaring need for the population being served is affordable housing. As the cost of basic safe and available housing continues to increase, the ability for individuals on fixed poverty level income to access housing decreases. While BMHS has increased affordable housing opportunities through CHA a recent policy change at the Baltimore City Housing Section 8 Office has reduced the number of Section 8 certificates that are set aside for individuals with psychiatric disabilities. We are working with the Maryland Disability Law Center (MDLC) and the City to hopefully reverse this decision.

In Baltimore City the impact of the Assisted Living Regulations continues to be felt. The room and board providers who have historically provided housing with minimal supports are slowly but steadily being forced out of business or are needing to increase their charges in order to accommodate their raising costs. Social Security Income recipients no longer have sufficient income to purchase this living arrangement.

Among the other gaps identified are: Culturally competent shelters, training for the treatment of forensic patients, and technical assistance for small providers. The failure of service providers to expand Intensive Case Management was seen as a deficit. The reimbursement for this service is so low that it cannot be provided at a break even point for agencies without subsidy or expansion of case loads beyond the maximum for effective service delivery.

Although the need for State hospitals inpatient services is a Statewide issue, the situation in Baltimore City is reaching crisis proportions. A review of bed availability over the past few years will provide some explanation for the problem. One-half of the of the psychiatric beds in Maryland are State-operated (1204). The remaining are 712 beds in units of 29 acute general hospitals and 663 in private facilities.

In 1992, there were over 900 general hospitals beds available as compared to the 712 beds today, a decrease of 21%. State operated beds declined by 73% (4390 to 1204) between 1982 and 2002. Decreases in private psychiatric facilities also occurred. This produced a daily census decline in excess of 55%. With the increase in admissions, length of stays have continued to decline.

In Maryland, patients with mental disorders account for about 4% of all visits to emergency departments (ED). Nearly one-third of ED visits for patients with mental disorders result in admission for inpatient care. Compared with all ED visits, a larger proportion of patients with mental disorders is admitted for inpatient care following treatment in the ED. (Source: Maryland Health Care Commission data reported for calendar year 2000 for ICD-9 codes 290-319). Since 7 of the top 15 Maryland hospitals for ED visits are in Baltimore City, the decrease in bed availability is most acutely felt by our hospitals especially those that operate psychiatric inpatient units. A significant number of the individuals using the ED have complicated co-occurring disorders such as a developmental disability or substance abuse disorder making dispositions even more difficult.

The increase in the need for acute admission would lead one to expect that the admissions to the State facility accepting patients meeting criteria for acute inpatient admission would show a significant increase. The opposite is true. A review of the changes in service patterns at the Walter P. Carter Center (Baltimore City's acute care State hospital) reveals some unexpected information. In fiscal year 1999, there were 1230 admissions to the hospital which declined to 783 in FY'02. A drop of 57%. But the drop in the percent of admissions of Baltimore City residents was even greater 63% (1019 to 376). Since the admissions to State regional facilities is significantly extended for individuals in acute hospital beds, the chances of Baltimore City residents having access to this service has caused grave concern among both providers of inpatient and outpatient services. BMHS will be requesting a meeting with MHA to review this information and the need to develop access to longer term care for those patients who are caught in the revolving door of early discharge to community care that can not meet their needs.

W. P. Carter admission demographics between FY'99 and FY'02 show that the percentage of individuals admitted voluntarily declined from 68% in '99 to 46% in '02. The percentage of total admissions by court order nearly doubled from 8% to 15% during that same period, but the actual number of court ordered admissions increased by only 19. The length of stay for those discharged from WPC in FY'99 was 13 days. This has nearly doubled to a LOS of 23.3 days during the period July '01 to October '02 which may indicate the need for longer periods of care and/or the inability to move patients to regional facilities.

Another area identified in our needs assessment is the lack of mental health resources in the area north of North Ave. and south of Coldspring Ave. This area includes portions of Baltimore City with the most pressing needs and represent zip codes 21215 and 21217. This void was created by the closing of Liberty Medical Center and the movement of most outpatient services to the Bon Secours site in West Baltimore. We are encouraging outpatient providers to locate in this area of the city.

6. Reporting and Analyzing Data

a) Narrative Analysis of Service Utilization of the Public Mental Health System

The following is an analysis of the use of the PMHS by Baltimore City residents. The information used in the following analysis was compiled from MHP's claims data base. It reflects services for which there was a paid claim and for claims paid through 10/31/02.

1) Unduplicated Baltimore City Consumers Comparison of FY'00-FY'02

Category	FY'00 Number and Percent	FY'01 Number and Percent	FY'02 Number and Percent
Medicaid recipients in the waiver	20,041 (79%)	21,397 (78%)	22,643 (79%)
Gray zone (uninsured) individuals	3,651 (14%)	4,012 (15%)	4,737(16%)
Medicaid individuals not waiver eligible	1,839 (7%)	2,092 (7%)	1,452(5%)
TOTAL	25,531	27,501	28,832

2) **Unduplicated Baltimore City Consumers Comparison by Age Group from FY'00 - FY'02**

AGE GROUP	FY'00	FY'01	FY'02
0-5	1,134 (5%)	1,395 (5%)	1,559 (4.5%)
6-12	6,170 (24%)	6,789 (25%)	7,131 (24.5%)
13-17	3,134 (12%)	3,674 (12%)	4,211 (15%)
18-21	827 (3%)	966 (4%)	1,089 (4%)
22-64	12,811 (50%)	13,299 (48%)	13,755 (48%)
65 AND OVER	1,455 (6%)	1,378 (5%)	1,087 (4%)
TOTAL	25,531	27,501	28,832

Ages 0-17 representation grew from 41% of those seen in '00 to 44% in '02.

