

**BALTIMORE  
MENTAL HEALTH SYSTEMS, INC.  
(BMHS)**

<http://www.bmhsi.org>

# Annual Report

Fiscal Year 2005

July 1, 2004 to June 30, 2005

---

Stephen T. Baron, LCSW-C  
President

Beverly T. Hoffberg  
Board Chairperson

# TABLE OF CONTENTS

	<u>PAGE</u>
<b>PREFACE</b> .....	2
 <b>GOALS &amp; PROGRESS REPORTS</b>	
GOAL #1: Ensure that a wide range of services are available and accessible to meet the needs of the mentally ill.....	3
GOAL #2: Improve continuity of care.....	10
GOAL #3: Ensure the availability of affordable housing for individuals with psychiatric disabilities.....	19
GOAL #4: Ensure efficient & accountable financial management.....	22
GOAL #5: Maintain a quality management program to continuously evaluate and improve Baltimore Mental Health Systems, Inc. and the Public Mental Health System.....	23
GOAL #6: Community Education.....	33

## **P**REFACE

Baltimore Mental Health Systems, Inc.'s (BMHS) annual report for FY'05 reflects the organization's commitment to innovation, access and accountability. The goals describe projects that moved from a planning or beginning phase into implementation. These include but are not limited to the Behavioral Emergency Services Team (BEST) mental health/police initiative, the mental health court, expansion of school-based services, monitoring of outcomes for specific services, mental health early childhood initiatives, integrated care, continued improvement with our contract compliance and completing the transition of the outsourcing of our financial operations.

In addition, a number of projects are close to implementation or still in their planning stages. These include the child wrap-around services, expansion of crisis services, collaborations with the Department of Juvenile Services (DJS) and the juvenile courts, expansion of consumer drop-in centers, and our subsidiary the Mental Health Policy Institute for Leadership and Training's poverty and depression project and certificate training program for individuals working with juvenile sex offenders.

Unfortunately, due to the state's transition to the new Administrative Services Organization (ASO) data for FY'05 was not available in time to be included in this report.

This report reflects the talent and commitment of BMHS' staff, the staff and leadership of the providers that make up Baltimore City's Public Mental Health System (PMHS) as well as the contributions and input of the consumers and family members who use the system.

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

## **ADULT SERVICES**

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

Strategy(s):

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

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

As a result of the contract change from Maryland Health Partners to APS-MD to provide administrative services, no data on services provided during FY '05 was available.

Drop-in center surveys were completed in October 2004. They were conducted at Hearts and Ears (H&E), On Our Own (OOO), and HOPE. There were a total of 65 participants, however, not all participants answered all of the questions on their surveys. The purpose of the survey was to obtain a picture of service utilization, see how consumers who frequent drop-in centers rate specific services in the PMHS and to identify unmet needs. Each center has its own unique consumer population.

Hearts and Ears is a center for people who are Gay, Lesbian, Bi-Sexual, and Transgender (GLBT) with mental illness. The center functions as an advocacy group and a social meeting place. The center participants join in activities such as Gay Pride Day and gender specific support groups. Some of the members also visit On Our Own. Hearts and Ears has provided 178 peer support sessions. The members have been active in community health fairs and parades.

On Our Own has several locations in Maryland. We surveyed their two sites in Baltimore City. OOO is an organization that functions as a resource and social meeting place for persons with a mental illness. Some of the members also participate at Hearts and Ears. In FY'05, 307 consumers participated in the peer support offered by the centers.

HOPE is a drop-in center for those who are homeless and have a mental illness. It is a place for daytime shelter, connection to an outreach/case manager and other services, have a

snack, shower, and/or do laundry. There are several social and educational activities scheduled each month.

The survey results reflected the particular characteristics of each of the drop-in centers. Hearts and Ears members were very concerned with the way their sexual orientation was seen as an illness to some therapists and doctors in the mental health system. Many members felt that their treatment practitioner treated them negatively, and therefore, their mental illness was not understood or treated. Also, many H&E members did not have support from family and felt even more isolated for having a mental illness and not being heterosexual.

On Our Own participants were concerned with negative treatment from emergency room staff, obtaining and paying for medications, and finding work.

HOPE members were unhappy about the cost of transportation, lack of family shelters and permanent housing. They were not satisfied with the time it took for them to be linked to services by outreach and case management staff.

Baltimore Mental Health Systems will continue to work on the expansion of these programs, especially on the west side of the city. The directors of each program will be invited to participate on the Adult Service Committee of the Baltimore Mental Health Systems Board of Directors. Finally, we will be working with the drop in centers to develop an educational package for Advanced Directives and explore a process for storing Advanced Directives with the Administrative Services Organization (APS-MD).

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

- Strategy(s):
1. Provide 100 consumers moving into independent housing with a start-up loan or grant.
  2. Assist 50 consumers to return and/or remain in the community from state hospital centers.
  3. Assure that 15 individuals with serious mental illness are identified 3 months prior to mandatory discharge from the Patuxent Institution and are referred for community placement services through the Patuxent Initiative.

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 with community plans.

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

Eighty-seven (87) consumers received a grant or loan, which is an increase of 11 recipients from the previous fiscal year. Of that number, 23 received a grant to pay for Baltimore Gas and Electric bills, which was made possible through a grant from the Baltimore Community

Foundation. Although many more applications were received, many either did not follow through with completion of the process or did not qualify under the policy guidelines.

Sixty-two individuals were assisted with transition to the community from state hospitals through various initiatives. BMHS Adult Service Coordinators were able to assist State Hospital Centers with the placement of twenty-five persons (25) to residential rehabilitation programs. For another 15 consumers BMHS was able to assist with direct community placements. The Capitation Programs admitted 22 individuals from State Hospitals. In addition, discharge-planning assistance was provided to general hospital psychiatric in-patient units to reduce the need for transfer to a State facility.

The interventions that were directed at assisting consumers to remain in the community included rental assistance, referral to more intensive clinical services through the Fee for Service system, payment for psychotropic medications while the individual was awaiting benefits, and the services of Baltimore City's crisis intervention program, Baltimore Crisis Response, Inc. (BCRI). In FY'05 1036 calls from hospital emergency rooms resulted in ongoing service being provided by BCRI for 512 individuals. BCRI responded to 2159 referrals for crisis services received through their 24-hour hotline. This was a 5% increase over FY'04 when 2048 interventions were provided. In FY'04 89 (4%) of the interventions resulted in hospitalization while in this year the number was reduced to 30 (1%).

Eleven persons were transitioned to the community from the Patuxent Institution through the Patuxent Initiative and another 5 are working on their community plans. In addition, Adult Services was able to provide direct assistance with discharge planning to state prison mental health staff for seven persons returning to Baltimore City using our mental health outreach/ case management staff. Staff met the returning individual at time of release to arrange housing and service linkage.

**Objective 1C: Maintain service access and delivery to individuals 65 years and older and served by the PMHS and BMHS grants targeting this population.**

Strategies: 1. To track and record services to seniors from MHP and grant programs data for FY 2003, 04, and 05.

2. Compare rate of services delivered to target population across fiscal years.

Indicator: Number of services provided to seniors in each of the following program types: OMHC, ICM, PRP, RRP.

**PROGRESS: This objective was met.**

Baltimore Mental Health Systems supports 3 grant funded programs specifically for seniors. These are the Psychogeriatric Assessment and Treatment in City Housing (PATCH) and the Senior Outreach Services (SOS), which provides mobile mental health assessment and treatment teams to seniors in their homes and Glenmore Manor, an intensive RRP serving 8

seniors with mental illness and somatic care needs. Six of the eight residents at Glenmore Manor are former long-term state hospital patients.

### Utilization Data on PATCH and SOS

Year	# of clients expected to serve	# of clients served	# of clients in on-going treatment
PATCH '03	100	149	57
PATCH '04	90	57*	39
PATCH '05	70	66	40
SOS '03	125	116	57
SOS '04	125	108	39
SOS '05	90	99	40

\*Staff turnover/higher than usual  
(Fee-for-service data for seniors was not available.)

