LOCAL BEHAVIORAL HEALTH AUTHORITY

FISCAL YEAR 2021 ANNUAL PLAN

PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

Prince Georges Proud

HEALTH DEPARTMENT
Prince George's County

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PART 1: INTRODUCTION

A. INTRODUCTION

The Local Behavioral Health Authority (LBHA) is a government body that is located within the Prince George's County Health Department (PGCHD). In collaboration with the Maryland Department of Health (MDH), Behavioral Health Administration (BHA), the LBHA is designated to serve as the local authority for mental health and substance use/addictions for Prince George's County.

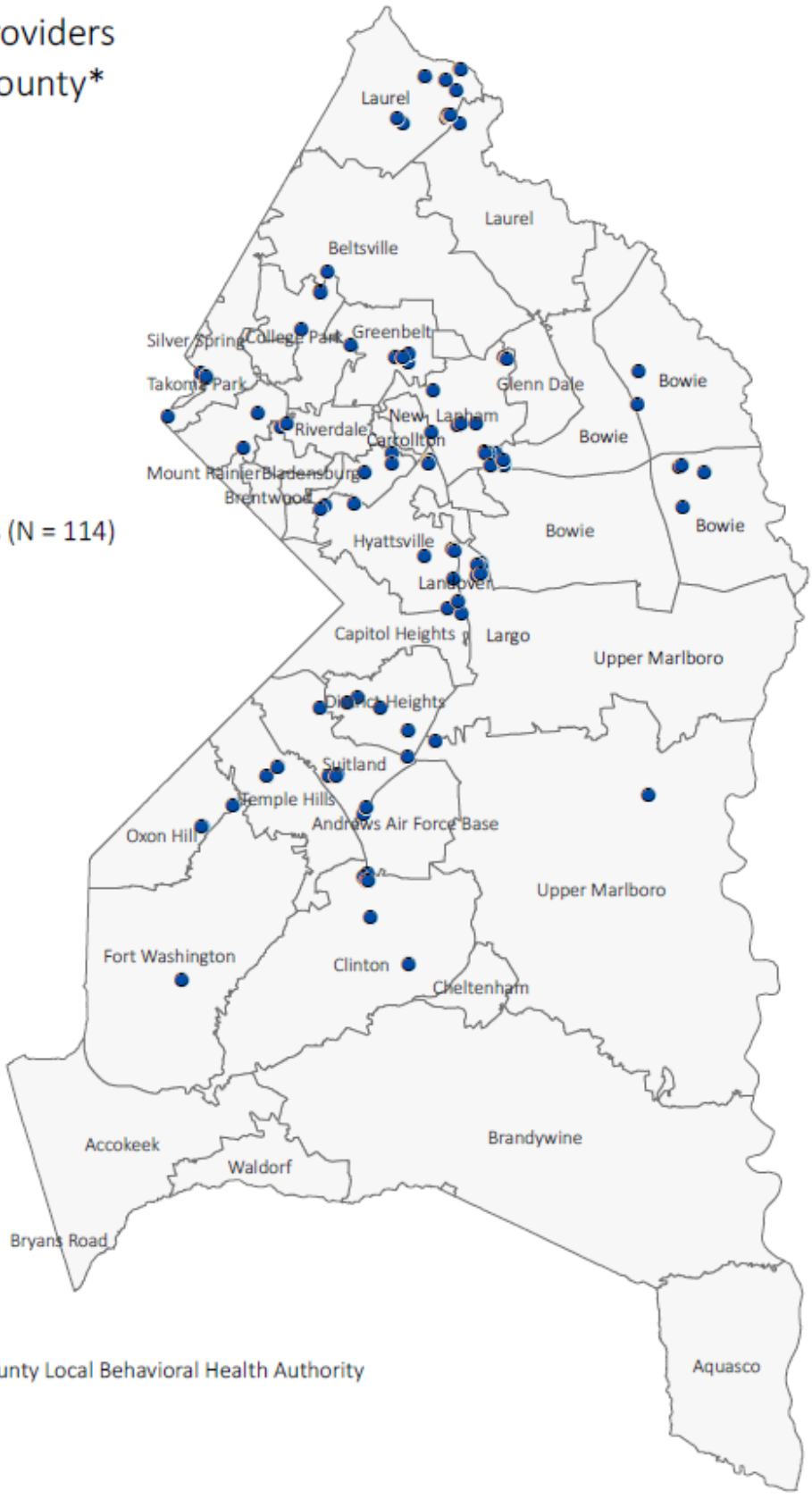
A primary role of the LBHA is planning, managing and monitoring of the publicly funded behavioral health system. The Public Behavioral Health System (PBHS) is comprised of services that are reimbursable via the Medicaid fee for service system. In addition to PBHS oversight, the LBHA awards and oversees grant-funded behavioral health service contracts, which are not Medicaid reimbursable. Other responsibilities include identifying programmatic needs, securing funding and monitoring community mental health and substance use disorder (SUD) providers to ensure that providers are meeting the needs of the community. Through grant funding and participation in state and local planning activities, the LBHA makes certain that a full range of prevention, early intervention, recovery and peer support services are available to address the County's extensive behavioral health needs.

The LBHA provides the technical support, oversight and monitoring of a range of services through resources provided with Federal, State and local funding that improves communication and establishes a system of care for individuals with mental illness and SUD across the lifespan. Public Behavioral Health System services available to residents in the County include:

- Crisis services
- Inpatient services
- Intensive SUD outpatient services
- Methadone Maintenance
- Mobile Treatment
- Outpatient Mental Health Clinic services
- Outpatient SUD Treatment services
- Partial Hospitalization Programs
- Psychiatric Rehabilitation Programs
- Residential Rehabilitation Programs
- Residential Treatment
- Respite Care
- Supportive Employment Programs
- Targeted Case Management

The following map provides geographical representation of all PBHS providers in Prince George's County.

Behavioral Health Providers in Prince George's County*



Behavioral Health Providers (N = 114)

- Provider Location

*As of January 15, 2020
Data Source: Prince George's County Local Behavioral Health Authority

In addition to publicly funded behavioral health programs, the LBHA provides oversight and monitoring of grant-funded programs that offer services for individuals with mental health, substance-related and co-occurring disorders. Through these programs, consumers received services in the following areas:

- America Sign Language interpreters and signing therapists
- Assertive community Treatment (ACT)
- Assisted living for elderly individuals with mental illness
- Care coordination
- County-wide crisis response with mobile crisis
- Emergency psychiatric services and 23-hour hospital observation beds
- Homeless housing and assistance
- In-Home Intervention for Children (IHIP-C)
- Jail-based mental health
- Medication Assisted Treatment
- Mental Health Court case management
- Spanish-speaking outpatient substance use
- SUD assessment and case management for adults
- Outreach
- Peer support and peer recovery support
- Psycho-geriatric nursing
- Transition Age Youth

In 2018, BHA distributed the Local Systems Management Levels of Integration Self-Assessment (LSMSAT) tool that required each local jurisdiction to assess their current level of integration in seven key domains:

1) Leadership and Governance
2) Budgeting and Operations
3) Planning and Data-Driven Decision Making
4) Quality
5) Public Outreach, Individual and Family Education
6) Stakeholder Collaboration
7) Workforce

BHA requires each local authority to draw from the content of the self-assessment that was submitted to ensure that local integration activities are a clear part of the annual plan. It is expected that the self-assessment will guide the LBHA towards continued integration of the behavioral health system. As a result of the self-assessment, the Prince George's County LBHA has identified three systems management areas to focus on that will assist with progressing toward greater behavioral health integration:

- Domain #3 – Planning and data driven decision making;
- Domain #5 – Public outreach, individual and family education; and
- Domain #6 – Stakeholder collaboration.

To guide in the development of the County's goals, objectives and strategies, the LBHA has utilized Behavioral Health Administration's Level of Integration Local Systems Manual Self-Assessment Tool as well as the FY 2019-2020 Cultural and Linguistic Competency Strategic Plan (CLCSP).

B. NEW DEVELOPMENTS AND CHALLENGES

In FY 2018 to 2019, there were new developments, changes and challenges affecting the delivery of behavioral health services in Prince George's County.

State Opioid Response (SOR)

In 2019, Prince George's County was awarded State Opioid Response (SOR) funding to implement a medication assisted treatment (MAT) program in the Prince George's County Department of Corrections (DOC) to treat Opioid Use Disorder while individuals are incarcerated. This was done to address the high incidence of relapse of opioid use and overdose upon release from the detention center. The MAT program in the Prince George's County DOC program offers two tracks and served 72 detainees during FY 2019:

- The first track provides buprenorphine, substance abuse counseling, and clinical reentry connection to additional counseling and medication management upon release.
- The second track provides substance abuse counseling and an initial dose of Vivitrol at detainee's release, combined with clinical case management, counseling and medication management post-release.

The Health Department also received supplemental funding to implement services for House Bill 116 (HB 116) *Public Health - Correctional Services - Opioid Use Disorder Examinations and Treatment* for FY 2020. HB116 establishes specified programs of opioid use disorder screening, evaluation, and treatment in local correctional facilities. Because of the SOR program, Prince George's County is well prepared to have all required components of HB116 in place by the established November 2020 deadline. The biggest challenge for the program is the length of stay for the average participant. Typically, the participant in the MAT program stays no more than 11 days, thus making it difficult to provide continuity of care. Case management services have been limited solely to resource referral. The short-term stay also inhibits the department from enrolling or re-establishing health insurance for the participant.

Under HB116, DOC will continue its existing protocols regarding the MAT program. However, all enrollees will be interviewed so that they will be able to go to a community facility to continue with the medication, substance abuse counseling sessions (both individual and group), peer recovery specialists support, case management services, to include health insurance enrollment, and assistance with accessing community resources (housing, employment, mental health services). The goal is to provide continuing care to Opioid users to prevent relapse, so they can remain sober.

Overdose Data to Action (OD2A)

The Prince George's County Health Department decided to use the Overdose to Action Grant to embark upon strategic planning. The goal of this plan is to continue to provide targeted overdose prevention activities for heroin users, but also broaden the perspective to those who use other drugs such as cocaine and PCP. The preliminary data indicated that the number of individuals who have been dying with cocaine and PCP in their toxicology from the Office of the Chief Medical Examiner (OCME) have been increasing. From discussions around the state and from the overdose fatality review process, it was unclear that these individuals who were dying used opioids as their drug of choice. It was possible that they were people who use drugs (PWUD) who were opioid-naïve and died from fentanyl-laced non-opioid drugs. Therefore, it was identified that overdose activities need to have a broader addiction

focus to target those who use other drugs as well. PCP is a drug that is uniquely endemic to the drug market of Prince George's County and creates a significant degree of morbidity because of the associated aggression and medical complications, although less likely to be fatal. Providers and partners in the opioid prevention area have identified a need for resources for other drugs such as PCP because of these concerns. The LBHA will be assisting with the project.

Community Schools Network (formerly TNI@School Supplemental Insurance Program)

The Community Schools Network began in the 2016-2017 school year to provide counseling services to students in schools, who would not otherwise be able to access mental health counseling services. Through this initiative, supplemental funding is authorized for treatment for students who meet the following criteria:

- Students without insurance coverage accepted by the behavioral health provider in the school; or
- Students that have difficulty seeing a counselor covered by their insurance provider

For the 2018-2019 school year, ten (10) behavioral health providers rendered counseling services to a total of 27 elementary, middle and high schools within Prince George's County. The LBHA has reviewed and authorized 445 requests for services representing a 128% increase in authorizations from the previous school year. TNI@School was also renamed to Community Schools Network in anticipation of further program expansion to 64 schools. Under this initiative, a Request for Proposal (RFP) was advertised in December 2019 seeking additional vendors to provide mental health services for elementary and secondary school students. The Prince George's County school district will oversee the project.

Grants for TAY Youth

The Center for Children was selected as the new Targeted Case Management provider for children and adolescents as part of the RFP process recently conducted by Anne Arundel County CSA in collaboration with the Prince George' County LBHA. The Center for Children already has experience providing Targeted Case Management (TCM) Care Coordination services in several Maryland counties. Anne Arundel County CSA has also recently released an RFP for IHIP-C as part of the Crownsville Project. Prince George's County youth and families will benefit from these services.

The Health Department, with the Department of Social Service (DSS) as a partner, applied for and received another four-year SAMHSA SOC Expansion Grant, specifically geared toward transitional age youth (TAY). The grant will focus on sixteen to twenty-four year olds and will strive to provide services that are developmentally appropriate and seamless. The goals for the new grant are to:

- Enact local policies that mandate youth-guided input, service integration and coordination, cultural and linguistic competency, and linkage to health care reform to improve accessibility and availability of services for TAY;
- Increase the number of behavioral health providers working with the TAY age group;
- Enhance the capacity of behavioral health, education and social service providers to address the unique needs of TAY;
- Increase the involvement of TAY in the development and design of services; and

- Increase the number of TAY receiving developmentally appropriate behavioral health and wraparound services.

In FY 2019, the Prince George's County Health Department and the Department of Social Services received a Policy Advancing Transformation and Healing grant from the Center for Law and Social Policy (CLASP) located in the District of Columbia. CLASP is a national non-profit organization that offers state and local agencies and system leaders in mental health, human services, youth, and aligned sectors an opportunity to partner with experts around the country to advance policies that support transformation and healing for TAY (ages 16-17) and young adults (ages 18-24) in low income communities. The work performed under the CLASP grant was intended to help prepare the LBHA and DSS to be able to implement a new SAMHSA System of Care (SOC) Expansion Grant for transitional age youth and a HUD-funded Youth Homeless Demonstration Project (YHDP) grant, while integrating the efforts between the systems.

The CLASP grant established three (3) main goals as a guide through the end of FY 2019 and into FY 2020. The goals are as follows:

1) Align eligibility criteria and definitions across the child and adult systems to reduce gaps and barriers for young people currently accessing services;
2) Deliver training and technical assistance to local behavioral health, education and social service providers to enhance county-wide capacity to address TAY needs in a culturally/linguistically competent, and developmentally appropriate manner; and
3) Develop and begin to implement a cross sector, system wide youth engagement strategy focused on system capacity to address social determinants of health.

<u>Office Based Opioid Treatment</u>

Two (2) Office Based Opioid Treatment (OBOT) providers began services in Prince George's County during FY 2019. OBOTs provide outpatient treatment services outside of Opioid Treatment Programs (OTPs) and typically include a prescription for buprenorphine. The addition of these providers has increased network availability in the County, providing county residents easier opportunity to receive medication assisted treatment (MAT) for opioid users.

<u>Improvements to Behavioral Health Services in Local Hospitals</u>

To improve behavioral health patient care, changes are occurring within the Prince George's County hospital system. The University of Maryland Capital Region Health (UMCRH), formerly Prince George's Hospital Center, has increased inpatient psychiatric adult beds from 28 to 32. To assist with providing comprehensive care to those presenting in the emergency room, a Screening, Brief Intervention and Referral to Treatment (SBIRT) team was added to the UMCRH emergency department and another SBIRT team is expected to begin in two additional hospitals, Bowie Health Center and Laurel Regional Hospital. Both Bowie and Laurel will also have tele-mental health options. The three hospitals are the largest hospitals in Prince George's County, making it vital to continue to develop their behavioral health services to enhance access to integrated care and promote recovery.

A new hospital is being built in Largo, Maryland and is expected to be open to the public in April 2021, replacing the UMCRH in Cheverly. The new location is accessible by all means of transportation. The

hospital will include 28 adult beds and six (6) medical detox beds. Lastly, the acute psychiatric observation unit will have seven (7) total beds with two (2) dedicated to children.

Administrative Services Organization (ASO) Transition

In July 2019, Optum was awarded the Administrative Service Organization contract with Maryland Department of Health, replacing Beacon Health Options as Maryland's ASO. As of January 1, 2020, Optum went live, in which the primary focus remains authorization and payment of services for providers serving consumers in need of behavioral health services. One of the changes implemented with Optum is to eliminate Maryland Recovery Net (MDRN) support funds reimbursements via the ASO. Instead, the Behavioral Health Administration (BHA) assumed the task of reimbursement for MDRN expenses until the funds are distributed to the local authorities as grant funds in July 2020. At that point, the local authorities will reimburse for MDRN consumer support expenses. This may be a challenge for some local jurisdictions and system-wide consistency would be enhanced if this was handled by the ASO.

Several providers in Prince George's County reported difficulties transitioning from the former ASO to Optum, citing specific difficulties with reimbursement, inability to get in contact with the ASO to ask questions and resolve issues, and difficulties receiving electronic communications. The LBHA will continue to offer support to providers during this transition by coordinating provider/ASO trainings and following a streamlined process for communicating all concerns to the ASO and BHA.

Challenges

The LSM Self-Assessment, previous described in the introduction section, identified separate funding streams at both the state and federal levels for oversight of mental health and of SUD/addiction activities, which remains a barrier to taking integrated approaches. Through the guidance of a consultant team working on BHA's System Management Integration project, recommendations were made to support the LBHA's continued progress.

Prince George's County had three (3) MCORR Certified Recovery Residences in FY 2019. The LBHA attempted to contract with the two (2) of the three (3) certified recovery residences for FY 2019 but progress towards that goal was stalled due to the need to provide the potential providers with technical assistance regarding the contract process requirements. Currently, of the three MCORR Certified Recovery Residences, only one (1) remains certified. The County will attempt to enter into a contract for FY 2021 with the remaining MCORR Recovery Residence.

One of the recovery residences that closed is in the process of becoming a Level 3.1 residential treatment service provider. As more providers have become willing to provide residential treatment, however, it has been a challenge for them to obtain Medicaid (MA) provider numbers so they may open their doors to the community to provide the needed service. This serves as a major roadblock for both providers and clients.

During FY 2019, one of the two Prince George's County TCM providers decided to cease the provision of TCM services. All clients were seamlessly transferred to existing provider without incident. As mentioned previously, a new TCM provider for care coordination has been selected as part of the RFP

process in collaboration with Anne Arundel County. The TCM Request for Applications (RFA) for adults was also issued locally under separate cover in January 2020.

There is a need for more bilingual behavioral health professionals in Prince George's County. After surveying the PBHS providers, it was discovered that less than 15% (17/114) had a therapist or behavioral health staff member that provided services in a language other than English. According to the American Community Survey 2013-2017 5-Year estimates, 14.4% of residents in Prince George's County report speaking Spanish at home and of the 14%, 55.7% report Limited English Proficiency. The LBHA collaborated with an epidemiologist to map services to identify where gaps exist. This information will be used for further system planning.

Obtaining proper documentation in order to get a Real ID has been a statewide challenge for consumers in Residential Rehabilitation Programs (RRP). Valid identification is vital for consumers to access their entitlements, and in October 2020, it will be mandatory for all Maryland residents to become Real ID compliant. Two documents that show the consumers' current address is required by the Motor Vehicle Administration (MVA), which RRP consumers do not possess the required documentation. To rectify this issue, the LBHA has mailed a letter addressed to the consumer to the RRP program where the consumer resides. The consumer can then use that document to show proof of address.

C. LBHA ORGANIZATIONAL OR REORGANIZATIONAL STRUCTURE

Process used to evaluate the need for change in the organizational structure

Effective July 2014, the Core Service Agency (CSA) and Local Addiction Authority (LAA) merged to become the Local Behavioral Health Authority to combine the oversight and management of publicly funded mental health and substance use/addiction services. The plan for integration of the CSA and LAA was encouraged by BHA and local jurisdictional leaders and had no adverse effect on stakeholders. Stakeholders have been supportive as the purpose for integration is to develop a culturally and linguistically competent comprehensive system of care, ultimately providing consumers with a "no wrong door" experience, regardless at what point they enter treatment. In 2018, the LBHA completed an initial Local Systems Management Integration Self-Assessment, which resulted in the identification of key areas the LBHA needed to target to reach full integration. In October 2019, to show progression toward integration, the LBHA has updated the assessment tool and will continue to do so on an annual basis, per BHA's directive. Efforts to reach full systems integration will be ongoing.

LBHA Organizational Structure

The Local Behavioral Health Authority (LBHA) is located within the Prince George's County Health Department. In January 2017, the Health Department fully integrated the Addiction and Mental Health Authority's functions. The Local Addictions Authority (LAA) staff were placed under the Core Service Agency (CSA) Director, whose working title was changed to LBHA Manager. The LBHA Manager provides leadership and oversight to the staff and functions of the LBHA. The LBHA Manager reports directly to the Deputy Health Officer.

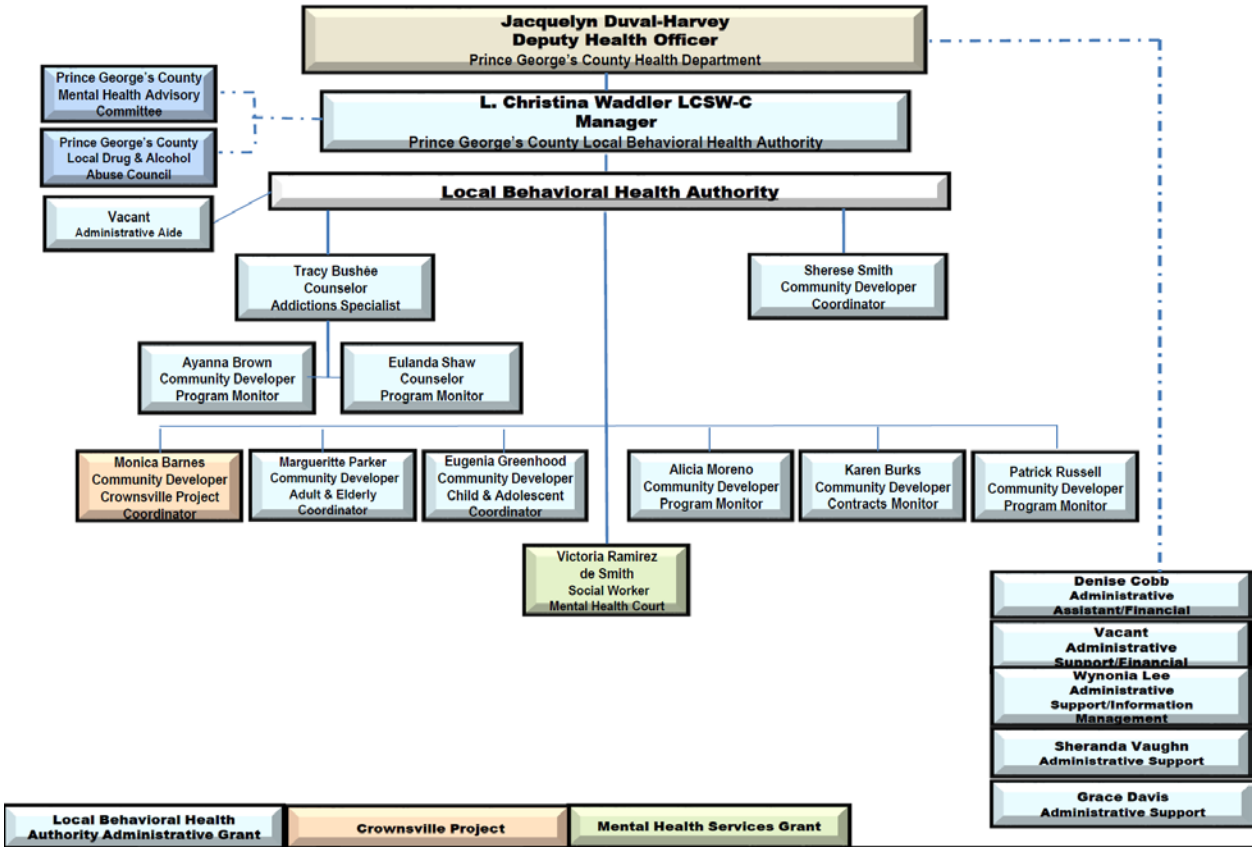
The LBHA staff consists of a Manager, Assistant Manager, Addictions Specialist, Adult and Elderly Coordinator, Child and Adolescent Coordinator, Contracts Monitor, four Program Monitors, Crownsville Project Coordinator and an Administrative Aide. There are also four administrative and fiscal support staff and a Contract Specialist.

The LBHA works with the Mental Health Advisory Committee (MHAC) to review the needs of the behavioral health system, evaluate existing services and participate in the development of the LBHA Annual Plan. The LBHA is in the process of obtaining approvals for the new members identified for the Local Drug and Alcohol Advisory Committee (LDAAC). The LDAAC will then be merged with the Mental Health Advisory Committee (MHAC) to form the Behavioral Health Advisory Committee (BHAC).

The Opioid Intervention Team (OIT) has LBHA representation, but is not under the purview of the LBHA. OIT is a combined meeting along with the Drug Overdose Fatality Review Team (DOFRT). LBHA representation provides feedback to DOFRT to facilitate improved coordination and collaboration between member agencies/entities.

Organizational Chart

The following organizational chart shows the structure of the LBHA within the County's Health Department. It includes classifications, working titles and funding sources.



D. FY 2019 HIGHLIGHTS AND ACHIEVEMENTS

System Management and Coordination Activities

In FY 2019, the LBHA continued to focus on strengthening the behavioral health provider network and promoting the integration of mental health and substance use disorder (SUD) services, while managing the number of new community-based providers, ensuring the provision of quality care and investigating complaints.

In FY 2019, public behavioral health system (PBHS) services were provided to over **29,035** residents accessing mental health services and SUD services. Prince George's County serves the third largest public behavioral health population in the state of Maryland behind Baltimore City and Baltimore County.

The LBHA plays a vital role in assisting potential community-based providers (in the Medicaid funded Public Behavioral Health System) through the application process for state licensure. The number of behavioral health providers operating PBHS programs continued to grow substantially from FY 2018 to FY 2019. The LBHA entered into agreements with an additional 19 behavioral health providers, increasing the number of providers from 100 to 119 and the number of PBHS programs available to residents to over 250.

LBHA is working to develop staff capacity to coincide with the growing number of behavioral health programs and consumers. The LBHA hired an additional program monitor to enhance program management and quality assurance.

Public Behavioral Health System (PBHS) Services and Total Number Served

In addition to managing the PBHS, during FY 2019 the LBHA monitored the implementation of 35 behavioral health grant contracts (32 mental health contracts and 3 SUD contracts) and assisted with the implementation and monitoring of the final year of the System of Care (SOC) Expansion grant activities, which included six (6) contracts. A selected few of those grant-funded programs are highlighted below along with additional LBHA activities for FY 2019.

Substance Abuse Treatment Outcome Partnership (STOP)

STOP has services and supports that promote recovery, resiliency, health, and wellness for individuals who have or are at risk for emotional, substance-related, addictive and/or psychiatric disorders. During FY 2019, approximately 160 clients received coordinated services during their hospital admission. Additionally, naloxone training via hospital bedside was made available to clients with substance abuse history with the goal of increasing harm reduction and preventing potential opioid overdoses.

Opioid Related Services

The LBHA is represented on the Opioid Intervention Team (OIT), which is a part of the Opioid Operational Command Center (OOCC). Specific outcomes from OOCC activities included providing services to 148 non-fatal overdose persons and 136 families, distribution of 285 Naloxone kits, and dissemination of over 1,500 flyers, posters and brochures throughout the community.

Expanding Service Array

Two (2) new SUD residential treatment centers became licensed to provide Level 3.1 and 3.3 services in southern Prince George's County, helping to expand network adequacy.

Crisis Services

In FY19, the Prince George's County LBHA, utilizing state and federal grant funds, continued to ensure Prince George's County residents have access to an array of crisis services. The crisis services programs assist with diverting individuals from unnecessary hospital admissions and involvement with the justice system by providing mental health services to residents who experience or witness a mental health crisis, identifying appropriate community resources and ensuring that residents are connected to services. Services include emergency psychiatric evaluations and crisis observation beds to uninsured persons presenting in the emergency room at University of Maryland Capital Region Health and the County's Crisis Response System (CRS).

- The Crisis Response System answered 8,576 calls for assistance and followed up with 1,974 callers, 498 involved children under the age of 18. Mobile Crisis Team diverted eighty-four percent (84%) of persons served avoiding inpatient hospitalization and detention.
- The Crisis Intervention Team (CIT) held four (4) CIT trainings designed to improve interactions between first responders and individuals with mental illness. There were 94 first responders trained with representation from the County Police, Sheriff's Department, Department of Corrections, Park Police, Parole and Probation and Fire/EMS.
- Emergency Psychiatric Evaluations were conducted for 325 individuals presenting at University of Maryland Capital Region Health. Forty percent (40%) of individuals who received EPS were diverted from inpatient admission.

Efforts to Prevent Homelessness and Provision of Housing Resources

Assistance in Community Integration Services (ACIS) program is an initiative of the State of Maryland's Medicaid 1115 Health Choice Waiver. The Prince George's County ACIS Program serves high-risk, high-utilizing Medicaid enrollees who are at risk of institutional placement or experiencing homelessness. ACIS is focused on addressing the needs of the County's familiar faces that cycle in and out of multiple systems with chronic health conditions, mental illness, addictions and a history of incarceration and/or experiencing homelessness. Working with community partners, ACIS serves individuals who are Medicaid eligible with the goal of providing low or no barrier stable housing, and well-integrated medical care with wrap-around services. The LBHA Adult Coordinator serves as a member of the ACIS Steering Committee, which meets twice per month and includes case conferencing. All ACIS referrals must come through the Health Department, or one of its partner entities.

Through the Homeless ID Project, the LBHA was able to process applications that enabled individuals to receive birth certificates and identification cards. Upon receipt of the birth certificates and identification cards, it is the expectation that individuals who are experiencing homelessness will be able to access behavioral health services, entitlements and other community supports. Prince George's County utilized the Homeless ID Project Fund to provide 103 state IDs and 25 birth certificates to individuals experiencing homelessness while living with mental illness in the community. LBHA staff conducted four (4) presentations essentially helping to spread the word about this project. The outreach resulted in a 66% increase in the number requests from FY 2018 to FY19.

Other housing supports and homeless prevention efforts:

- There are six (6) community providers that operate 398 Residential Rehabilitation Program (RRP) beds. The LBHA reviews applications from community programs and state hospitals and manages the extensive waitlist. State hospital referrals receive priority.
- The homeless outreach program served 179 individuals experiencing homelessness with mental illnesses linking 115 persons to behavioral health services. Sixty-six (66) individuals received stable housing while in the program.
- Projects and Assistance for Transitional Housing (PATH) provided behavioral health and housing services to 85 individuals.
- Continuum of Care (CoC) housing program provides rehabilitative services and supportive services to those with behavioral health diagnoses and forensic backgrounds. The program housed 19 individuals and 16 families.

Behavioral Health Supportive Services

State Care Coordination (SCC) services are designed to help target high-risk individuals in SUD treatment to remain engaged in their recovery and promote independence and self-sufficiency as they enter the recovery community. A care coordinator works with the consumer to identify health care and recovery support needs and initiate any referrals to supportive services. SCC continues to trend upwards in individuals served. In FY 2019, the SCC program served 537 people, an almost 20% increase from the number of individuals served in FY 2018.

SUD community case management services were provided to over 600 county residents. Services included helping clients get connect with benefits, obtaining necessary medical services and enrolling in residential treatment.

Children, Adolescents and Transition Age Youth Services

Twelve families were served in the In-Home Intervention Program where children and adolescents received intensive in-home behavioral health services. Consumer satisfaction surveys distributed to families yielded a 94% overall satisfaction for IHIP-C services.

In the fourth and final year of the System of Care (SOC) Expansion Implementation Grant, mobile response and stabilization services, family and youth peer support, respite care, in-home intervention for families and other services continued to be available to children and families in the County. Emphasis during this year focused on a media campaign (STEP FORWARD: Empowering Young People, Adults, and Families to Live Healthier Lives) that involved a host of community partners, county agencies, and advocacy organizations to make it the brand name for all promotions in the Health Department's Behavioral Health Services Division.

In FY 2019, there was an increased collaboration with the school system due to new legislation requiring behavioral health access for students. The STEP FORWARD campaign was used to educate and inform school personnel and youth Board of Education members at meetings and during in-service training days about mental health and wellness of families and children. In addition, Health

Department staff and Maryland Coalition for Families (MCF) peer support specialists provided informational presentations and trainings to students and families about mental health.

The Health Department was able to enter into a contract with a vendor for a customizable telehealth platform to provide telehealth and mental health services to children with behavioral health needs. The vendor will create a HIPPA-compliant, cloud-based audio/video telehealth platform for broadcasting prevention programs and consultation in identified school sites that are part of the county-wide Community Schools Network initiative.

Older Adults and Long Term Services and Supports

The LBHA Adult and Elderly Coordinator continued to work closely with the Preadmission Screening and Resident Review (PASRR) specialist for the Maryland Southern region to include Prince George's, Anne Arundel, Calvert, Charles, and Saint Mary's counties. PASRR specialist conduct evaluations for mental illness or intellectual disability for all applicants to help ensure that individuals are not inappropriately placed in nursing homes for long term care. This fiscal year, the LBHA coordinated a PASRR training where attendees included behavioral health providers and individuals who work with the older adult population.

Justice-Involved

Through the Maryland Community Criminal Justice Treatment Program (MCCJTP) jail based treatment program, the Prince George's County Department of Corrections provided mental health evaluations and treatment to 750 inmates.

The LBHA continues to fund a social work position (half-time) located at the District Court of Maryland to support the ongoing operations of the Mental Health Court (MHC). The MHC serves individuals with mental illness who have misdemeanor charges. Mental Health Court served 147 individuals, and 73% (108/147) of the clients served were not re-incarcerated for non-compliance with MHC mandates.

Through the Jail-Based Substance Abuse Treatment (JBSAT) program 562 clients received treatment, exceeding the target number to be served by 362. The target for the number of clients assessed was also exceeded by 24%, as there were 373 clients assessed. The program received no audit findings for the fourth year in a row from the BHA.

The Court Assessment & Case Management program provides behavioral health brief screening, referral and limited case management (linkage) to persons who are referred by the Department of Parole and Probation. The case manager ensures that each participant receives appropriate services that are needed and can act as a liaison between the court, the participant, the other participating agencies, and service providers. The Assessment and Case Management Unit consists of a Clinical Supervisor and three (3) counselors. In an effort to increase the number of clients screened, walk-in's were screened and Parole and Probation staff were provided education on community programs that offer services for persons with legal involvement. This activity led to 192 clients screened including 34 8-505 assessments, exceeding the target by 10%.

Evidence-Based Programs/Services

The Assertive Community Treatment (ACT) program is an evidenced based model that provides multidisciplinary, comprehensive, flexible treatment and support to individuals with severe and persistent mental illness, as well as those with co-occurring disorders who are at high risk for psychiatric hospitalizations or criminal justice involvement due to their mental illness. The ultimate goal is recovery. There were 106 consumers who received ACT services in FY 2019. Consumer satisfaction surveys yielded an 81% overall satisfaction rate. The ACT provider has placed 33 individuals in the Crownsville/5-County Project Housing Subsidy slots.

SSI/SSDI Outreach, Access and Recovery (SOAR) assists with expediting the receipt of SSI eligibility benefits for eligible mental health consumers. The program had an 86% approval rate in SOAR applications filed. The program also secured $86,281 in retroactive payments, annual income awards and monthly benefits, assisting to expedite the receipt of SSI eligibility benefits for eligible mental health consumers.

Wellness, Recovery, Peer Support and Advocacy

On Our Own (OOO) of Prince George's County hosted an open house after moving to their new site after a tragic fire left their space uninhabitable. OOO held 57 One on One Peer Support sessions, 84 social activities, 19 in house informational sessions for participants and 10 community outreach events.

NAMI Prince George's County made strides in educating the community on mental health matters. NAMI presented and/or sponsored 26 educational events with one being focused on the Latino community, and participated in 28 Health Fairs and Expos with three focused on the Latino community. NAMI held 80 Family Support Group sessions in locations throughout the County and 71 Peer Support Group sessions. Additionally, NAMI presented two Family to Family 12-week educational courses and two NAMI Program Leader trainings.

During FY 2019, nine (9) Peer Recovery Specialists (PRS) provided services to approximately 630 clients. Four (4) Certified Peer Recovery Specialist (CPRS), averaged approximately 156 client contacts per month. The average caseload for each PRS is approximately 35 clients. The team supported their clients in Intensive Outpatient Program sessions, NA/AA meetings, and employment searches. They served clients by escorting them to various appointments, including inpatient facilities and court proceedings.

The Peer Recovery Specialists, in conjunction with the Naloxone team, participated in the Police Ride Along program where peer recovery specialists accompany police to addresses where EMS were dispatched for possible overdose. They administered approximately 270 Narcan trainings throughout the county. Each person trained received a Narcan kit. Kits were distributed in homes, stores, and throughout the communities. The team also participated in the 2019 Chesapeake & Potomac Regional Convention of Narcotics Anonymous and supported a local outpatient center in their health fair (the 2nd Annual National Recovery Month Community Cookout). As a part of the Naloxone Team, they trained approximately 30 community residents.