3) **Total Expenditures FY'00 - FY'03**

Year	Total Expenditures	Number served	Average Expenditure Per User
2000	\$ 100,444,429	25,531	\$3,934
2001	\$114,671,759	27,501	\$4,170
2002	\$123,777,701	28,832	\$4,293

From FY'00 to FY'01, total expenditures increased by 14% while the average cost per user increased by 6%. The same is true in looking at changes from FY'01 to FY'02 where the total expenditures increased by 8% while the average cost per user increased by 3%. From '00 to '02 total expenditures increased by 23% while the average cost per user increase by 9%.

4) **Expenditures, Utilization and Charges from FY'00 - FY'02**

The following compares the number of individuals served and expenditures for five service types in '00 and '02. This data varies somewhat as it is based on MHA through 9/30/02.

Service	# seen '00	# seen '02	% change	\$s spend '00	\$s spend 02	% change
O/P(incl. output and partial)	27,082	32,361	19%	37,570,196 (\$1,387/user)	48,946,493 (\$1,5133/user)	30% on total 9% per service

Rehab.	4,571	6,560	44%	23,676,574 (\$5,180/user)	32,626,552 (\$4,897/user)	36% on total (5%) per user
I/P	3,069	2,959	(4%)	27,645,855 (\$9,008/user)	29,166,123 (\$9,857/user)	5% on total 9% per user
RTC	215	178	(17%)	9,397,754 (\$43,710/user)	10,210,109 (\$57,383/user)	9% 31% per user

One of the concerns of the change in the system was that the fee for service system could reduce the focus on individuals most in need. While it is difficult to determine if individuals with the most serious and complex needs are being served and being served well, the data we looked at does indicate that the predominant user of the PMHS is an individuals with a SED or Serious Mental Illness (SMI).

5) Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Utilization

Ages 0-17 Serious Emotional Disturbance

Year	Number Seen	Number with SED	% SED
'00	10,438	8,060	77%
'01	11,858	9,335	79%
'02	12,901	10,290	80%

Ages 18-64 Serious Mental Illness(SMI)

Year	Number Seen	Number with SMI	% SMI
'00	13,638	7,933	58%
'01	14,265	8,845	58%
'02	14,844	8,977	60%

b) Narrative Analysis of Gaps in Services

Based upon our analysis of the data and our assessment of the service system, BMHS has identified the following gaps. The needs assessment and our FY04 goals will support and provide information regarding BMHS's plan to meet the identified need.

- % Due to the high rate of substance abuse among many of the individuals receiving services in the PMHS in Baltimore City, there is a need for integrated mental and substance abuse services.
- % The high rate of poverty, substance abuse in Baltimore City and violence witnessed or experienced by Baltimore City children requires specialized school-based and community-based services for children and adolescents as well as special initiatives for adults dealing with the consequences of poverty.
- % The elderly have special needs that are not being addressed by the current system.

- % There is a need for expanded vocational services for individuals with serious mental illness.
- % Affordable housing for individuals with serious mental illness needs to be expanded.
- % Service providers need greater clinical expertise and comfort in providing services to the forensic population and those with co-occurring substance abuse disorders
- % There is a need to increase evidence-based practices.
- % The problems in the ED and inpatient need to be addressed.

7. FY 2004 Goals, Objectives, and Strategies

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

<p>GOAL #2: Improve continuity of care.</p>

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.

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.

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.

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.
- 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 Justice (DJJ) in the continued implementation of facility-based mental and intensive aftercare mental health service programs.
2. Continue to collaborate with the juvenile court through the (LINKS) initiative.

GOAL 3: Ensure that affordable, safe and comfortable housing is available.

- Objective 3A: Inspect 100% of housing operated by residential rehabilitation programs (RRP) to ensure compliance with Code of Maryland Regulations (COMAR).**
- Indicator: Number of RRP units, number/percent inspected and the type of approvals.
- Strategy: Conduct an initial, annual and follow-up inspections of RRP housing in Baltimore City and report findings to providers and the Office of Health Care Quality.
- Objective 3B: Interview 50% of consumers in RRP housing in Baltimore City to evaluate satisfaction with housing conditions.**
- Indicator: Number of consumers in RRP housing, number/percent interviewed and the level of satisfaction reported.
- Strategies: 1. Conduct one-on-one interviews with consumers living at each RRP in Baltimore City.
2. Prepare a written report of the interview findings and submit the results to providers and BMHS.
- 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 .

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

Indicator: Number of housing units that fail inspections.

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

<p>GOAL #4: Ensure efficient & accountable financial management.</p>

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.

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.

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.

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

and

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.

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 RRPs or receiving a level change.
 2. Conduct clinical reviews with RRP providers to review charts.
 3. Provide report of findings.

Objective 5C: Implement comprehensive contract management processes that ensure increased accountability and effective monitoring of local state and federally funded contracts.

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

- Strategies:
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. BMHS will have up-to-date written contract policies and procedures.
 4. 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.
 5. Quality improvement and fiscal staff will conduct an annual training on contract management procedures.
 6. Quality improvement staff will conduct annual and bi-annual contract site visits to evaluate services and to provide technical assistance to providers.
 7. The Board of Directors Quality Improvement Committee will meet regularly and review quality improvement activities.

Objective 5D: Assist community mental health providers in Baltimore City in complying with COMAR regulations.

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

Objective 5E: Monitor and report sentinel events (consumer deaths, formal complaints, help calls, and unusual incidents).

Indicators: Number of MHA death reports, demographics, number of complaints and the types of complaints.

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

Goal #6: Community Education

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 a 60% participation.

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 of 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.

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.

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.

APPENDIX #1

APPENDIX #2