## CHILD AND ADOLESCENT SERVICES

**Objective 1D:**        **Ensure the availability of mental health services to children 0 - 5 through partnerships with Baltimore City Head Start Program, the Family League of Baltimore City (FLBC), and Judy Centers.**

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

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

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

The Head Start Mental Health Project, funded jointly by local Head Start and the Mental Hygiene Administration (MHA), continued providing consultations to Head Start staff and services to young children and their families during FY05. Through contracts with Johns Hopkins Bayview Medical Center, Kennedy Krieger Family Center, UMB-Center for Infant Study, and Villa Maria, 8.5 mental health clinicians provided mental health services to 10 Head Start Programs. The chart below provides composite information on mental health services provided through the Head Start Mental Health Project.

ACTIVITY	YTD TOTAL
Referrals Received	353
Children receiving early childhood clinical services	315
Child Prevention Activities	513
Observations	828
<b>Family Consultations</b>	
? Total (Child behavior/mental health)	232
? Of the above, the number of children who received 3 or more (Child behavior/mental health)	29
? Other	79
<b>Staff Consultations</b>	
? Total (Child behavior/mental health)	523
? Of the above, the number of children who received 3 or more (Child behavior/mental health)	117
? Other	325
Family Workshops/Groups	63
Staff Development Sessions	82
Program Meetings	401
Number of children discussed at program meetings	1417
Total Head Start Funded Enrollment	2097
Total Number of Head Start Programs Served	10
Total Number of FTEs	8.5

In addition to partnering with Baltimore City Head Start, BMHS continues to collaborate with Baltimore City Public Schools' Judy Center pre-school program at John Eager Howard Elementary School. In FY05 a 0.5 FTE mental health clinician provided 491 hours of mental health consultative services to teaching staff and identified childcare providers.

In FY05 The Baltimore City Safe Start Initiative entered its fifth and final year of implementation. Forty-two new referrals related to children under the age of five, who were exposed to violence, were received. The focus of the initiative has moved to sustainability of the Safe Start components and the larger issue of childhood exposure to violence.

**Objective 1E: Provide purchase of care and transition services to twenty children/young adults ages 14 - 23.**

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.

Indicator: Number of children and youth served.

**PROGRESS: This objective was met.**

During FY05, The Transitioning Age Youth (TAY) program maintained the capacity to serve up to 20 youth at any given time, with a total of 23 transition-age youth served.

BMHS provided funding our Purchase of Care funding for 3 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-to-one support services were provided for one youth to prevent out of home placement and to another family to provide interim supports until an appropriate vendor could be identified and authorization obtained for Therapeutic Behavioral Support services. Additionally 4 families were helped with transportation. These funds are limited and the BMHS Resource Coordination staff involve other child-serving systems to provide funding, whenever possible.

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

Strategies: 1. Maintain the collaborative partnership with Baltimore Public School System (BCPSS) to facilitate the accessibility of quality school-based mental health services and to maintain collaborative funding.

2. In collaboration with the FLBC fully implement the truancy initiative in three schools.

Indicators: 1. Number of schools with school-based clinicians.

2. Number of children receiving mental health services in BCPSS schools.

**PROGRESS: This objective was met.**

In an effort to increase the number of students served by school-based mental health, BMHS and Baltimore City Public School System (BCPSS) collaborated on the development of a Request for Proposals (RFP) to identify new mental health providers. The RFP process did increase the number of schools served from 85 to 108. The new providers are only funded through the PMHS Fee for Service System (FFS), which limits prevention and consultation activities as providers are only paid for direct clinical services.

During FY'05, the number of unduplicated students receiving school-based mental health services was 4,858. An essential component of serving youth is partnering with key adults in their lives. Thus, consultations to parents/families totaled 13,993 and consultations to teachers totaled 15,804. Consistent with previous years' outcomes, data available for academic year 2004-2005 reveal 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, which were 1,356 youth.

? 71% 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

Baltimore Mental Health Systems has continued to work cooperatively with the Family League of Baltimore City on the Truancy Reduction and Prevention Initiative. Funding from this Initiative supports mental health clinicians in three schools, where in addition to traditional school-based mental health services, attendance monitoring interventions and strategies are also provided.

**Objective 1G: Continue to collaborate with city and state agencies on the development of a high-end/high-cost service initiative for children and adolescents.**

- 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.

Indicator: Have the approval of all necessary state and federal agencies in place.

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

While the planning for the child wrap-around continued during the fiscal year, a number of the necessary agreements between the state and the Center for Medicare and Medicaid Services (CMS) are still not in place. Therefore, the planning focused on developing two phases for implementation. Phase I would hopefully allow the project to begin in '06 by using current state general fund dollars through the Governor's of Children (GOC) and the Public Mental Health Systems' (PMHS) Fee for Service (FFS) structure. This financing structure is not ideal as it has limitations in its ability to develop individualized flexible services for the youth and their families. At the same time the state would continue its discussions with CMS to develop the project for Phase II using a case rate.

At the end of FY'05 the plan was for the development of a single Request for Proposal (RFP) to be issued by Montgomery County Collaboration Council for Children, Youth and Families, Inc. for both jurisdictions in FY'06. The goal is that the RFP process will select one vendor to serve as the Case Management Entity (CME) for both jurisdictions. The RFP would attempt to identify a vendor who would meet all of CMS requirements and could easily move into Phase II without the need for another RFP.

A major highlight for the year was the Governor's FY'06 budget included \$1 million specifically for this project in the City and Montgomery County.

**GOAL #2:** Improve continuity of care.

## **ADULT SERVICES**

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

- Strategies:
1. Acquire and monitor funding for mental health services to homeless persons.
  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.

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

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

Adult Services continued to receive PATH funding as well as funding through OHS for BMHS' Shelter Plus Care program. Additional PATH funding was received to provide case management services for the women who complete the TAMAR's Children program. People Encouraging People hired the case manager. They are presently providing services to 11 mothers and their children living in Shelter Plus Care.

This fiscal year, OHS physically moved into the Baltimore City Health Department building and changed its name to Baltimore Homeless Services (BHS). BHS is now a nonprofit organization.

The collaboration between BMHS and our outreach mental health teams, BHS, and RISE Again that provides outreach services to street homeless individuals (which falls under BHS) continues to be a strong working alliance. The goal continues to focus on an integrated system of outreach and linkages to services for the homeless in a coordinated manner. The multiple service providers coordinate through a collaboration known as Hands in Partnership (HIP). In addition, to the city case management teams, two BMHS funded provider agency members, HOPE's Ethel Elan Safe Haven, which has 19 beds, and University of Maryland's Safe Haven, which has 20 beds, served 27 and 58 individuals, respectively are important resources to HIP. Occupancy at both residences exceeded 98%.

HIP members have collaborated to engage 37 street homeless individuals. Through the leadership of BHS the group has begun to use the Housing First philosophy to guide the development of housing for this population. The goal is to provide affordable housing first and add on the needed services once the individual is housed.

Baltimore Homeless Services now has the responsibility of gathering data from various city agencies according to function. The service and outcome data is presented at quarterly Homeless Stat meetings. The program directors, BHS and BMHS review the information obtained to evaluate service delivery.

**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.**

- Strategies:
1. Collaborate with the Baltimore Police Department (BPD), NAMI, BCRI UMMS, and other emergency room facilities to ensure that BEST initiative is functioning well.
  2. Develop a plan for continued funding for the BEST initiative.
  3. Collaborate with the Department of Public Safety and Corrections to sustain and improve services with appropriate discharge planning.
  4. Collaborate with providers and the criminal justice system to develop a mental health court.

Indicator:        Ensure that the Behavioral Emergency Services Team (BEST) is operating in the Central District, that there is mental health staff stationed in the Southern District Court, and that they are involved in the development and implementation of special court proceedings.

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

BMHS has been very active this year with the BEST training. There have been four training classes this year. Since the projects inception in January 2004, the BEST Project has trained 73 Baltimore City Police Officers, 10 Sheriffs, and 22 Downtown Partnership Guides. BMHS is hopeful of its third of funding from the Governor's Office of Crime Control and Prevention.