The Adolescent Clubhouse is a recovery-oriented program that provides recovery support and continuing care for youth ages 12 – 17. Adolescents appropriate for admission receive SUD treatment,

including for opioid use disorders. The Clubhouse had major accomplishments in FY 2019 that included 22 completed intakes and serving 151 unduplicated clients. There also were 6,485 peer encounters and 709 visits completed per month. Nine (9) participants obtained part-time jobs while enrolled at school and two (2) of the Recovery Clubhouse youth graduated from high school and have enrolled in higher education.

The Clubhouse took participants on field trips to a wide variety of places and participated in a mental health campaign. Staff attended several community outreach fairs to promote the Adolescent Clubhouse during Recovery Month. The Clubhouse also provided The Strengthening Families Program where six (6) parents and 13 youth participated. Outreach included several community fairs in nearby schools and conducted presentations to promote the program in the community.

Special Population Groups

Services were provided to consumers who are deaf and hard of hearing and in need of mental health services. Signing Therapists services were provided to 49 individuals in an Outpatient Mental Health Center, Psychiatric Rehabilitation Program and Residential Rehabilitation Program. American Sign Language (ASL) Interpreters provided 426 hours of ASL interpretation to 143 program participants.

Psychogeriatric services were provided to assist 34 elderly and/or medically fragile individuals in their homes by providing medically trained staff, a registered nurse and Certified Nursing Assistants to provide education and care to individuals within the Residential Rehabilitation Program (RRP) setting.

During FY 2019, 35 clients actively received Pregnancy/Post-Partum Recovery Services, assisting them with overcoming challenges, such as unstable housing situations, mental health crises, homelessness and lack of entitlements. The commitment, time and determination of the Pregnancy/Post-Partum Specialist enabled staff to provide a level of support that was instrumental in helping the clients remain sober-free during their times of high vulnerability.

E. PLANNING PROCESS

Collaborative Efforts with Providers to Ensure "No Wrong Door" Experience

The work of the LBHA is geared towards building partnerships with providers and key stakeholders to ensure that consumers will have a "no wrong door" experience. The LBHA works to educate the providers about what services exists, assists them with obtaining licensure for integrated behavioral health services programs and equip them with the necessary resources to ensure that individuals are connected to the services needed regardless of what point they access treatment.

The Department of Social Services (DSS) utilized the LBHA's quarterly SUD provider meeting as platform to strengthen lines of communication between DSS staff and the SUD providers. The goal is to keep the identified individuals in SUD treatment beyond the case being closed by DSS.

Additionally, the LBHA provider meetings (i.e. Quality Improvement Interagency Committee and SUD Provider meetings) are held regularly and as a vehicle to educating providers about existing organizations and services, as well as state and local policies and initiatives. Provider meetings are used as a platform to present information about all community resources and for providers to collaborate with each other regarding best ways to connect with consumers. In 2020, the LBHA hosted five (5) virtual provider meetings, two (2) for mental health providers, two (2) for SUD Providers and one (1) for all providers. The purpose of these meetings are to network and create integrated partnerships.

The Network of Care (NOC) is another mechanism that continues to be a resource for consumers and family members, enabling them to quickly locate local behavioral health programs and make informed choices about what services they need. The LBHA screens providers who request their program information to be placed in the NOC database and ensures up-to-date and accurate information is available to consumers. New providers are encouraged to participate by submitting a request for their program information to be added to the network. In FY 2019, the LBHA worked with the NOC Content Manager to reorganize the site and streamline search categories making PBHS services more accessible to users. Similarly, the Health Department has created an online behavioral health locator of all county providers, where individuals seeking services can easily see all the providers in a selected area. Recently a county request has the LBHA working on a process that will keep the website current.

The Local Behavioral Health Authority is often the first point of contact for individuals seeking behavioral health resources. When contacted by consumers requesting information regarding services, warm hand-offs are completed to ensure consumers are directly connected and to promote collaboration between agencies. We continuously strive to improve our ability to assist consumers by obtaining appropriate resources, developing our provider network, and thereby allowing consumers to have access to an improved continuum of care. Collaborative efforts with community providers and stakeholders minimizes barriers that prevent access to treatment and recovery supports, and strengthens the continuity of care.

Investigating Provider Complaints and Enhancing Contract Monitoring Functions

The LBHA has been restructured to address the number of licensed PBHS programs and grant contract responsibilities, which continue to grow. While the number of staff responsible for investigating provider complaints and monitoring contract functions has remained relatively the same over the years, the LBHA hired a fourth program monitor in June 2019 to assist with the oversight of the growing number of providers and programs. This new position, along with the other program monitors will also be responsible for site visits to the grant funded programs and will handle investigation of all complaints. Bi-monthly program monitor meetings were implemented during FY 2019 for monitors to have a platform to collaborate with one another to more effectively address provider relations and investigate/resolve complaints.

The LBHA Contracts Monitor provides ongoing oversight of grant-funded services and technical assistance to sub-grantees to ensure compliance with the Conditions of Award (COA). Beginning in FY 2021, each sub-grantee contract will contain the COA as an attachment to ensure each condition is included in the agreements between the LBHA and sub-grantee. The contracts with the sub-grantees will continue to include requirements of Prince George's County government. To further improve

contract monitoring functions, the LBHA began requesting supportive documentation to accompany grant-funded programs invoice submissions, such as receipts and timecards for staff.

Planning Process Used to Identify Unmet Needs and Gaps

The planning process used to identify unmet needs/gaps included scheduling internal planning meetings, participation in various community planning workgroups and encouraging involvement of the Mental Health Advisory Committee.

Comparable to the process utilized in FY 2019, the LBHA hosted two planning meetings in FY 2020 to engage all LBHA staff in the planning process. Staff identified challenges as well as strengths observed within the behavioral health system in the County throughout FY19.

Additionally, the LBHA completed an organizational Cultural and Linguistic Competency (CLC) assessment in FY 2019 to identify needs, gaps, strengths and priorities to meet the cultural and linguistic needs of all individuals and families served in the PBHS. The LBHA was tasked with using the National CLAS Standards as guidelines for developing this year's Annual Plan and a CLC strategic plan, referred to from hereafter as the CLCSP. The CLCSP will be used to develop strategies to improve CLC competency.

The LBHA staff and Mental Health Advisory Committee (MHAC) Chair and Co-Chair continue as active members of the Behavioral Health Advisory Group (BHAG), Prince George's Health Action Committee (PGHAC) and numerous other community behavioral health workgroups and committees. The MHAC Committee met on six occasions, where feedback was obtained on the adequacy of the County's publicly-funded behavioral health services. Appendix A contains a complete listing of all collaborative efforts in FY 2019.

Plans to Engage Stakeholders in Planning and Evaluating Program Services

The LBHA will continue to utilize the MHAC, BHAG and the Assessment and Education subcommittee of the PGHAC for stakeholder input. These groups are made up of community partners who remain key behavioral health stakeholders in our community. The MHAC and PGHAC Assessment and Education subcommittee includes stakeholders from community based behavioral health organizations, county agencies, as well as family members. The BHAG consists of representation from the LBHA, county agencies, faith-based organizations, adult and child-serving organizations, advocacy groups, the school system, behavioral health providers, primary care physicians, family members and youth. The purpose of the advisory group is to increase communication and support to/from local communities and stakeholders as well as providing input into the strategic planning of the Prince George's County behavioral health system. It was established by the previous administration's Office of the County Executive and placed under the auspices of the Health Department, which provides staff support to the group.

LBHA Relationship and Interaction with Local and State Behavioral Health Advisory Councils

The LBHA Manager serves as a non-voting participant within the local Mental Health Advisory Committee (MHAC) and the LBHA Child and Adolescent Coordinator serves as staff support. Currently, the MHAC and LDAAC committees are being integrated into a single committee, the Local Behavioral

Health Advisory Committee. The committee will be comprised of all legislatively mandated members. Members have been identified and will be forwarded through the Health Officer to the County Executive for appointment. Each discipline will maintain specialized input on behavioral health system needs; however, the goal of the committee will be to maintain an integrated approach to planning and consultation on all matters. This entity will also align with the work of the existing Behavioral Health Advisory Group to ensure information sharing that can ultimately better address the behavioral health needs of the community.

Coordination of Activities in Response to Emergencies

The early stages of planning are underway to tweak the LBHA's existing behavioral health disaster plan for the County. It will address behavioral health during all phases of disasters. The LBHA is tasked with assisting with identifying participants for the interagency committee that will include stakeholders who serve the community. The committee will address behavioral health gaps in current disaster preparedness plans and address the entire community's behavioral health needs surrounding disasters. The Committee will be spearheaded by the Public Health Emergency Preparedness Division within the Health Department.

The Health Department Behavioral Health Services Division also has a Continuity of Operations Plan (COOP). The purpose of the COOP is to make certain that all critical health resources and services remain available to the public during active emergencies. The LBHA also utilizes the Crisis Response System to assist with any behavioral health emergencies.

All Hazards Plan

All County agencies are required to have Emergency Preparedness Plans. Additionally, all County providers are expected to have emergency preparedness plans. Within the Health Department, the LBHA collaborates with the Emergency Preparedness Unit to update the LBHA's All Hazards Plan. See attachment for a copy of the All Hazards Plan.

F. SERVICE DELIVERY AND RECOVERY SUPPORTS

1. Treatment Services

Behavioral Health Treatment and Recovery Support Services

Services are made available for individuals with an array of behavioral health needs. The following is a listing of behavioral health treatment and recovery support services provided to individuals and families across the lifespan to include special population groups.

CRISIS SERVICES

Crisis Response System (CRS) – Provides crisis mental health services to Prince George's County residents. Conducts evaluations for diverting patients presenting in the emergency room or for possible inpatient admission. The CRS includes the following components:

- Operations Center

- Crisis Screening
- Mobile Crisis Team
- Urgent Care appointments
- Transportation
- Temporary Housing
- In-Home Intensive Family Intervention

Mobile Crisis Team Augmentation (MCTA) – Provides enhancements to the existing Crisis Response System. Its purpose is to divert individuals from inpatient hospitalization and identifying appropriate community resources.

Crisis Intervention Team (CIT) – Responsible for training police and other first responders in a crisis intervention model designed to assist individuals with accessing mental health services as opposed to entering the criminal justice system.

Emergency Psychiatric Services (EPS) and 23-Hour Crisis Beds – The provision of psychiatric evaluations and 23-Hour crisis beds services are available at University of Maryland Capital Region Health (UMCRH) to uninsured individuals with mental illness, who are Medicaid ineligible.

JUSTICE-INVOLVED

Maryland Community Criminal Justice Treatment Program (MCCJTP) – Provides mental health services to inmates with mental illness at the Department of Corrections to include mental health assessments, therapy sessions, crisis intervention, linkages to community mental health and substance use services and post-release follow-up to individuals

Trauma, Addiction, Mental Health and Recovery (T.A.M.A.R) – Female inmates at the Department of Corrections are provided with trauma services and HIV/AIDS education services.

Drug Court – The Prince George's County Health Department collaborates with the Problem-Solving Court Programs, which includes Circuit Adult Drug Court, District Drug Court, Juvenile Drug Court, and Veterans Court. These voluntary, supervised, sanctioned and incentive based programs require about 12-months to complete. Case managers provide substance abuse screenings, linkage to needed supports or services and follow-up. Participants are Prince George's County residents who are referred from the State's Attorney's Office, private attorney or Office of the Public Defender.

Jail-Based Substance Abuse Treatment (JBSAT) – The JBSAT, located within the Prince George's County Department of Corrections, provides screening, assessment, and evidenced-based treatment to self and court referred individual. In addition, referrals are made to aftercare and community resources upon release into the community.

Prince George's County Offender Reentry – Provides case management and referrals for individuals who are incarcerated at Prince George's County Department of Corrections. Participants in the

Offender Reentry Program must be residents of Prince George's County, diagnosed with substance use or co-occurring disorders, have served a minimum of three months, and are within four months of release. Case Managers begin to work with the enrolled individuals while they are still incarcerated to identify services needs and assist with linkages and follow-up for up to one-year post release.

Assessment and Case Management Unit – Provides behavioral health screenings for clients referred by Parole and Probation and or the court system. Based upon the results of the screenings, clients may be referred to community treatment providers for further assessment and treatment. The ACM Unit's staff also complete Health General Article 8-505 Assessments, which are court ordered for the purpose of determining whether an individual may have a substance related disorder that may require treatment.

HOMELESS, HOUSING & OTHER SUPPORTS

Outreach with Treatment Services – Outreach services connecting individuals who are experiencing homelessness and have a mental health diagnosis to treatment, housing and other support services.

PATH (Projects and Assistance to Transitioning from Homelessness) – Assists individuals who are chronically homeless with mental illness locate and secure housing. PATH collaborates with private landlords and/or apartment complexes in an effort to provide placement assistance to consumers with mental illness, who are experiencing homelessness or at risk of becoming homeless.

SSI/SSDI Outreach, Access, and Recovery (SOAR) Program – Provides assistance to consumers of the Projects for Assistance in Transitioning from Homelessness (PATH) program and other homeless individuals with mental illnesses with completing SSI/SSDI applications. The goal is to expedite the receipt of SSI eligibility benefits for eligible mental health consumers.

Continuum of Care Program (CoC) – Provides housing assistance and support services to individuals with mental illness, or co-occurring mental illness and SUD needs, who were recently released from detention or have justice system involvement. The CoC program ensures linkage to supportive services necessary for achieving and maintaining independent living.

Residential Rehabilitation Program (RRP) – The LBHA is responsible for overseeing the RRP Program for Prince George's County. The RRP program provides housing and supportive services to individuals living with mental illness. The LBHA manages the wait list based upon the BHA priorities: state hospital referrals and individuals released from the detention center. Prince George's County has 398 beds amongst six (6) community providers.

Homeless I.D. Project – Provides funding for birth certificates and I.D. cards for individuals who experience homelessness. The LBHA processes applications that enables individuals to receive identification cards and birth certificates. It is the expectation that after receiving birth certificates and identification cards, individuals who are experiencing homelessness will be able to access behavioral health services, entitlements and other community supports.

Consumer Support Services – Funding offers individuals with mental illness assistance with urgent psychotropic medication requests, transportation and other consumer support needs, such as assistance with rent to prevent eviction or secure housing, activating utility services or paying past due utility payments, as well as obtaining basic household goods.

Temporary Cash Assistance – Collaboration with the Department of Social Services to provide substance abuse screenings, linkage and follow-up to Temporary Cash Assistance applicants who are referred by the Department of Social Services. If the screening indicates that an applicant may benefit from treatment services, he or she is referred to a community treatment provider. The Health Department Addiction Specialist works in partnership with the treatment provider to monitor and report progress to DSS.

State Care Coordination – Care coordination services to individuals in SUD residential treatment programs or actively engaged in outpatient services. Assistance is provided with accessing recovery support services.

Housing First Initiative – Provides increased support to individuals in Prince George's County, Baltimore City, and Montgomery County who have a mental illness or co-occurring substance use disorder who are experiencing homelessness, or at risk for homelessness. Individuals are referred by, or served by, the SOAR program; or are individuals being discharged from a state psychiatric hospital or transitioning from an RRP general bed to a less restrictive permanent housing situation.

SPECIAL POPULATIONS

Signing Therapists and American Sign Language Interpreting Services – Includes therapists certified in American Sign Language to assist with communication for deaf or hard of hearing consumers participating in clinic and rehabilitation services.

Outpatient SUD Services for Spanish-Speaking Residents – Providers SUD services to Spanish-speaking residents of Prince George's County in an outpatient setting. Program is funded by Governor’s Office for Crime Control and Prevention.

Senate Bill 512 – Senate Bill 512 (Children in Need of Assistance – Drug-Exposed Newborns) has been in effect since October 1, 1997. As a result, the PGCHD works collaboratively with the DSS. Addiction counselors conduct assessments on referred individuals in the hospital, home, or local DSS office. Referrals are made to community treatment or service providers as indicated. Currently, DSS is working with the Health Department and LBHA to provide strategies to help improve connections, communications, and collaborative capacities across systems and are bringing community providers into the fold as part of the SAFERR (Screening and Assessment for Family Engagement, Retention, and Recovery) Program.

House Bill 7 – House Bill 7 (The Integration of Child Welfare and Substance Abuse Treatment Services Act) was passed in the 2000 session of the Maryland General Assembly. As a result, the Prince George’s County Health Department works in partnership with the Department of Social Services to assess

individuals and families who are identified in the child welfare system as having a substance related disorder as evidenced by a positive drug test. If the assessment indicates that individuals could benefit from treatment services, the House Bill 7's Addictions Specialist provides a referral to a community provider. House Bill 7 participants will also benefit from the efforts of the SAFERR program described under SB512.

The Pregnancy Post-Partum Program uses a strength-based trauma informed approach to assist pregnant women and post/partum women addicted to opioids. The goal is to alleviate barriers through comprehensive care coordination using a multisystem (holistic) approach to improve outcomes.

Department of Corrections (DOC) MAT Program – Provides MAT (i.e., vivitrol and suboxone) services to individuals in DOC. Services include peer recovery specialists support, and case management services, to include health insurance enrollment, and assistance with accessing community resources (such as housing, employment, mental health services) upon discharge.

PEER SUPPORT AND RECOVERY

On Our Own (OOO) of Prince George's County – Peer support program for individuals with mental illness that provides outreach activities, Wellness & Recovery (WRAP) trainings and educational forums to reduce stigma and promote recovery and wellness.

NAMI of Prince George's County– Non-profit organization that provides advocacy, support and education to individuals with mental illnesses, their families and the community. NAMI offers a range of free support groups and courses to relatives, caregivers and individuals with mental illness. Some programs/courses include: Family-to-Family, Peer-to-Peer, Homefront, NAMI Basics, and Say It Out Loud for youth.

Adolescent Clubhouse – The Recovery Clubhouse serves as an additional support to traditional outpatient substance abuse treatment by providing non-clinical services to Prince George's County youth ages 12 to 18 with primary substance abuse disorders and/or co-occurring mental health disorders that may hinder the recovery process. Services offered at the Clubhouse include case management and advocacy, support and life skills groups, tutoring and computer lab, GED and college preparation, job readiness and coaching, and enriching field trips.

YAPRSS (Young Adult Peer Recovery Support Specialist) – Provides recovery supports to youth (12-17) at the Clubhouse. The YAPRSS will engage with youth in an effort to improve hope and optimism, increase self-esteem, build overall health and wellness, reduce workplace stigma surrounding substance use and co-occurring mental health and substance use disorders and to inform non-peer staff about recovery from a youth perspective.

CHILD AND ADOLESCENT SERVICES

Transitional Age Youth (TAY) Program – A residential program that provides (6) family units with housing, mental health treatment, psychiatric rehabilitation services, case management, independent

living skills, childcare, assistance with applying for benefits and linkages to job training programs to help youth age 16-23 live independently in the community.

EVIDENCE-BASED

In-Home Intervention Program for Children and Adolescents (IHIP-C) – As a part of the Five County Crownsville Project, the IHIP-C program provides individualized therapeutic intervention services to families with youth at risk of entering, or returning from, a residential treatment center (RTC).

Assertive Community Treatment (ACT) – ACT is an evidence-based model, also a part of the Five County Crownsville Project, which incorporates wraparound services to at-risk individuals with severe and persistent mental illness, as well as those with co-occurring disorders, with the ultimate goal being recovery.

OLDER ADULT

Psychogeriatric Services – Psychogeriatric nursing services are provided in an RRP environment to elderly persons with mental illness. Services include case management, daily monitoring of medications, structured day program activities, transportation to clinical appointments and assistance with other daily living activities.

Enhanced Client Support to Psycho-geriatric Nursing Services – Provides elderly individuals with mental illness that required additional assistance to be successful in a community placement.

Collaborative Integrated Behavioral Health Treatment and Recovery Supports

While the focus has been on integrating its behavioral health system management functions, the discussion and planning has also included for integrating treatment services and recovery supports. The LBHA's collaborative efforts and community partnerships are manifested across a broad spectrum of systems. The LBHA will continue to work collaboratively with community providers by contracting with sub-grantees, entering into Memorandums of Understandings (MOUs) with stakeholders and embracing networking opportunities. Subsequent information sharing around program development and program needs assists both providers and the LBHA with expanding existing services and determining untapped services for consumers. The LBHA will also continue to assess, promote and facilitate co-occurring training opportunities for behavioral health providers and internal health department somatic care staff.

Monthly meetings with UMCRH will continue as a platform to discuss services needed for the co-occurring population at various levels of care. Last fiscal year, the LBHA began efforts to connect with Primary Care Physicians (PCPs) providing them with behavioral health provider information. The LBHA plans to continue these efforts through the distribution of STEP FORWARD behavioral health informational materials to PCP offices, and making these resources readily available to their patients. This outreach will assist all treatment providers, public and private entities, hospitals, and residents to have access to a full spectrum of health care resources.

To further promote our LBHA systems integration efforts, the LBHA will engage MDH's Maryland Primary Care Program, and explore opportunities to develop local integration amongst behavioral health and primary care.

Behavioral Health Service Needs of the System

- Need for transportation assistance

Transportation has been identified as a barrier to accessing services outside of the Beltway. To better accommodate clients who live in areas where there is limited public transportation, and who are accessing services that are grant funded, the LBHA works with providers to ensure that transportation is included in the budget.

- Lack of housing options for individuals with behavioral health needs.

Access to affordable and transitional housing is also a challenge to those with behavioral health needs. Housing services remains to be the most sought out resource for callers who contact the LBHA for assistance.

- Need for hospital detox beds

The LBHA was made aware of the need for detox beds from UMCRH hospital staff. Staff expressed that there are not many places that will accept Medicaid, and often consumers are sent out of county for alcohol (ETOH) detox before they can go to a lower level of care.

- Diversity in program locations and service types

There is a need for more variety in service locations, especially in the more rural areas of the county. Many providers in Prince George's County offer programs that are concentrated in areas near commercial real estate and that are metro accessible. There is also a lack of providers who offer bilingual services in areas where there is limited English proficiency (LEP) or heavily populated with individuals who speak Spanish. The LBHA recently worked with an epidemiologist to create geomaps of existing services. Once analyzed, the LBHA plans to use the information to share with potential providers and existing providers who are considering service expansion. The LBHA will continue to focus on increasing provider capacity to expand upon the location and types of mental health and SUD programs available for residents.

- Increasing residents' knowledge of available services

More outreach is needed in the areas where services may be underutilized. Similarly, existing providers need to have more of a working knowledge of services available in the community beyond what they, themselves, offer to be able to more effectively connect consumers to appropriate programs and ensure all behavioral health needs are met. The LBHA plans to hire, or contract for, an education and outreach coordinator to assist with increasing community outreach efforts, including to special populations such as the elderly, women with children, veterans and LEP individuals.

- Adequate discharge planning for consumers returning to the community for care after hospital discharge

To prevent unnecessary visits to the emergency room, it is essential that proper discharge planning occurs and includes accurate instruction for referrals to community behavioral health services. Patients are often discharged from local hospital emergency departments without linkage or detailed information on community mental health resources, or notifying family members or behavioral health residential providers in advance of patient discharge. The LBHA has resumed meetings with community providers and pertinent hospital behavioral health and ED staff to discuss discharge practices and community resources. The Director of Behavioral Health Services for the University of Maryland Capital Region Health has been very present in the community, working with the LBHA to access the gaps in service delivery and listening to the needs of the providers who serve behavioral health consumers. This "open-door policy" has allowed the LBHA to work closer with behavioral health hospital staff at UMDRCH for case consultations.

Coordinating the Care of High Risk and High Cost Individuals

Through the distribution of grant funds, participation on committees and collaborating with providers and other stakeholders, the LBHA will continue to address the needs of high risk and high cost users.

Individuals with SUD are identified as high risk and high cost individuals when they have participated in residential treatment at any level – 3.7WM, 3.7, 3.5, 3.3, or 3.1. Upon entering treatment, individuals are connected with State Care Coordination (SCC) program staff. State Care Coordination, coupled with Maryland Recovery Net (MDRN), assists with the care of high risk and high cost individuals with SUD, specifically, by helping an individual transition from intensive services (residential) to community recovery. Community service connections include assistance with accessing resources pertinent to their recovery. Individuals receive assistance with referral to and/or scheduling appointments for primary medical care and mental health services, and transportation may also be arranged to assist with accessing recovery services and activities.

Previously, the LBHA has reached out to individuals identified as high utilizers to provide them with community based resources. The LBHA will identify what resources an individual may have accessed and assist the service provider with reconnecting with the consumer. The focus has been adjusted to ensuring that the hospitals that are serving many of these individuals are equipped with adequate resources as well. The reestablished monthly meetings with UMCRH behavioral health staff will also be a platform for case consultations for individuals who frequently access emergency hospital services.

Stakeholder partnerships and case consultations with the various county agencies and community programs that provide services to individuals who frequently access costly services is pertinent to coordinating the care of these individuals. Participation on the Mobile Integrated Health Committee, ACIS Steering Committee, community collaborations and consumer meetings are all methods in which the LBHA assists with care coordination.

The LBHA is an active participant at the Mobile Integrated Health (MIH) Committee meetings. Prince George's Fire and Emergency Management Services initiated the MIH program to train teams to assist high risk and vulnerable residents with hospital discharge instructions, including medication and disease education, chronic disease management, and connections to primary care and specialty care. The Network & Workforce Development sub-committee of the Health Department's Behavioral Health

Advisory Group is collaborating with Mindoula Health, a behavioral health management organization that offers "tech-enabled, 24/7 care extension and psychiatric services to populations with behavioral health challenges and medical comorbidities across the continuum of care". Mindoula's Readmissions Reduction Program provides support to patients with serious mental illness and medical comorbidities for 32 days after hospital discharge. The goal is to reduce hospital readmission and to connect individuals with community resources. The Readmissions Reduction Program operates out of Southern Maryland Hospital and reports a 75% reduction in readmissions. Mindoula is also working in collaboration with the County's Federally Qualified Health Centers (FQHCs).

To ensure that the programs that serve individuals considered high risk and/or high utilizers have access to updated behavioral health resources, the LBHA will also work with programs such as Prince George's Healthcare Alliance, which is a non-profit that provides community care coordination services to high risk, high need, high utilizers in healthcare needs. The program applies evidence-based practices and workflows to effectively assist hospitals with their care transitions to home, nursing facilities and rehabilitation centers. The Prince George's Healthcare Alliance team connects the patient to their primary care physician, specialists and other community providers.

Assessment of Training Needs of the ASAM Patient Placement Criteria

During provider meetings, the LBHA assesses local training needs. Additionally, during a future all provider meeting, a survey of training needs will be issued. ASAM training has consistently been identified as a need. The LBHA will assist with the coordination of an ASAM training in FY 2020-21 and will continue to share information with providers on upcoming ASAM-related training opportunities.

Addressing Housing Needs and Gaps

The LBHA will continue to increase its presence in stakeholder groups that have been developed to address community housing needs. As mentioned previously, LBHA staff is currently assisting with the implementation of an SOC Expansion Grant, which includes opportunities for TAY youth. This grant will address the housing needs for the TAY population.

Through further collaboration with the ACIS initiative, the LBHA assists the ACIS Steering Committee with case conferencing. Housing needs for these individuals will continue to be addressed through ACIS. The LBHA has also identified the need to expand the number of RRP providers. The purpose is to obtain a provider that has the experience necessary to adequately serve the TAY population in need of behavioral health services in Prince George's County.

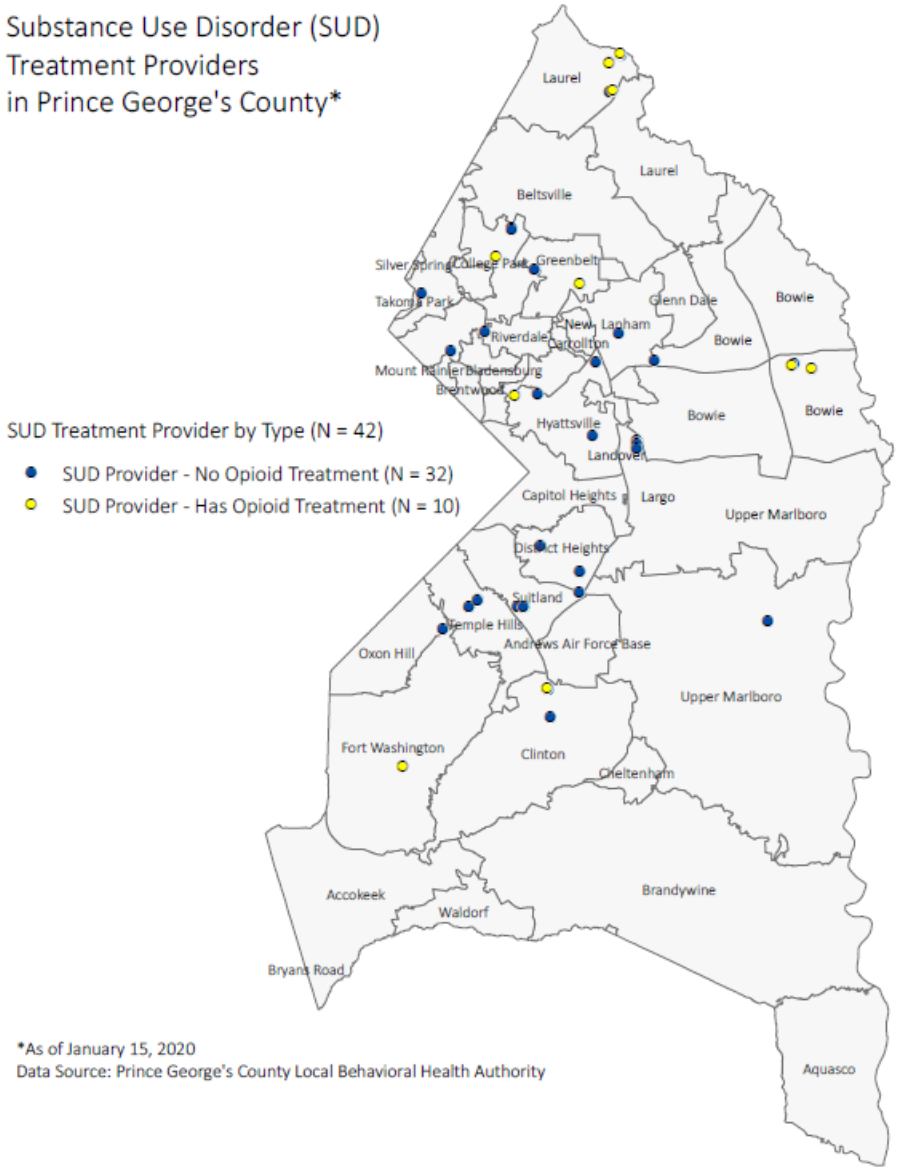
The LBHA works the Department of Housing and Community Development (DHCD) to ensure that the needs of individuals with disabilities (including behavioral health needs) are addressed in the County's housing plan. The LBHA has obtained housing vouchers through an MOU with DHCD.

Community providers have, in the past, applied for Community Bond Funds. Residential providers who were awarded the funds have utilized them to improve RRP housing. The LBHA received one request for a letter of support from an RRP provider in FY 2019, but is unaware of any more recent applicants or awardees.

Office Based Buprenorphine Therapy

Prince George's County currently has two (2) Office Based Opioid Treatment Centers (OBOT), one in College Park, the second in Laurel. The Laurel provider is licensed to offer Level 1, Level 2.1, outpatient and intensive outpatient services, in addition to being licensed as a Psychiatric Rehabilitation Program (PRP) for Adults. The LBHA is in communication with a potential new Opioid Treatment Program that will have a methadone clinic in addition to providing buprenorphine therapy.

The Health Department Cheverly clinic continues to offer buprenorphine therapy as well. In addition, there are seven (7) SUD providers that are connected to physicians who have been issued a waiver to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000, referenced as DATA 2000 practitioners. The DATA 2000 practitioners provide easy linkage to MAT for consumers. One buprenorphine provider in the County offers primary care and diabetes prevention services in the community and has indicated that they are considering obtaining a license for SUD services in the future. The following map indicates the County location of SUD Programs that do not provide opioid treatment and those providers that are OBOT providers or are providers connected to a Data2000 doctor:



Efforts to Address Co-occurring Disorders & Promote Dual Diagnosis Capability Training

A series of brief training sessions have been scheduled for mental health providers and other stakeholders to increase their ability to address SUD issues within their scope of work. Part of these training sessions will focus on the introduction to SUD language and ASAM levels, and other areas will educate providers on the process of making SUD referrals and the mental health providers' role.

In the past, several Dual Diagnosis Capability (DDC) trainings were provided for mental health and substance use disorder professionals. The LBHA will plan to provide DDC training again in FY 2021, as there has been a regained interest and identification of need for the training amongst providers.

Efforts to Address Crisis Response Services and Diversion Activities

The LBHA makes every effort to maintain partnerships with local emergency rooms including University of Maryland Capital Region Health (formerly Prince George's Hospital Center and referred to as UMCRH) and Medstar Southern Maryland Hospital Center to discuss adequate discharge planning/practices and linkages to behavioral health resources. The goal is to help facilitate the linkages to community programs and divert individuals from hospital emergency rooms when appropriate.

The LBHA also contracts out for additional Crisis Response System (CRS) services to make available an additional part-time, independently licensed clinician (LCSW-C/LCPC) for emergency department and detention center evaluations for the purposes of diverting patients presenting in the emergency room, or from possible inpatient admission. The goals are to increase the availability of urgent care psychiatric services by four per week in response to anticipated increase in demand from the emergency department for urgent care appointments and to ensure that the supplemental crisis services are connected or coordinated with existing crisis response services.

The CRS provider has been working to enhance their relationships with the local hospitals. CRS entered into an agreement with Laurel Regional Hospital and MedStar Southern Maryland Hospital Center to assist with rendering hospital diversion services. The initiative has faced some challenges. While at Laurel Regional Hospital, the diversion clinician's recommendations were seldom followed by the emergency department. Despite the evaluation conducted by the diversion clinician indicating targeted individuals could safely and successfully be served in the community, the individuals were almost always admitted for inpatient treatment. The recent agreement between the CRS provider has been more productive than previous collaborations; however, the diversion clinician recently resigned and the position is currently vacant. Although the position will need to be filled, the diversion efforts by CRS continues. Recent work began with UMCRH on a program designed to help reduce the hospital recidivism rate. Patients discharged from the inpatient unit will be connected to the Crisis Response System. The CRS will utilize mobile crisis teams to check in with discharged individuals for updates on their connection to community providers, assist them with making appointments when needed, assist with obtaining transportation, if needed, and provide psycho-education.

The Prince George's County Health Department also has behavioral health staff referred to as hospital liaisons located at UMCRH to assess, serve as a resource, and divert SUD consumers to community-based care when appropriate.

Pathological Gambling Addiction Services

Service providers conduct gambling assessment for every consumer as part of the intake and treatment plan development process. Prince George's County has identified at least ten (10) providers who have received training on gambling treatment via the Maryland Center of Excellence on Problem Gambling at the University of Maryland, School of Medicine.

Gambling assessments are conducted for all those who enter services with a SUD regardless of age. The gambling assessments used would be appropriate for the age group assessed (i.e., adolescent assessments for adolescent population).

Tobacco Cessation Services

The Tobacco Program works in collaboration with multiple private and public organizations to provide community prevention and education on the dangers of tobacco use. Some providers are cessation certified via the American Lung Association. The Tobacco Program offers 12-week smoking cessation classes, nicotine replacement therapy in the form of patches (7mg, 14mg, and 21mg) to assist persons to quit smoking, and counseling sessions. Prince George's County residents, age 18 and older, are eligible for free nicotine patches if identified as having a nicotine addiction. Nicotine Replacement Therapy is offered to consumers free of charge.

The Health Department offers nicotine replacement therapy in the form of patches for staff who smoke to assist them with quitting. In addition, Employee Assistance Program (EAP) services are offered to staff who seek additional assistance with smoking cessation.

Engagement of Peer Recovery Specialists (PRS) and/or Certified Peer Recovery Specialists (CPRS)

The Health Department's Certified Peer Recovery Specialists partners with individuals with substance use and co-occurring disorders to support their efforts of living a clean and sober life. In that effort, the CPRS works with family members to support the clients in improving their health and wellness.

The CPRS share their lived experiences as a tool to support individuals with their recovery. The CPRS provides peer mentoring and coaching designed to develop a one-on-one relationship with individuals. The specialists facilitate or lead recovery-oriented group activities and provide additional support in assisting with outpatient groups and the intensive outpatient program at the Cheverly clinic. They also provide transportation to NA and AA meetings for individuals.

The Adolescent Recovery Specialist participates in weekly and bi-weekly meetings at the Clubhouse where program activities and updates on youth participants are discussed. In addition to phone calls, group meetings, guest speakers, community service projects, and various cultural, recreational and educational activities, the team strives to keep the youth engaged in the program by introducing various evidence-based curriculums (e.g., Botvin Life Skills and Strengthening Families Program). This helps to spark the participant's interests in having healthy dialogue regarding changing behaviors and making informed decisions.