By the end of the fiscal year, BMHS has developed a BEST Coordinator position and has hired part-time a Baltimore City Police Patrol Officer in this position. The new BEST Coordinator now routinely notifies BMHS regarding any barriers to implementation of the initiative that the BEST officers encounter. The new BEST Coordinator and an Adult Service Coordinator from BMHS also have begun to visit individually with emergency departments to review any difficulties or issues that occur in the implementation of the initiative. NAMI, BCRI, BPD and BMHS also participate in regular meetings to address any obstacles to the success of the project.

BMHS collaborates regularly with BPD, NAMI, BCRI and emergency departments to assess the functioning of the BEST Project and to improve its delivery system. In particular, BMHS has most recently involved six emergency departments, including UMMS, in an initiative

to collect data related to the number of emergency petitions evaluations requested by BPD and to develop policies to facilitate efficient processing of the BEST officer from the emergency department and back to the streets.

BMHS held their 10th Annual Forensic Conference, "Responding to the Scene" on April 8, 2005. The Keynote Speaker was Christiane Tellefson, MD who addressed the clinical interview and interventions for forensic clients. There were 148 attendees from the fields of law, social work, psychiatry and psychology.

**Objective 2C: To Improve the continuum of care for persons leaving RRP.**

Strategies: 1. Review 80% of discharge and separation forms received from RRP's to assess continuum of care and outcomes.

Indicator: Number of forms received, reviewed and reported on to the provider.

**PROGRESS: This objective was not met.**

During this fiscal year MHA assigned new duties to CSAs. BMHS Adult Services Division became responsible for the managed care component of Psychiatric Rehabilitation Services (PRP) for non-Medicaid individuals and for all of our Residential Services (RRP). This shift required staff to review requests for care, both initial and ongoing treatment, and to monitor the expenditure of dollars. A considerable amount of time was needed to learn the system that was developed by the new ASO, MAPS-MD, and to complete the daily reviews. As a result, our plan to assess the continuum of care for individuals leaving RRP services was postponed to FY '06.

In order to begin a review of utilization of residential rehabilitation services and programs, the following information was gathered from FY'05 RRP utilization data.

Bed Type	BMHS Total Beds	# of Beds		Discharges		Days V acant		Occupancy		Avg. Time		% Turnover	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<b>Alliance</b>													
General	20	17	3	5	1	479	66	92%	94%	95.8	66.0	29%	33%
Intensive	18	12	6	4	2	412	273	91%	88%	103.0	136.5	33%	33%
<b>TOTAL</b>	<b>38</b>	<b>29</b>	<b>9</b>	<b>9</b>	<b>3</b>	<b>891</b>	<b>339</b>						
<b>Harbor City</b>													
General	22	17	5	1	4	1498	0	76%	100%	1498.0	0.0	6%	80%
Intensive	29	23	6	7	0	582	49	93%	98%	83.1	0.0	30%	0%
<b>TOTAL</b>	<b>51</b>	<b>40</b>	<b>11</b>	<b>8</b>	<b>4</b>	<b>453</b>	<b>499</b>						
<b>Harford-Belair</b>													
General	22	13	9	1	2	0	225	100%	93%	0.0	112.5	8%	22%
Intensive	24	16	8	4	1	453	274	92%	91%	113.3	274.0	25%	13%
<b>TOTAL</b>	<b>46</b>	<b>29</b>	<b>17</b>	<b>5</b>	<b>3</b>	<b>453</b>	<b>499</b>						
<b>Key Point</b>													
General	32	21	11	3	2	276	142	96%	96%	92.0	71.0	14%	18%
Intensive	17	13	4	4	2	331	128	93%	91%	82.8	64.0	31%	50%
<b>TOTAL</b>	<b>49</b>	<b>36</b>	<b>15</b>	<b>7</b>	<b>4</b>	<b>607</b>	<b>270</b>						
<b>New Phases</b>													
General	5	4	1	0	0	0	161	100%	56%	0.0	0.0	0%	0%
Intensive	18	11	7	1	2	60	3	99%	100%	60.0	1.5	9%	29%
<b>TOTAL</b>	<b>23</b>	<b>15</b>	<b>8</b>	<b>1</b>	<b>2</b>	<b>60</b>	<b>164</b>						
<b>NBC</b>													
General	34	30	4	7	0	221	0	98%	100%	31.6	0.0	23%	0%
<b>TOTAL</b>	<b>34</b>	<b>30</b>	<b>4</b>	<b>7</b>	<b>0</b>	<b>221</b>	<b>0</b>						
<b>PEP</b>													
General	37	19	18	2	2	71	148	99%	98%	35.5	74.0	11%	11%
Intensive	36	24	12	3	0	282	0	97%	100%	94.0	0.0	13%	0%
<b>TOTAL</b>	<b>73</b>	<b>43</b>	<b>30</b>	<b>5</b>	<b>2</b>	<b>353</b>	<b>148</b>						
<b>VOA</b>													
General	6	6	0	0	0	0	0	100%	N/A	0.0	0.0	0%	0%
Intensive	22	14	8	2	1	5	31	100%	99%	2.5	31.0	14%	13%
<b>TOTAL</b>	<b>28</b>	<b>20</b>	<b>8</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>31</b>						
<b>Baltimore City TOTAL</b>								<b>Average</b>					
General	178	127	51	19	11	2545	742	95%	91%	250	46	15%	22%
Intensive	164	113	51	25	8	2125	758	95%	95%	537	72	22%	16%
<b>TOTAL</b>	<b>342</b>	<b>240</b>	<b>102</b>	<b>44</b>	<b>19</b>	<b>4670</b>	<b>1500</b>						

\* Glenmore Manor (senior housing) 8 beds not included

## **CHILD AND ADOLESCENT SERVICES**

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

- Strategies:
1. Provide opportunities for increased visibility within the community regarding services provided by B-CARS and the CDCP programs.
  2. Participate on B-CARS Advisory Board to monitor challenges and unmet needs related to transition between crisis services and longer term services.
  3. Monitor B-CARS and CDCP's quarterly progress reports.
- Indicators:
1. Documentation of the numbers of children/families served by B-CARS and by CDCP.
  2. Documentation of the number of children/families served by CDCP who have been transitioned to longer-term care.

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

During FY05 B-CARS received 1298 requests for psychiatric crisis services, of which 1160 were deemed eligible for B-CARS services and of those, 569 agreed to participate in an assessment by the Child Mobile Crisis Teams. Of those assessed, 421 children and their families received up to two weeks of intensive services: 398 children and adolescents were successfully served as an alternative to Psychiatric hospitalization, with the remaining 23 receiving B-CARS services as part of an agreed upon step-down plan following inpatient hospitalizations at Johns Hopkins, University of Maryland, or Shepard Pratt Hospitals.

There was a decrease in the number of B-CARS requests received, assessments provided, and services rendered as compared to FY04. This decrease is related to the B-CARS Director needing to shift her efforts away from outside marketing and public relations to cover operations due to a vacancy in the Program Supervisor position.

<b>FY05 B-CARS Referral Sources</b>	<b>% of Total Referrals</b>
Family Members	60%
Baltimore City Public Schools	9%
Hospital ERs	13%
Hospital - Other	5%
Mental Health Agencies	3%
Baltimore City Police	4%
Baltimore City DSS	4%
Department of Juvenile Services	2%
<b>FY05 TOTALS:</b>	<b>100%</b>

The Baltimore Child and Adolescent Crisis System's crisis teams begin planning for transitions to community-based services from the point of admission. During the two weeks of B-CARS service, referrals are made to mental health providers in the community for every client served, with transition back to any providers that had served the families prior to B-CARS involvement. At the closing session, follow-up plans are reviewed with the family and a letter is sent with agreed upon plans and referral contact information for community-based on-going treatment. Assurance of successful connection to on-going services is achieved in several ways. Families may call B-CARS after the end of formal service, if additional assistance is needed, and also Families Involved Together (FIT) provides telephone follow-up to every family one-week and again 20 days after discharge. If any problems with connection to on-going services have occurred, B-CARS will become involved to assure successful linkage to on-going services.