2. Outreach and Public Awareness

Through various mechanisms, including conducting outreach, disseminating resource materials and collaboration with our community partners, the LBHA will continue to ensure that the public has information on services and benefits available to them while also targeting specific populations.

The LBHA provided resources and educational materials for distribution to the public (i.e. churches, hospitals, public officials) and for redistribution at various community events. In FY 2019, the LBHA, separate from our community partners, distributed over 500 resource materials.

More outreach will be targeted to those who have Medicaid, to educate them on the full spectrum of behavioral health services available. The LBHA will continue community presentations as opportunities

arise. It can be assumed, via the Medicaid enrollment and penetration rate data that will be discussed later in this plan, that individuals are obtaining their Medicaid benefits, but are using them to access somatic care rather than behavioral health services. The LBHA will work to identify who may not be accessing services and what challenges/obstacles persist preventing individuals from accessing treatment.

The LBHA also collaborated with NAMI to create a resource packet for individuals served by local hospitals and to 1,000 mental health consumers, family members, and community residents to inform them about available services. The LBHA is determining a strategy to build upon this project and considering possibly adding STEP FORWARD resources in the packets.

Lastly, the LBHA has allocated funding to hire, or contract for, an Education and Outreach Coordinator to assist with informing the community on available services and how to access them. This person will also be responsible for coordinating trainings for targeted groups to include the Hispanic community and older adults with mental illness and behavioral health providers that work with this population.

Promotion of Evidence-Based Practices for Individuals with Mental Illness and SRD

The LBHA supports the increase and collaboration amongst providers to enhance access to care and treatments that have been proven to be effective treatment and recovery practices.

SBIRT (Screening, Brief Intervention and Referral to Treatment) is an evidence-based tool used to provide early intervention and treatment to individuals who use substances and puts them at risk for health problems. In FY 2019, the LBHA collaborated with The Mosaic Group at University of Maryland Capital Region Health (UMCRH) as they planned to use SBIRT to connect with Peer Recovery Support (PRS) in community. The Mosaic Group, based in Baltimore County, was awarded a SOR (State Opioid Response) grant to implement SBIRT and the initiation of MAT in the UMCRH in the Emergency Department. The LBHA connected Mosaic with Peer Recovery Support specialists to help facilitate a warm hand off from someone who was at the hospital to a community provider.

Other EBPs implemented by programs funded and/or monitored by the LBHA include: Assertive Community Treatment, Supportive Employment Program, Crisis Intervention Team, Peer Support and SSI/SSDI Outreach, Access and Recovery.

Mental Health and SUD Prevention Promotion and Awareness Activities

The STEP FORWARD: Empowering Young People, Adults, and Families to Live Healthier Lives campaign continued to increase the community's understanding of mental illness, to promote access to and utilization of services available in the continuum of care, and to improve stability and recovery. Materials (such as brochures, rack cards and posters) were developed in English, Spanish and French and distributed to doctor's offices, libraries, recreation centers, and other community events and providers. The MCF Youth Peer Support person with the involvement of our media partner, video-taped :30 and :60 second public service spots which were aired over local radio stations, social media and other large public events.

The LBHA encouraged providers to participate in Recovery Month Awareness activities. As a result, one (1) provider hosted a community-based event where information regarding SUD treatment and recovery services was provided. The event was attended by the public and other community-based providers.

3. Sub-grantee Monitoring

Sub-grantees are required to enter into written grant agreements with the County. All conditions of the grant award are covered in the contract agreements with sub-grantees. As part of the grant agreement, the contract monitor will develop a Scope of Services, which outlines the program's responsibilities including, but not limited to service provision, reporting and invoicing. Sub-grantees are required to submit program reports that are reviewed by the contract monitor. Additionally, site visits are conducted to ensure program compliance. Sub-grantees receive a full compliance audit according to the provisions in the BHA Conditions of Award.

G. TARGETED MENTAL HEALTH CASE MANAGEMENT CAPACITY ANALYSIS

Prince George's County has a population of 909,308, representing 15% of the state's population. It is one of the most diverse counties in the state of Maryland. The majority of the county's population is Black (64.6%), 12.7% is White, and 18.5% of the county residents identify as Hispanic/Latino. One in five residents was born outside of the United State and over one-quarter of residents speak a language other than English at home.

A 2019 Community Health Needs Assessment (CHNA) indicated that the County's provider to resident ratio for mental health providers is 1:890. Residents reported the top barriers to care included: no money for co-pays or medication, no health insurance and time limitations. More than half of the residents reported lack of transportation as a barrier for making appointments.

According to the National Institute of Mental Health, 4.5% of adults, aged 18 or older, live with an SMI. This would translate to almost 32,000 Prince George's County adult residents. In FY 2013, through a competitive bid process, two providers were selected to render TCM services to adults and children with SMI and case management needs in Prince George's County.

Data retrieved from the 2019 CHNA also indicated that 91,000 Prince George's County residents remain uninsured. PBHS data shows a 19.3% increase from FY 2018 to FY 2019 for individuals who were uninsured when accessing PBHS services. As the number of individuals without insurance who access the PBHS continues to increase at a greater rate than all other insurance types, it is imperative to have programs, such as TCM, that can assist these individuals with obtaining their entitlements and necessary supports.

Over the past five years, TCM services for all ages increased by 67%. In FY 2019, residents who accessed TCM services represented less than one percent of the total number of residents who utilized PBHS

services. Individuals accessing TCM service utilization in Prince George's County was also lower than the State's average.

Children and adolescent utilization of TCM/CCO services declined by 18.9% from FY 2018 to FY 2019, after an increase of 39.5% in FY 2017 to FY 2018. During this time, the TCM/CCO relied on three major points of access for referrals: TCM provider generated, Crisis Response/stabilization service program, and the community in general. Data retrieved for referrals from FY 2016 to FY 2019 shows that the former CCO received an average of 35 child and adolescent referrals each year. After referrals were accepted and initial contact with families have been made, some families declined services or did not schedule their initial appointments, which contributed to the decreased in the number of families served.

There was also a reduction in the number of adults who utilized TCM services from FY 2017 to FY 2018 (-14.1%) and FY 2018 to FY 2019 (-17.1).

Historically, during the fiscal years when there were two (2) TCM providers fully staffed and operating, the number of consumers served has increased dramatically. The data indicates that although the TCM average capacity may be lower in the County compared to the State's average, the need for these services remains.

There have been challenges experienced relating to the provision of TCM services in the County, which ultimately affected its utilization. The County's crisis provider, was a major referral source for the TCM program. Staff turnover, departures at leadership levels of the crisis provider, and the reduction from two (2) to one (1) TCM provider contributed to the decrease in the number of clients served. During FY 2019, a TCM provider made the decision to cease operating as a care coordination organization due to the difficulties of being able to recruit and hire appropriate and qualified staff, and the need to perform more aggressive community outreach and marketing without adequate staffing. Consumers were transitioned to the remaining provider to continue receiving care. Outreach and marketing efforts soliciting referrals declined amongst TCM providers. To overcome some of the barriers to service delivery which effect TCM capacity and increase referral volume, the following actions have been identified:

- Develop clear and concise material to be distributed to the community and partner agencies that describes TCM services, expectations, and service outcomes/successes.
- Encourage TCM providers to implement the use of a standardized assessment tool by agencies that will establish universal evaluation criterion with which to measure success.
- Specifically, for child and adolescent referrals, build upon the SOC relationship with the school system to include targeting specific programs/staff within schools.
- Convene a regular meeting with supervisors of TCM programs to discuss specific systemic barriers and solutions in relation to outreach and marketing for referrals.
- Conduct ongoing community presentations to professionals/agencies, families/caregivers and others about TCM services.

The LBHA partnered with the Anne Arundel County CSA to issue and select a new Care Coordination Organization (CCO) to provide TCM for children and adolescents through a competitive bid process. Along with Prince George's, this provider will serve clients in Anne Arundel, Calvert, Charles and St. Mary's counties. The TCM RFP for adults was issued by Prince George's County. The current adult TCM vendor as well as a new provider to the county were both selected1 The new TCM provider is expected to begin services in July 2020. LBHA integration challenges ultimately delayed the issuance of the TCM RFP for adults. The LBHA and entities involved in the county's RFP process are fully aware of the need to be compliant with this federal requirement and with the current knowledge of the RFP process, the LBHA does not foresee any barriers with issuing the RFP within the five-year cycle in the future.

PART 2: DATA AND PLANNING

This Annual Plan provides an analysis of the PBHS trends in Prince George's County for purposes of planning and evaluation. The summary of data section utilizes data retrieved from the required data templates issued by BHA unless otherwise specified. The sources for the required standardized templates include Beacon Health Options Intelligence Connect Reporting platform MARF0004 and S-MARF0004 Total System Expenditures by Service Group, Coverage Type and Age Group, MARF5120 Expenditures and Consumer Count by Dual Diagnosis and ADAA. The data on the required templates will reflect trends in the fee-for-service PBHS utilization and expenditures for children and adults. Shaded cells represent those instances where a count is between 1 – 10. This may result in very little data being produced for small populations and it may require, in some instances, additional suppression of non-sensitive data (e.g., corresponding expenditures) to ensure adequate protection of private health information. In addition, it should be noted that the data represents claims paid through September 30, 2019. The data from FY 2017 and FY 2018 has been updated and may be slightly different from what was reported in previous annual plans. FY 2019 data is incomplete as claims may be submitted up to twelve months from date of service.

Summary of Data

The following trends were identified for Prince George's County:

- PBHS utilization and expenditures continue to increase
- State and County are very similar in proportion of PBHS services used
- Majority of the consumers served by the PBHS are adults
- Individuals who are uninsured accessed mental health services at a higher rate than all other service types each year from FY 2017 to 2019
- Outpatient mental health services is the most utilized service in the PBHS
- Lab services, along with SUD outpatient treatment, are the most utilized SUD services
- Transitional Age Youth, ages 18-21, receiving mental health services, increased at a higher percentage than all other age groups, although the money spent for services for TAY decreased
- The cost per mental health consumer served was $4,791 and for SUD consumers was $1,726

- ❖ Prince George's County continues to have the lowest penetration rate in the State for both mental health and SUD services
- ❖ Opioid deaths in the County decreased by 42% from FY 2017 to FY 2019
- ❖ Veterans receiving mental health services has declined each year from FY 2017 to FY 2019, while Veterans accessing SUD services has increased during the same period

The following Tables 1a through Table 3b contain the Maryland and Prince George's County PBHS mental health and SUD data, as well as Medicaid penetration rates, Primary SUD Substances Used at Admission, Opioid-Related Overdose Deaths and Veterans data for all Maryland jurisdictions. This year, Tables 2ci and 2cii were included to show the percentages of TCM services used by children/ adolescents and adult consumers in FY 2019.

Service Utilization for Individuals Receiving Mental Health Treatment in the Public Behavioral Health System (PBHS)

Table 1a.Three Year Comparisons By Age

	Persons Served						Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
Early Child (0-5)	682	732	7.3%	775	5.9%		$1,377,304	$1,403,751	1.9%	$1,711,837	21.9%
Child (6-12)	3,697	4,086	10.5%	4,396	7.6%		$13,814,118	$15,009,200	8.7%	$17,388,241	15.9%
Adolescent (13-17)	2,988	3,198	7.0%	3,426	7.1%		$16,018,658	$15,621,127	-2.5%	$16,827,618	7.7%
Transitional (18-21)	1,412	1,466	3.8%	1,664	13.5%		$4,910,171	$6,217,533	26.6%	$5,559,971	-10.6%
Adult (22 to 64)	10,592	11,613	9.6%	12,364	6.5%		$56,149,758	$60,634,824	8.0%	$65,693,660	8.3%
Elderly (65 and over)	216	215	-0.5%	234	8.8%		$2,093,285	$2,327,061	11.2%	$2,377,466	2.2%
TOTAL	**19,587**	**21,310**	**8.8%**	**22,859**	7.3%		**$94,363,294**	**$101,213,496**	**7.3%**	**$109,558,793**	**8.2%**

*Based on claims paid through September 30, 2019.

Table 1a.i Number and Expenditures by Age Group as a Percentage of the Total

	Persons Served				Expenditures		
	FY 2017	FY 2018	FY 2019		FY 2017	FY 2018	FY 2019
Early Child (0-5)	3.48%	3.44%	3.39%		1.46%	1.39%	1.56%
Child (6-12)	18.87%	19.17%	19.23%		14.64%	14.83%	15.87%
Adolescent (13-17)	15.26%	15.01%	14.99%		16.98%	15.43%	15.36%
Transitional (18-21)	7.21%	6.88%	7.28%		5.20%	6.14%	5.07%
Adult (22 to 64)	54.08%	54.50%	54.09%		59.50%	59.91%	59.96%
Elderly (65 and over)	1.10%	1.01%	1.02%		2.22%	2.30%	2.17%
TOTAL	**100.00%**	**100.00%**	**100.00%**		**100.00%**	**100.00%**	**100.00%**

*Based on claims paid through September 30, 2019.

Table 1b. Three Year Comparisons By Service Type

	Persons Served					Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
Case Management	222	211	-5.0%	174	-17.5%	$361,810	$350,310	-3.2%	$362,395	3.4%
Crisis	215	264	22.8%	318	20.5%	$915,572	$1,421,767	55.3%	$1,515,917	6.6%
Inpatient	2,080	2,102	1.1%	2,001	-4.8%	$22,814,588	$24,333,324	6.7%	$25,944,744	6.6%
Mobile Treatment	802	769	-4.1%	748	-2.7%	$4,819,950	$5,338,965	10.8%	$5,566,866	4.3%
Outpatient	18,113	19,799	9.3%	21,281	7.5%	$35,551,570	$38,533,470	8.4%	$41,738,726	8.3%
Partial Hospitalization	130	143	10.0%	118	-17.5%	$744,109	$1,092,217	46.8%	$672,420	-38.4%
Psychiatric Rehabilitation	3,169	3,639	14.8%	4,359	19.8%	$24,338,171	$26,607,996	9.3%	$30,563,109	14.9%
Residential Rehabilitation	628	645	2.7%	699	8.4%	$1,774,913	$1,788,110	0.7%	$1,845,810	3.2%
Residential Treatment	40	31	-22.5%	23	-25.8%	$2,597,694	$1,226,162	-52.8%	$666,572	-45.6%
Respite Care	0					$0				
Supported Employment	227	228	0.4%	261	14.5%	$430,886	$474,947	10.2%	$558,610	17.6%
BMHS Capitation										
Emergency Petition	47	36	-23.4%	33	-8.3%	$3,360	$5,932	76.5%	$8,711	46.8%
Purchase of Care										
PRTF Waiver				0					$0	
****TOTAL**	**19,587**	**21,310**	**8.8%**	**22,859**	**7.3%**	**$94,363,296**	**$101,213,496**	**7.3%**	**$109,508,793**	**8.2%**

*Based on claims paid through September 30, 2019.

Table 1c. Three Year Comparisons By Coverage Type

	Persons Served					Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
Medicaid	18,731	20,451	9.2%	21,855	6.9%	$86,697,672	$91,996,416	6.1%	$100,442,081	9.2%
Medicaid State Funded	2,439	2,563	5.1%	2,817	9.9%	$6,109,447	$7,255,744	18.8%	$6,890,594	-5.0%
UnInsured	894	1,050	17.4%	1,253	19.3%	$1,556,176	$1,961,337	26.0%	$2,176,118	11.0%
****TOTAL**	**19,587**	**21,310**	**8.8%**	**22,859**	**7.3%**	**$94,363,295**	**$101,213,497**	**7.3%**	**$109,508,793**	**8.2%**
DUALLY Dx^	**4,330**	**4,697**	**8.5%**	**4,940**	**5.2%**	**$35,411,625**	**$35,843,939**	**1.2%**	**$40,258,497**	**12.3%**
Percent of Total Served/Expenditures	**22.1%**	**22.0%**		**21.6%**		**37.5%**	**35.4%**		**36.7%**	

*Based on claims paid through September 30, 2019.
Data Source: MARF0004

**Does not include adjustments included in Table 1a..
Also, TOTAL is unduplicated as an individual may have more than one service or have be covered by multiple funding streams throughout the fiscal year.

^ Dually Dx/Co-Occurring is based on those individuals with a primary mental health diagnosis and a secondary substance abuse diagnosis.
Data Source: MARF5120

Shaded cells represent suppressed data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Table 2a. Child / Adolescent - 0 - 17

	Persons Served					Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
Case Management	38	53	39.5%	43	-18.9%	$62,502	$76,717	22.7%	$111,416	45.2%
Crisis		0		0	#DIV/0!		$0		$0	#DIV/0!
Inpatient	368	350	-4.9%	373	6.6%	$7,173,000	$7,158,353	-0.2%	$8,272,120	15.6%
Mobile Treatment										
Outpatient	7,248	7,898	9.0%	8,445	6.9%	$17,259,258	$18,787,945	8.9%	$20,663,942	10.0%
Partial Hospitalization	13	20	53.8%	20	0.0%	$35,011	$79,270	126.4%	$158,311	99.7%
Psychiatric Rehabilitation	1,400	1,531	9.4%	1,871	22.2%	$4,081,710	$4,750,595	16.4%	$5,961,282	25.5%
Residential Rehabilitation		0		0	#DIV/0!	SUPPRESS	$0		$0	#DIV/0!
Residential Treatment	39	29	-25.6%	23	-20.7%	$2,558,754	$1,152,929	-54.9%	$666,573	-42.2%
Respite Care	0					$0				
Supported Employment	0	0	#DIV/0!			$0	$0	#DIV/0!		
BMHS Capitation	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
Emergency Petition										
Purchase of Care	0	0	#DIV/0!			$0	$0	#DIV/0!		
PRTF Waiver				0					$0	
****TOTAL**	**7,367**	**8,016**	**8.8%**	**8,597**	**7.2%**	**$31,210,081**	**$32,034,077**	**2.6%**	**$35,877,697**	**12.0%**

*Based on claims paid through September 30, 2019.

Table 2b. Adults - Ages 18 and Over

	Persons Served					Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
Case Management	184	158	-14.1%	131	-17.1%	$299,308	$350,310	17.0%	$250,979	-28.4%
Crisis	213	264	23.9%	318	20.5%	$907,697	$1,421,767	56.6%	$1,515,917	6.6%
Inpatient	1,712	1,752	2.3%	1,628	-7.1%	$15,641,588	$24,333,322	55.6%	$17,672,624	-27.4%
Mobile Treatment	796	761	-4.4%	742	-2.5%	$4,791,442	$5,338,965	11.4%	$5,543,878	3.8%
Outpatient	10,865	11,901	9.5%	12,836	7.9%	$18,292,312	$38,533,470	110.7%	$21,074,783	-45.3%
Partial Hospitalization	117	123	5.1%	98	-20.3%	$709,097	$1,092,217	54.0%	$514,109	-52.9%
Psychiatric Rehabilitation	1,769	2,056	16.2%	2,488	21.0%	$20,256,460	$26,607,996	31.4%	$24,601,827	-7.5%
Residential Rehabilitation	626	645	3.0%	699	8.4%	$1,774,474	$1,788,110	0.8%	$1,845,810	3.2%
Residential Treatment				0					$0	
Respite Care	0	0	#DIV/0!	0	#DIV/0!	$430,887	$2,035	-99.5%	$0	-100.0%
Supported Employment	227	228	0.4%	259	13.6%	$2,410	$474,947	19607.3%	$557,547	17.4%
BMHS Capitation										
Emergency Petition	43	33	-23.3%	29	-12.1%	$6,288	$5,932	-5.7%	$5,551	-6.4%
Purchase of Care										
PRTF Waiver	0	0	#DIV/0!	0	#DIV/0!	$0	$1,849	#DIV/0!	$0	-100.0%
****TOTAL**	**12,220**	**13,294**	**8.8%**	**14,262**	**7.3%**	**$63,153,213**	**$101,213,494**	**60.3%**	**$73,631,097**	**-27.3%**

*Based on claims paid through September 30, 2019.

Data Source: MARF0004

**Does not include adjustments included in Table 1a..

Also, TOTAL is unduplicated as an individual may have more than one service or have be covered by multiple funding streams throughout the fiscal year.

Table 2ci. Percent of TCM Services Used by Children/Adolescents in FY19								
	Persons Served				Expenditures			
	State	%	CSA	%	State	%	CSA	%
Allegany	2,043	2.6%	9	0.7%	$6,893,983	1.8%	$3,136	0.1%
Anne Arundel	2,043	2.6%	76	1.2%	$6,893,983	1.8%	$187,493	0.8%
Baltimore City	2,043	2.6%	324	1.8%	$6,893,983	1.8%	$751,363	0.7%
Baltimore County	2,043	2.6%	134	1.0%	$6,893,983	1.8%	$388,495	0.6%
Calvert	2,043	2.6%	22	2.5%	$6,893,983	1.8%	$58,780	2.2%
Caroline	2,043	2.6%	31	4.1%	$6,893,983	1.8%	$115,616	4.4%
Carroll	2,043	2.6%	56	3.6%	$6,893,983	1.8%	$203,015	3.1%
Cecil	2,043	2.6%	35	1.9%	$6,893,983	1.8%	$73,024	1.0%
Charles	2,043	2.6%	68	5.6%	$6,893,983	1.8%	$167,233	3.4%
Dorchester	2,043	2.6%	62	5.8%	$6,893,983	1.8%	$165,526	5.0%
Frederick	2,043	2.6%	128	4.2%	$6,893,983	1.8%	$316,335	1.8%
Garrett	2,043	2.6%	14	3.0%	$6,893,983	1.8%	$58,948	5.2%
Harford	2,043	2.6%	114	3.6%	$6,893,983	1.8%	$568,125	4.5%
Howard	2,043	2.6%	111	5.2%	$6,893,983	1.8%	$319,406	3.5%
Kent	2,043	2.6%	20	5.4%	$6,893,983	1.8%	$66,720	6.5%
Midshore	2,043	2.6%	147	4.3%	$6,893,983	1.8%	$469,397	4.7%
Montgomery	2,043	2.6%	5	0.1%	$6,893,983	1.8%	$18,652	0.1%
Prince George's	2,043	2.6%	43	0.5%	$6,893,983	1.8%	$111,416	0.3%
Queen Anne's	2,043	2.6%	14	2.6%	$6,893,983	1.8%	$61,088	5.9%
St. Mary's	2,043	2.6%	52	5.6%	$6,893,983	1.8%	$150,909	5.3%
Somerset	2,043	2.6%	71	7.9%	$6,893,983	1.8%	$214,902	4.5%
Talbot	2,043	2.6%	20	3.0%	$6,893,983	1.8%	$60,448	3.1%
Washington	2,043	2.6%	395	12.8%	$6,893,983	1.8%	$1,722,577	13.5%
Wicomico	2,043	2.6%	266	11.3%	$6,893,983	1.8%	$1,084,321	9.3%
Worcester	2,043	2.6%	19	1.6%	$6,893,983	1.8%	$25,822	0.8%

*Based on claims paid through September 30, 2019.
Data Source: MARF0004

Table 2cii. Percent of TCM Services Used by Adults in FY19								
	Persons Served				Expenditures			
	State	%	CSA	%	State	%	CSA	%
Allegany	4,538	3.1%	77	2.1%	$9,308,627	1.3%	$83,954	0.7%
Anne Arundel	4,538	3.1%	284	2.5%	$9,308,627	1.3%	$395,315	0.7%
Baltimore City	4,538	3.1%	932	2.3%	$9,308,627	1.3%	$2,060,831	0.9%
Baltimore County	4,538	3.1%	211	1.0%	$9,308,627	1.3%	$275,865	0.3%
Calvert	4,538	3.1%	138	6.6%	$9,308,627	1.3%	$230,794	4.3%
Caroline	4,538	3.1%	37	3.2%	$9,308,627	1.3%	$70,640	2.1%
Carroll	4,538	3.1%	306	9.7%	$9,308,627	1.3%	$682,147	2.9%
Cecil	4,538	3.1%	138	4.1%	$9,308,627	1.3%	$173,924	1.5%
Charles	4,538	3.1%	133	4.6%	$9,308,627	1.3%	$220,782	2.0%
Dorchester	4,538	3.1%	33	2.1%	$9,308,627	1.3%	$68,457	1.0%
Frederick	4,538	3.1%	368	8.3%	$9,308,627	1.3%	$717,380	3.5%
Garrett	4,538	3.1%	30	3.5%	$9,308,627	1.3%	$82,623	3.0%
Harford	4,538	3.1%	53	0.9%	$9,308,627	1.3%	$81,931	0.4%
Howard	4,538	3.1%	94	2.3%	$9,308,627	1.3%	$172,693	0.9%
Kent	4,538	3.1%	7	1.1%	$9,308,627	1.3%	$5,368	0.2%
Midshore	4,538	3.1%	106	2.0%	$9,308,627	1.3%	$194,324	1.0%
Montgomery	4,538	3.1%	72	0.6%	$9,308,627	1.3%	$115,571	0.1%
Prince George's	4,538	3.1%	131	0.9%	$9,308,627	1.3%	$250,979	0.3%
Queen Anne's	4,538	3.1%	14	1.5%	$9,308,627	1.3%	$22,069	0.6%
St. Mary's	4,538	3.1%	160	6.3%	$9,308,627	1.3%	$381,234	3.9%
Somerset	4,538	3.1%	50	4.9%	$9,308,627	1.3%	$50,359	1.1%
Talbot	4,538	3.1%	15	1.5%	$9,308,627	1.3%	$27,790	0.8%
Washington	4,538	3.1%	1094	18.3%	$9,308,627	1.3%	$2,598,175	12.6%
Wicomico	4,538	3.1%	91	2.4%	$9,308,627	1.3%	$147,222	0.9%
Worcester	4,538	3.1%	196	11.3%	$9,308,627	1.3%	$289,989	5.4%

*Based on claims paid through September 30, 2019.
Data Source: MARF0004

Table 3a. Fiscal Year 2019 State & County Comparisons								
	Persons Served				Expenditures			
	STATE*		COUNTY		STATE*		COUNTY	
AGE	**Number**	**Per Cent**	**Number**	**Per Cent**	**Number**	**Per Cent**	**Number**	**Per Cent**
Early Child	7,965	3.5%	775	3.4%	$20,190,165	1.8%	$1,711,837	1.6%
Child	41,251	18.3%	4,396	19.2%	$193,269,229	17.6%	$17,388,241	15.9%
Adolescent	29,719	13.2%	3,426	15.0%	$163,147,281	14.9%	$16,827,618	15.4%
Transitional	13,769	6.1%	1,664	7.3%	$56,845,853	5.2%	$5,559,971	5.1%
Adult	129,591	57.5%	12,364	54.1%	$638,416,123	58.3%	$65,693,660	60.0%
Elderly	2,965	1.3%	234	1.0%	$23,160,689	2.1%	$2,377,466	2.2%
TOTAL	**225,260**	100.0%	**22,859**	100.0%	**$1,095,029,340**	100.0%	**$109,558,793**	100.0%
SERVICE TYPE								
Case Management	6,581	2.9%	174	0.8%	$16,202,610	1.5%	$362,395	0.3%
Crisis	2,808	1.2%	318	1.4%	$14,852,172	1.4%	$1,515,917	1.4%
Inpatient	18,775	8.3%	2,001	8.8%	$253,559,133	23.2%	$25,944,744	23.7%
Mobile Treatment	4,409	2.0%	748	3.3%	$41,187,110	3.8%	$5,566,866	5.1%
Outpatient	210,766	93.6%	21,281	93.1%	$419,037,021	38.3%	$41,738,726	38.1%
Partial Hospitalization	2,162	1.0%	118	0.5%	$9,660,214	0.9%	$672,420	0.6%
Psychiatric Rehabilitation	45,053	20.0%	4,359	19.1%	$270,117,173	24.7%	$30,563,109	27.9%
Residential Rehabilitation	5,317	2.4%	699	3.1%	$12,277,663	1.1%	$1,845,810	1.7%
Residential Treatment	452	0.2%	23	0.1%	$37,718,724	3.4%	$666,572	0.6%
Respite Care	437	0.2%			$1,136,928	0.1%		
Supported Employment	3,791	1.7%	261	1.1%	$9,714,050	0.9%	$558,610	0.5%
BMHS Capitation	367	0.2%			$9,099,972	0.8%		
Emergency Petition	424	0.2%	33	0.1%	$152,275	0.014%	$8,711	0.0%
Purchase of Care	23	0.01%			$220,649	0.020%		
PRTF Waiver	31	0.01%	0	0.0%	$93,646	0.009%	$0	0.0%
TOTAL	**225,260**	100.0%	**22,859**	100.0%	**$1,095,029,340**	100.0%	**$109,508,793**	100.0%
COVERAGE TYPE								
Medicaid	215,660	95.7%	21,855	95.6%	$985,970,664	90.0%	$100,442,081	91.7%
Medicaid State Funded	30,324	13.5%	2,817	12.3%	$91,355,423	8.3%	$6,890,594	6.3%
UnInsured	9,496	4.2%	1,253	5.5%	$17,703,253	1.6%	$2,176,118	2.0%
TOTAL	**225,260**	100.0%	**22,859**	100.0%	**$1,095,029,340**	100.0%	**$109,508,793**	100.0%
DUALLY DIAGNOSED INDIVIDUALS								
All with DD #	**73,908**	**32.8%**	**4,940**	**21.6%**	**$505,174,207**	**46.1%**	**$40,258,497**	**36.8%**

*Based on claims paid through September 30, 2019.
Data Source: MARF0004

Dually Dx/Co-Occurring is based on those individuals with a primary mental health diagnosis and a secondary substance abuse diagnosis.

Shaded cells represent suppressed data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Table 3b. FY 2019 Comparisons: Cost per Person Served				
	State	County	Difference	Index^
AGE				
Early Child	$2,535	$2,209	-$326	87.1
Child	$4,685	$3,955	-$730	84.4
Adolescent	$5,490	$4,912	-$578	89.5
Transitional	$4,129	$3,341	-$787	80.9
Adult	$4,926	$5,313	$387	107.9
Elderly	$7,811	$10,160	$2,349	130.1
TOTAL	**$4,861**	**$4,793**	**-$68**	**98.6**
SERVICE TYPE				
Case Management	$2,462	$2,083	-$379	84.6
Crisis	$5,289	$4,767	-$522	90.1
Inpatient	$13,505	$12,966	-$539	96.0
Mobile Treatment	$9,342	$7,442	-$1,899	79.7
Outpatient	$1,988	$1,961	-$27	98.6
Partial Hospitalization	$4,468	$5,698	$1,230	127.5
Psychiatric Rehabilitation	$5,996	$7,011	$1,016	116.9
Residential Rehabilitation	$2,309	$2,641	$332	114.4
Residential Treatment	$83,449	$28,981	-$54,467	34.7
Respite Care	$2,602			
Supported Employment	$2,562	$2,140	-$422	83.5
BMHS Capitation	$24,796			
Emergency Petition	$359	$264	-$95	73.5
Purchase of Care	$9,593			
PRTF Waiver	$3,021	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	**$4,861**	**$4,791**	**-$71**	**98.5**
COVERAGE TYPE				
Medicaid	$4,572	$4,596	$24	100.5
Medicaid State Funded	$3,013	$2,446	-$567	81.2
UnInsured	$1,864	$1,737	-$128	93.2
TOTAL	**$4,861**	**$4,791**	**-$71**	**98.5**

*Based on claims paid through September 30, 2019.

^The index is that number that represents how much more or less a County's cost is when compared to the State cost. Any number over 100 indicates a higher County cost than the State.

Ex: 125 means a cost is 25% more than the State cost. 85 means a cost that is 15% less than the State cost.

Number of Veterans Receiving Mental Health Services and Related Expenditures in FY 2017-2019

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

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

*Based on claims paid through September 30, 2019.
Data Source: ASO Report #152820.1.01

Vetaran status is based on individual response to question, "Are you a Veteran?"

Fiscal Year is based on date of service. County refers to an individual's county of residence.

Statewide Total is unduplicated and may not equal the sum of individual lines.

FY 19 data is not final as a provider has up to 12 months from the date of service in which to submit a claim for payment.

Average Medical Assistance Eligibility, PBHS MA Participation, and PBHS MA Penetration Rates
Fiscal Year 2019 - PBHS claims as of September 30, 2019

Accessing the Public Behavioral Health System

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

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

	Avg MA Eligible^	MA Served In MH/PBHS	Penetration Rate	Total County Population*	% of County MA Eligible
Caroline	12,054	1,842	**15.3%**	33,304	36.2%
Dorchester	12,936	2,541	**19.6%**	31,998	40.4%
Kent	5,003	953	**19.0%**	19,383	25.8%
Queen Anne's	8,428	1,426	**16.9%**	50,251	16.8%
Talbot	8,589	1,583	**18.4%**	36,968	23.2%
Mid-Shore Total	**47,010**	**8,345**	**17.8%**	**171,904**	**27.3%**

Service Utilization for Individuals Receiving Substance Related Disorder Treatment Services in the Public Behavioral Health System (PBHS)

Table 1a.Three Year Comparisons By Age

	Persons Served						Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
Early Child (0-5)											
Child (6-12)	26	31	19.2%	36	16.1%		$6,902	$9,798	42.0%	$8,348	-14.8%
Adolescent (13-17)	305	351	15.1%	352	0.3%		$239,344	$304,189	27.1%	$293,660	-3.5%
Transitional (18-21)	288	370	28.5%	337	-8.9%		$243,410	$242,011	-0.6%	$169,681	-29.9%
Adult (22 to 64)	4,541	5,406	19.0%	5,380	-0.5%		$5,860,585	$10,029,881	71.1%	$10,060,708	0.3%
Elderly (65 and over)	39	49	25.6%	67	36.7%		$44,636	$88,270	97.8%	$129,542	46.8%
TOTAL	**5,206**	**6,210**	**19.3%**	**6,176**	**-0.5%**		**$6,396,893**	**$10,677,313**	**66.9%**	**$10,662,564**	**-0.1%**

*Based on claims paid through September 30, 2019.

Table 1a.i Number and Expenditures by Age Group as a Percentage of the Total

	Persons Served				Expenditures		
	FY 2017	FY 2018	FY 2019		FY 2017	FY 2018	FY 2019
Early Child (0-5)							
Child (6-12)	0.50%	0.50%	0.58%		0.11%	0.09%	0.08%
Adolescent (13-17)	5.86%	5.65%	5.70%		3.74%	2.85%	2.75%
Transitional (18-21)	5.53%	5.96%	5.46%		3.81%	2.27%	1.59%
Adult (22 to 64)	87.23%	87.05%	87.11%		91.62%	93.94%	94.36%
Elderly (65 and over)	0.75%	0.79%	1.08%		0.70%	0.83%	1.21%
TOTAL	**100.00%**	**100.00%**	**100.00%**		**100.00%**	**100.00%**	**100.00%**

Table 1b. Three Year Comparisons By Service Type

	Persons Served						Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
SUD Inpatient	110	86	-21.8%	95	10.5%		$291,319	$313,542	7.6%	$272,510	-13.1%
SUD Outpatient	2,413	2,855	18.3%	2,792	-2.2%		$1,593,187	$2,443,451	53.4%	$2,330,670	-4.6%
SUD Partial Hospitalization	107	92	-14.0%	37	-59.8%		$316,784	$272,598	-13.9%	$75,965	-72.1%
SUD Labs	3,591	4,472	24.5%	4,300	-3.8%		$1,970,656	$2,195,842	11.4%	$1,733,408	-21.1%
SUD MD Recovery Net	446	403	-9.6%	430	6.7%		$162,258	$129,259	-20.3%	$157,905	22.2%
SUD Methadone Maint.	360	383	6.4%	402	5.0%		$876,939	$868,618	-0.9%	$932,145	7.3%
SUD Residential ICFA	18	13	-27.8%				$111,468	$107,268	-3.8%		-98.8%
SUD Intensive Outpatient	322	368	14.3%	429	16.6%		$684,026	$1,165,081	70.3%	$1,478,051	26.9%
SUD Gambling	0			29			$0			$26,653	
SUD Invitation for Bid	25	17	-32.0%	0	-100.0%		$390,256	$172,324	-55.8%	$0	-100.0%
SUD Court Ordered Placement - Residential	0	13	#DIV/0!	28	115.4%		$0	$227,997	#DIV/0!	$535,604	134.9%
SUD Women with Children/Pregnancy - Residential	0						$0				
SUD Residential All Levels	0	397	#DIV/0!	443	11.6%		$0	$2,316,185	#DIV/0!	$2,539,342	#DIV/0!
SUD Residential Room/Board	0	396	#DIV/0!	443	11.9%		$0	$428,833	#DIV/0!	$483,883	#DIV/0!
**TOTAL	**5,206**	**6,210**	**19.3%**	**6,176**	**-0.5%**		**$6,396,893**	**$10,677,314**	**66.9%**	**$10,662,565**	**-0.1%**

*Based on claims paid through September 30, 2019.