The Child Development Community Policing (CDCP) program responded to 117 calls from the community requesting on site assistance from a trauma response team. The chart below provides composite information about the CDCP trauma responses:

ACTIVITY	YTD NUMBERS SERVED
Type of Violent Event	
? Community Violence	78
? Domestic Violence	15
? Other	11
Children present	
? Ages 0 – 6	20
? Ages 7 & older	137
Referrals Made	
? OMHC	13
? Mentoring	1
? DSS	5
? Case Management	1
? Other	7

In addition to trauma response, CDCP provides various training opportunities to police staff, mental health professionals, and community members. The following chart provides information on the training provided by CDCP during this fiscal year.

TRAINING	YTD NUMBER OF TRAINING OPPORTUNITIES	YTD TOTAL PARTICIPANTS
3 day Fellows Training (Designed to train police, mental health professionals, and community members to be part the trauma response team)	3	11
Training with Police Staff	1	7
Community Forum	24	858

**Objective 2E:**      **Assure the continuity of mental health services and supports for children and adolescents throughout the developmental continuum into adulthood.**

- Strategy:
1. Support the mental health needs of young children as they transition from Head Start to Kindergarten through the use of the Head Start Mental Health Transition Protocol.
  2. BMHS C&A staff participation on the LCC to assure an appropriate level of mental health supports and resources for Baltimore City children and adolescents.
  3. Conduct site visits to in-state Residential Treatment Centers (RTCs) to monitor length of stay and any discharge concerns of Baltimore City children and adolescents in residence.
  4. Provide information about Transition Age Youth (TAY) program to the mental health provider community.

- Indicator:
1. Documentation of the number of children leaving Head Start who is in need of continued mental health services.
  2. Documentation of the number of children who participate in the Local Coordinating Council (LCC) process.
  3. Documentation of the number of site visits to Residential Treatment Centers (RTC) to monitor length of stay and any discharge concerns of Baltimore City children and adolescents in residence.
  4. Documentation of the number of youth referred to the TAY program.

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

During FY05 Head Start Clinicians provided mental health treatment services to approximately 51 four year olds who are eligible for kindergarten in the fall. Of the 51 children who will be eligible for kindergarten, 31 four year olds will continue to need mental health treatment services in the fall; clinical staff worked with those families to identify the best option

for continued mental health services. Options have included transferring the case to a school based mental health provider or providing services at the clinician's home agency. Work has begun on a Head Start Transition Protocol that will be helpful in supporting the mental health needs of families as their child transitions into kindergarten.

Baltimore Mental Health Systems has continued regular weekly participation at the Local Coordinating Council (LCC) to assure an appropriate level of mental health supports and resources for Baltimore City children and adolescents. Additionally, during FY05, BMHS participated in planning for the Family League's new Families FIRST One Stop Center, and has provided training on the Public Mental Health System and mental health resources to assist the Center staff as they began serving families. 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.

Information on site visits to Residential Treatment Centers, as well as number of Baltimore City youth whose cases were reviewed are provided in the following chart:

RTC	# of visits	# of Youths reviewed
Sheppard Pratt-Ellicott City	1	9
Sheppard Pratt-Mann Center	1	11
Good Sheppard Center	0	
Potomac Ridge-Rockville	1	14
Woodbourne Inc.	2	32
Potomac Ridge-Crownsville	2	15
Edgemeade-Upper Marlboro	1	9
The Jefferson School, RTC	0	
New Directions	1	1
Chesapeake Youth Center	1	1
Villa Maria	0	
Pines RTC/ Norfolk, VA	1	11
Advo-Serv/ Bear, DE	1	1
*RICA-Baltimore	0	
*Although no formal Site Visit was conducted in FY05, BMHS staff participated in three case presentations at RICA Baltimore.	Total: 12 site visits	Total: 104 reviews

During FY'05, BMHS staff has been regularly involved in the process for reviewing the Certificate of Need (CON) prior to all children and adolescents receiving final approval for admission to an RTC. Although this process is very demanding of staff time, it has promoted increased telephone communication between BMHS staff and the admission directors of the various RTCs.

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

- Strategies:
1. Collaborate with MHA and the Department of Juvenile Services (DJS) in the continued implementation of court-related mental health services and intensive aftercare mental health service programs.
  2. Continue to collaborate with the juvenile court through the LINKS initiative.
  3. Ensure that the BMHS staff deployed to DJS's Fallsway Center are linked with community providers.
  4. Continue to collaborate with DJS on the development of the wrap-around initiatives for youth with serious emotion disturbance (SED) who have been high-end/high-cost users of the Public Mental Health System.

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

**PROGRESS: This objective was met.**

Baltimore Mental Health Systems continues to provide a Resource Coordinator on-site at the Baltimore City Juvenile Justice Center 2 days per week to provide resource linkage and consultation to judges, masters, public defenders, states attorneys, as well as to staff of other systems (DJS, DSS, and the Baltimore City Public School System) dealing with court-involved youth. This program known as LINKS exceeded its goal for number of children/families served, with a total of 147 served. This year the LINKS program implemented two support groups, one for families and one for girls, which were well attended. The group meetings included dinner, guest speakers, community resource materials and services that empowered each parent to advocate for their child (ren). The girls support group was well attended. The girls participated in job shadowing projects which focused on career oriented goals; they toured various colleges and universities in Maryland, which sparked their interest in higher education; participated in a field trip to Jessup Women's Detention Center and met with the inmates. None of the females involved in the LINKS girls group have experienced any significant problems with the juvenile justice system or Baltimore City Public School system since joining the girl's group. In addition the girls school attendance and grades have improved.

Through the Family Intervention Specialist (FIS) project, which partners with DJS teams in assisting youth to successfully return to the community, a total of 818 youth received services.

During FY05, BMHS worked collaboratively with the chief judge of the juvenile court, Judge Welch and DJS to plan for a court mental health evaluation service that will provide the type of information needed by judges and masters in making appropriate decisions regarding

youth, who appear before them. This Court Medical Evaluation Team (CMET) operated by the Medical Services of the Circuit Court will be in full operation beginning in FY06.

In addition to these on-going initiatives, BMHS participated in a series of meetings with the DJS Behavioral Health Services Director and staff of the Charles Hickey School to plan for BMHS involvement in identifying a mental health program to provide mental health services to youth residing at Hickey. Work on this project will continue in FY06.

For further information on the Wrap-around Initiative please refer to OBJECTIVE 1G.

<p><b>GOAL 3:</b>            Ensure the availability of affordable housing for individuals with psychiatric disabilities.</p>
---

**Objective 3A:**            **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.**

Community Housing Associates and its subsidiaries continue to lease the 88 owned units, and ended the year by administering 161 Shelter Plus Care (S+C) certificates, for individuals who are both very-low income and diagnosed with a chronic psychiatric disability. (BMHS transferred 10 certificates to At Jacob's Well, a provider for individuals with a psychiatric disability.) During FY05, CHA housed 282 individuals and their families, as compared to 271 individuals the prior year.

**Objective 3B:**            **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.**

In FY04, 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 at the

point of annual inspection.

During this year, CHA developed a tracking system to monitor the pass/success rate of units at the point of 90-day inspection. In data collected during FY05, 100% of units passed the 90, 60 or 30-day inspection. No units failed HQS standards at annual inspection.

**Objective 3C:           Inspect 100% of housing operated by residential rehabilitation programs (RRP) to ensure compliance with Code of Maryland Regulations (COMAR).**

Strategies:       Conduct initial, annual and follow up inspections of RRP housing in Baltimore City and report findings to providers and The Office of Health Care Quality.

Indicators:       Number of RRP units, number/percent inspected, type of approvals, inspection reports are issued.

**PROGRESS:           This objective was met.**

Baltimore City has 8 Residential Rehabilitation Programs (RRP). These programs operated 132 housing units with the capacity to serve 350 adults. BMHS' Quality Improvement (QI) staff inspected 100% of the housing units. The overall quality of residential housing in the City is good. Most residences are located in decent neighborhoods, all have access to public transportation and the physical environments are clean and comfortably furnished. Providers consistently complied with the majority of the Code of Maryland Regulations (COMAR) 10.21.22, which govern RRP services. Violations were generally non-serious involving structural repairs and routine maintenance (e.g. painting, carpet, gutters, roofing). As of June 30<sup>th</sup>, QI staff conducted 231 inspections. Inspections consisted of annual inspections and follow up inspections to ensure violations were corrected. Providers were allowed 30 days to make necessary repairs and bring violations into compliance. 114 (86%) of the housing units were granted a general approval (no violations) at year-end. The remaining 18 (14%) units received a provisional approval (repairs needed) at year-end as in these situations; the providers were waiting for supplies or repairs to be done by landlords.

The following table provides a list of the RRP providers, number of housing units available and the results of annual inspections as of June 30, 2005. Detailed reports for each provider are available from the QI division upon request.

Residential Rehabilitation Program Annual Inspections				
Provider	Housing Units	Total Beds	General Approval	Provisional Approval
Alliance	15	46	15	
Harbor City	20	51	20	
Harford/Belair	15	46	15	
Key Point	20	49	13	7
North Baltimore Center	17	34	6	11
Bons Secours New Phases	10	23	10	
People Encouraging People	29	73	29	
Volunteers of America	6	28	6	
<b>Total</b>	<b>8</b>	<b>132</b>	<b>114</b>	<b>18</b>
*Progressive Horizon	1	3	1	0
*Baltimore Crisis Response Inc.	6	12	6	0

BMHS also conducted annual housing inspections for Baltimore Crisis Response Inc.'s crisis beds, Fellowship House and Mosaic Community Services adult group homes for persons with mental illness and Progressive Horizons through a contractual agreement. BMHS used the RRP housing standards. All programs were in compliance for FY'05.

**2. Objective 3D: Interview 33% of consumers in RRP housing in Baltimore City to evaluate satisfaction with housing conditions.**

- Strategies:
1. Conduct one on one interview with consumers living at each RRP in Baltimore City.
  2. Prepare a written report of the interview findings and submit results to providers and BMHS.

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

**PROGRESS: This objective was met.**

Baltimore Mental Health Systems exceeded this objective by 37%. Staff noted there were 347 residents in housing at the time of the annual inspections. The residential specialist interviewed 243 (70%) of the residents. The number of residents fluctuates throughout the year as residents leave housing for various reasons. BMHS staff developed a 23-question survey that addressed a number of issues including resident satisfaction with housing conditions, mental health services, personal safety, and employment and family involvement. Interviews are conducted one on one in a private area as much as possible and participation was voluntary. Overall, residents reported being satisfied with their homes and the services. BMHS residential specialist met with providers during the annual inspection and shared any concerns expressed by residents and followed up with a written report to the program. Sample questions/results from the satisfaction survey are shown in the table below. A complete list of survey questions and answers for Baltimore City RRP residents is available from the QI division upon request.

Residential Satisfaction Survey- Sample Questions and Results				
	N =	Agree	Neutral	Disagree
I am satisfied with the condition of my household furniture.	243	243 (100%)	0	0
I am satisfied with the time it takes to fix things & the quality of repairs.	243	217 (89.3%)	6	20
My family is supportive of me.	243	199 (81.9%)	0	44
I feel staff treat me the same as others in the program	243	239 (98.4%)	0	4
The services I receive are helpful to me.	243	242 (99.6%)	0	1
I have a job and earn a paycheck.	243	48 (19.8%)	1	194 (79.8%)
I feel safe in this neighborhood.	243	237 (97.5%)	2	4
My religious/spiritual beliefs help me cope with problems	243	216 (88.9)	1	26

**GOAL #4: Ensure efficient & accountable financial management.**

**Objective:** Improve the financial stability of Community Housing Associates, Inc.

**Indicator:** Financial statements on an interim basis; FY audits as a final determinant.

Strategy: Continue improvements made in expenditure containment; continue seeking outside sources of funding; continue efforts to expand supporting subsidies. Continue increased board oversight of financial conditions.

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

Community Housing Associates continued another year of improving its financial condition. Given that prior year efforts focused around improvements in internal operations procedures resulted in a more efficient operation, FY05 efforts continued around securing outside subsidies for unfunded units, cost containment in S+C operations and timelier remediation of errors. As a result, CHA applied for HUD subsidies for 46 units, and is in discussion regarding approvals for those, redirected ten S+C certificates to bring program size into a manageable administrative scale, and continues outside fundraising beyond current funders.

Community Housing Associates received a \$300,000 grant from The Harry and Jeannette Weinberg Foundation to support operations within CHA and its subsidiaries. \$150,000 was received in FY'05. Community Housing Associates expects to receive a second (and final) \$150,000 during FY'06.

**GOAL #5: Maintain a quality management program to continuously evaluate and improve Baltimore Mental Health Systems, Inc. and the Public Mental Health System.**

## ADULT SERVICES

**Objective 5A: Collect and monitor the outcome measures for COMAR approved 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. Continue development of outcome measures for OMHCs with the providers.

**PROGRESS: This objective was met.**

The mobile treatment outcomes group continued to meet regularly. The group made a number of refinements to the data collection tool that targeted data reporting in the areas of

somatic care and current housing situation. During the year enrollment in the seven city mobile treatment programs were about 465 individuals at anytime, over 55% of the enrollees were seen 5 or more times a month, only 7% of the enrollees at anytime had a psychiatric hospitalizations and by the end of the fourth quarter over 90% of the enrollees were in stable housing as reported by the providers and of those needing somatic care 94% were seen by a medical provider.

The adult PRP providers met quarterly throughout the year. The participation for PRP programs began the year with 1,531 enrollees which was about 200 individuals or an 11% decrease from prior years. The group felt that this was directly related to the new case rate, which was implemented in February of 2004. By the end of '05 enrollment in PRPs had increased by about 6% to 1,621 individuals. During the course of the year psychiatric hospitalizations ranged from about 4.5-6% for any quarter. Programs reported low rates of homelessness (2%) and incarcerations (less than 1%) for individuals they were serving. Employment rates continue to be low (less than 20%) and this has become a goal for the group as we move into '06.

Supported Employment Program (SEP) providers in Baltimore City continued to meet with BMHS quarterly throughout FY'05. Major changes occurred in the data collection for outcome measures. A new form was drafted and implemented as well as a new discharge form for collecting outcomes after clients have left the program. Besides pre-placement services, the focus was on those working and the specifics of their employment, e.g.: hours per week, salary per hour, type of employment, and job retention. Service utilization continues to grow. Baltimore City SEP providers served a total of 336 persons in FY '05, 157 of those consumers were employed, representing 46% of the total.

The system of authorization also changed for SEP in FY'05 as the paper process was replaced by the on-line authorization for service through the new ASO after the 1st Quarter of the fiscal year. Our one Evidenced Based Practice site for SEP at the Chesapeake Connections Capitation program continues to do very well. It is expected that at least one more site be set to come on board next fiscal year.

**Objective 5B: Provide clinical reviews at 50% 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 and of charts reviewed. 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.

**PROGRESS: This objective was not met.**

Most of the adult high cost users receive RRP services. Many changes occurred in the system from the time this goal was written as previously addressed in Objective C. The lack of data from the ASO impeded our ability to address this goal. BMHS recognizes the value of these clinical reviews and once the data system is reestablished we will continue with our original goal and visit 50% of the RRP's in FY '06.

## **CHILD AND ADOLESCENT SERVICES**

**Objective 5C: Collect and monitor the outcome measures for COMAR approved PRP providers in Baltimore City.**

Strategies 1. Fully implement collection of quarterly reports from Child Psychiatric Rehabilitation Programs (PRPs) serving Baltimore City children and adolescents.