Table 1c. Three Year Comparisons By Coverage Type

	Persons Served						Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change		FY 2017	FY 2018	% Change	FY 2019	% Change
Medicaid	4,829	5,847	21.1%	5,765	-1.4%		$5,730,036	$8,900,745	55.3%	$8,488,762	-4.6%
Medicaid State Funded	178	673	278.1%	713	5.9%		$35,949	$1,168,180	3149.5%	$1,639,506	40.3%
UnInsured	594	609	2.5%	677	11.2%		$630,908	$608,389	-3.6%	$534,296	-12.2%
**TOTAL	**5,206**	**6,210**	19.3%	**6,176**	**-0.5%**		**$6,396,893**	**$10,677,314**	**66.9%**	**$10,662,564**	**-0.1%**

*Based on claims paid through September 30, 2019.
Data Source: S-MARF004

**Does not include adjustments included in Table 1a.
Also, TOTAL is unduplicated as an individual may have more than one service or have been covered by multiple funding streams throughout the fiscal year.

FY 19 data is not final as a provider has up to 12 months from the date of service in which to submit a claim for payment.

Suppressed cells represent data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Table 2a. Child / Adolescent - 0 - 17

	Persons Served					Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
SUD Inpatient				0					$0	
SUD Outpatient	211	212	0.5%	176	-17.0%	$96,373	$107,668	11.7%	$73,539	-31.7%
SUD Partial Hospitalization	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Labs	230	272	18.3%	283	4.0%	$49,509	$48,627	-1.8%	$50,523	3.9%
SUD MD Recovery Net	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Methadone Maint.	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Residential ICFA	14					$87,228				
SUD Intensive Outpatient		20		35	75.0%		$64,765		$177,348	173.8%
SUD Gambling	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Invitation for Bid	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Court Ordered Placement - Residential	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Women with Children/Pregnancy - Residential	0	0	#DIV/0!	0	#DIV/0!	$0	$0	#DIV/0!	$0	#DIV/0!
SUD Residential All Levels	0	0	#DIV/0!			$0	$0	#DIV/0!		
SUD Residential Room/Board	0	0	#DIV/0!			$0	$0	#DIV/0!		
****TOTAL**	**338**	**385**	**13.9%**	**392**	**1.8%**	**$248,262**	**$317,152**	**27.7%**	**$302,632**	**-4.6%**

*Based on claims paid through September 30, 2019.

Table 2b. Adults - Ages 18 and Over

	Persons Served					Expenditures				
	FY 2017	FY 2018	% Change	FY 2019	% Change	FY 2017	FY 2018	% Change	FY 2019	% Change
SUD Inpatient	104	83	-20.2%	95	14.5%	$280,629	$312,519	11.4%	$272,509	-12.8%
SUD Outpatient	2,202	2,643	20.0%	2,616	-1.0%	$496,454	$2,335,784	370.5%	$1,357,131	-41.9%
SUD Partial Hospitalization	107	92	-14.0%	37	-59.8%	$316,784	$272,598	-13.9%	$75,965	-72.1%
SUD Labs	3,361	4,200	25.0%	4,017	-4.4%	$1,921,147	$2,147,215	11.8%	$11,682,884	444.1%
SUD MD Recovery Net	446	403	-9.6%	430	6.7%	$162,258	$129,259	-20.3%	$157,905	22.2%
SUD Methadone Maint.	360	383	6.4%	402	5.0%	$876,939	$868,617	-0.9%	$932,145	7.3%
SUD Residential ICFA										
SUD Intensive Outpatient	319	348	9.1%	394	13.2%	$679,564	$1,100,315	61.9%	$1,300,703	18.2%
SUD Gambling	0			29		$0			$26,653	
SUD Invitation for Bid	25	17	-32.0%	0	-100.0%	$390,256	$172,324	-55.8%	$0	-100.0%
SUD Court Ordered Placement - Residential	0	13	#DIV/0!	28	115.4%	$0	$227,997	#DIV/0!	$535,604	134.9%
SUD Women with Children/Pregnancy - Residential	0					$0				
SUD Residential All Levels	0	397	#DIV/0!	442	11.3%	$0	$2,316,185	#DIV/0!	$2,538,632	9.6%
SUD Residential Room/Board	0	396	#DIV/0!	442	11.6%	$0	$428,834	#DIV/0!	$483,792	12.8%
****TOTAL**	**4,868**	**5,825**	**19.7%**	**5,784**	**-0.7%**	**$5,148,271**	**$10,360,162**	**101.2%**	**$19,459,931**	**87.8%**

*Based on claims paid through September 30, 2019.
Data Source: S-MARF004

**Does not include adjustments included in Table 1a.

Also, TOTAL is unduplicated as an individual may have more than one service or have be covered by multiple funding streams throughout the fiscal year.

FY 19 data is not final as a provider has up to 12 months from the date of service in which to submit a claim for payment.

Suppressed cells represent data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Table 3a. Fiscal Year 2019 State & County Comparisons

	Persons Served				Expenditures			
	STATE*		COUNTY		STATE*		COUNTY	
AGE	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Early Child	34	0.0%			$8,967	0.00%		
Child	334	0.3%	36	0.6%	$138,261	0.03%	$8,348	0.1%
Adolescent	3,221	2.8%	352	5.7%	$2,830,381	0.61%	$293,660	2.8%
Transitional	4,748	4.1%	337	5.5%	$8,791,942	1.91%	$169,681	1.6%
Adult	106,527	91.4%	5,380	87.1%	$443,000,220	96.00%	$10,060,708	94.4%
Elderly	1,646	1.4%	67	1.1%	$6,681,053	1.45%	$129,542	1.2%
TOTAL	**116,510**	100.0%	**6,176**	100.0%	**$461,450,824**	100.0%	**$10,662,564**	100.0%
SERVICE TYPE								
SUD Inpatient	3,350	2.9%	95	1.5%	$11,617,108	2.52%	$272,510	2.6%
SUD Outpatient	74,905	64.3%	2,792	45.2%	$91,942,709	19.92%	$2,330,670	21.9%
SUD Partial Hospitalization	3,329	2.9%	37	0.6%	$10,382,133	2.25%	$75,965	0.7%
SUD Labs	75,387	64.7%	4,300	69.6%	$64,588,292	14.00%	$1,733,408	16.3%
SUD MD Recovery Net	4,751	4.1%	430	7.0%	$3,810,446	0.83%	$157,905	1.5%
SUD Methadone Maint.	33,867	29.1%	402	6.5%	$97,752,416	21.18%	$932,145	8.7%
SUD Residential ICFA	55	0.0%			$361,324	0.08%		
SUD Intensive Outpatient	16,757	14.4%	429	6.9%	$66,409,755	14.39%	$1,478,051	13.9%
SUD Gambling	236	0.2%	29	0.5%	$155,447	0.03%	$26,653	0.2%
SUD Invitation for Bid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SUD Court Ordered Placement - Residential	767	0.7%	28	0.5%	$18,440,606	4.00%	$535,604	5.0%
SUD Women with Children/Pregnancy - Residential	238	0.2%			$5,252,978	1.14%		
SUD Residential All Levels	11,548	9.9%	443	7.2%	$75,928,530	16.45%	$2,539,342	23.8%
SUD Residential Room/Board	11,520	9.9%	443	7.2%	$14,809,080	3.21%	$483,883	4.5%
****TOTAL**	**116,510**	100.0%	**6,176**	100.0%	**$461,450,824**	100.0%	**$10,662,565**	100.0%
COVERAGE TYPE								
Medicaid	109,717	94.2%	5,765	93.3%	$382,453,269	82.9%	$8,488,762	79.6%
Medicaid State Funded	19,708	16.9%	713	11.5%	$60,749,134	13.2%	$1,639,506	15.4%
UnInsured	11,068	9.5%	677	11.0%	$18,248,421	4.0%	$534,296	5.0%
TOTAL	**116,510**	100.0%	**6,176**	100.0%	**$461,450,824**	100.0%	**$10,662,564**	100.0%

*Based on claims paid through September 30, 2019.
Data Source: S-MARF004

FY 19 data is not final as a provider has up to 12 months from the date of service in which to submit a claim for payment.

Suppressed cells represent data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Table 3b. FY 2019 Comparisons: Cost per Person Served				
	State	County	Difference	Index^
AGE				
Early Child	$264			
Child	$414	$232	-$182	56.0
Adolescent	$879	$834	-$44	94.9
Transitional	$1,852	$504	-$1,348	27.2
Adult	$4,159	$1,870	-$2,289	45.0
Elderly	$4,059	$1,933	-$2,126	47.6
TOTAL	**$3,961**	**$1,726**	**-$2,234**	**43.6**
SERVICE TYPE				
SUD Inpatient	$3,468	$2,869	-$599	82.7
SUD Outpatient	$1,227	$835	-$393	68.0
SUD Partial Hospitalization	$3,119	$2,053	-$1,066	65.8
SUD Labs	$857	$403	-$454	47.1
SUD MD Recovery Net	$802	$367	-$435	45.8
SUD Methadone Maint.	$2,886	$2,319	-$568	80.3
SUD Residential ICFA	$6,570			
SUD Intensive Outpatient	$3,963	$3,445	-$518	86.9
SUD Gambling	$659	$919	$260	139.5
SUD Invitation for Bid	N/A	N/A	N/A	N/A
SUD Court Ordered Placement - Residential	$24,043	$19,129	-$4,914	79.6
SUD Women with Children/Pregnancy - Residential	$22,071			
SUD Residential All Levels	$6,575	$5,732	-$843	87.2
SUD Residential Room/Board	$1,286	$1,092	-$193	85.0
****TOTAL**	**$3,961**	**$1,726**	**-$2,234**	**43.6**
COVERAGE TYPE				
Medicaid	$3,486	$1,472	-$2,013	42.2
Medicaid State Funded	$3,082	$2,299	-$783	74.6
UnInsured	$1,649	$789	-$860	47.9
TOTAL	**$3,961**	**$1,726**	**-$2,234**	**43.6**

*Based on claims paid through September 30, 2019.

^The index is that number that represents how much more or less a County's cost is when compared to the State cost. Any number over 100 indicates a higher County cost than the State.
Ex: 125 means a cost is 25% more than the State cost. 85 means a cost that is 15% less than the State cost.

FY 19 data is not final as a provider has up to 12 months from the date of service in which to submit a claim for payment.

Suppressed cells represent data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Primary Substance at Admission to SRD Treatment All Ages by County FY 2017-2019

Statewide

	FY 2017	FY 2018	FY 2019	17-18 Change	18-19
Alcohol	9,056	10,405	11,184	7.49%	6.97%
Amphetamines	169	205	251	22.44%	18.33%
Barbiturates				#DIV/0!	#DIV/0!
Benzodiazepines	445	527	526	-0.19%	-0.19%
Cocaine	2,615	3,161	3,546	12.18%	10.86%
Diphenyllhydantoin (Dilantin)				#DIV/0!	#DIV/0!
GHB/GBL	0	0	0	#DIV/0!	#DIV/0!
Hallucinogens	72	92	84	-8.70%	-9.52%
Inhalants	11			#DIV/0!	#DIV/0!
Ketamine	24	13	17	30.77%	23.53%
Marijuana/Hashish	4,886	5,102	4,516	-11.49%	-12.98%
Meprobamate				#DIV/0!	#DIV/0!
Opiates	40,640	27,224	27,688	1.70%	1.68%
Over the Counter	46	40	42	5.00%	4.76%
PCP	294	259	292	12.74%	11.30%
Sedatives	30	36	29	-19.44%	-24.14%
Stimulants	67	84	123	46.43%	31.71%
Tranquilizers				#DIV/0!	#DIV/0!
Synthetic Cannabinoids	110	85	86	1.18%	1.16%
Other Substance	4,239	4,248	4,953	16.60%	14.23%
None	986	17	122	617.65%	86.07%
TOTAL	**63,700**	**50,426**	**53,394**		
Heroin (Opiates subset)	**31,563**	**20,541**	**20,837**		
Percentage Heroin of Total Admits	**49.5%**	**40.7%**	**39.0%**		

*Based on authorization data through September 30, 2019.
Data Source: ASO Report 151172.1.01

County

	FY 2017	FY 2018	FY 2019	17-18 Change	18-19
Alcohol	721	817	855	13.31%	4.65%
Amphetamines	11		13	-18.18%	44.44%
Barbiturates	0		0	#DIV/0!	-100.00%
Benzodiazepines		11	11	266.67%	0.00%
Cocaine	198	207	186	4.55%	-10.14%
Diphenyllhydantoin (Dilantin)	0	0	0	#DIV/0!	#DIV/0!
GHB/GBL	0	0	0	#DIV/0!	#DIV/0!
Hallucinogens		19	14	90.00%	-26.32%
Inhalants	0		0	#DIV/0!	-100.00%
Ketamine				-66.67%	200.00%
Marijuana/Hashish	700	707	579	1.00%	-18.10%
Meprobamate	0	0		#DIV/0!	#DIV/0!
Opiates	557	416	422	-25.31%	1.44%
Over the Counter	0	0			#DIV/0!
PCP	131	113	133	-13.74%	17.70%
Sedatives				100.00%	0.00%
Stimulants				33.33%	50.00%
Tranquilizers	0	0			#DIV/0!
Synthetic Cannabinoids					200.00%
Other Substance	56	116	111	107.14%	-4.31%
None	27	0			#DIV/0!
TOTAL	**2,425**	**2,425**	**2,345**		
Heroin (Opiates subset)	**428**	**286**	**307**		
Percentage Heroin of Total Admits	**17.6%**	**11.8%**	**13.1%**		

*Based on authorization data through September 30, 2019.
Data Source: ASO Report 151172.1.02

Shaded cells represent data where counts are between 1-10. Data is suppressed to avoid possible disclosure of Personally Identifiable Information (PII).

Average Medical Assistance Eligibility, PBHS MA Participation, and PBHS MA Penetration Rates
Fiscal Year 2019 - PBHS claims as of September 30, 2019

Accessing the Public Behavioral Health System

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

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

	Avg MA Eligible^	MA Served In SUD/PBHS	Penetration Rate	Total County Population*	% of County MA Eligible
Caroline	12,054	1,011	**8.4%**	33,304	36.2%
Dorchester	12,936	1,401	**10.8%**	31,998	40.4%
Kent	5,003	625	**12.5%**	19,383	25.8%
Queen Anne's	8,428	852	**10.1%**	50,251	16.8%
Talbot	8,589	768	**8.9%**	36,968	23.2%
Mid-Shore Total	**47,010**	**4,657**	**9.9%**	**171,904**	**27.3%**

Number of Veterans Receiving Substance Related Disorder Treatment Services and Related Expenditures in FY 2017-2019

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

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

*Based on claims paid through September 30, 2019.
Data Source: ASO Report #152820.1.01

Vetaran status is based on individual response to question, "Are you a Veteran?"

Fiscal Year is based on date of service. County refers to an individual's county of residence.

Statewide Total is unduplicated and may not equal the sum of individual lines.

FY 19 data is not final as a provider has up to 12 months from the date of service in which to submit a claim for payment.

Number of Opioid Related Overdose Deaths by County

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

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

Analysis of Required Data Templates

Table 1a – Three Year County Comparison

The overall number of individuals receiving PBHS mental health and SUD services in Prince George's County continues to grow, however there was a slight decrease in the number of individuals accessing SUD services from FY 2018 to FY 2019. In FY 2019, there were 22,859 consumers who accessed mental health services. There were 6,176 consumers who accessed SUD services in FY 2019, which represents 34 consumers less than the number served in FY 2018.

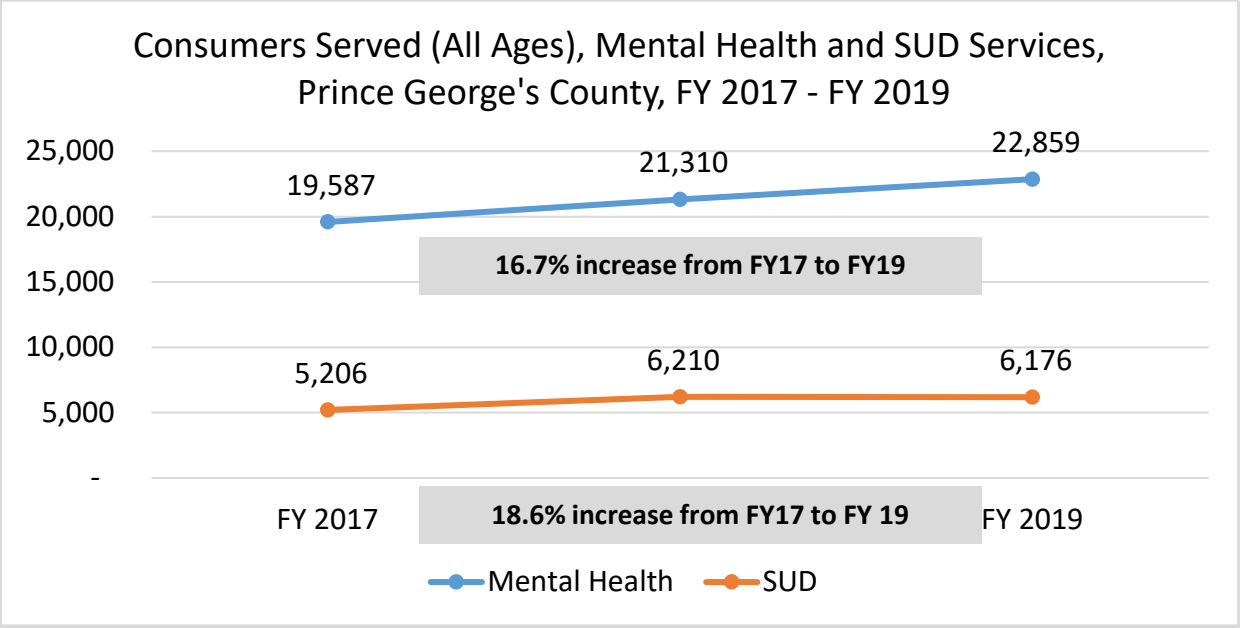
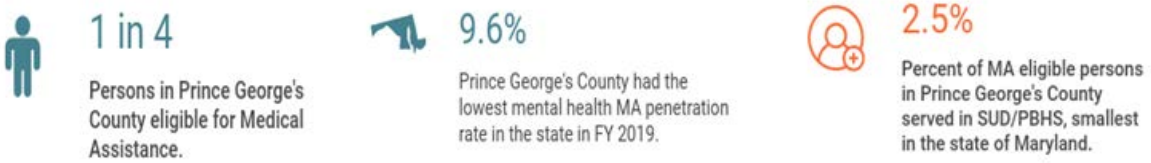
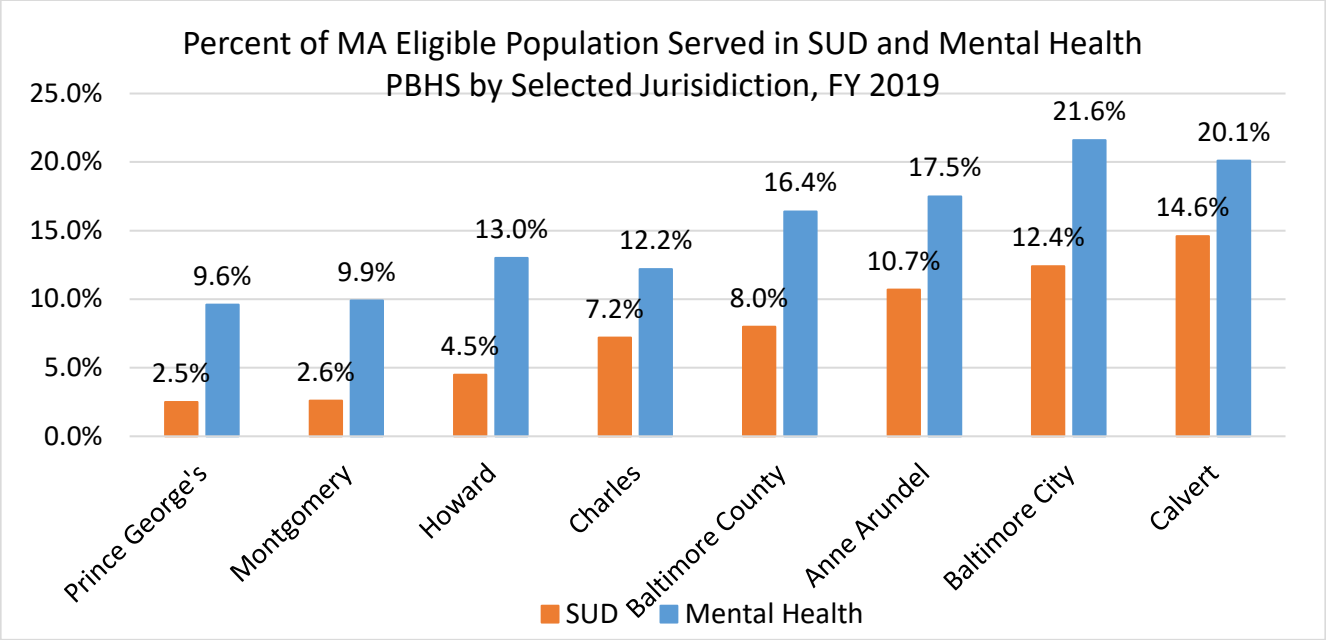


Table 4 – Prince George's County Medicaid Penetration Rate

Less than 10% of individuals eligible to receive mental health treatment via the PBHS accessed services that were available to them. As the utilization data is reviewed, here are some data points to consider:





According to the data, approximately 25% (228,609/909,308) of Prince George's County residents are Medicaid eligible. The County's MA eligible population represents 21% (288,609/1,405,552) of the total number of those who are MA eligible statewide.

The Medicaid penetration rate for consumers accessing mental health services in FY 2019 was 9.6% and the Medicaid penetration rate for consumers accessing SUD services in FY 2019 was 2.5%. Both penetration rates continue to represent one of the lowest percentage rates in the State behind Montgomery County.

The low penetration rates in these neighboring jurisdictions may be indicative of the high foreign-born population in both counties. Prince George's County has 21.4% of its residents born outside of the U.S. and 23.3% speak a language other than English at home. In fact, 14.4% of residents speak Spanish as their primary language, and of those individuals, over 55% report as having Limited English Proficiency. Although further analysis is required to determine whether there are unidentified barriers to accessing services in these areas, the LBHA has allocated funding for education and outreach activites that will be provide targeted outreach efforts.

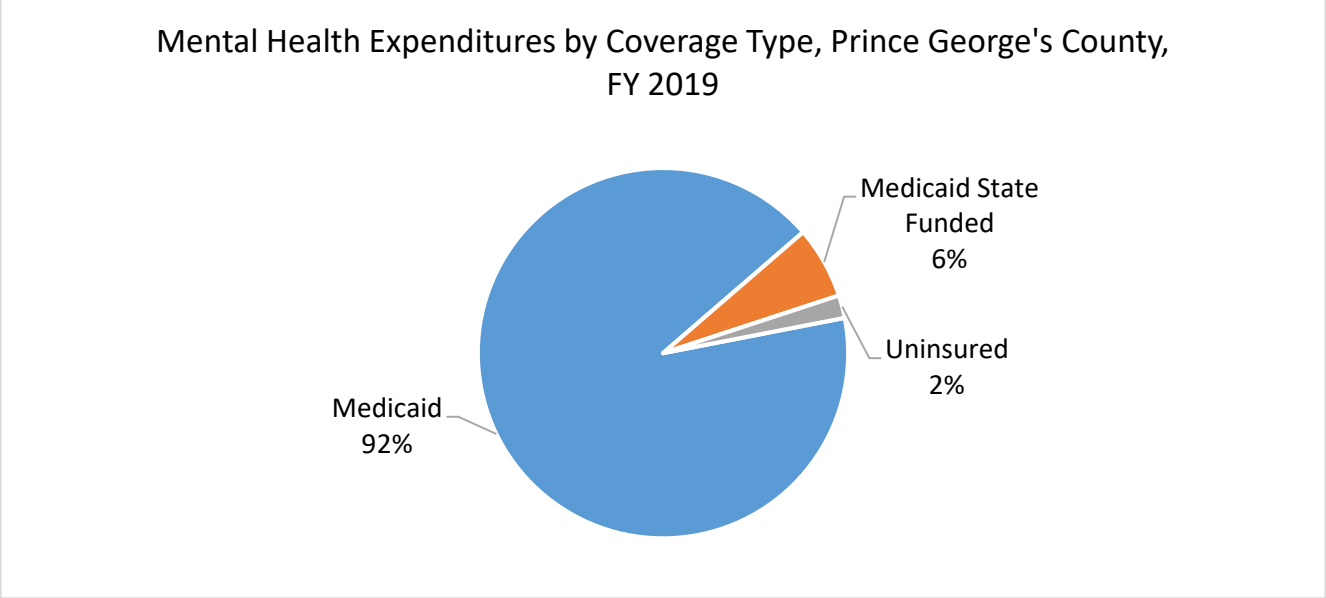
Table 1c. Mental Health Consumers Served and Expenditures by Coverage Type

40%

Increase in the number of uninsured persons served in FY 2019 compared to FY 2017.

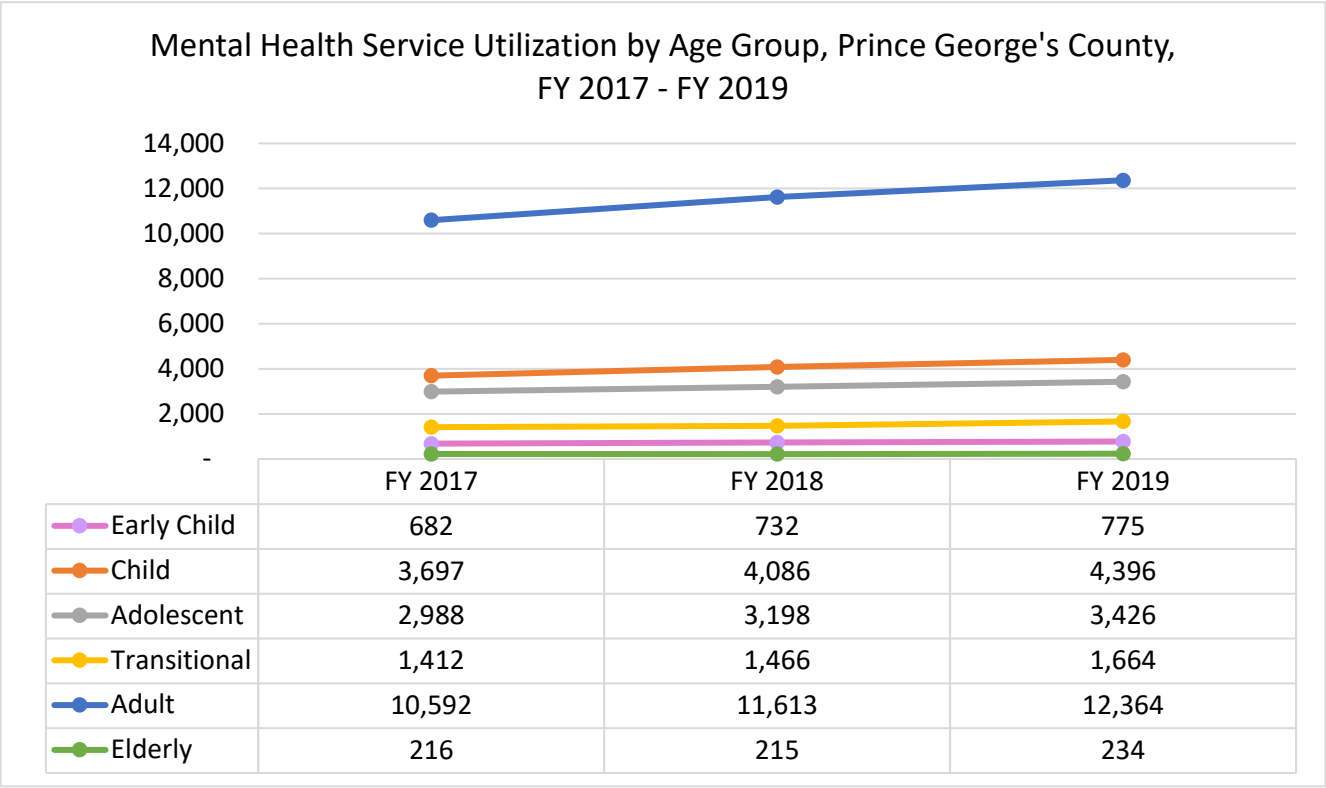
Individuals accessing PBHS without insurance continues to increase at a higher rate than individuals accessing services with Medicaid and Medicaid State-Funded coverage, although representing the least

number served. The LBHA authorizes outpatient treatment for individuals who are uninsured. Of note, the LBHA has not received an increase in requests for uninsured exceptions from providers.



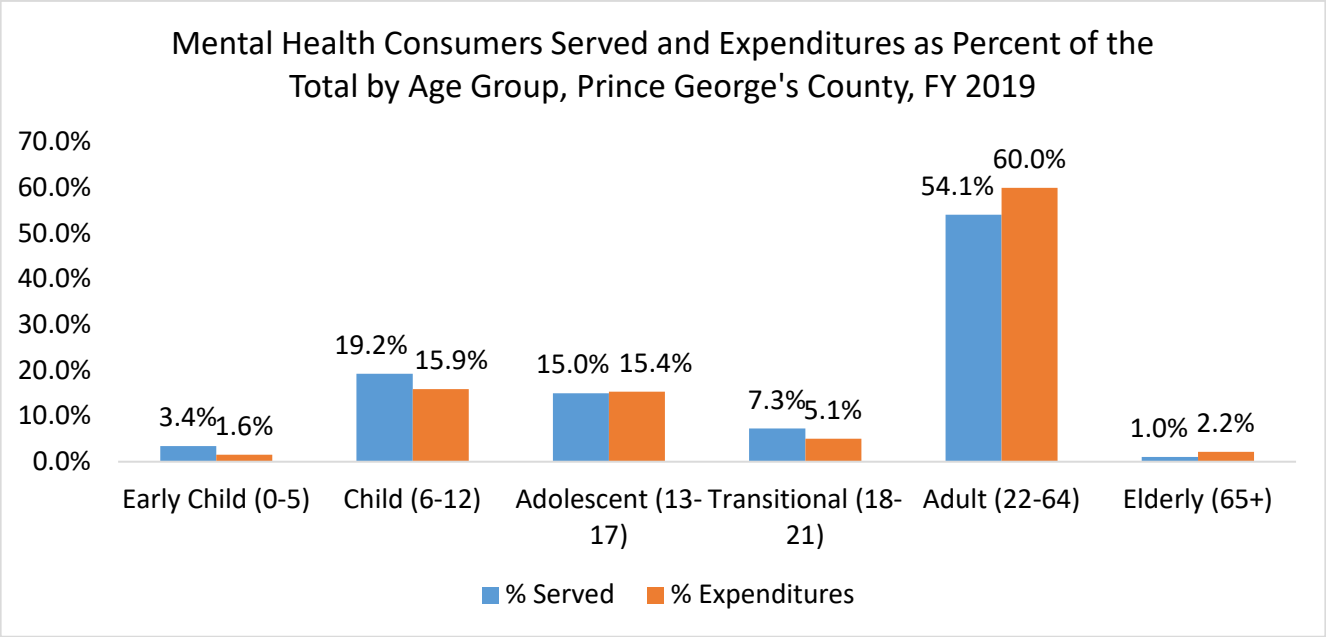
Most consumers who accessed PBHS services had Medicaid insurance. As a result, in FY 2019, 92% of all PBHS expenditures ($100,442.081/$109,508,793) were covered by Medicaid.

Table 1a – Three Year Comparisons by Age

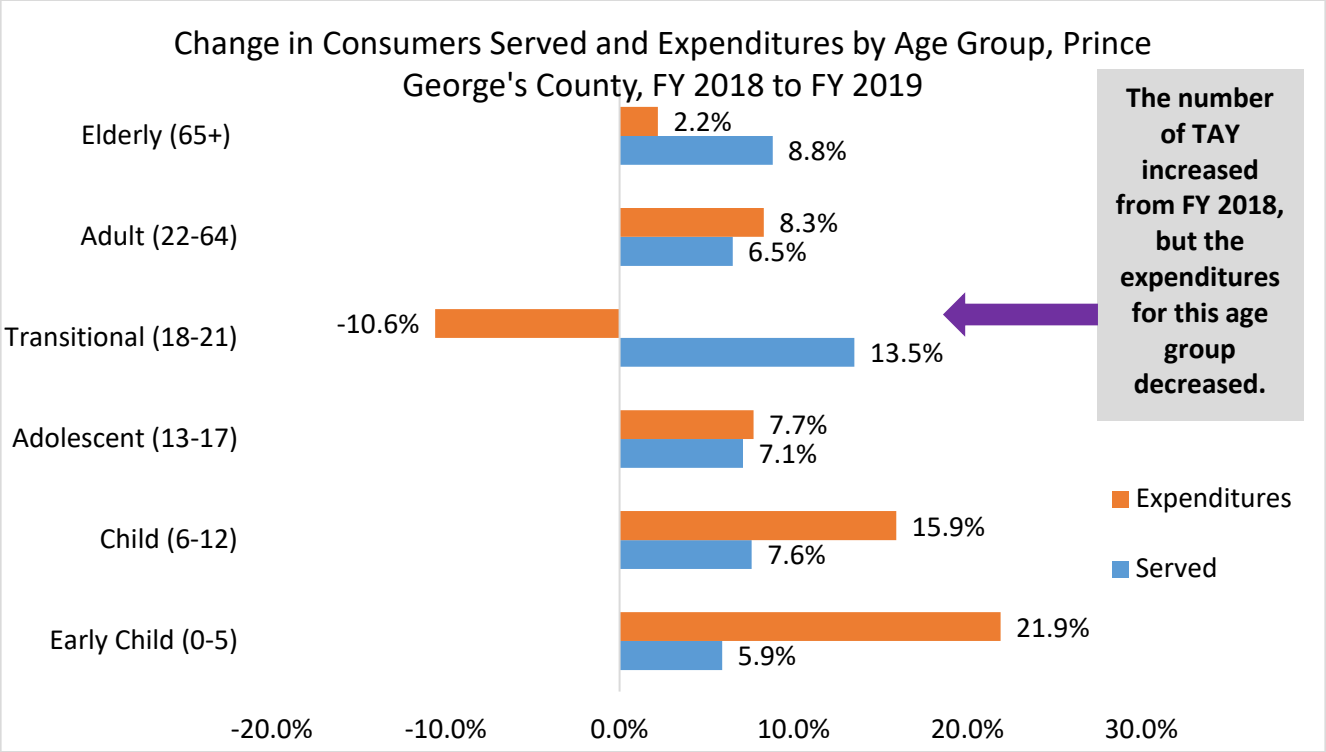


	FY 2017	FY 2018	FY 2019
Early Child	682	732	775
Child	3,697	4,086	4,396
Adolescent	2,988	3,198	3,426
Transitional	1,412	1,466	1,664
Adult	10,592	11,613	12,364
Elderly	216	215	234

The chart above displays the number of consumers by age group that received mental health services over the past three fiscal years. Adults (22-64) utilized more mental health services than all other age groups, representing 54.1% of all served. Children and adolescents, were the second highest category with regard to mental health services utilization in FY 2019. Apart from transitional age youth (18-21), the number of consumers accessing services in FY 2019 remained comparable to previous fiscal years.



There were more expenditures for services for adults (22-64) in the PBHS, than any other age groups. Adults who accessed PBHS mental health services also consumed 60% of the total expenditures.