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

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

There have been tremendous difficulties in meeting this goal that are directly related to the new case rate reimbursement structure. A number of Baltimore City PRP programs that have continued to submit the quarterly data, are reporting dramatic reductions in the number of children served by their PRP, since the shift to the monthly case rate and a number of other programs have determined that continuing to offer this service is no longer financially viable.

In spite of the overall poor compliance with submission of the BMHS Child and Adolescent Quarterly PRP report, the available data did point to some encouraging trends. The charts below provides an overview of interesting findings:

	<b>1<sup>st</sup> Quarter</b>	<b>3<sup>rd</sup> Quarter</b>
<b><i>Data item: Children who have had at least one ER visit for psychiatric reasons</i></b>		
For 3 months prior to involvement with PRP services	21%	21%
While actively involved with PRP services	5%	3%
At time of discharge from PRP	7%	0%
<b><i>Data item: Children with reported contact with police</i></b>	<b>1<sup>st</sup> Quarter</b>	<b>3<sup>rd</sup> Quarter</b>
For 3 months prior to involvement with PRP services	21%	13%
While actively involved with PRP services	14%	8%
At time of discharge from PRP	10%	4%
<b>TOTAL NUMBER OF PRPs INCLUDED IN SUMMARY DATA REPORT</b>	10	8
<b>TOTAL NUMBER OF CHILDREN &amp; ADOLESCENTS INCLUDED IN REPORT:</b>	<b>112</b>	<b>157</b>

## QUALITY IMPROVEMENT

**Objective 5D: Monitor utilization and claims data for consumers served in Baltimore City.**

- Strategies:
1. Extract and download claims records from the Administrative Service organization's public mental health system database.
  2. Design a new database to store claims data downloaded from the ASO
  3. Identify reports needed by BMHS and develop customized reports for Baltimore City utilizing and claims data collected by the Administrative Service Organization.

Indicators: Availability of reports, and staff access to database.

**PROGRESS: This objective was not met.**

These reports were not made available by the ASO. APS prepared a limited number of client specific reports and as mentioned before not the aggregate data reports necessary to address this objective.

**Objective 5E: 100% of BMHS contracts will be executed on or before the date services begin (DHMH by July1)**

- Strategies:
1. Vendor contract committee will meet regularly to monitor contracting process and develop strategies for improvement.
  2. Contract monitors will follow up with vendors in a timely manner on contract issues such as, delays in returning documents, budgets, etc.
  3. Conduct annual training for staff to ensure consistency in the implementation of contract procedures.

Indicators: Minutes from meetings, emails, documentation of follow up, training records

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

Baltimore Mental Health Systems issued 136 contracts by year-end. MHA approved funding for 121 contracts and 118 (98%) of these contracts were executed by July 1 2004. The three contracts executed late were a result of logistical issues at the vendor site beyond BMHS' control. BMHS initiated major organizational changes in April 2004 that had a direct impact on contracts. All major monitoring and tracking functions were centralized within the quality improvement and operations division. This resulted in improved accountability and efficiency. The 98% performance on this objective reflects staff's commitment to compliance in this area.

Vendor contract committee met monthly and held several informal meetings to keep the contract process on track. QI Director conducted training for BMHS staff on contract policies and procedural changes to be implemented in FY05.

**Objective 5F: BMHS will establish contractual agreements with vendors who provide quality services and comply with BMHS contract deliverables.**

- Strategies:
1. QI staff will conduct annual and bi-annual site visits to verify actual services delivered and issue reports.
  2. Providers will be required to maintain documentation at the site of services delivered and make available to BMHS upon request.
  3. Program monitors will work with providers throughout the contract period providing technical assistance and ongoing evaluation.
  4. Findings from monitoring activities will be communicated to provider and others as appropriate.
  5. BMHS Board of Directors QI committee will meet and review QI activities.

Indicators: Number of contracts required to submit progress reports/ documentation of services delivered, number of contract complying with requirement, number of contracts in full compliance (Met) by year end.

**PROGRESS: This objective was met.**

Baltimore Mental Health Systems issues contracts for services not funded by the Public Mental Health System's (PMHS) fee-for-service structure. Individuals or agencies providing services did so through written contractual agreements that outlined contract deliverables and performance measures. Most of the funded providers receive a site visit every other year by BMHS QI staff.

During FY'05, BMHS staff conducted 76 annual and bi-annual site visits. Site visit reports indicated that 75(99%) of the providers that had a site visit were found to be in compliance. Staff determined compliance by, reviewing progress reports, supporting documentation, records at the site and interviews with staff and clients when possible. QI staff met with BMHS program director responsible for overseeing the single contract found to have serious performance issues. The program director agreed to follow up with the vendor and take corrective action.

For providers not due for a site visit, had their contacts monitored on a regular basis by BMHS staff. In these situations, staff met regularly with vendors and reviewed documentation

submitted quarterly to BMHS. BMHS has standardized progress reporting and require the majority of vendors to submit the contract Appendix A form that lists contract deliverables, performance measures and reporting requirements. In addition, standardizing provider reporting, provider training and technical assistance has led to improved provider accuracy and timeliness in report submission. The table below summarizes vendor compliance with submission of Appendix A progress reports through June 30, 2005.

<b>Vendor Compliance With Submission of Appendix A Reports*</b>	
Contracts Required to Submit Appendix A	123
Contracts Submitting 100% of Appendix A	116 (94%)
Contracts Submitting 100% of Appendix A: Rated as "Met" or On Target to Meet"	114/116 (98%)
Contracts with Incomplete Reporting	7(6%)

**Objective 5G:**        **BMHS will be in compliance with administrative, fiscal, and programmatic requirements established by funders of Non-DHMH contracts.**

- Strategies:
1.     Develop and implement formal policies and procedures for Non-DHMH contracts that address administrative, fiscal, and programmatic requirements.
  2.     Provide training to staff.
  3.     Vender contract committee will monitor the implementation and effectiveness of new procedures.

Indicators:     Number of non-DHMH contracts, new/revised policies procedures, training, compliance issues.

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

Baltimore Mental Health Systems executed approximately 36 contracts funded by non-DHMH sources including Baltimore City Head Start, Baltimore City Public Schools, Baltimore Community Foundation, Blaustein Foundation, Casey Foundation, Department of Human Resources, Housing and Urban Development, Family League of Baltimore City, Governor's Office of Crime Control and Prevention, Mayor's Office of Employment Development, SAMHSA, and a number of private foundations including the Aaron and Lillie Straus Foundation, the Krieger Fund, the Baltimore Community Foundation, the Abell Foundation, the Blaustein Foundation and the Stuhlman Foundation. Non-DHMH contracts follow BMHS contract's normal policies and procedures.

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

- Strategies:
1. Provide technical assistance to providers submitting applications for new services in Baltimore City and submit recommendations to the Office of Health Care Quality.
  2. Review provider performance improvement plans (PIP) and provides technical assistance as needed.
  3. Monitor providers continued compliance with conditions of deemed status award granted by Mental Hygiene Administration and issue reports.
  4. Conduct at least one training with providers on COMAR related topics identified during monitoring activities or at their request.
  5. Collaborate with Mental Hygiene Administration and MAPS to identify providers who meet established criteria for a site visit. Conduct targeted site visits.

Indicators: Number new applications, OHCQ site visits, approvals from OHCQ less than one year, if approvals greater than one year, performance improvement plans required, training, site visits conducted by QI staff.

**PROGRESS: This objective was met.**

Baltimore City is fortunate that the city has a range of community-based mental health services providers. As of June 30<sup>th</sup>, 93 agencies in the City were authorized to deliver publicly funded community mental health services. These agencies provided a range of clinical and rehabilitation services to children, adolescents and adults. Quality Improvement staff collaborated with the Office of Health Care Quality Mental Hygiene Administration, MAPS-MD and providers in an effort to provide ongoing education and technical assistance focused on improving quality and increasing compliance with regulations. This year BMHS received 18 applications from individuals or providers interested in delivering services in Baltimore City. As of June 30<sup>th</sup> the OHCQ had approved only two of the applications. The remaining 16 applications are pending. Applications may be pending for several reasons such as missing documents, problems with credentialing or staffing or non-compliance with regulations. QI staff reviewed applications within the guidelines required by regulations. QI staff participated in 42(95%) of the 44 site visits conducted by Office of Health Care Quality to evaluate provider compliance with regulations. Eighty-six percent (38) of the providers were required to submit performance improvement plans. The majority of providers were cited for documentation issues unrelated to quality of care. Unfortunately, a small number of providers had serious quality of care violations and billing errors. The high number of PIPs may be related in part to MHA's increased focus on credentialing and billing errors. Providers with more serious deficiencies had less experience (approval 3 years or less) delivering services.