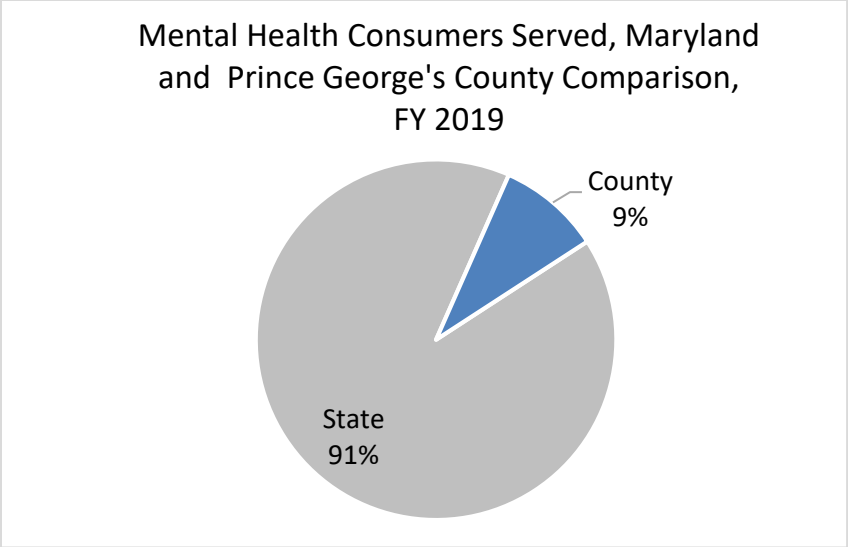


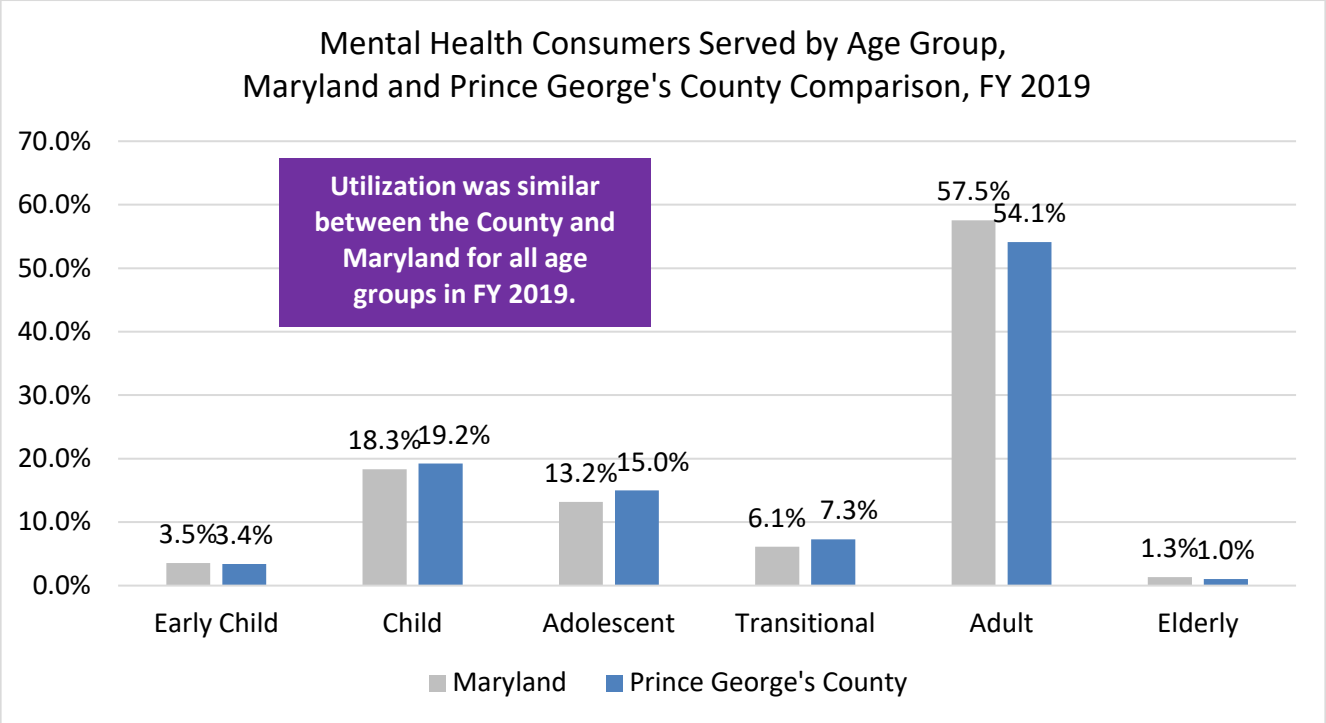
Expenditures increased by 21.9% for early child, ages 0-5, from FY 2018 to FY 2019. This age group also had the least amount of growth over the last two fiscal years, but the highest increase in expenditures compared to all other age categories. Overall, PRP usage for the early child age group nearly doubled during the same period, which likely contributed to the increase in expenditures.

The most significant growth in consumers served was shown in TAY, ages 18-21, whereas 13.5% more youth accessed mental health services from FY 2018 to FY 2019. After a 26.6% increase in expenditures for TAY consumers utilizing services from FY 2017 to FY 2018, there was a 10.6% decrease from FY 2018 to FY 2019. In fact, TAY was the only age group that decreased in expenditures in FY 2019. Elderly, age 65 and over, saw an 8.8% increase in utilization from FY 2018 to FY 2019. The increase may be attributed to the elderly population being the fastest growing population in the County.

Table 3a – State and County Comparison – Mental Health Consumers Served

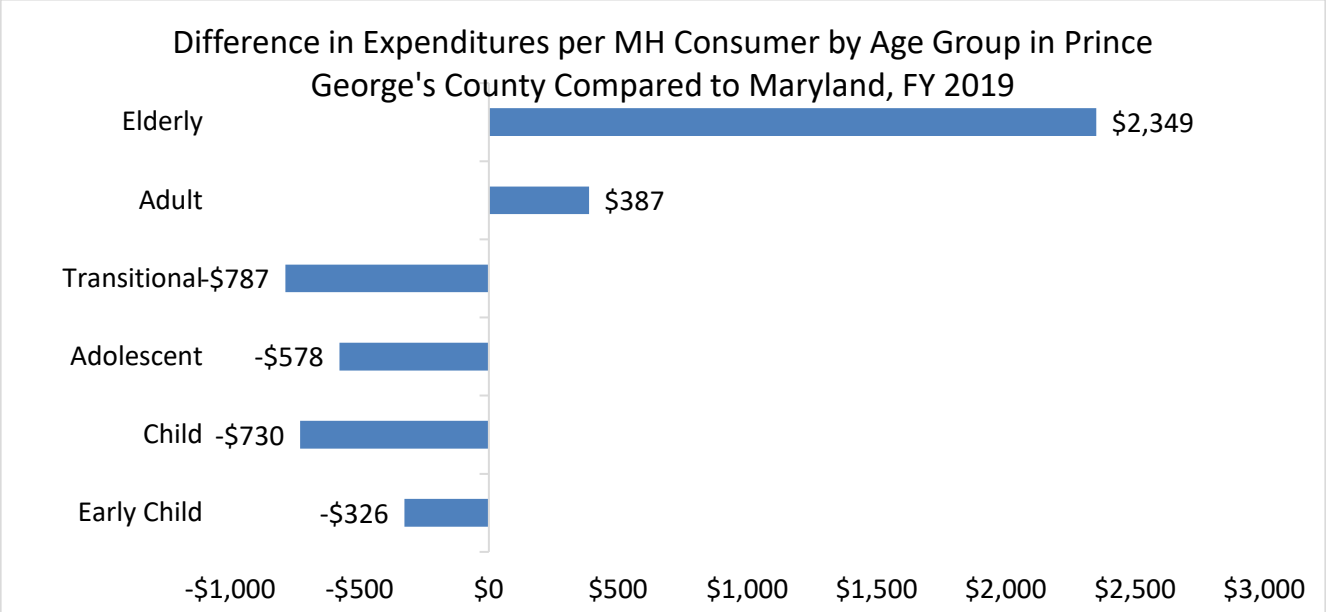
Prince George's County residents who received mental health treatment represented 10% (21,080/212,929) of the total number of consumers served in the PBHS Statewide and utilized 9.9% ($99,670,122/$1,004,778,041) of the total expenditures.





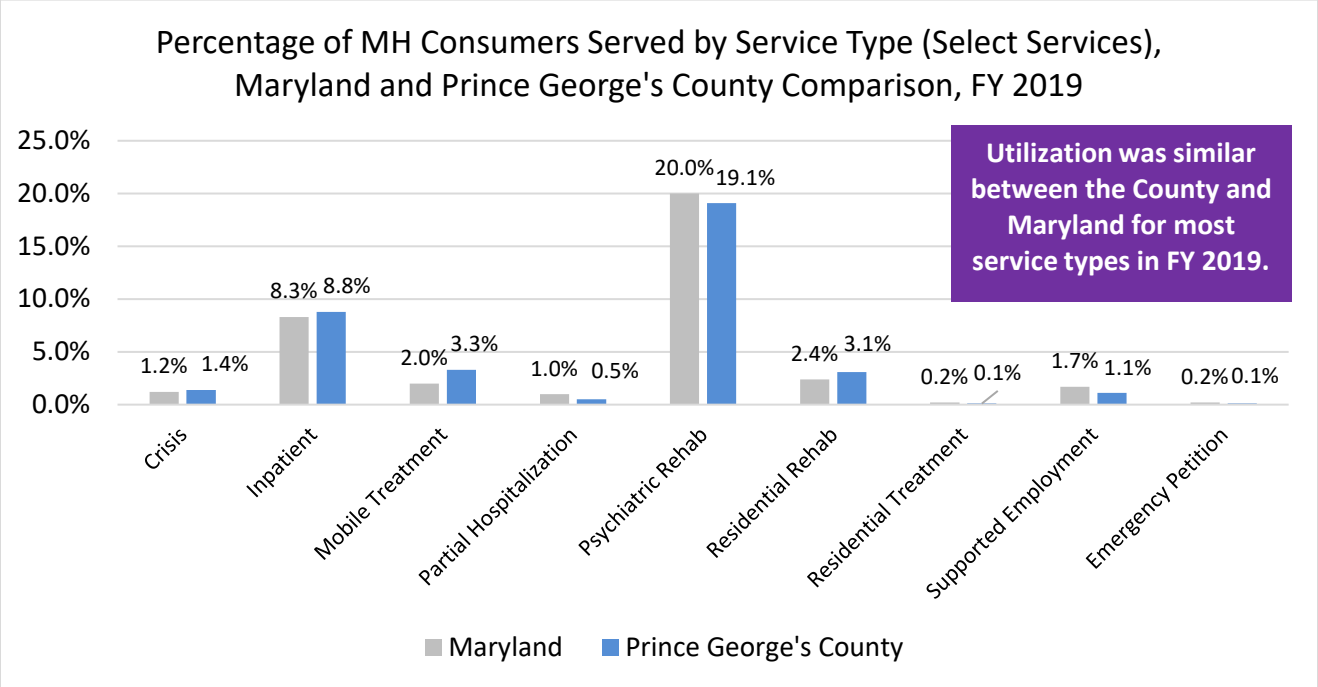
Adults, ages 22-64, overwhelmingly accessed mental health services more than any other age category. Children, adolescents and transitional age youth continue to have a slightly larger representation in the County compared to the State. The elderly population for the County, which has the least representation in the PBHS, has representation that is comparable to the State's at 1.0%.

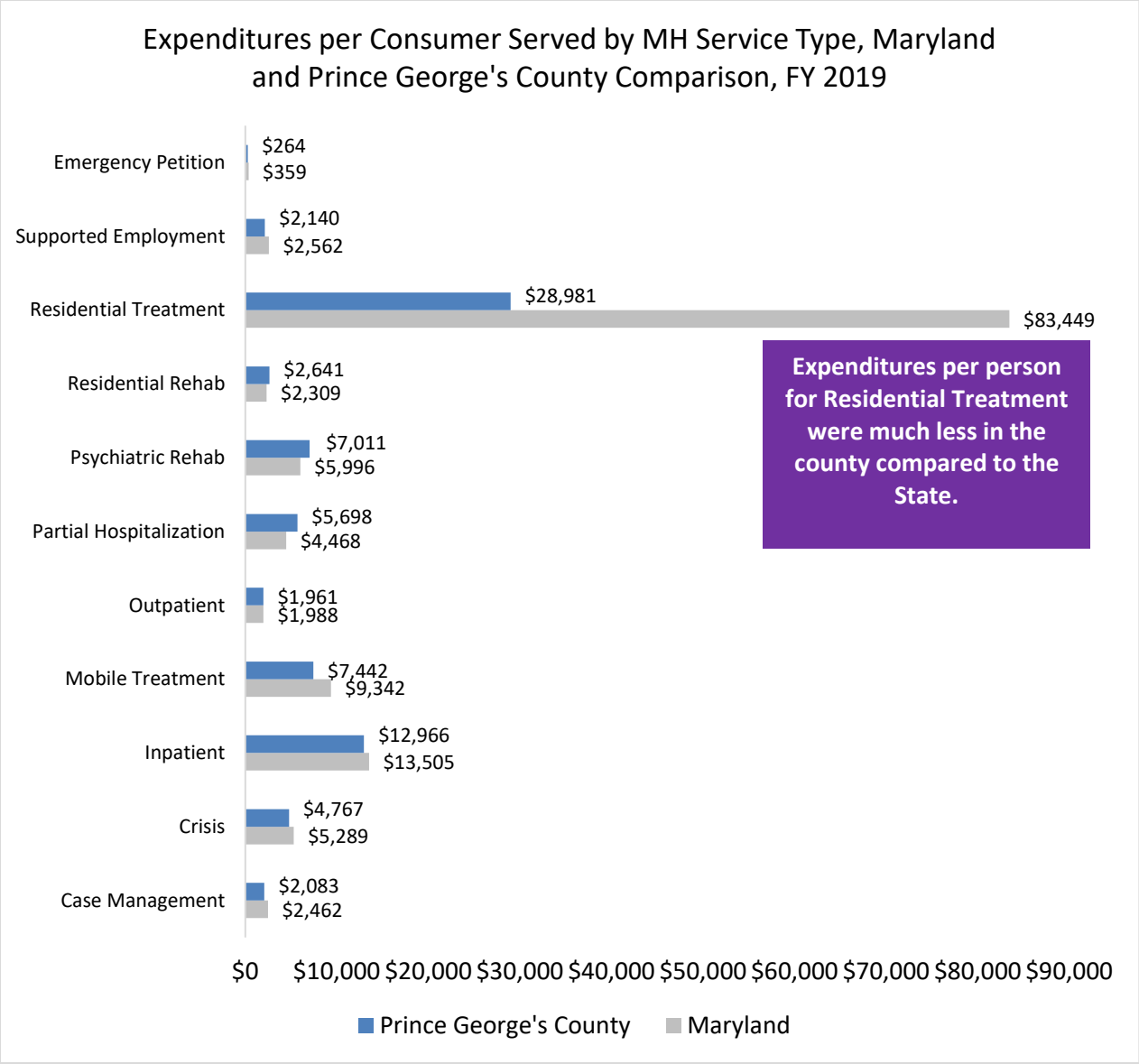
Table 3b – State vs. County – Cost per Consumer



Prince George's County PBHS expenditures for each age group are very similar to the State percentages; however, there are marginal differences that exist. The most significant difference is shown in the percentage of expenditures for the elderly, ages 65 and over, who accessed PBHS services. The County expended less funding on mental health services for TAY, ages 18-21, when compared to the percentage of state expenditures for this age group; however, a higher percentage of TAY were served.

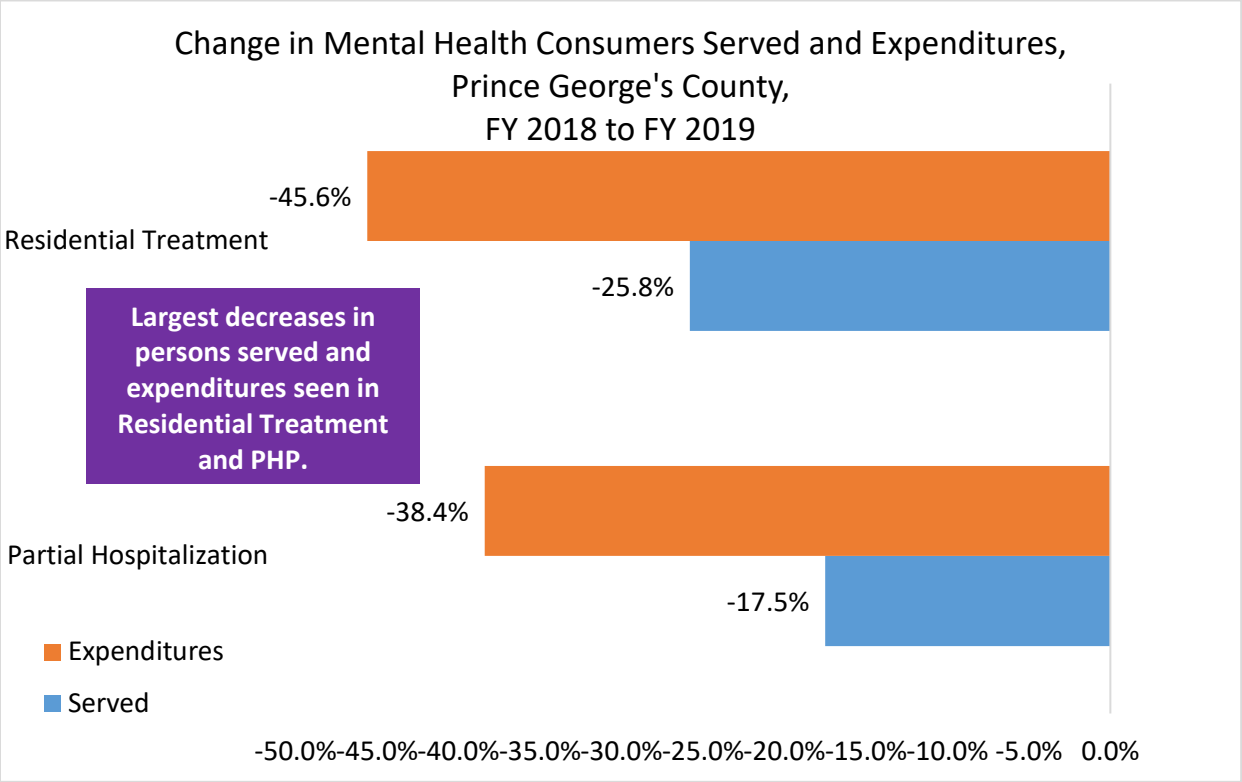
Table 3a – State and County Comparison by Service Type



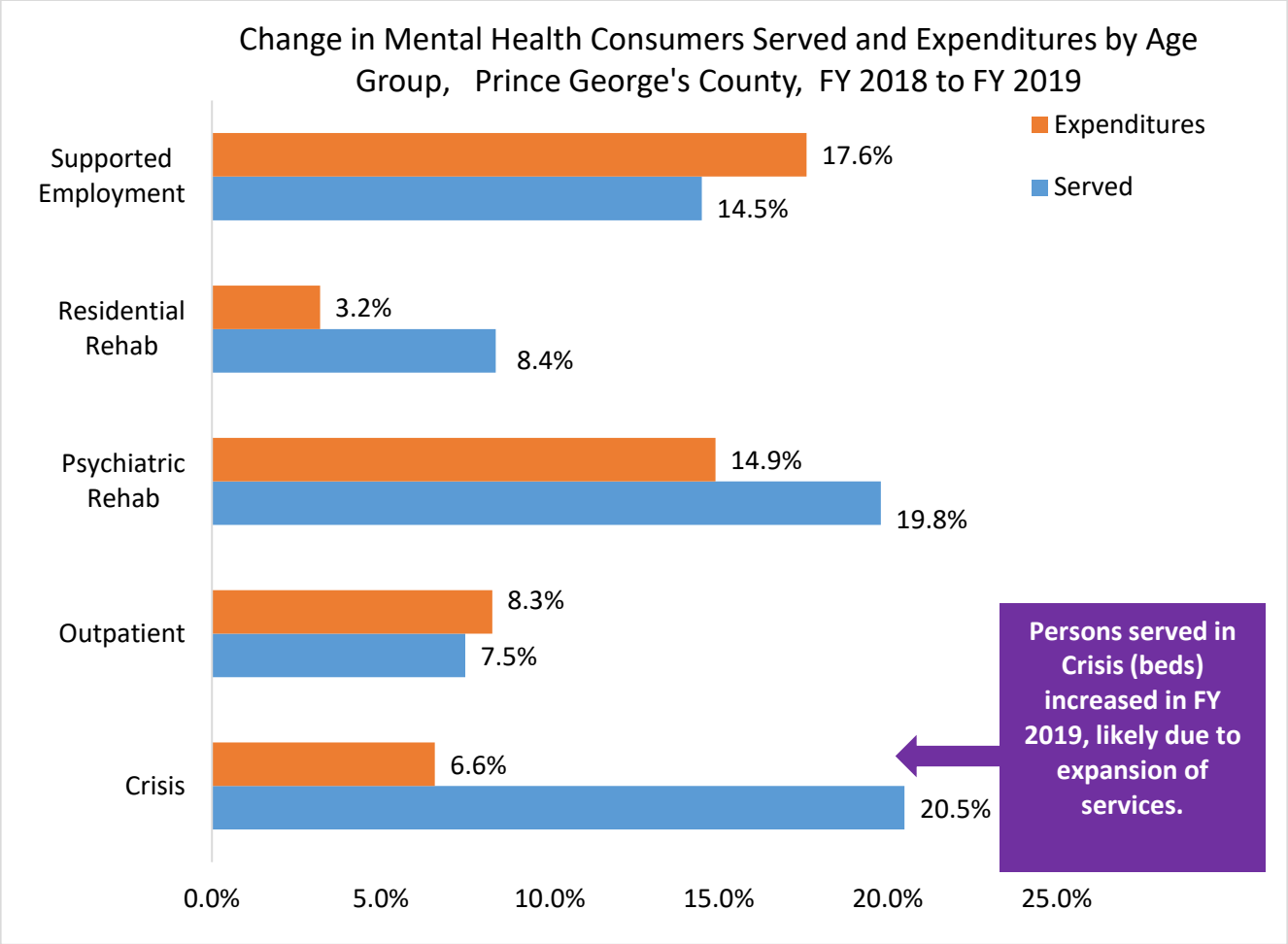


Prince George's County had a higher percentage of expenditures for partial hospitalization program (PHP), psychiatric rehabilitation program (PRP) and residential rehabilitation program (RRP) services than for the State.

Table 1b. Three Year Comparisons by Service Type

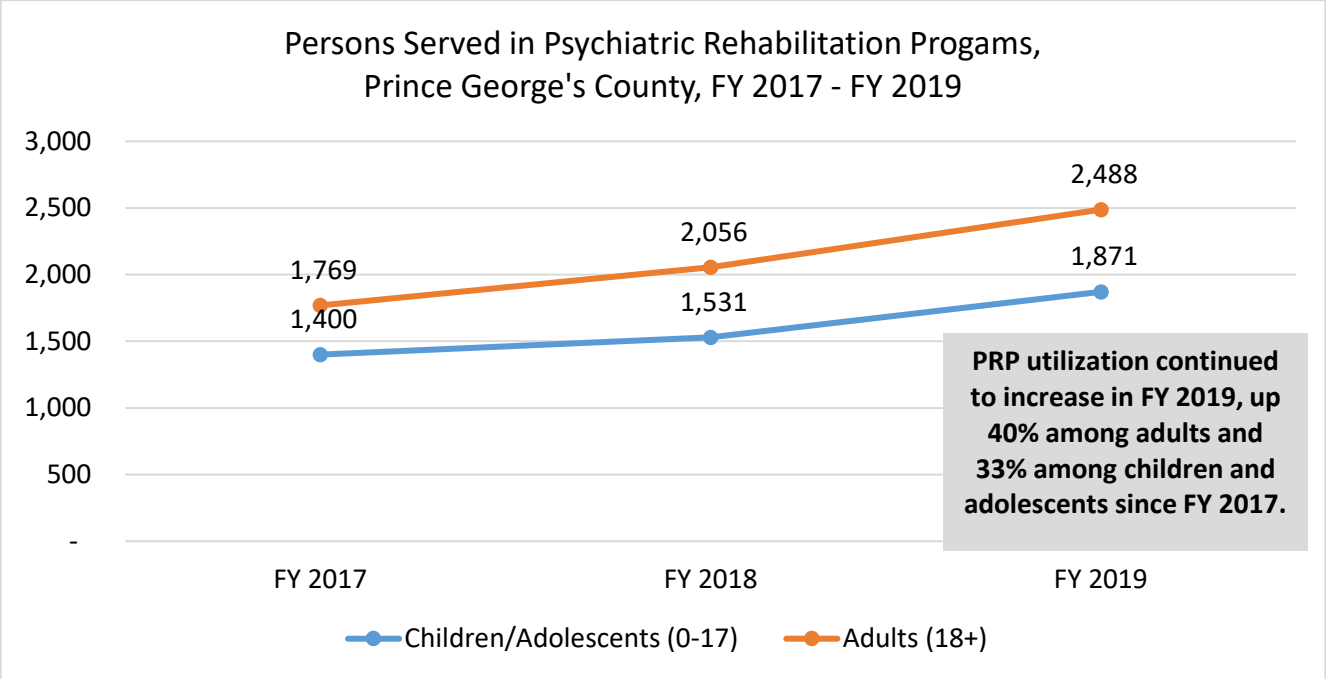


Residential treatment and PHP services and expenditures both decreased in FY 2019. With only six (6) residential treatment facilities available, each varying in eligibility criteria, there is typically a wait for placements to occur due to bed availability. Regarding PHP services, there are two in the County. One program is at Laurel Regional Hospital that can serve 22 patients and the other located at UMCRH, which has the capacity for 14 patients. When the new UMCRH hospital opens in April 2020, it will have the capacity to serve 28 PHP clients. The PHP programs are heavily underutilized in the County, however, the UMCRH behavioral health staff have increased their outreach efforts and are working with community providers to educate them about PHP services offered and how they can be accessed.



Utilization and expenditures both increased in FY 2019 for SEP, RRP, PRP, outpatient and crisis residential services. Authorizations also increased for SEP. In FY 2019, there were 369 SEP authorizations, a 17% increase from FY 2018 (307). The Prince George's County residential crisis beds provider recently expanded to Howard County and is working towards expanded services to Washington County. The LBHA program monitors have also increased their efforts to encourage providers to utilize crisis beds to assist with client stabilization and as an alternative to filing emergency petitions. The increased access to crisis bed services, albeit in a nearby county, accompanied by the actions of the LBHA staff, may explain the overall percent increase in usage.

Table 2b – Three Year Comparison Children and Adults



20%

Increase in the number of PRP providers in Prince George's County from FY 2018 to FY 2019.

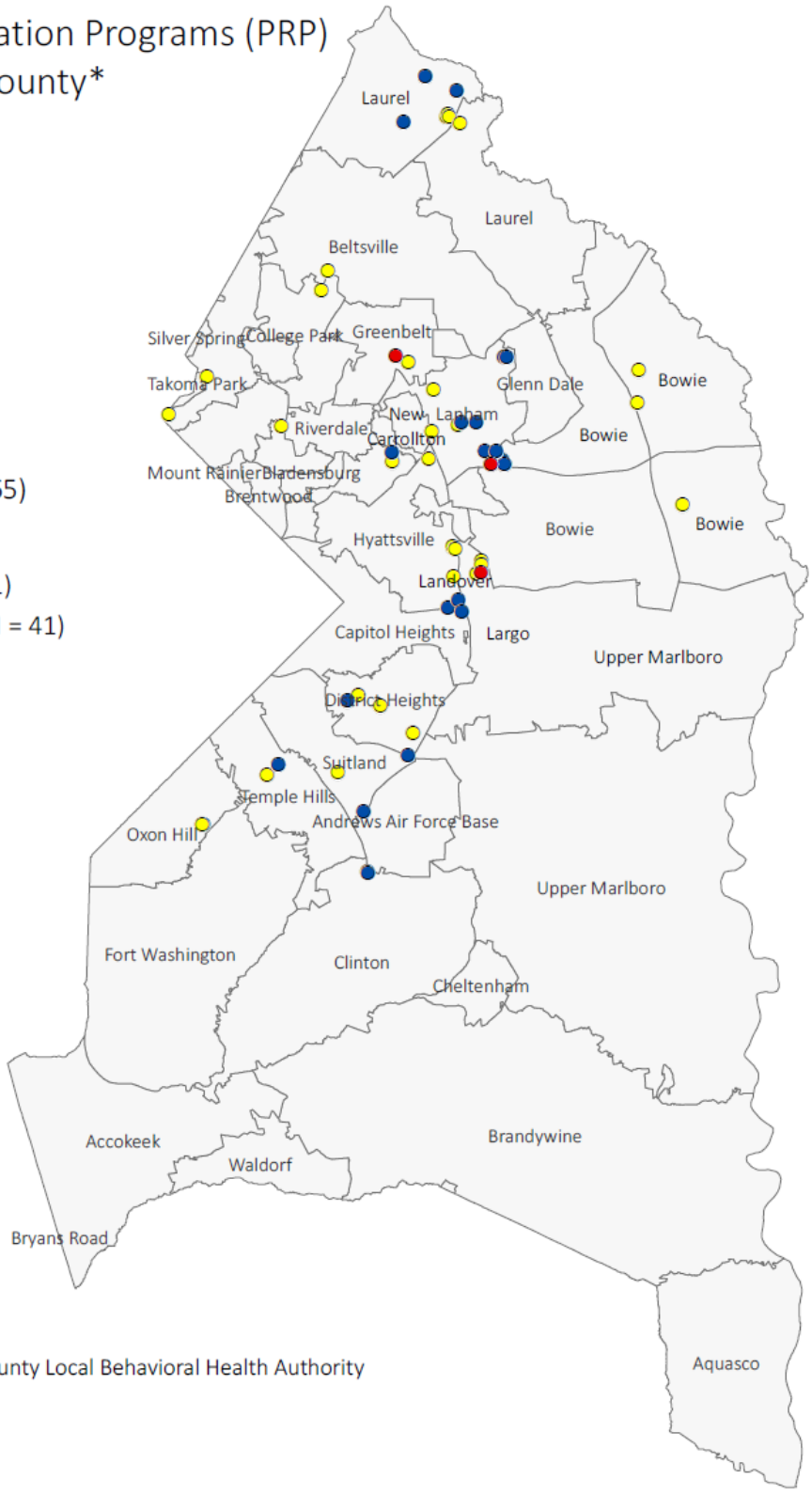
There are more PRP programs than any other PBHS services in the County and the number of PRP providers continues to increase. In FY 2019, there were 66 licensed adult PRP programs and 48 licensed child/adolescent PRP programs. At the time of this report, there were 65 adult PRP programs making services more accessible to residents. The increase in usage of these services can also be attributed to the overall growth of the PBHS.

Below is a map of PRP services monitored by the Prince George's County LBHA as of January 2020.

Psychiatric Rehabilitation Programs (PRP) in Prince George's County*

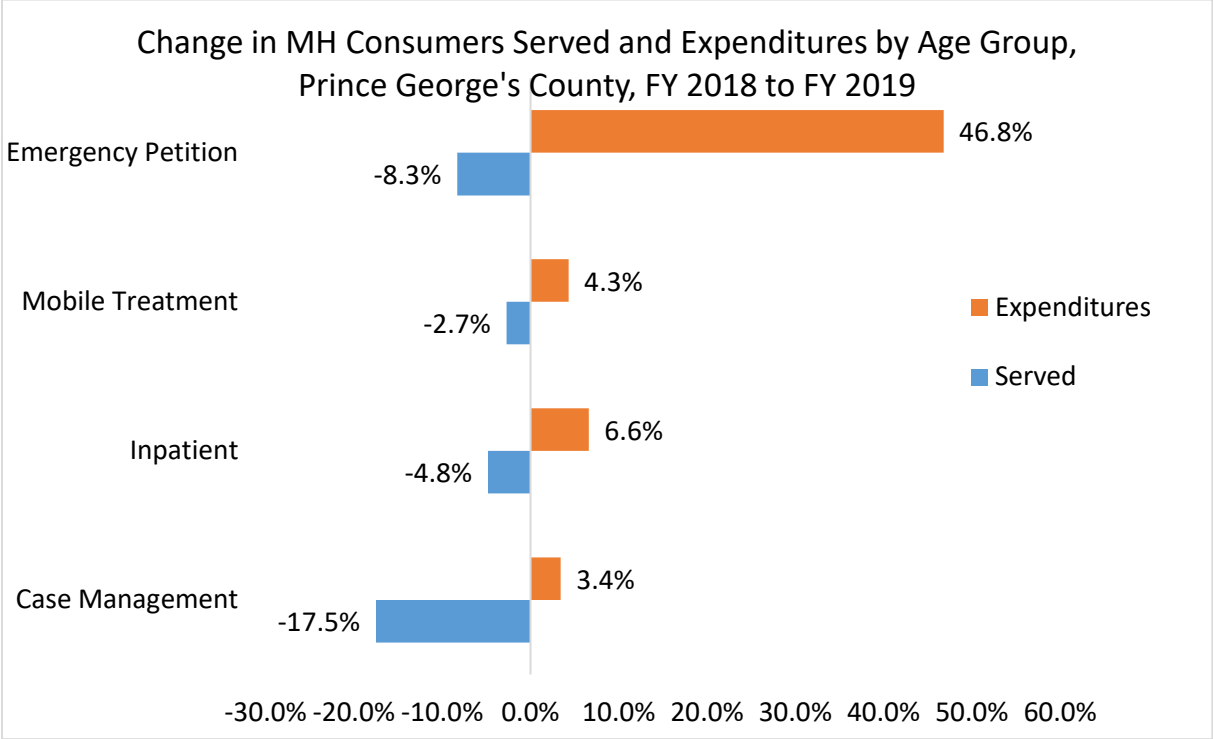
PRP Program by Type (N = 65)

- Child PRP Only (N = 3)
- Adult PRP Only (N = 21)
- Child and Adult PRP (N = 41)



*As of January 15, 2020
Data Source: Prince George's County Local Behavioral Health Authority

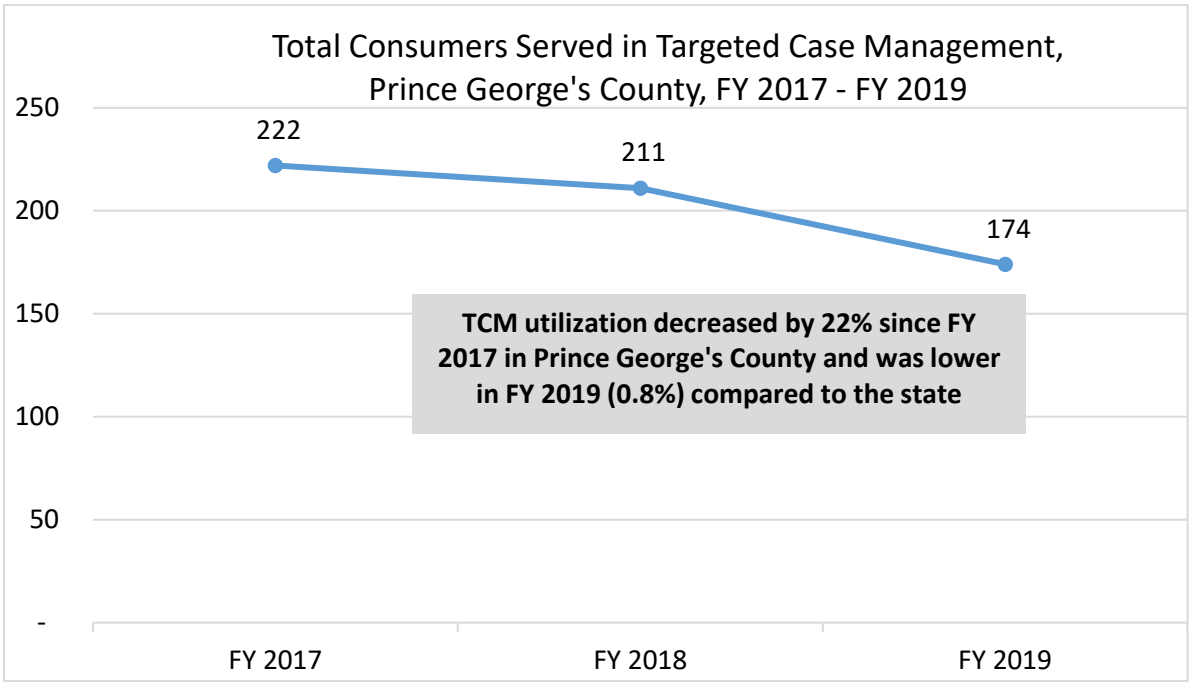
Table 1a – Services and Expenditures that Moved in Opposite Directions



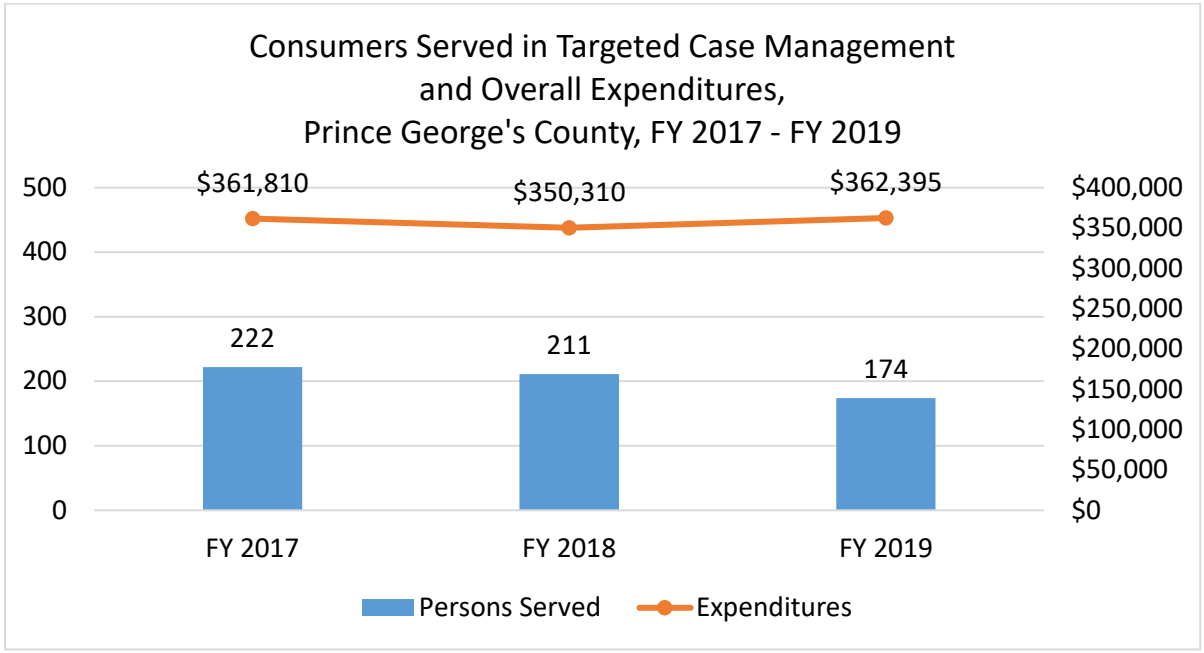
Case management, inpatient admissions, mobile treatment and emergency petitions usage decreased in FY 2019, however, expenditures for these services increased during the same period. The County has gained new mobile treatment providers to bring the total to four (4) providers. Mobile treatment providers are encouraged to enhance their outreach efforts. While emergency petitions appear to have a significant increase in expenditures (46%), this percentage represents a total amount of $2,779. The decrease in inpatient services utilization may be contributed the diversion efforts of the LBHA and grant-funded services, such as the hospital diversion staff and Crisis Response Clinician, and increased communication with behavioral health hospital staff at UMCRH.