The following table summarizes the type of services in Baltimore City.

<b>Number and Type of Services in Baltimore City</b>	
Adult Group Homes	7
Children Therapeutic Group Homes	3
Mobile Treatment Services	10
Outpatient Mental Health Clinics	58
Psychiatric Rehabilitation Programs (PRP)	78
Residential Rehabilitation Programs (RRP)	8
Residential Crisis Services (RCS)	3
Respite Care Services (RC)	2
Targeted Case Management	7
Partial Hospitalization Program	9
<b>Total</b>	<b>197</b>

**Objective 5I: Implement a compliance monitoring system to ensure COMAR provider are delivering services consistent with Maryland regulations.**

- Strategies:
1. Develop written policies and procedures for compliance monitoring
  2. Develop criteria for selection of providers for site visits
  3. Conduct site visits to COMAR providers in Baltimore City and review medical records and policies for compliance with regulations
  4. Submit reports to the appropriate agencies for follow up as needed.

Indicators: Number of providers/ services, number of site visit, findings from site visit, follow up.

**PROGRESS: This objective was met.**

Baltimore Mental Health Systems collaborated with MAPS –MD, MHA Office of Managed Care Compliance and Maryland Association of Core Service Agencies (MACSA) in developing quality standards for documenting outpatient mental health clinic and psychiatric rehabilitation program services. Draft standards were piloted in Baltimore City. MHA approved the standards for use throughout the state. Compliance audits seek to identify potential Medicaid

fraud or abuse in addition to quality of care issues. The increased focus on compliance resulted in identifying serious billing errors in several programs and the rescinding of payments. In Baltimore City alone three providers were been indicted for fraud and one provider received a prison sentence. QI staff lead the initial investigation in one of the cases based on an anonymous tip and turned the information over to MHA. MHA worked with the Office of Inspector General who determined the findings met the standard of potential fraud and proceeded with prosecution.

**Objective 5J: Monitor and Report Sentinel Events (consumer deaths, level III appeals, complaints, help calls, unusual incidents)**

Strategies: BMHS staff will respond to complaints, help calls, etc. and forward forms to QI staff for compilation and reporting.

Indicators: Number of MHA death reports, demographics, number of complaints, type of complaints, number of help calls.

**PROGRESS: This objective was met.**

The following tables summarize data collected by BMHS throughout the year. Community mental health providers are required to submit death reports if they become aware of that a client had died while enrolled in their program.

FY05 Summary of Consumer Death Reports					
Consumer Deaths	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Total
Total Reported	16	10	23	17	66
Males	8	6	12	8	34
Females	8	4	11	9	32
Cause of Death Known	13	8	18	15	54
Cause of Death Unknown	3	2	5	2	12
Mean Age	51	53	56	53	53

BMHS received only 18 formal complaints in FY05. BMHS worked with the person filing the complaints to resolve it directly with programs whenever possible. Consumers, family members and advocates filed complaints. Example of the type of complaints included quality of services, access to care, housing conditions, rule violation consequences.

BMHS receives numerous requests for information and referral to mental health services. The calls are forwarded to program staff that makes every effort to facilitate linkage to services if applicable.

FY05 Number of Help Calls Received				
1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Total
368	371	441	363	1,543

During FY05 BMHS processed 156 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 were denied by the state's ASO. The majority of the grievances were filed by a large hospital based program and an outpatient clinic. Services that were frequently requested in the grievances were, inpatient and outpatient mental health clinic services. 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. BMHS did not comply with timeliness due to outside psychiatrists not being able to review the documents and send them back to BMHS on time. However, all grievances were processed and responses sent to Mental Hygiene Administration as required.

FY05 Summary of III Level Grievances Received				
	Grievances Received	Grievance Approved	Grievance Denied	Other (Partial authorization or Pending decision)
1 <sup>st</sup> Quarter	84	33	39	12
2 <sup>nd</sup> Quarter	26	17	4	5
3 <sup>rd</sup> Quarter	32	10	15	7
4 <sup>th</sup> Quarter	14	5	7	2
Total	156	65	65	26
Services Frequently Requested	Inpatient Services (95), Outpatient Mental Health Clinics (39) and Psychiatric Rehabilitation Program (20)			

## 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 waivers approved assisted living providers in Baltimore City.
  3. Offer a minimum of 1 workshop for identified providers with 60% participation.

**PROGRESS: This objective was partially 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 most often serve our population, an SSI recipient with a mental illness disability rather than frail elderly. This is an on-going workgroup. However we anticipate that there will be substantive legislative changes in FY '06.

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. The curriculum developed by BMHS for the proposal may be submitted to OHCQ for approval, based on their timeline.

Baltimore Mental Health Systems has not offered a large workshop. We have provided mental health/behavioral training and consultation to 14 individual assisted living providers.

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

Indicator: Number of individuals trained and lists 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.

**PROGRESS: This objective was met.**

Baltimore Mental Health Systems and our crisis intervention program, Baltimore Crisis Response (BCRI) were mobilized during the disaster drill, Harbor Base II, conducted by Baltimore City with participation of the surrounding counties. Mental health service providers from BCRI and our volunteer list also assisted at inoculation clinics set up in response to the mock disaster. During this past winter, Baltimore City Health Department again provided shelter for homeless persons in its operation, Code Blue. BMHS provided mental health professionals to assist the residents with accessing mental health services and with support.

The Mental Hygiene Administration initiated disaster response training for mental health professionals during FY '05. Therefore, BMHS did not offer additional training this year.

**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 that receives 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 met.**

Baltimore Mental Health Systems held their 10<sup>th</sup> Annual Forensic Conference, "Responding to the Scene" on April 8, 2005. The Keynote Speaker was Christiane Tellefson, MD who addressed the clinical interview and interventions for forensic clients. Overall, 148 individuals from both the mental health and legal fields were in attendance.

A major training initiative for case managers and outreach workers was implemented this year. Over 100 mental health workers attended at least one of the three programs presented. The trainings began with a presentation on the role of BMHS and its special programs. Line staff presented information on their education needs and learning objectives. The trainings included:

- ? NAMI's group "In Our Own Voices" was presented by consumers to illustrate their experiences with mental illness and substance abuse.
- ? The AIDS Administration provided AIDS/HIV training. The decision to provide these trainings was made in the beginning of fiscal year 2005; therefore the goal of four trainings per year was not attainable. The total number of workers trained last year was 104.
- ? University of Maryland Walter P. Carter Center staff presented on their philosophy and program for persons dually diagnosed with mental illness and substance abuse.

BMHS trained approximately 800 providers during FY05 in total. The agency issued continuing education credits for social workers, psychologists, and licensed professional counselors. The agency supported continuing education for employees as well providing financial support for 12 employees to attend various conferences or workshops.

**Objective 6D: 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.**

In April Dr. Marta Hopkinson left BMHS and Crista Taylor, LCSW-C was hired to serve as the coordinator of the capitation project.

Regular quarterly meetings were held with the providers during the fiscal year. These meetings focused on areas of clinical concern, managing serious medical issues as well as continuous focus on improving the data system. During the year Dr. Katherine Harrison initiated medical grand rounds at Chesapeake Connections. The FY'04 evaluations were completed and both programs scored an A. Using data through FY'04 the following positive effects of the program were identified:

- ? \$28,356 person/year cost vs. \$180,000 person/year in the state hospital; 50% of enrollees are from state hospital facilities
- ? 7% of total Capitation Program costs are spent on inpatient psychiatric care vs. 18% of the state's mental health budget for community inpatient. Program participants average only 3.38-inpatient psychiatric days/year
- ? 46% of participants hold a job at some point during the year compared to an overall employment rate of less than 15% for individuals with a serious mental illness
- ? An average of 99.4% of participants get housing and stay in it resulting in an almost non-existent homeless population among program participants
- ? 63% of participants live in independent housing compared to 16% in the program's early years; the average retention rate for independent housing is 91%
- ? 84% of participants received regular medical care during '04
- ? Program participants spend very little time incarcerated averaging 1.28-jail days/participant

**Objective 6E:            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 Minkoff-Cline model was introduced to both the Baltimore Substance Abuse Systems, Inc. (BSAS) providers and the BMHS providers. The effort focused on implementing this model in the BSAS programs per the OSI grant. The BMHS programs were invited to a Provider Co-Occurring Networking Fair to establish relationships with the BSAS providers and

to link regarding referrals (per the Minkoff-Cline Dual Diagnosis Competency aspect of the model). All programs were asked to complete the Minkoff-Cline program evaluation, and several did so. Meetings were not held that included consumers and providers.

**Objective 6F: Continue with the grant from Open Society Institute begun in FY 04 to implement screening for mental illness at all grant funded substance abuse clinics.**

**Indicator:** Number of BSAS-funded clinics implementing standardized screening for mental illnesses, number of meetings with the substance abuse providers to build consensus for new screening and assessment procedures, number of training events on best practices and systems change.

**Strategies:**

1. Attend the Directorate, the trade group of Baltimore substance abuse treatment providers' quarterly, to discuss implementation issues and address barriers to implementation.
2. Provide system-wide training events at least quarterly, with smaller trainings provided monthly to substance abuse treatment providers to improve competency and comfort level of clinicians in dealing with mental health issues in their clients.

**PROGRESS: This objective was met.**

The project's consultant met with the Baltimore City Directorate to plan and implement the project as well as meeting with individual providers.

Between February 2005 and the end of June 2005, 13 trainings were provided. Three of these trainings were offered for support staff and 10 for clinical (addictions counselors) staff. Sixty-two (62) staff attended the 3 support staff trainings and 294 were trained in the clinical trainings. These trainings ranged from information on the Minkoff/Cline model, on mental illness in general, and on specific disorders, including a special 4-hour session on trauma that was provided by a trauma expert from Johns Hopkins. Each training was videotaped, and these tapes will be available in a video library for programs to use. In addition, each training has been approved for CEUs for counselors and for social workers.

In mid-April, Dr. Marta Hopkinson left the initiative for another position. Yvonne Perret, the coordinator of the project assumed the primary role and Dr. Ann Hackman, Medical Director, PACT, University of Maryland Medical System, was hired as a training consultant and advisor for four hours/week.

A series of trainings for the first part of '06 was developed. This series will cover, among the topics, personality disorders, psychotic disorders, psychopharmacology, domestic violence, and spirituality. In addition, we are planning for a ½ day-day-long session early next year on cultural competence/cultural sensitivity.

Several on-site trainings have been offered to specific programs that requested them. These were duplicates of some of the trainings offered to the larger community, e.g., Understanding the Public Mental Health System.

At the end of May, a Provider Networking Fair was held. Invited to this fair were all the BMHS and BSAS community providers. Approximately 100 people attended representing both of the system's providers. There was time for meeting and learning about each other's services, and Dr. Annelle Primm on the "Ethnic and Racial Disparities in Substance Use and Mental Health Care" gave a one-hour presentation. Lastly, each attendee received, on CD or floppy disk, an updated copy of the BMHS and the BSAS provider directories for adult services.

Evaluation Plan: Dr. Elaine Swift, from BSAS, worked with a representative committee from BSAS and BMHS to develop a data plan to evaluate the outcome of the use of the Mental Health Symptom Screening Form. Preliminary data for the April 1- June 30<sup>th</sup> quarter indicated that substance abuse providers increased their identification identify individuals at the time of in-take as having a mental health needs by 5%. The data showed 16% of new admissions identified with a mental health need as compared to 11% in previous quarters. Programs continue to be encouraged to do the data entry for this screening but, anecdotally, the programs are definitely finding the screening to be clinically useful.

American Public Health Association Meeting: BSAS staff submitted a proposal to the APHA for a presentation on this initiative at the annual APHA conference in New Orleans in November 2005. The proposal was accepted for a poster session. (Conference changed to Philadelphia in December 2005 because of hurricane.)

**Objective 6G: Provide and/or support opportunities for community education on children's mental health targeted to providers, consumers and the Baltimore City community.**

- Strategies:
1. Provide early childhood mental health training series, which will include at least one session on cultural competency.
  2. Hold informational and training sessions for school-based mental health service providers.
  3. Conduct informational meetings with providers on the Baltimore City child and adolescent PMHS.
  4. Support parent/family advocacy organizations in providing training/educational opportunities for the public on children's mental health issues.
  5. Respond to requests from Baltimore City Health Department or community groups for participation in Health Fairs/Community Resource Fairs.

- Indicators:
1. Documentation of training sessions held.
  2. Documentation of number of provider meetings.
  3. Completion of contract(s) with parent/family advocacy organizations.
  4. Documentation of the number of requests received for a mental health presence at Health Fairs / Community Resource Fairs.

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

Early Childhood Mental Health training series focused on increasing the number of providers with training in providing mental health services to young children and their families impacted by violence. Six additional mental health providers expressed an interest in participating in these training opportunities and becoming part of the Safe Start Network. In order to participate in the network mental health providers agreed to have clinical staff participate in three training opportunities and submit non-identifying data about their program to the Safe Start initiative. Data submission will begin in FY06. Listed below are the training opportunities offered, the mental health providers in the Safe Start Network, and the number of clinical staff who attended each session:

Mental Health Provider	Number of Staff Trained		
	Assessing Young Children Impacted by Violence (5/10/05)	Play Therapy for Young Children Impacted by Violence (5/24/05)	PTSD Preschool Protocol (6/28/05)
Awele Treatment and Rehabilitation Clinic	2	3	2
Center for Infant Study*	0	4	3
Institute for Life Enrichment	3	2	2
Johns Hopkins Bayview Medical Center	12	11	12
Johns Hopkins Children's Mental Health Clinic	3	3	3
Villa Maria	1	1	1
<b>TOTAL</b>	<b>21</b>	<b>24</b>	<b>23</b>

\*Center for Infant Study currently uses the three Safe Start Assessments as a regular part of their clinical practice and staff has been trained on the use of these tools.

In addition to the above training opportunities, two trainings on Sexual Abuse Treatment for Young Children were offered in January and April. Cultural Competency training was offered but was cancelled due to low registrations. This session will be offered again in FY 06 as part of the fifth Early Childhood Mental Health Training Series.

FY05 Trainings for School-Based Clinicians included the following topics:  
 9/1/04 "Wellness for the School-Based Clinicians" presented by Dr. Henry Gregory; attended by approximately 75 persons.  
 4/29/05 "Trauma and it's Impact on Children and Adolescents:"

Practice Models for School Mental Health Clinicians” presented by Kennedy Krieger’s Trauma Intervention Program; attended by approximately 80.

Baltimore Mental Health Systems has continued to provide contract support to both the Maryland Coalition of Families for Children’s Mental Health and for Families Involved Together. These family advocacy organizations were involved in numerous conferences and training presentations including a Transition Conference (October, 2004) and the Children’s Mental Health Conference (April, 2005).

During the FY’05 year, Baltimore Mental Health Systems’ C&A division received more than 100 requests for Mental Health information to be provided at various health fairs. BMHS provided information in the form of brochures from BMHS and from a number of mental health advocacy programs including Mental Health Association of Maryland and NAMI, as well as lists of the various Outpatient Mental Health Clinics that serve children and adolescents in Baltimore City. Whenever possible and appropriate, BMHS also involved B-CARS in providing resource information, doing presentations, and/or staffing a resource table.