Tables 1b and 2cii – Targeted Mental Health Case Management Analysis

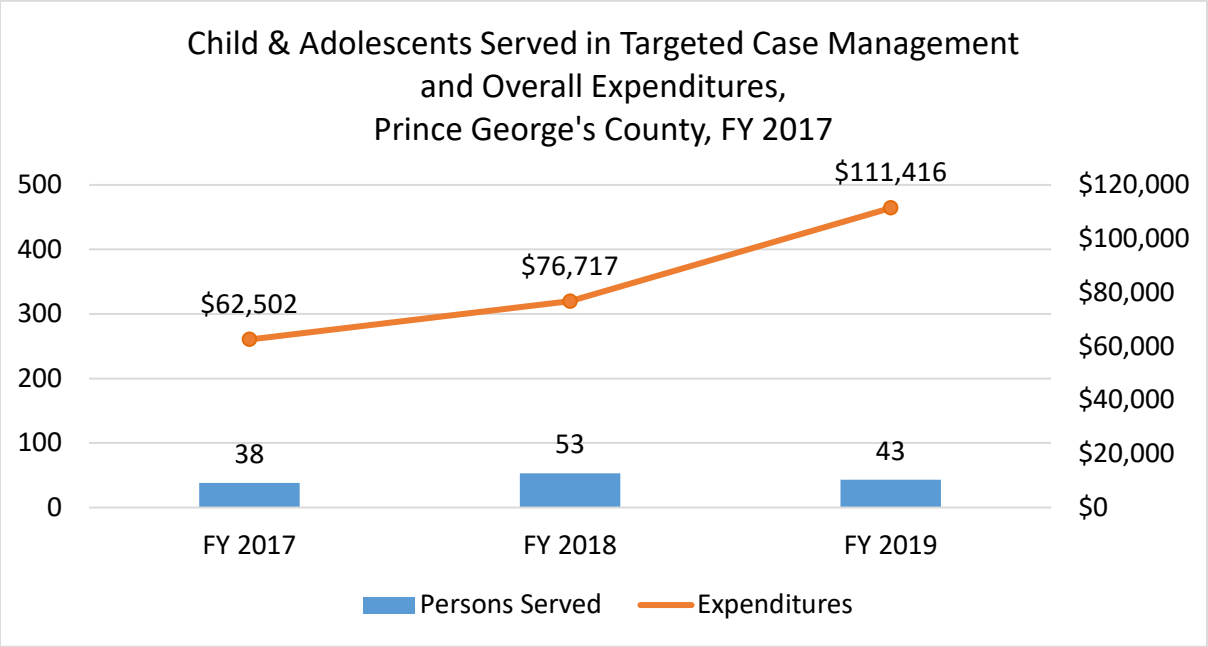
To meet the requirements of the Centers for Medicare and Medicaid Services, the Behavioral Health Administration has mandated local authorities to report on TCM utilization of adolescents and adults compared to the statewide average of these services. The following graphs provide an analysis of the utilization of TCM in Prince George' County:



Utilization for Targeted Case Management services continued to decreased from FY 2017 to FY 2019.



Although the total number of consumers who received TCM services decreased over the past three fiscal years, the total overall expenditures slightly decreased from FY 2017 to FY 2018 and slightly increased from FY 2018 to FY 2019, generally remaining somewhat consistent over the two year period.



The increase in overall TCM expenditures from FY 2018 to FY 2019 is directly related to the children and adolescents who received TCM services, as the expenditures for the adult consumers declined from FY 2018 to FY 2019 (see chart below). The 45% increase in expenditures is attributed to the 3.5% reimbursement rate increase for FY 2019. It is also possible that the TCM program served less clients for longer lengths of time.

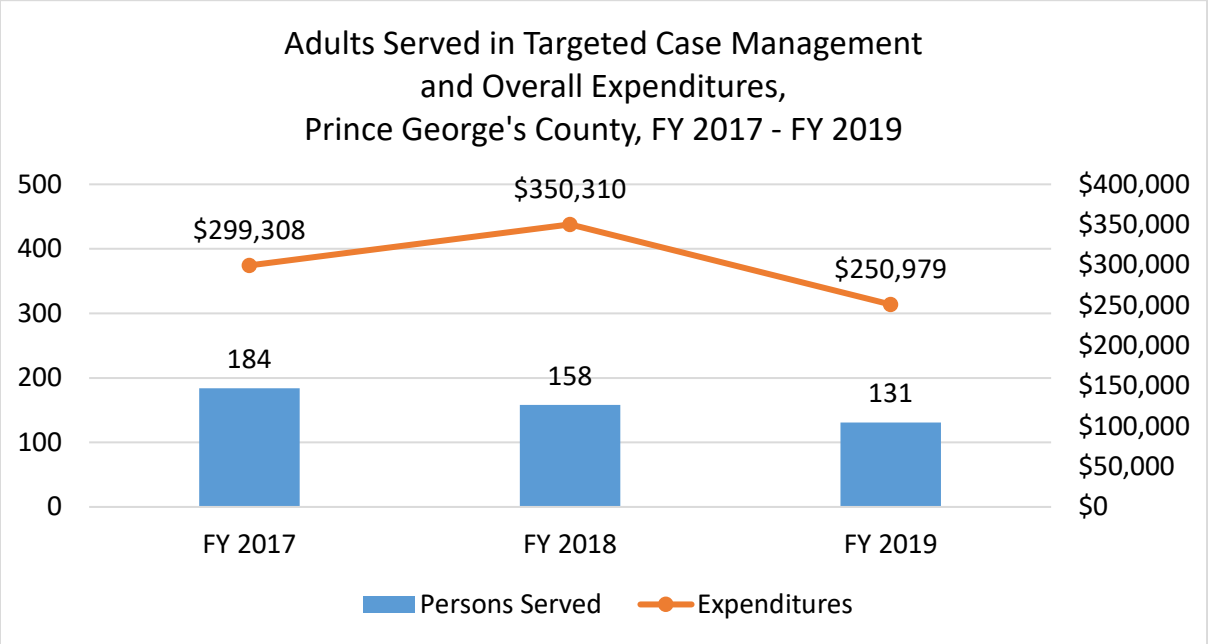
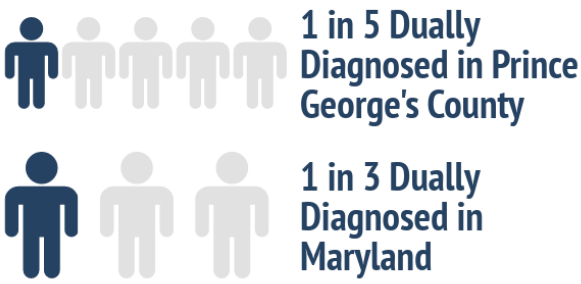
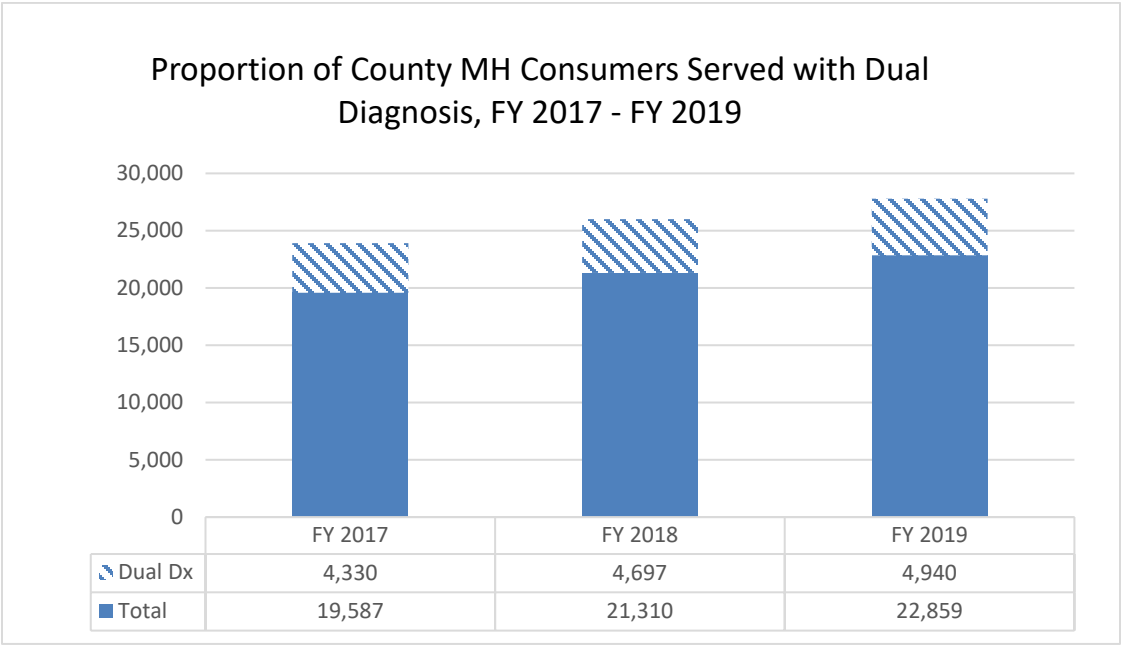


Table 3a and 3c – State and County Comparison – Dually Diagnosed Individuals

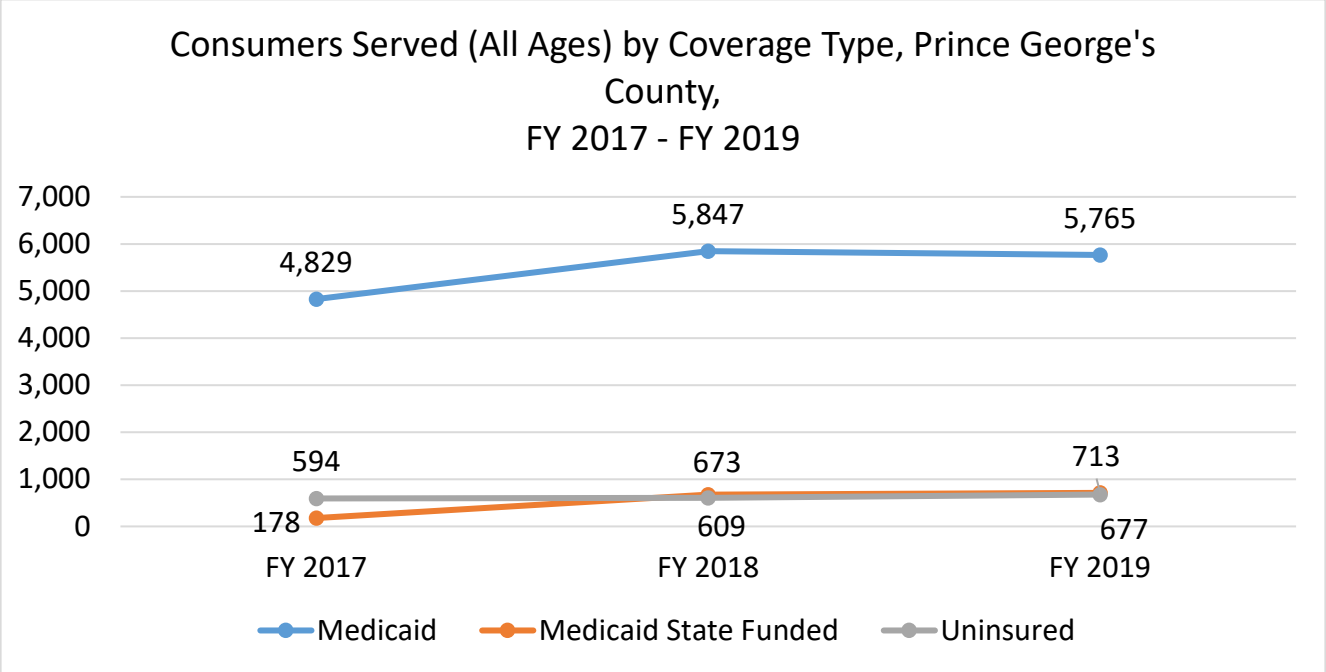


The data indicates that the number of consumers with dual diagnoses have continued to increase each year. In FY 2019, 21.6% of consumers served in the County's PBHS had a primary mental health diagnosis and a secondary substance related diagnosis, and utilized 36.7% ($40,258,497/$109,508,793) of the total expenditures. Expenditures increased at a higher rate than the number of consumers served.

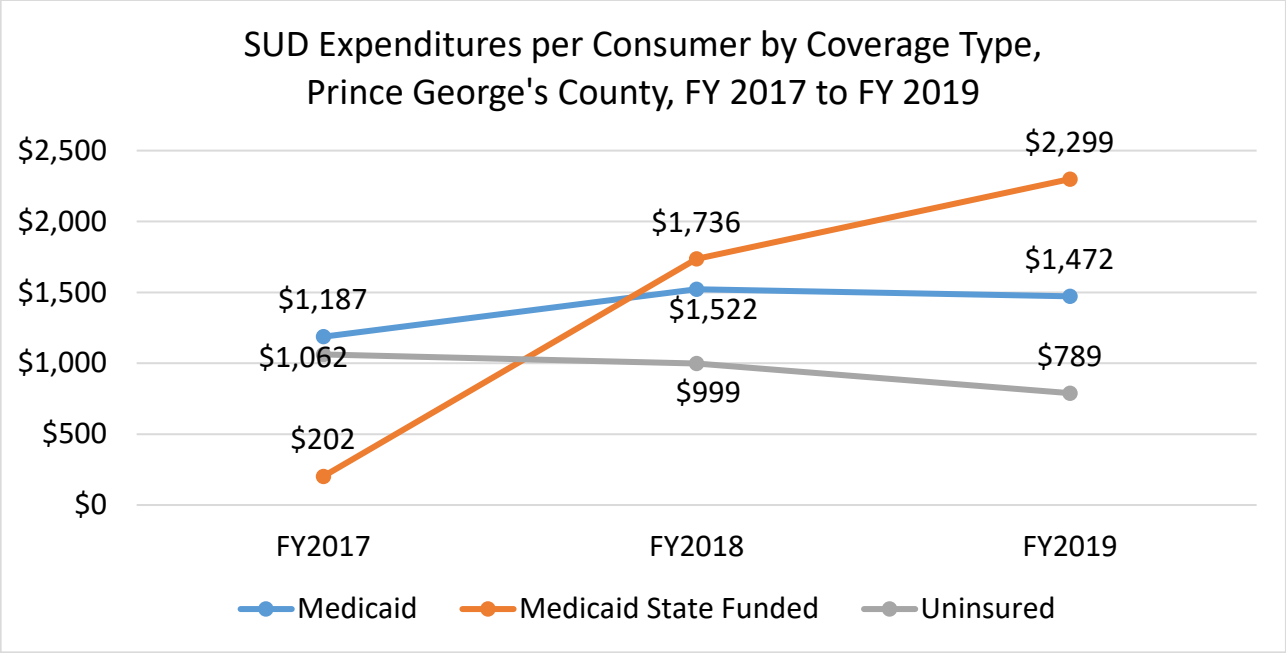


SUD Data Analysis

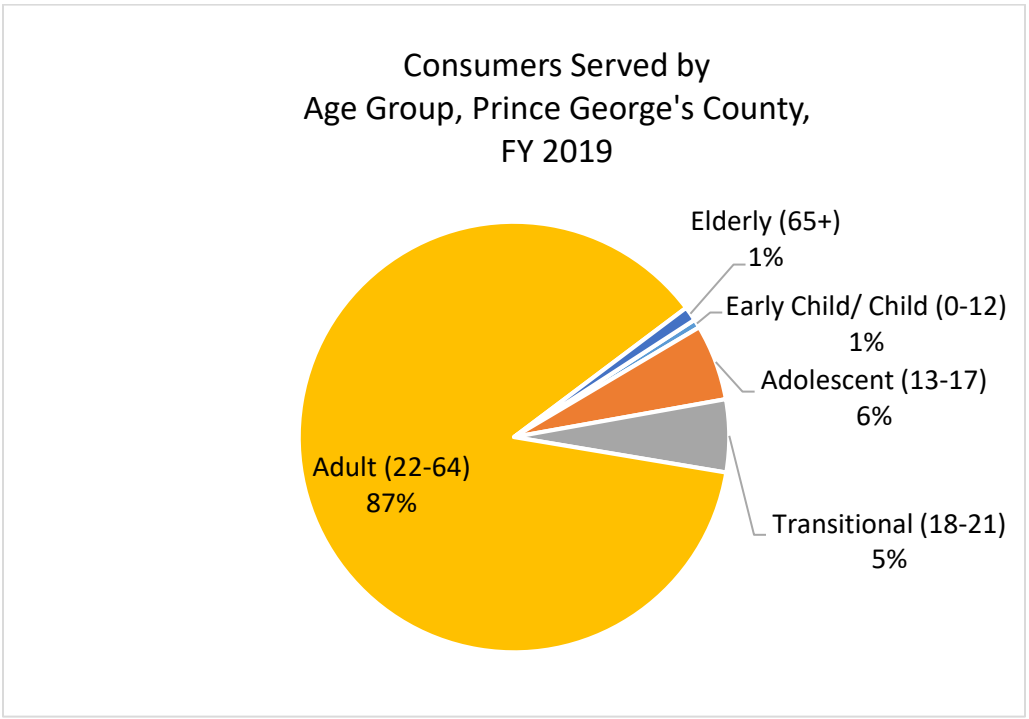
Table 1c. SUD Three Year Comparisons by Coverage Type



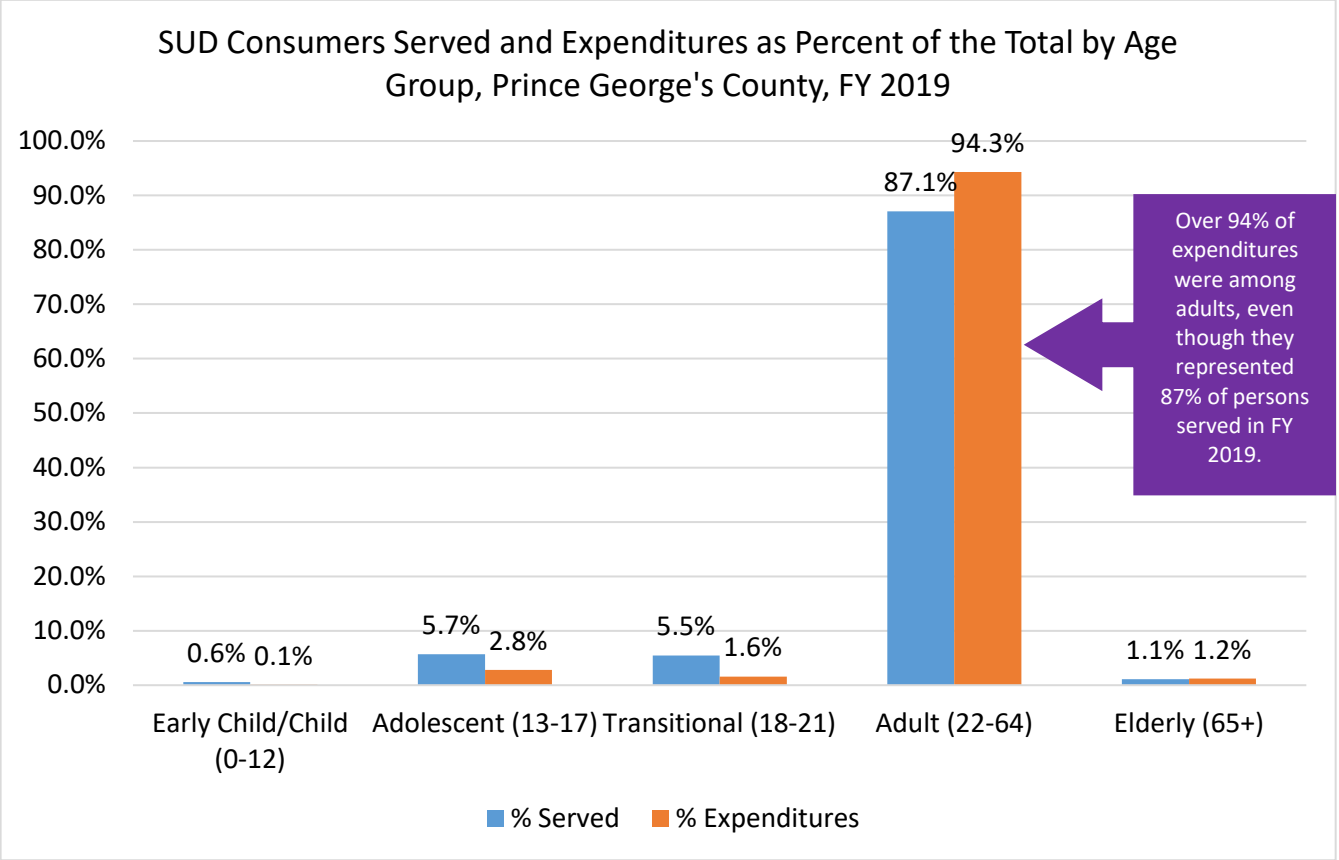
In FY 2019 93% of the consumers served had Medicaid, 12% received services covered by Medicaid State Funds, and 10% were uninsured. From FY 2017 to FY 2018 there was an increase in consumers served with Medicaid of 21%, but from FY 2018 to FY 2019 there was a small decrease in service utilization by 1.4%. There was a significant increase in consumer use of Medicaid State Funding from FY 2017 to FY 2018 of 278%. This increase was likely the result of residential treatment going fee for service July 1, 2017, and room and board being reimbursed via Medicaid State Funds. Medicaid State Funding increased slightly by 5.9% from FY 2018 to FY 2019. The number of consumers who were uninsured and utilized services from FY 2017 to FY 2018 increased modestly by 2.5%, and again from FY 2018 to FY 2019 by 11.2%.



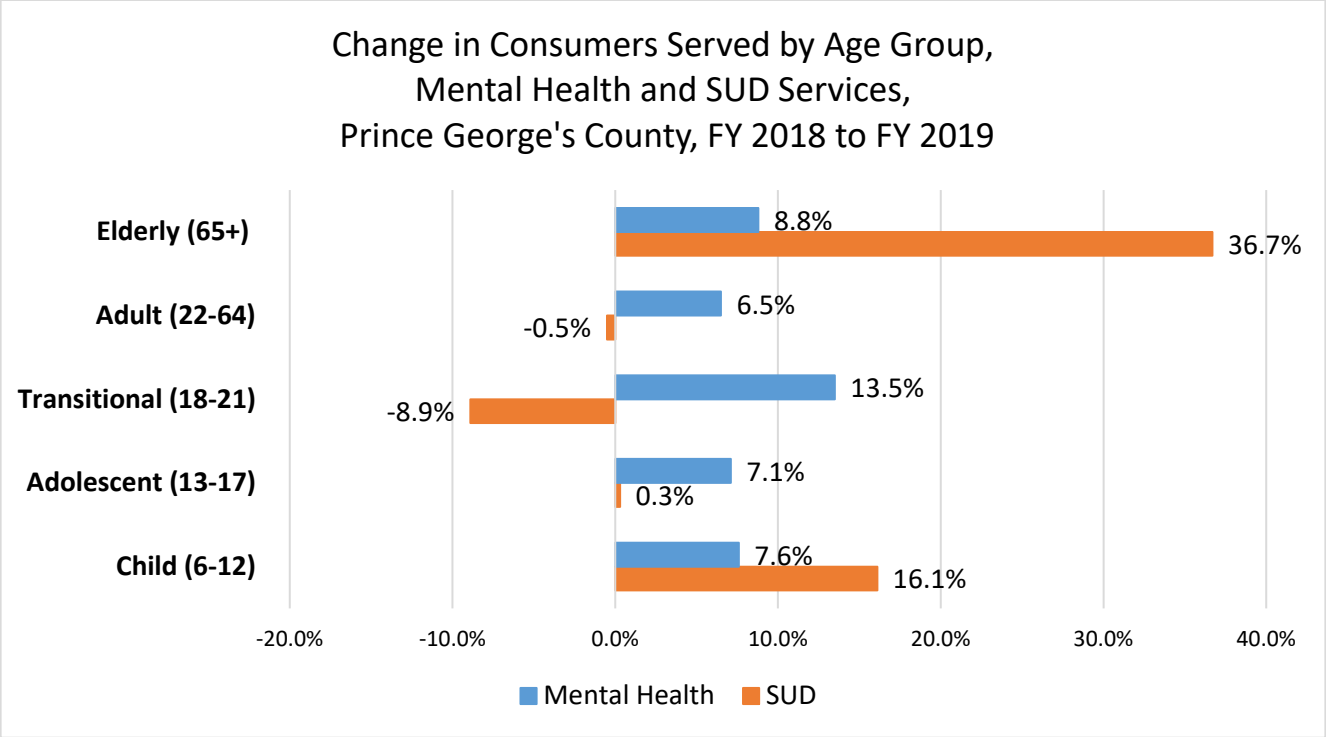
From FY 2017 to FY 2019, there was a steady increase in Medicaid State Funded expenditures, while expenditures for all other coverage types decreased. The most significant increase was in FY 2018, whereas Medicaid State Funded expenditures increased more than 30 times the amount of the previous fiscal year's expenditures, ($35,949 to $1,168,180). Expenditures continue to increase more modestly, by 40%, from FY 2018 to FY 2019. SUD residential treatment became Medicaid reimbursable July 1, 2017, under which Medicaid State Funds reimbursed costs for room and board. This new reimbursement likely explains the sharp increase in Medicaid State Funded expenditures across FY 2017 – FY 2019.



The total number of consumers receiving substance use disorder services decreased by 34 (0.5%) from FY 2018 to FY 2019. Consumers served during FY 2019 were predominantly adults, ages 22-64, (5,380/6,176), with adolescents, ages 13-17 and transitional aged youth (18-21) being the second and third most served populations.



Expenditures for adults, ages 22-64, served outpaced the number of adults served during FY 2019. There were more adults served compared to all other age groups in FY 2019. Adults also accessed more costly services, such as residential treatment. The percentage of expenditures for children, adolescents and transitional age youth, ages 0-21, were less than the percentage of consumers served. This may be due to children and adolescents accessing less costly outpatient services.

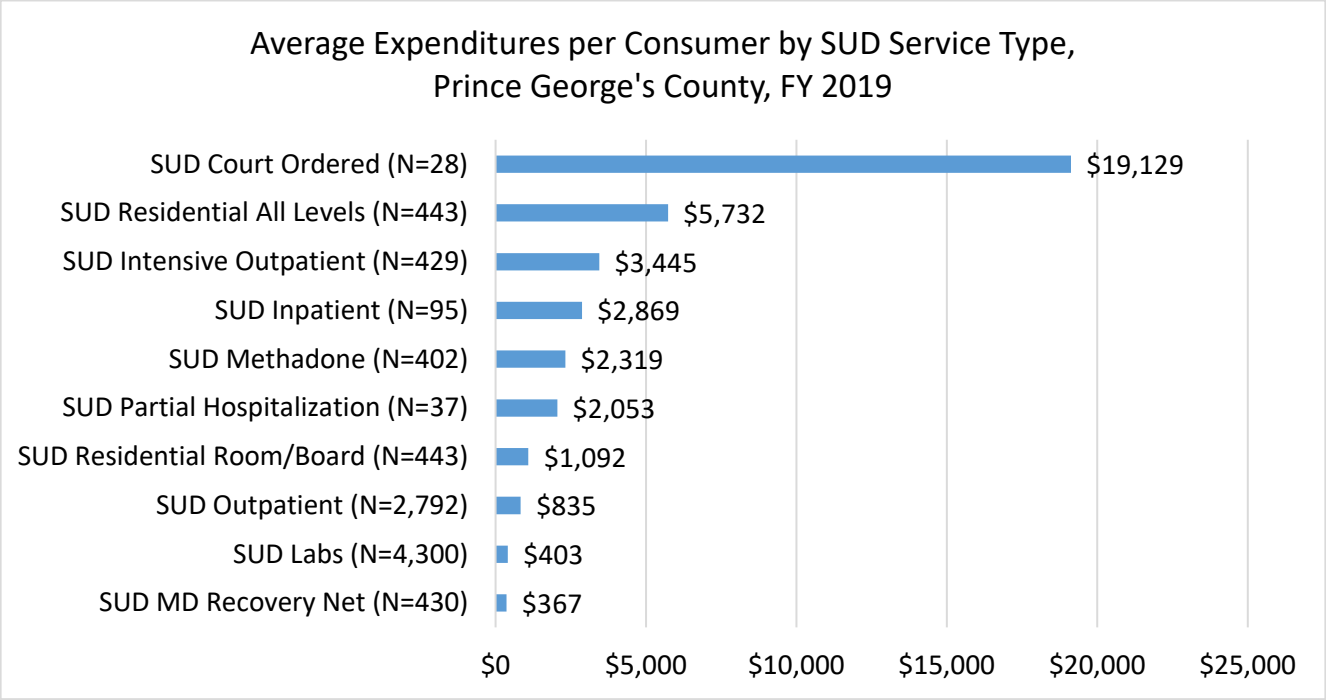


The data above indicates that the number of mental health and SUD consumers for all age groups increased from FY 2018 to FY 2019, except for transitional aged youth, ages 18-21, and adults, ages 22-64, receiving SUD services.

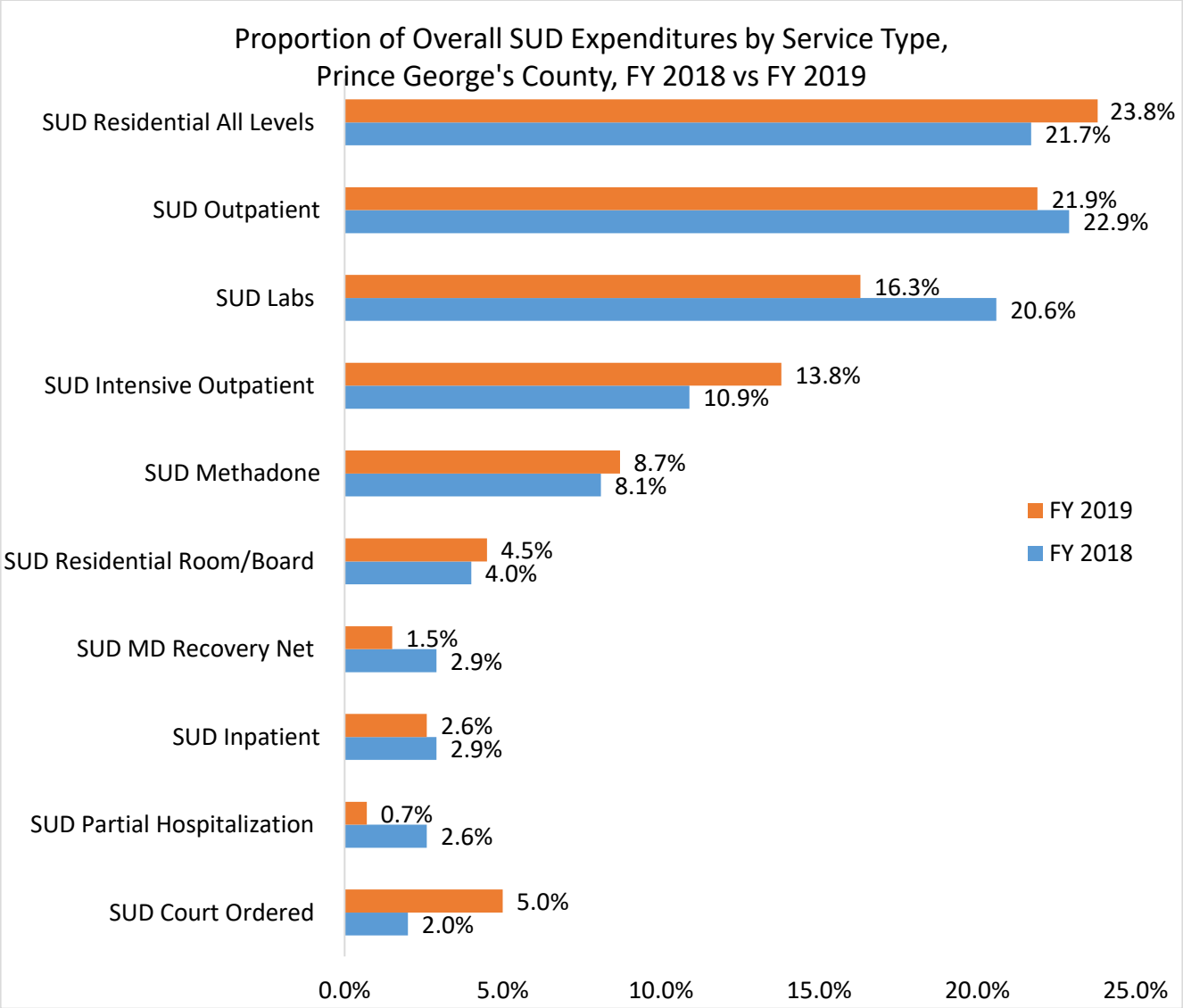
The largest percent increase for SUD services was seen in the elderly population, ages 65 and over, from FY 2018 to FY 2019, which increased by 36.7%. Elderly consumers exhibited an increase of SUD outpatient treatment and methadone maintenance during this period.

It can be speculated that the decrease in transitional age youth receiving SUD services may be the result of fewer youth seeking treatment since marijuana was decriminalized. The TAY population accessed more outpatient mental health treatment, SEP and PRP services in FY 2018 compared to FY 2019, which contributed to a 13.5% increase in the number of TAY served during the same period.

Table 1b. Three Year Comparisons by Service Type

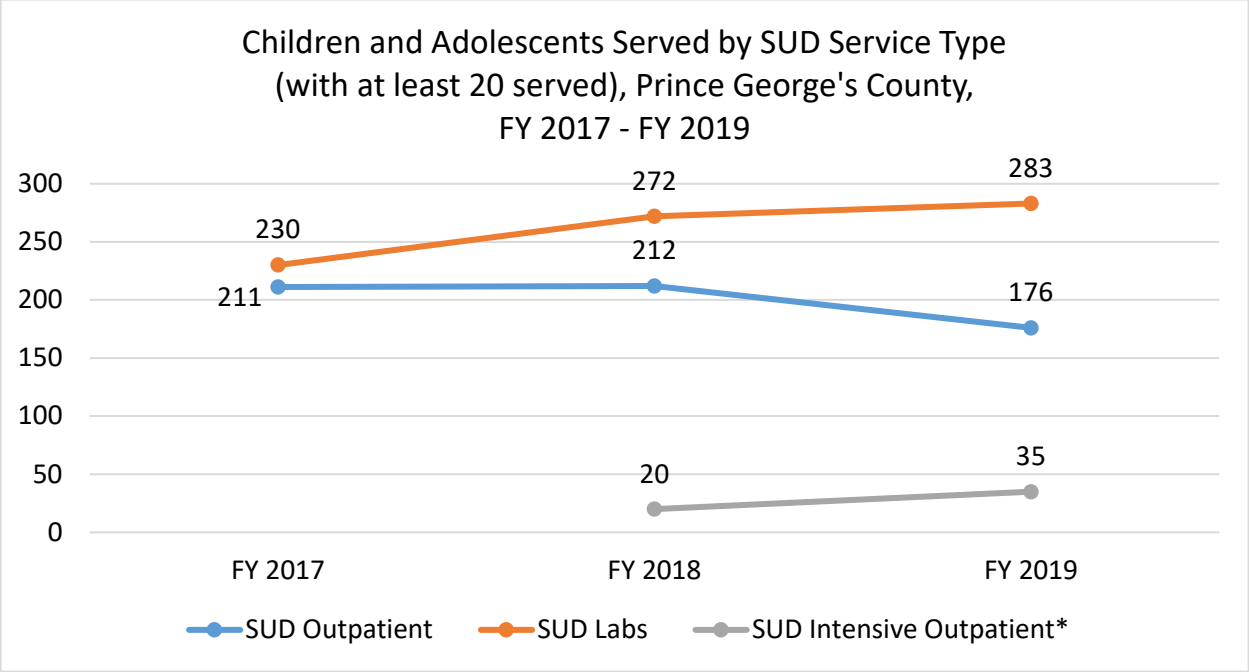


The most expensive service type per consumer in FY 2019 was SUD court ordered treatment. The cost per person for SUD court ordered placement for residential services is higher than all other service types, followed by all levels of residential treatment and IOP. However, compared to the State, court ordered treatment per consumer is 20% less than the State's average.



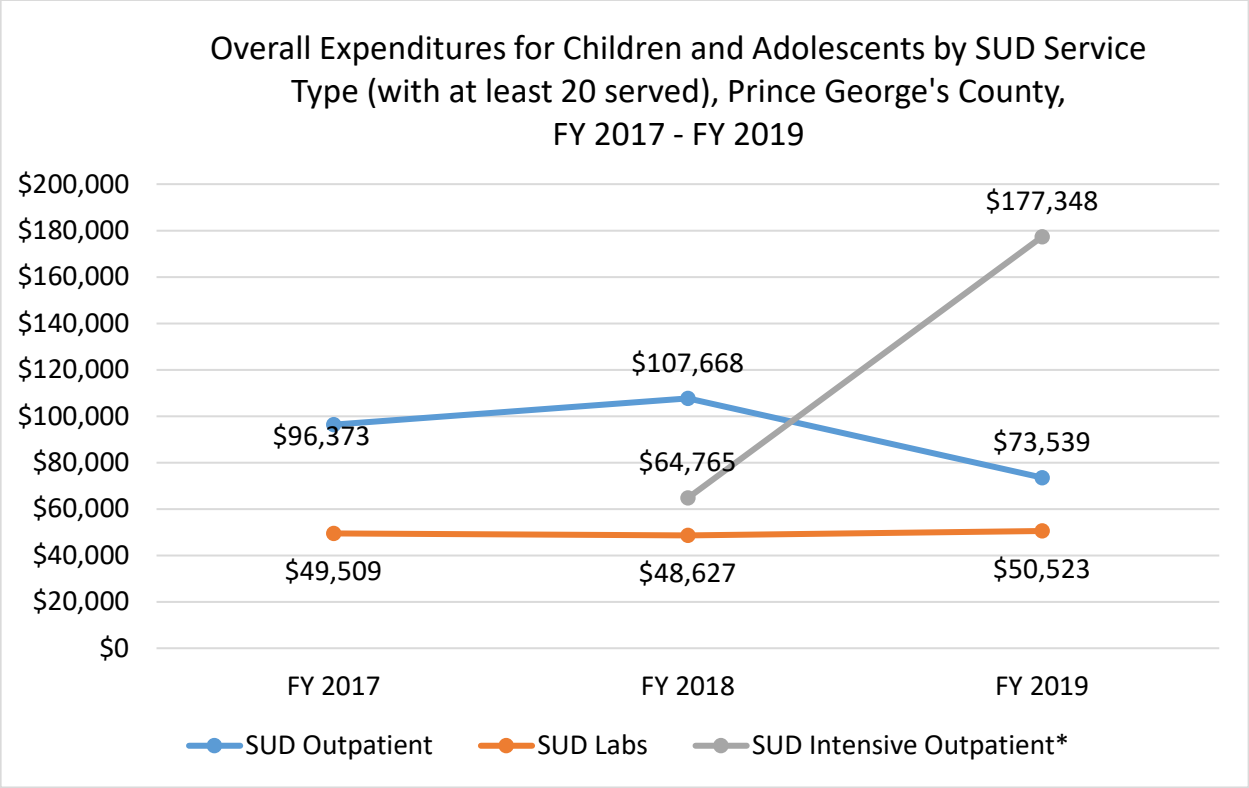
SUD residential treatment at all levels (3.7,3.3, 3.5) along with SUD outpatient and labs, consumed the largest percentage of overall expenditures in FY 2018 and FY 2019. Residential treatment level 3.1 transitioned to fee-for-service as of January 1, 2019, which may have contributed to the increase in service.

Table 2a. Child/Adolescents (0-17)



*Data for FY 2017 IOP services has been suppressed.

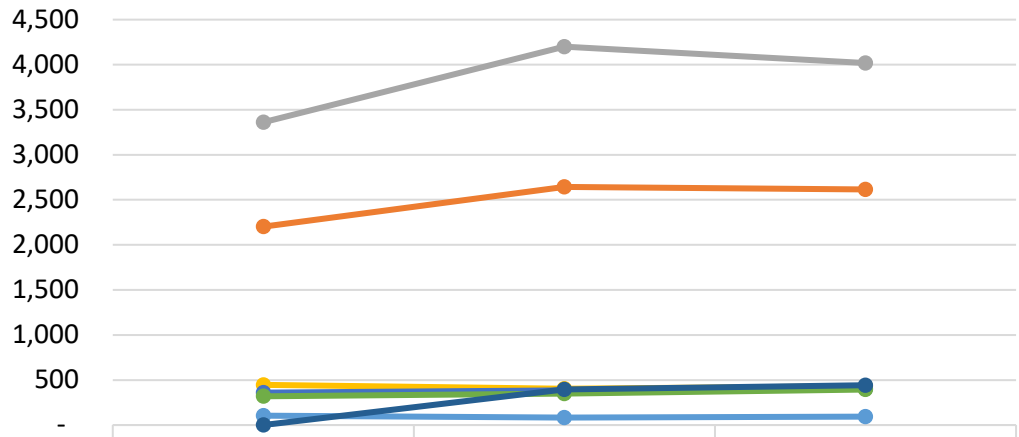
Although there was a 17% decrease in the number of children and adolescents receiving outpatient treatment, the number of children and adolescents receiving intensive outpatient treatment increased by 75%. This trend may be attributed to the absence of SUD residential programs statewide, which may have resulted in more adolescents accessing the next level of SUD services available to them.



*Data for FY 2017 IOP services has been suppressed.

Intensive outpatient treatment expenditures more than doubled from FY 2018 to FY 2019. As previously mentioned, it is likely that such a rise in expenditures occurred because of the statewide absence of any residential treatment facilities for adolescents.

Table 2b. Adults Age 18 and Over

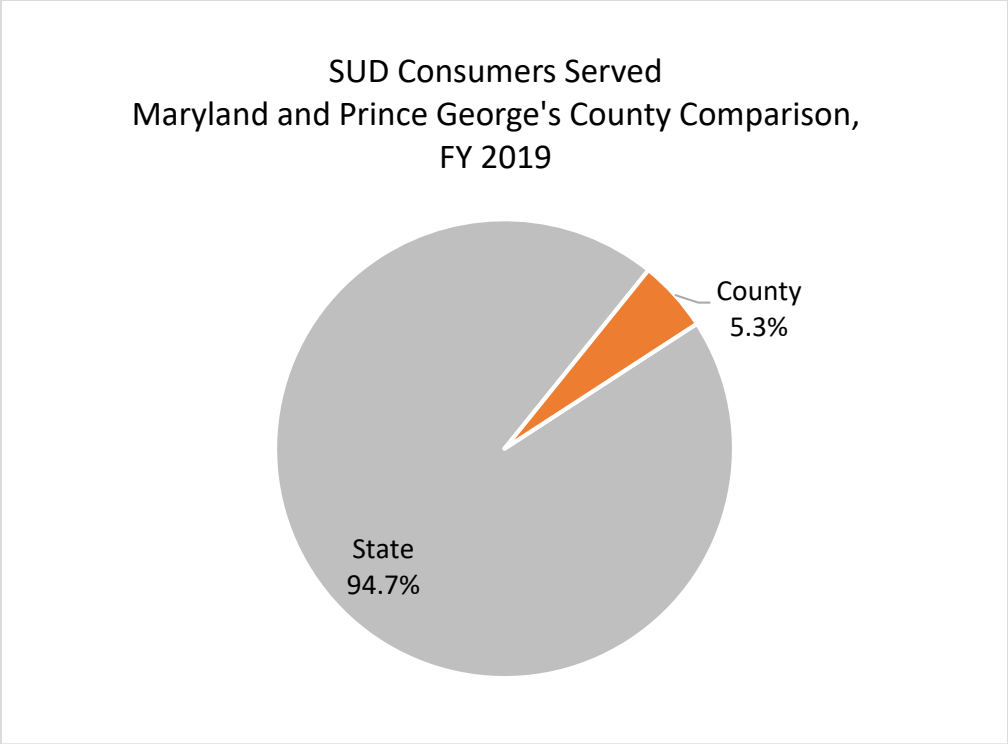


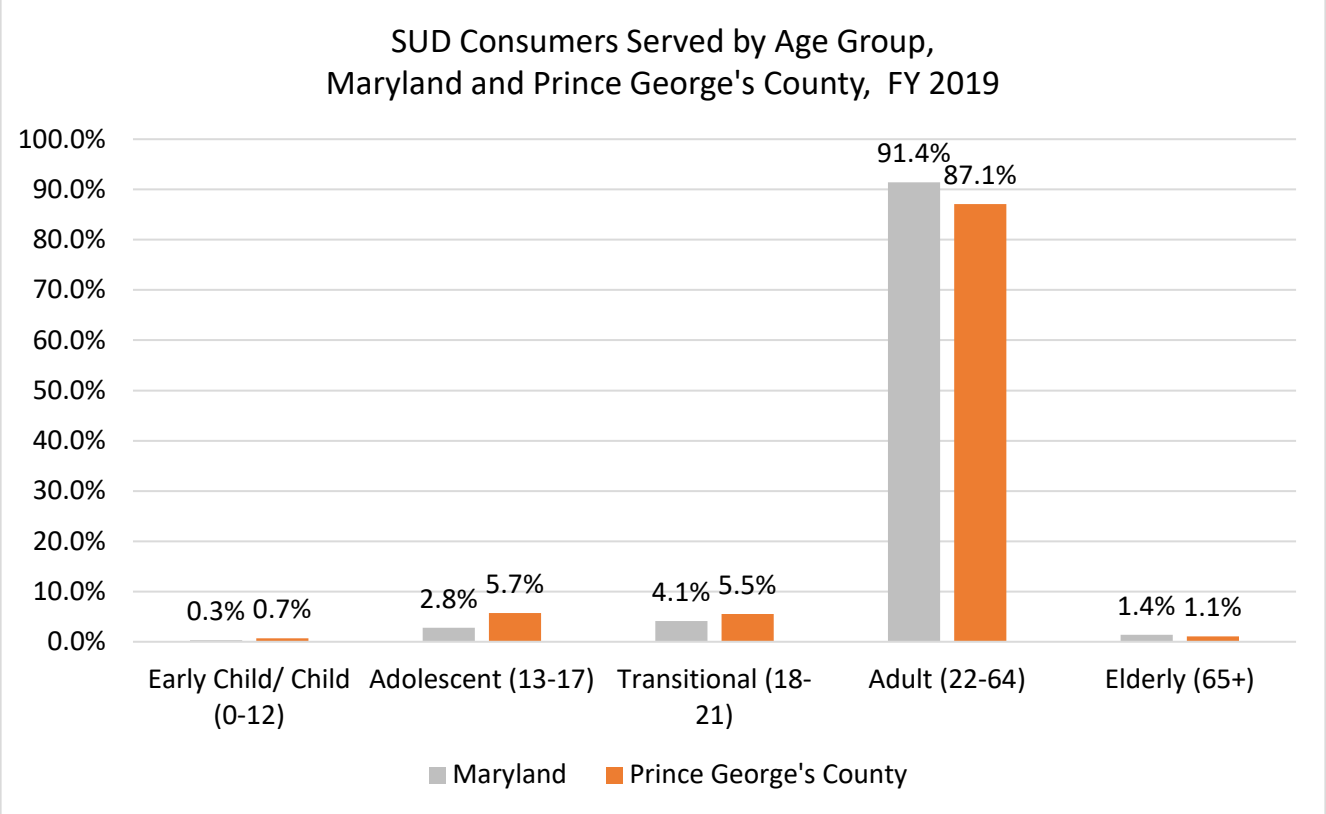
	FY 2017	FY 2018	FY 2019
SUD Inpatient	104	83	95
SUD Outpatient	2,202	2,643	2,616
SUD Labs	3,361	4,200	4,017
SUD MD Recovery Net	446	403	430
SUD Methadone	360	383	402
SUD Intensive Outpatient	319	348	394
SUD Residential All	-	397	442

Adults, ages 22-64, accessed lab and outpatient SUD services more than any other service category each year from FY 2017 to FY 2019; however, service utilization slightly decreased by 4.4% for SUD labs from FY 2018 to FY 2019.

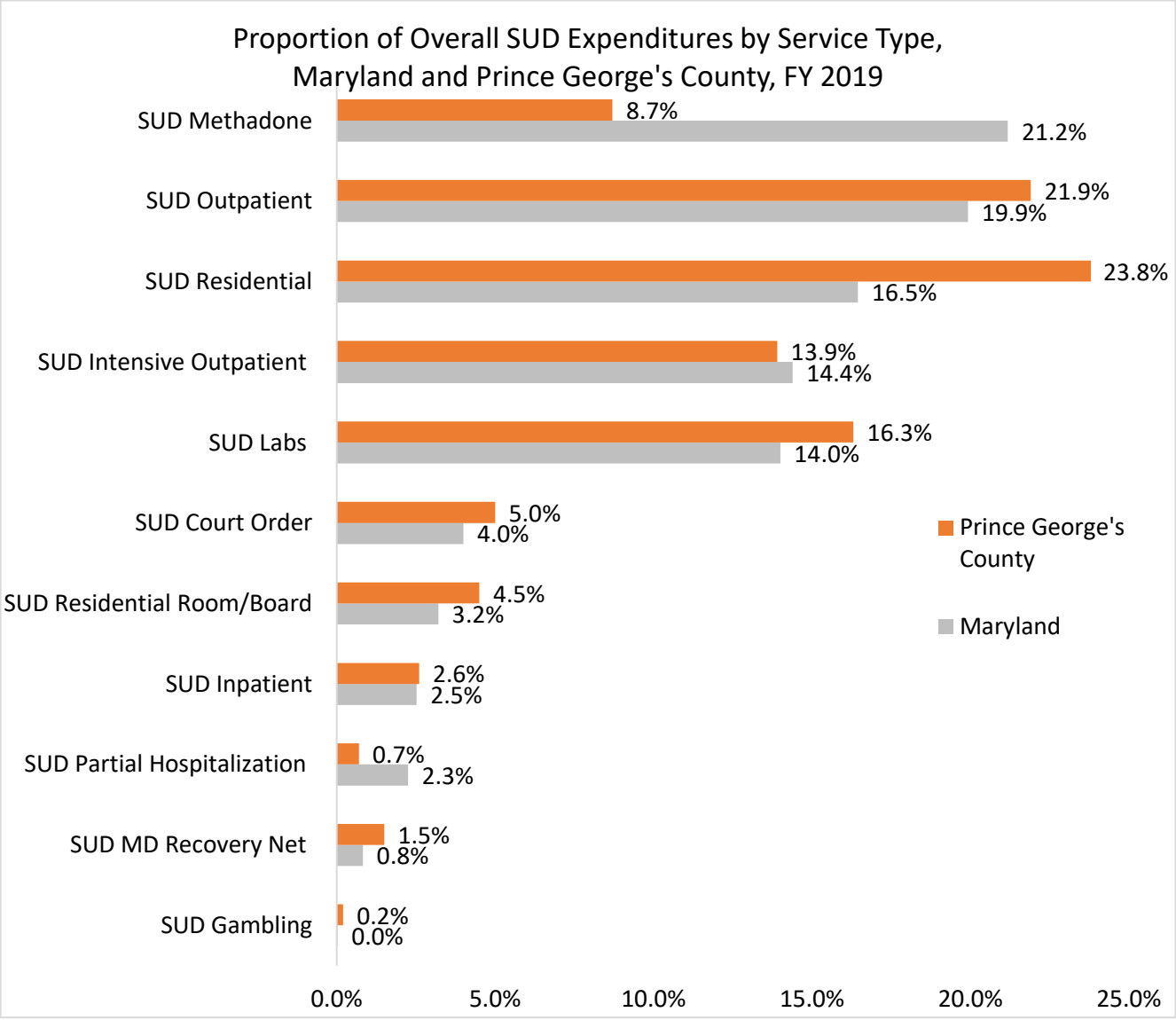
Table 3. SUD FY 2019 State and County Comparison

Prince George's County consumers who received SUD services represented 5.3% (6,176/116,510) of the total number of consumers served in the PBHS statewide and utilized 2.3% ($10,662,564/$461,450,824) of the PBHS expenditures in FY 2019.


SUD Consumers Served
Maryland and Prince George's County Comparison,
FY 2019
County
5.3%
State
94.7%


SUD Consumers Served by Age Group,
Maryland and Prince George's County, FY 2019
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.3%
0.7%
2.8%
5.7%
4.1%
5.5%
91.4%
87.1%
1.4%
1.1%
Early Child/ Child (0-12)
Adolescent (13-17)
Transitional (18-21)
Adult (22-64)
Elderly (65+)
Maryland
Prince George's County

The percentage of consumers served by age in Prince George's County was somewhat similar to the State's during FY 2019. Adults, ages 22-64, overwhelmingly accessed SUD PBHS services more than any other age category, however, they have a slightly lower representation compared to the State. Children, adolescents and transitional age youth, ages 0-21, who received SUD services continue to have a larger representation in the County compared to the State. The elderly population, ages 65, and over, for the County, which has the least representation in the PBHS, has representation that is comparable to the State's at 1.1% for SUD consumers.



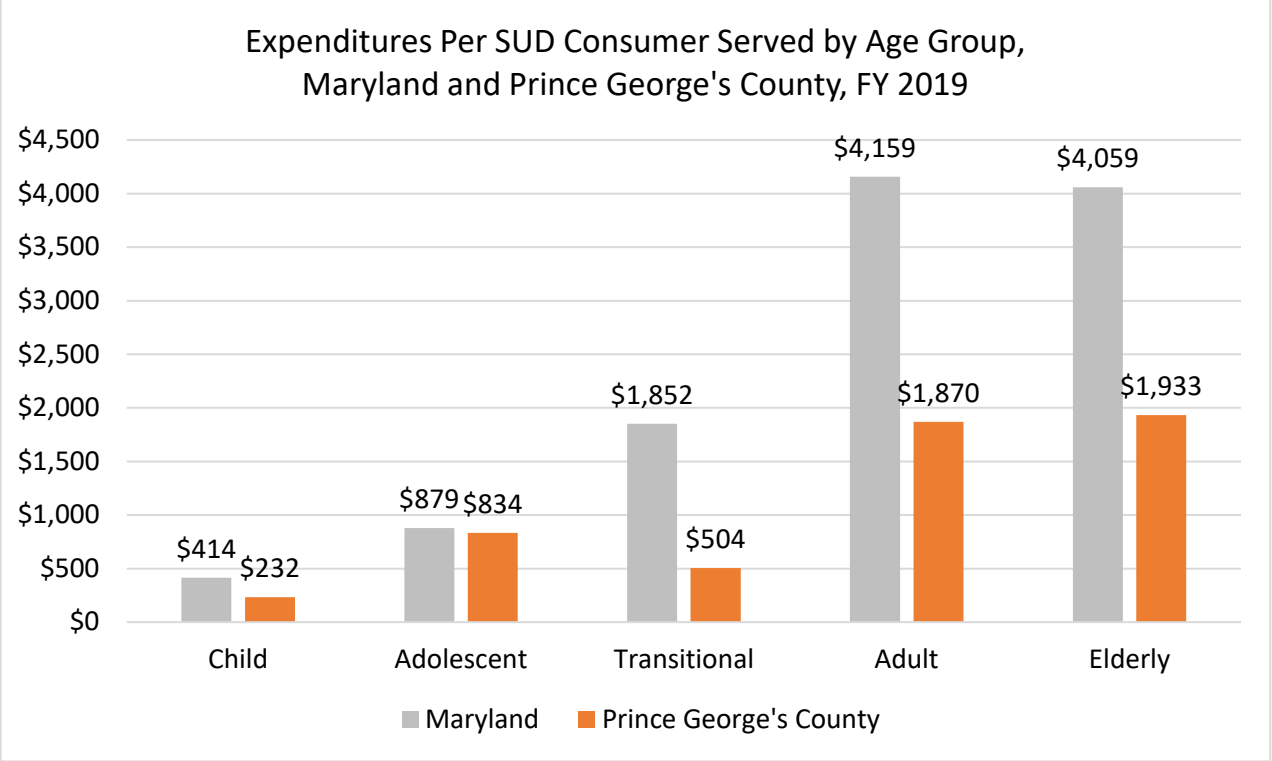
The County's expenditures for residential services was 7% higher than the State's. The percentage of expenditures for methadone maintenance were noticeably different for the County and State, 8.7% and 21.2%, respectively. Relatedly, methadone maintenance cost per consumer served were 20% less than the State's cost.

Table 3b. SUD Cost Per Person Served

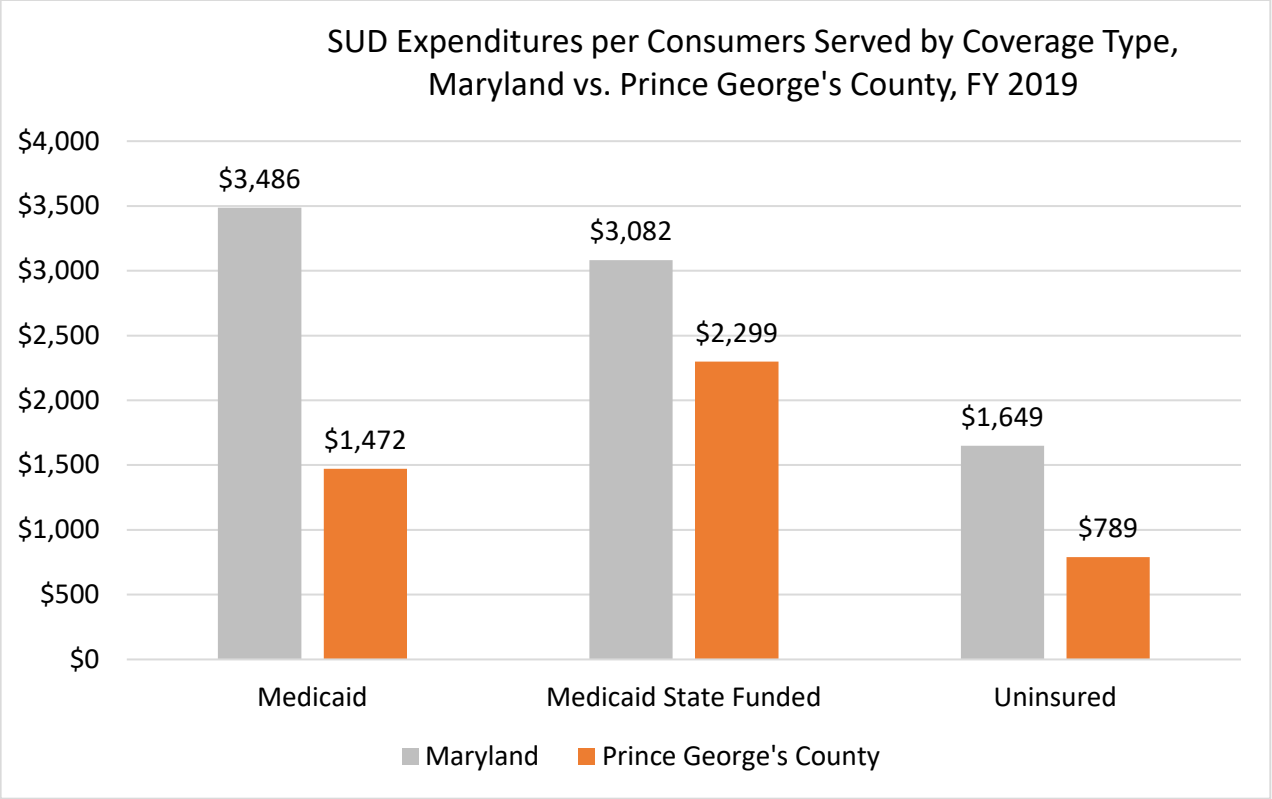
+ $2,234

Difference in cost per person served in Maryland compared to Prince George's County in FY 2019.

Table 3b. SUD Cost per Consumer Served



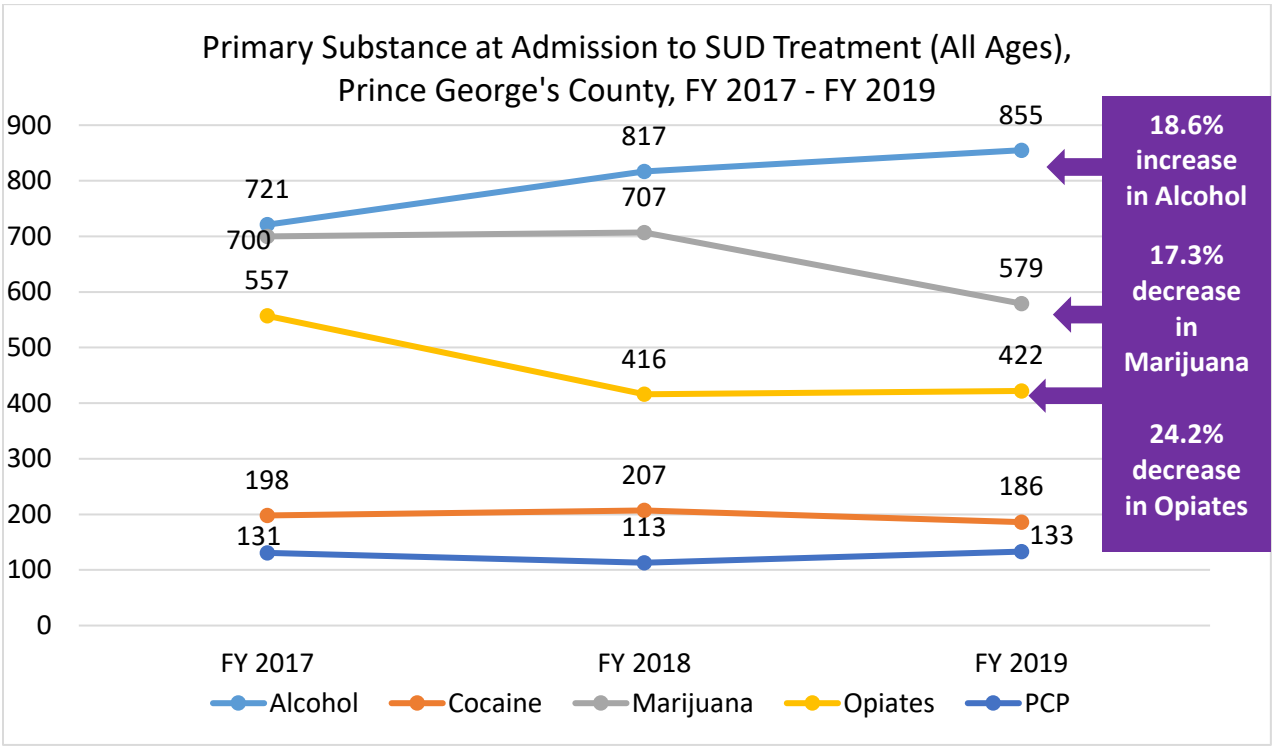
Prince George's County cost per consumer for all age categories were lower than the Statewide costs in FY 2019. Specifically, for adults, ages 22-64, costs per consumer were 55% lower than the Statewide costs; for the elderly, ages 65+ the costs were 52.4% less.

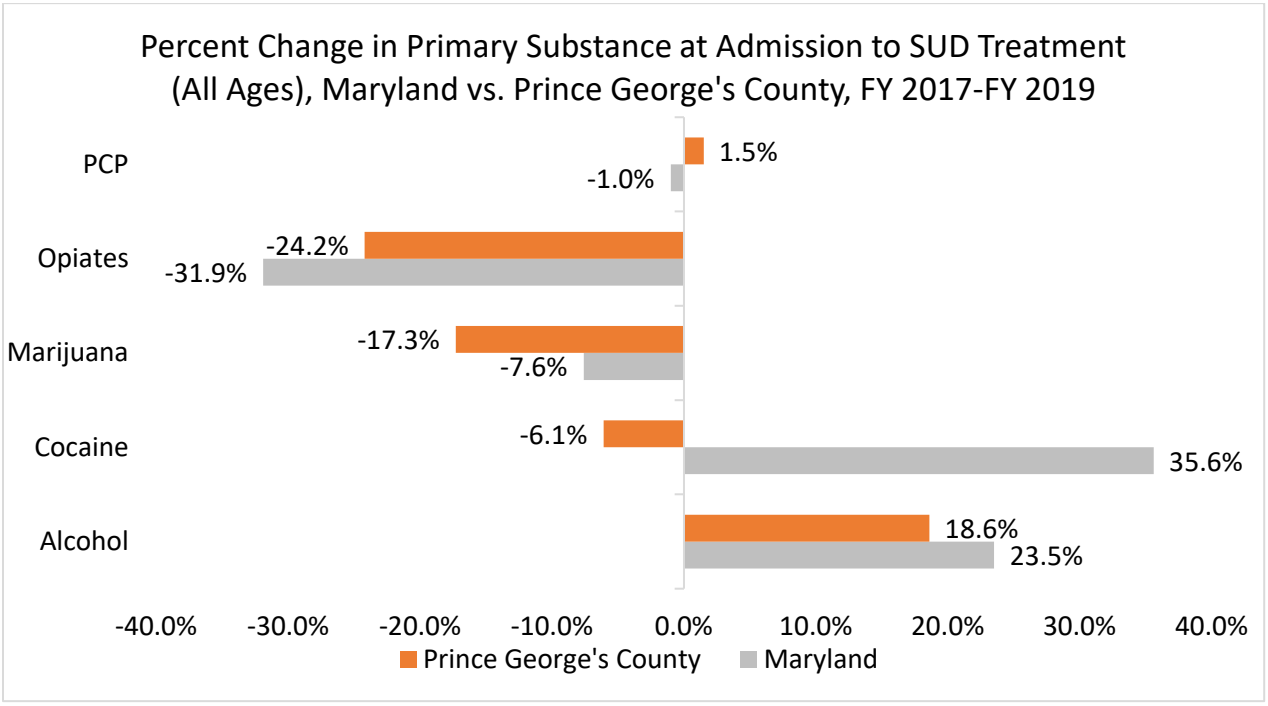


Prince George's County expenditures per consumer served by coverage type were lower than the Statewide costs in FY 2019. Specifically, Medicaid costs per consumer were 57.8% lower than the Statewide costs; for the uninsured the costs were 52.1% less.

Respectively, the State overwhelmingly spent more per consumer than did the County in each age group and coverage type. Although more analysis is needed, this can be attributed to more consumers using their Medicaid insurance to access more and/or more costly services in other jurisdictions.

Primary Substance at Admission to SUD Treatment (All Ages)



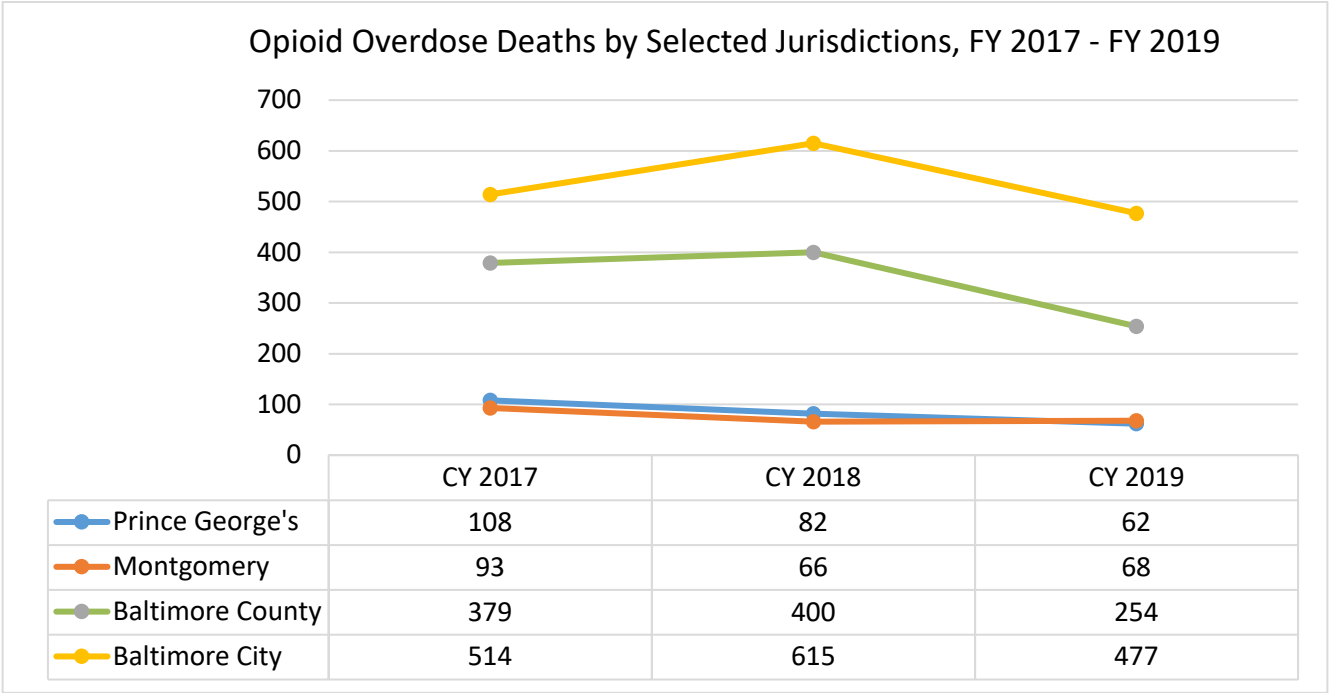


Alcohol, marijuana, opiates, and cocaine continue to be the top primary substances reported at admission for consumers accessing SUD treatment. Of the four substances, cocaine, reported as a

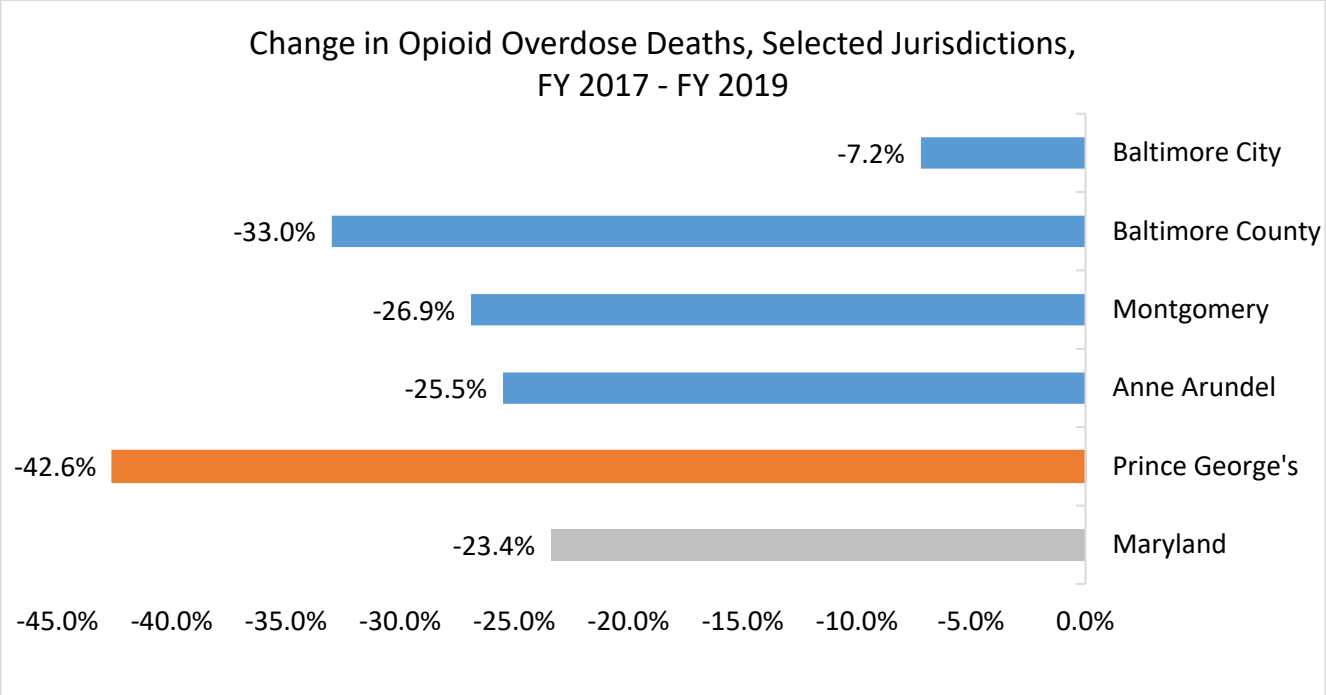
primary substance at admission, was the only substance to decrease, while the State's percentage increased.

The number of consumers reporting alcohol use as a primary substance increased by 18.5% in FY 2019, however, the number of consumers reporting opiates and marijuana use decreased by 24.2% and 17.3%, respectively. The County's variety of opioid prevention, education and outreach programs and partnerships may account for the decrease in the use of opiates, as well as easier access to Data2000 practitioners who can prescribe buprenorphine. It is unclear the reason behind the downward trend for marijuana reporting. Phencyclidine (PCP) is also an issue for County residents, and use has continued at a steady pace from FY 2018 to FY 2019. Community providers, Problem Solving Courts, and the local hospital have all reported the preponderance of PCP users and challenges the providers face in providing treatment for them.

Opioid Overdose Deaths



	CY 2017	CY 2018	CY 2019
Prince George's	108	82	62
Montgomery	93	66	68
Baltimore County	379	400	254
Baltimore City	514	615	477



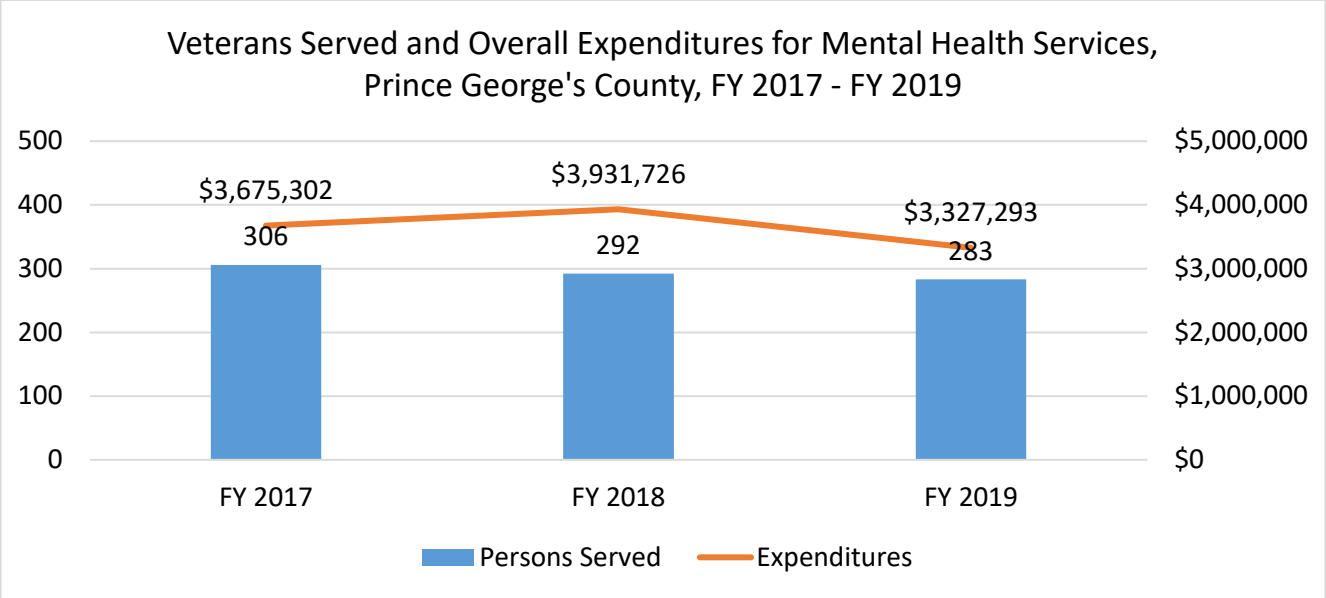
Prince George's County ranks fifth in the State for opioid related deaths, behind Baltimore City, Baltimore County, Anne Arundel and Montgomery counties. Of those five (5) counties, Prince George's County has experienced a 42% decrease in the amount of deaths from FY 2017 to FY 2019. The County's reduction in opioid related deaths is 19.2% less than the statewide percentage.

The County's education and stigma campaign, coupled with an increase in police and community naloxone training/distribution, and community outreach may have contributed to the steady decrease in opioid deaths in the County.

Veterans Served

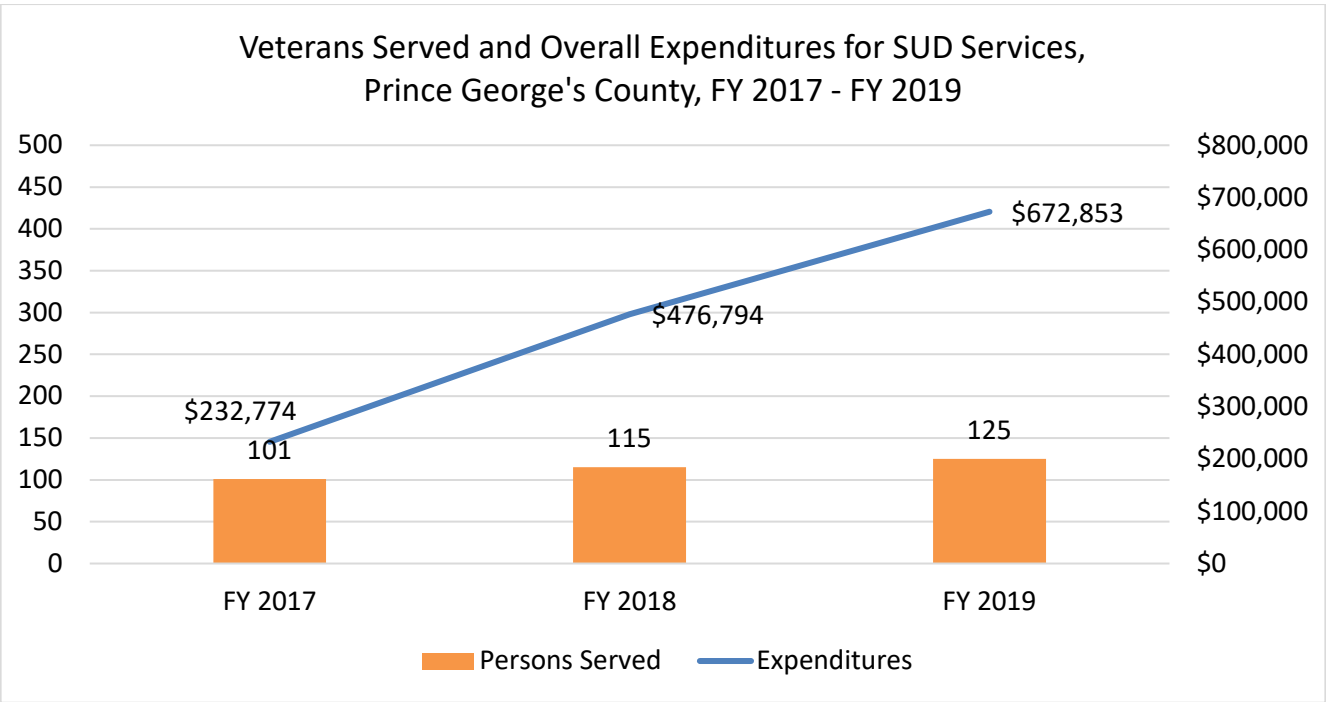
Veterans who received PBHS mental health services in Prince George's County continues to decreased from FY 2017 to FY 2019. Veterans who recieved mental health services represents 6.6% (283/4,303) of all veterans served in the PBHS statewide. The average cost per veteran served was $11,757, which is noticeably higher than the statewide average cost per veteran served, $8,310.

Conversely, veterans who received PBHS SUD services in the County contineus to increase from FY 2017 to FY 2019. Veterans receiving SUD treatment services represented 3% (125/3,915) of the statewide total. Similar to the mental health data for veterans, the average cost per veteran receiving SUD treatment was significantly higher than the State average. The cost per veteran accessing SUD services was $5,382.82 and the statewide average was $5,748.35.



$5,383

FY 2019 expenditure per veteran receiving SRD services in Prince George's County, up from $2,305 in FY 2017.



FY 2021 GOALS

As a result of the Local Integration Self-assessment previously mentioned, the LBHA has identified three systems management areas to focus on in FY 2020-2021 that will assist with progressing toward greater behavioral health integration: Domain #3) Planning and data driven decision making; Domain #5) Public outreach, individual and family education; and Domain #6) Stakeholder collaboration. To guide in the development of the County's goals, objectives and strategies, the LBHA has utilized Behavioral Health Administration's Level of Integration Local Systems Management Self-Assessment Tool as well as the FY 2019-2020 Cultural and Linguistic Competency Strategic Plan (CLCSP).

The Prince George's County LBHA goals, objectives and strategies for FY 2021 address the continued efforts to support the transformation of the PBHS in our County and are as follows:

FY 2021 LBHA Goals	
I	**Develop and implement a recovery-oriented, integrated system of care with clearly articulated quality and outcome standards.**
II	**Maintain and expand capacity to provide sufficient substance use, mental health and addictive disorder services to address the needs of individuals in care and their families. This includes prevention, intervention, treatment and recovery services and supports.**
III	**Implement a process for collecting, analyzing, and utilizing data.**
IV	**Implement a workforce development initiative to enhance access to culturally competent and quality behavioral health services.**

GOAL I: DEVELOP AND IMPLEMENT A RECOVERY-ORIENTED, INTEGRATED SYSTEM OF CARE WITH CLEARLY ARTICULATED QUALITY AND OUTCOME STANDARDS

Objective 1.1: Continue to collaborate with behavioral health care providers and other agencies to further develop mechanisms to promote integrated health care

Strategy 1.1-A: Assist programs to strategically align their services with practices that improve the outcomes for individuals with co-occurring disorders and support provision of Cultural and Linguistic Appropriate Services (CLAS)

- **Target:** The LBHA will coordinate at a minimum (1) one DDC/co-occurring training opportunity for behavioral health providers and disseminate information to encourage provider participation (LSM Self-Assessment Domain #6)

Strategy 1.1-B: The LBHA will identify Primary Care Physicians (PCPs) to assist with the integration of care between the public behavioral health providers and local PCPs

- **Target:** The LBHA will facilitate linkages between PCPs and behavioral health providers and provide a platform to share behavioral health and somatic resources to support a comprehensive healthcare system

Objective 1.2: Continue efforts that promote opportunities for recovery and supports in the areas of housing, benefits, and employment for individuals with behavioral health disorders across the lifespan

Strategy 1.2-A: Provide funding and/or support to local peer support, peer recovery and advocacy agencies

- **Target:** The LBHA will collaborate with OOO-PG, NAMI-PG, MHA-MD and PGCHD to support wellness and recovery activities promoting the continuance of the Wellness and Recovery Action Plan (WRAP) training, peer support training, expansion of peer support specialists, peer recovery specialists, advocacy and community education activities

Strategy 1.2-B: Provide funding and support to a local State Care Coordination provider

- **Target:** The LBHA will contract with a community behavioral health provider to support individuals receiving SUD treatment and recovery support services to connect them with community supports

Strategy 1.2-C: Provide funding to recovery residences that support individuals with the maintenance of their sobriety

- **Target:** The LBHA will collaborate with Maryland Certification of Recovery Residences (MCORR) Certified Recovery Residences to provide housing assistance for clients in recovery

Objective 1.3: Through a variety of approaches, the LBHA will monitor, evaluate and improve the appropriateness, quality, efficiency, cost-effectiveness and outcomes of behavioral health services

Strategy 1.3-A: Monitor the contractual obligations of all grant-funded programs, including conducting site visits to review billing, program reports, invoices, and attainment of contractual outcomes

- **Target:** The LBHA will provide at a minimum one (1) site visit to each grant-funded program

Strategy 1.3-B: Conduct annual site visits to newly licensed PBHS programs to monitor conditions, consumer records and quality of services

- **Target:** The LBHA will provide at a minimum one (1) site visit to each newly licensed PBHS program

Strategy 1.3-C: Monitor RRP usage and coordinate Quality Improvement Interagency Committee (QIIC) meetings for RRP providers

- **Target:** The LBHA will host ten (10) monthly QIIC meetings

Strategy 1.3-D: The LBHA will continue to participate in Office of Behavioral Health Licensing visits and track completion of behavioral health providers' program improvement plans

- **Target:** The LBHA will participate in all of Office of Behavioral Health Licensing visits

Strategy 1.3-E: Review Administrative Services Organization (ASO) audit finding reports and provide technical assistance to providers

- **Target:** The LBHA will review all of provider audits and conduct follow up visits as needed

GOAL II: MAINTAIN AND EXPAND CAPACITY TO PROVIDE SUFFICIENT SUBSTANCE USE, MENTAL HEALTH, AND ADDICTIVE DISORDER SERVICES TO ADDRESS THE NEEDS OF INDIVIDUALS IN CARE AND THEIR FAMILIES. THIS INCLUDES PREVENTION, INTERVENTION, TREATMENT AND RECOVERY SERVICES AND SUPPORTS

Objective 2.1: Continue to work collaboratively with appropriate agencies to improve access to behavioral health services for all ages and special populations groups

Strategy 2.1-A: Provide funding for interpreter and signing therapists for clinical and rehabilitation services for deaf and hard of hearing consumers

- **Target:** The LBHA will contract with the Family Services Foundation to provide signing therapists and American Sign Language interpreters for clinical and rehabilitation services for deaf and hard of hearing consumers, and link providers to resources for interpreter services as needed

Strategy 2.1-B: Provide psycho-geriatric nursing services to elderly consumers

- **Target:** The LBHA will contract with a community-based organization to provide psycho-geriatric nursing services to older adult consumers in select residential rehabilitation and assisted living facilities

Strategy 2.1-C: Collaborate with the Department of Corrections (DOC) to provide treatment and alternatives to incarceration for court and justice involved individuals diagnosed with behavioral health disorders

- **Target:** The LBHA will provide funding to DOC programs to offer Trauma, Addiction, Mental Health and Recovery (TAMAR) for women, provide jail mental health assessments and medication assisted treatment (MAT)

Strategy 2.1-D: Ensure that behavioral health professionals are equipped with the knowledge and resources to assist consumers with TBI

- **Target:** The LBHA will provide TBI training and/or informational sessions for community behavioral health providers

Objective 2.2: Continue efforts to address the crisis services needs in the County

Strategy 2.2-A: Ensure that programs and services are available for children and adults in psychiatric crisis and/or in need of SUD intervention, presenting in the ED or elsewhere in the community, are appropriately screened and linked to services

- **Target:** The LBHA will contract with University of Maryland Capital Region Health to provide emergency psychiatric services (EPS) and 23-hour emergency psychiatric beds for adult consumers in crisis who are uninsured or Medicaid ineligible
- **Target:** The LBHA will contract with a community-based organization to provide a Crisis Response System to include crisis screening, mobile crisis teams, urgent care, disaster mental health activities, in-home family intervention and other crisis services

Objective 2.3: Continue to facilitate and contribute to the development, implementation, integration and evaluation of services that address the needs of children, adolescents and transition age youth with behavioral health disorders and their families

Strategy 2.3-A: Ensure that outpatient and psychiatric rehabilitation services are available to transition age youth with children.

- **Target:** The LBHA will provide funding to support a Transitional Age Youth program to provide psychiatric rehabilitation services to include housing assistance, childcare, mentoring and linkage to services
- **Target:** The LBHA will provide staff support to the SOC Expansion (TAY) grant initiative

Strategy 2.3-B: Participate in activities that will improve access, engagement, and coordination of behavioral health and supportive services for TAY youth and their families

- **Target:** The LBHA will offer staff support to the Center for Law and Social Policy (CLASP) and Systems of Care Expansion Grant local grant initiatives

Objective 2.4: Continue to work with the behavioral health community to provide culturally and linguistically appropriate educational activities and disseminate current information related to psychiatric disorders, prevention mechanisms, treatment services and supports to the general public

Strategy 2.4-A: Coordinate community education events and trainings on a variety of topics for behavioral health professionals, consumers and their families, and targeted audiences who work with or assist special populations

- **Target:** The LBHA will plan, host, and/or sponsor community education trainings on topics related to behavioral health including two (2) on the topic of Mental Health First Aid
- **Target:** The LBHA will provide at least four (4) outreach activities and training on topics related to behavioral health issues in older adults

Objective 2.5: Identify and promote the implementation of evidence-based, effective, promising and best practices for behavioral health services in community-based programs

Strategy 2.5-A: Provide an In-Home Intervention Program for Children and Adolescents (IHIP-C) and an Assertive Community Treatment (ACT) program for adults

- **Target:** The LBHA will monitor and screen the quality of services to Prince George's County residents by the organizations providing IHIP-C services. Staff will refer all eligible individuals to appropriate programs (ongoing)
- **Target:** The LBHA will monitor and screen the quality of services to Prince George's County residents by the organizations providing ACT services. Staff will refer all eligible individuals to appropriate programs (ongoing)

GOAL III: CREATE AND IMPLEMENT A PROCESS FOR COLLECTING, ANALYZING, AND UTILIZING DATA

Objective 3.1: Collect and analyze data on consumer demographics, service utilization, expenditures and other pertinent information to improve the efficiency and effectiveness of the LBHA operations and behavioral health network adequacy

Strategy 3.1-A: Access and analyze the Administrative Services Organization's data reports in the analysis and evaluation of trends in the Public Behavioral Health System service utilization, expenditures and consumer counts

- **Target:** Create and analyze a Geomap of local PBHS locations and PBHS consumers to identify where services are needed

GOAL IV: IMPLEMENT A WORKFORCE DEVELOPMENT INITIATIVE TO ENHANCE ACCESS TO CULTURALLY COMPETENT BEHAVIORAL HEALTH SERVICES

Objective 4.1: Provide access to enhanced training and educational opportunities for behavioral health professionals that will assist with building new skills, gaining access to resources needed to be successful in the provision of treatment, address workforce gaps and assist with employment retention

Strategy 4.1-A: Develop and disseminate behavioral health workforce trainings and education tools

- **Target**: The LBHA will coordinate at a minimum two (2) behavioral health workforce trainings to behavioral health professionals

Objective 4.2: Strengthen cultural and linguistic competency within the County's behavioral health system and improve access to clinical services that are deemed culturally and linguistically appropriate for all populations

Strategy 4.2-A: Distribute Cultural and Linguistic Competency (CLC) assessments to all PBHS and BHA grant funded community behavioral health providers

- **Target**: The LBHA will assist with the distribution of CLC assessments to all licensed community behavioral health providers by June 30, 2021

APPENDIX A: COLLABORATIVE EFFORTS

LBHA Collaborative Efforts: Boards, Committee, Workgroups & Meeting Participation FY 2018 – FY 2019
Assistance in Community Integration Services (ACIS) Steering Committee
BHA/LBHA Adult Services Quarterly Meetings
Board of Education Interagency Attendance Committee
Bridge Center at Adam's House Partnership Meetings
Children's Mental Health Matters Campaign Local Team Meetings
Crownsville Five County Project Assertive Community Treatment Team and Managers Meetings
Crownsville Five County Project Housing Subsidy Providers, Managers, and Planning Team Meetings
Crownsville Five County Project In-Home Intervention Program Team and Managers Meetings
Department of Social Services (DSS) Adult Protective Services Interagency Team Meetings
Department of Social Service/Department of Juvenile Services Crossover Project Meetings
Department of Social Services Homeless Service Partnership (HSP) Meetings
High Intensity Drug Trafficking Area (HIDTA) Quarterly Regional Meetings
Integration Transition Committee (ITC)
Local Care Team (LCT)
Maryland Association of Behavioral Health Authorities Adult Coordinators Sub-Committee
Maryland Association of Behavioral Health Authorities Child & Adolescent Coordinators Sub-Committee
Mental Health Advisory Committee
Mental Health Court Advisory Meetings
Mobile Response and Stabilization Services Collaborative Meeting
Overdose Fatality Review Meetings
Prince George's Community Schools Network (formerly TNI @ Schools initiative)
Prince George's County Behavioral Health Advisory Group
Prince George's County CIT Steering Committee
Prince George's County Healthcare Action Coalition (PGHAC)
PGHAC Assessment & Education Workgroup
PGHAC Behavioral Health Advisory Group (BHAG)
PGHAC Behavioral Health Advisory Group (BHAG) Network and Workforce Development Subcommittee
Prince George's County Hoarding Taskforce
Prince George's County Homeless Services Partnership
Prince George's County LBHA SUD Provider Meetings
Prince George's County Mobile Integrated Healthcare Team Meeting
Quality Improvement Interagency Committee (QIIC)
Resource Connections, Inc. Board of Directors
SOAR Trained Case Managers Meetings
State Continuum of Care Meetings
State Maryland Community Criminal Justice Treatment Program (MCCJTP) Meetings
State Projects for Assistance in Transition from Homelessness (PATH)
State RRP Process Workgroup
State SOAR Housing Pilot Program Meetings
State SOAR Planning Workgroup

State Transitional Age Youth Meetings
System of Care Core Team Meetings
System of Care Leadership Meetings
Threat Assessment Team
Veteran’s Treatment Court Meetings

APPENDIX B: PLAN APPROVAL REQUIREMENTS

Each year, the Annual Plan is developed as a collaborative effort between LBHA staff and the Mental Health Advisory Committee (MHAC). The MHAC receives updates from LBHA staff and presentations from community providers on services within the Public Behavioral Health System. The Committee reviews the goals, objectives and strategies in the plan prior to submission to the Behavioral Health Administration. Members have an opportunity to review and provide their input during the planning process for the upcoming fiscal year. As a part of the BHA plan development guidelines, the LBHA completed the National CLAS Standards Self-Assessment, which helped to ensure that the diverse needs of County residents were considered through the development of the annual plan document and incorporated the outcomes of the LSM Self -Assessment into system management planning. Staff reviewed and analyzed statistical data from the former ASO, Beacon Health Options, to identify trends and issues of concern presented by the data.

Attached is a letter from the MHAC Chair, documenting the review and approval of the FY 2021 Annual Plan, as well as the MHAC membership list.

HEALTH DEPARTMENT
Prince George's County

February 6, 2020

Dr. Aliya Jones
Deputy Secretary/Executive Director
Behavioral Health Administration
Spring Grove Hospital Center, Dix Building
55 Wade Avenue
Catonsville, Maryland 21228

Dear Dr. Burgess:

As the Chair of the Mental Health Advisory Committee (MHAC), I am privileged and pleased to present the FY 2021 Annual Plan on behalf of the Local Behavioral Health Authority (LBHA) and the citizens of Prince George's County. The LBHA continues to play a vital role in the monitoring and coordination of the public behavioral health system and provider-consumer related matters. The MHAC continues to meet monthly to contribute their personal expertise and knowledge, demonstrating the commitment and responsibility entrusted to them by the LBHA, Prince George's County Government, and the Behavioral Health Administration. Additionally, MHAC continues to support "May is Mental Health Month" community education activities sponsored by the LBHA to help communicate mental health needs and raise awareness in the County.

The MHAC has provided input, reviewed and approved the Local Behavioral Health Authority's Fiscal Year 2020 Annual Plan during our regularly scheduled meeting held on December 17, 2019 and has no further recommendations. The Committee is pleased to have had such access and opportunity to participate in the LBHA's combined mental health and substance related disorder plan this year. In the upcoming fiscal year, we will work diligently with the LBHA to promote culturally competent behavioral health services as a priority in the planning of prevention, treatment and recovery support services for all Prince George's County consumers and their families.

Sincerely,

Makeitha H. Abdulbarr, Chair
Mental Health Advisory Committee
Prince George's County

Angela D. Alsobrooks
County Executive

Local Behavioral Health Authority
Dyer Regional Health Center
9314 Piscataway Road, Suite 150, Clinton, Maryland 20735
301-856-9500
www.princegeorgescountymd.gov

MHAC Membership List

Mental Health Advisory Committee (MHAC) FY 2019 Voting Membership			
Appointee Name/ Membership Type	**Address**	**Contact Information**	**Term Expiration**
Makeitha H. Abdulbarr Community Mental Health Clinic Provider Chair	Metropolitan Mental Health Clinic 96 Harry S. Truman Drive Upper Marlboro, MD 20772	abdulbarr@comcast.net (301) 343-7765 (C) (301) 324-0600 (O)	6/30/2018
Vacant Sheriff Department	Prince George's County Sheriff's Office Upper Marlboro, Maryland 20772		6/30/2017
Tomeka Bolden Community Rehabilitation Provider	Affiliated Santé Group 4372 Lottsford Vista Road Lanham, Maryland 20706	tbolden@voaches.org (301) 466-1537 (C) (301) 429-2171 (O)	6/30/2017
JB Moore Parent/relative of an adult consumer	National Alliance on Mental Illness 8511 Legation Road New Carrollton, Maryland 20784	JBmoore0303@gmail.com (240) 838-6527 (C)	6/30/2017
VACANT Consumer	N/A	N/A	6/30/2017

FY2019 Non-Voting MHAC Membership			
Ex-Officio Name	**Address**	**Contact Information**	**Agency**
Ernest L. Carter, MD, PhD Health Officer	1701 McCormick Drive Largo, Maryland 20774	(301) 883-7834 elcarter@co.pg.md.us	Prince George's County Health Department
L. Christina Waddler Manager Local Behavioral Health Authority	Dyer Regional Health Center 9314 Piscataway Road, Suite 150 Clinton, Maryland 20735	(301) 856-9500 (O) (240) 832-0718 (C) lcwaddler@co.pg.md.us	Prince George's County Health Department Local Behavioral Health Authority
TBD Council Member	County Administration Bldg. 2nd Floor Upper Marlboro, MD 20772	N/A	Prince George's County Council
Vacant Associate Director Behavioral Health Services	1701 McCormick Drive Largo, Maryland 20774	(301) 883-7903	Prince George's County Health Department
Eugenia Greenhood Community Developer Local Behavioral Health Authority Staff Support to MHAC	Behavioral Health Services 9314 Piscataway Road, Suite 150 Clinton, Maryland 20735	(301) 856-9500 (O) (240) 832-0723 (C) eagreenhood@co.pg.md.us	Prince George's County Health Department Local Behavioral Health Authority

APPENDIX C: ACRONYMS

ACT	Assertive Community Treatment
A&E	Adult and Elderly
ASIST	Applied Suicide Intervention Skills Training
ASL	American Sign Language
ASO	Administrative Service Organization
BHA	Behavioral Health Administration
BHAG	Behavioral Health Advisory Group (Prince George's County)
BHCSS	Behavioral Health Crisis Stabilization Center
BHI	Behavioral Health Integration
BHIPP	Behavioral Health Integration for Primary Providers
BHS	Behavioral Health Services (Division within the Prince George's Health Dept.)
BOE	Board of Education
C&A	Child and Adolescent
CCO	Care Coordination Organization
CFT	Child and Family Team Meetings
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CLC	Cultural and Linguistic Competency
COA	Conditions of Award
CoC	Continuum of Care, formerly Shelter Plus Care
CPRS	Certified Peer Recovery Specialist
CRS	Crisis Response System
CSA	Core Service Agency

DATA 2000	Drug Addiction Treatment Act of 2000
DDC	Dual Diagnosis Capable/Capability
DJS	Department of Juvenile Services
DOC	Department of Corrections
DSS	Department of Social Services
EBP	Evidence-Based Practice/Program
ED	Emergency Department
EP	Emergency Petition
EPS	Emergency Psychiatric Services
ETOH	Ethyl Alcohol
FBG	Federal Block Grant
FFS	Fee-for-Service
FPL	Federal Poverty Level
FY	Fiscal Year
GOC	Governor's Office of Children
HHS	Health, Human Services and Education
HSPC	Homeless Services Partnership Committee
HPRP	Homeless Prevention and Rapid Re-Housing Program
IFIT	Intensive Family Intervention Team
IHIP-C	In-Home Intervention Program for Children and Adolescents
JBSAT	Jail-Based Substance Abuse Treatment
LAA	Local Addiction Authority
LBHA	Local Behavioral Health Authority
LEP	Limited English Proficiency

LCT	Local Coordinating Team
MA	Medical Assistance or Medicaid
MABHA	Maryland Association of Behavioral Health Authorities (formerly MACSA)
MAT	Medication Assisted Treatment
MCCJTP	Maryland Community Criminal Justice Treatment Program
MCF	Maryland Coalition of Families
MCORR	Maryland Certification of Recovery Residences
MCT	Mobile Crisis Team
MCV	Maryland Commitment to Veterans
MDH	Maryland Department of Health
MDRN	Maryland Recovery Network
MHAC	Mental Health Advisory Committee
MHA-MD	Mental Health Association of Maryland
MHSS	Mental Health Stabilization Services (formerly Mental Health Mobile Crisis and Stabilization Services for Foster Children)
MOU	Memorandum of Understanding
MTS	Mobile Treatment Services
NAMI-PG	National Alliance on Mental Illness, Prince George's County Chapter
OBOT	Office Based Opioid Treatment
OOO	On Our Own
OOO-PG	On Our Own-Prince George's County
OMHC	Outpatient Mental Health Clinic
OMS	Outcome Measurement System
OTP	Opioid Treatment Programs
PATH	Projects for Assistance in Transitioning from Homelessness

PBHS	Public Behavioral Health System
PCPs	Primary Care Physicians
PEP	People Encouraging People
PGCHD	Prince George's County Health Department
PGCPS	Prince George's County Public Schools
PGHAC	Prince George's Healthcare Action Coalition
PHP	Partial Hospitalization Program
PRP	Psychiatric Rehabilitation Program
PRS	Peer Recovery Specialist
PSS	Peer Support Specialist
QIIC	Quality Improvement Interagency Committee
RFP	Request for Proposals
RRP	Residential Rehabilitation Program
RTC	Residential Treatment Center
SAFERR	Screening and Assessment for Family Engagement, Retention and Recovery
SafeTALK	Suicide Alertness for Everyone/Tell, Ask, Listen, Keep Safe
SEP	Supported Employment Program
SOAR	SSI/SSDI Outreach, Access and Recovery
SOC	System of Care (Grant)
SOR	State Opioid Response
SSI/SSDI	Supplemental Security Income/Social Security Disability Insurance
SUD	Substance Use Disorder
T.A.M.A.R	Trauma, Addiction, Mental Health and Recovery
TAY	Transitional Age Youth

TBI	Traumatic Brain Injury
TCA	Temporary Cash Assistance Program
TCM	Targeted Case Management
TNI	Transforming Neighborhoods Initiative
UMCRH	University of Maryland Capital Region Health
WRAP	Wellness Recovery Action Plan
YAPRSS	Young Adult Peer Recovery Support Specialist
YHDP	Youth Homeless Demonstration Project

FY 2021 CULTURAL AND LINGUISTIC COMPETENCY STRATEGIC PLAN
Prince George's County LBHA

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

Cover Page

(a) **Name of Agency/Organization:**
Prince George's County Local Behavioral Health Authority

(b) **Address:**
Dyer Regional Health Center
9314 Piscataway Road, Suite 150
Clinton, MD 20735

(c) **Region (MDH/BHA designated region):** Prince George's County

(d) **Name of contact person (Agency/Organization Lead or Designee):** L. Christina Waddler
E-mail: lcwaddler@co.pg.md.us
Telephone #: 301-856-9500

(e) **Brief overview of services provided by agency/organization (***no more than 95 words***):**
The Local Behavioral Health Authority (LBHA) is a government entity located within the Prince George's County Health Department (PGCHD). Designated to serve as the local authority for mental health and substance use/addictions for Prince George's County, its primary role is planning for public behavioral health services (PBHS) via oversight and monitoring. In addition, the LBHA awards and oversees grant-funded behavioral health service contracts and participates in state and local planning activities. The LBHA ensures that county residents have access to prevention, early intervention, recovery and peer support services across the lifespan.

(f) **Agency/organization mission statement:**
A healthy and thriving Prince George's County that:

- Provides access to quality health care services for all
- Provides policies and services that are culturally appropriate and acceptable
- Partners with individuals, organization and communities to accept responsibility for disease, injury and disability prevention and health advancement
- Ensures individuals and communities can achieve the best health possible

(g) **Agency/organization vision statement:**

The mission of Prince George's County Health Department is to:

- Protect the public's health
- Assure availability of and access to quality health care services
- Promote individual and community responsibility for the prevention of disease, injury and disability

PART 1: CLAS SELF- ASSESSMENT

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

Prince George's County Local Behavioral Health Authority

NATIONAL CLAS STANDARDS SELF-ASSESSMENT TOOL

	GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES	**LEVEL**			
1	Our Mission and Vision statements reflect organizational commitment to cultural and linguistic competence. (Standard 1)	0	1	2	3
2	We have established culturally and linguistically appropriate goals, management accountability, and infused them throughout the organization's planning and operations. (Standard 9)			2	
3	Our organizational governance and leadership promote and use CLAS standards in policies, practices and allocation of resources. (Standard 2)			2	
4	We have created conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. (Standard 14)			2	
5	We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (Standard 15)		1		
	GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS OF BEHAVIORAL HEALTH SERVICES				
1	We offer language assistance to individuals who have limited English proficiency and/or other communication needs including individuals who use American Sign Language, at no cost to them, to facilitate timely access to behavioral health services. (Standard 5)			2	
2	We inform all individuals of the availability of verbal, signing and written professional language assistance services in their preferred language or form of communication. (Standard 6)	0			
3	We ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (Standard 7)	0			
4	We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community. (Standard 8)	0			
	GOAL 3: CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES				
1	We conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of the community we serve. (Standard 12)			2	
2	We collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (Standard 11)			2	

GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS SERVED IN MARYLAND'S PBHS		LEVEL			
		0	1	2	3
1	We conduct ongoing assessments of our organization's CLAS-related activities and integrate CLAS-related quality improvement and accountability measures into program activities. (Standard 10)	0			
2	We partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. (Standard 13)			2	
GOAL 5: ADVOCATE FOR AND INSTITUTE ONGOING WORKFORCE DEVELOPMENT PROGRAMS IN CULTURAL AND LINGUISTIC COMPETENCE REFLECTIVE OF MARYLAND'S DIVERSE POPULATION					
1	We recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the community we serve. (Standard 3)	0			
2	We provide orientation and training to new and existing members of our governing body, leadership and staff on culturally and linguistically appropriate policies and practices on a regular basis. (Standard 4)	0			

PART 2: OVERARCHING GOALS AND SELECTED STANDARDS FOR PRIORITY FOCUS

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

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

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES
Selected a standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):* We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (Standard 15)
Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):* • Coordinate (1) event annually bringing all BH providers together and utilize meeting to discuss CLC and provider expectations • Create a platform for sharing information and resources
Performance Measures *(How will success be measured):* • *Percent of providers who indicate they have an increased awareness of CLAS standards (Issuance of post meeting survey)*
Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):* Stakeholders, residents and the public will be educated about the role of the LBHA and CLC appropriate services available.

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

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*
We inform all individuals of the availability of verbal, signing and written professional language assistance services in their preferred language or form of communications. (Standard 6)

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

- Determine what language access services are needed by formal and informal surveys
- Maintain provider information sheets which will contain up to date information about provider's availability of verbal, signing and written professional language assistance services
- Redesign the BH service directory on the PGC HealthZone website to ensure specialty services are listed and information is current
- Identify a language line service/resource to better assist callers with LEP or speak a language other than English

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

- Provide four (4) quarterly updates to the PGC HealthZone resource website regarding availability of language access services

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*
Ensure all residents have access to behavioral health services regardless of language spoken or form of communication.

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

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*
We collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (Standard 11)

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

- Collaborate with Health Department epidemiologist to identify County demographics

- Analyze data collected on location of current PBHS programs compared to where consumers live to measure accessibility of existing services

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

- Produce at least (1) GeoMap of services available and where consumers reside

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*
Identify gaps and needs (cultural barriers to residents accessing treatment).

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

Selected standard for priority focus *(What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):*
Conduct ongoing assessments of our organization's CLAS-related activities and integrate CLAS-related quality improvement and accountability measures into program activities. (Standard 10)

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

- Assign LBHA staff to be a part of the 2021 HD Strategic Planning committee to help to identify gaps and needs related to CLAS within Prince George's County

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

- Include at least one (1) action related to CLC in the Health Dept. Strategic Plan

Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):*
After gaps and needs are identified, the LBHA will be able to use the results to plan for and identify diverse services that meet the needs of the community we serve.

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

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

Provide orientation and training to new and existing members of our governing body, leadership and staff on culturally and linguistically appropriate policies and practices on a regular basis.
Strategies to build competency *(What tasks and activities will be implemented to build competency for the prioritized standard):* • Utilize resources that are allocated to initiate ongoing cultural and linguistic competency training opportunities for staff at all levels within the PBHS and stakeholders • Educate behavioral health providers about the diverse behavioral health needs of the County to promote the increase of a CLC competent workforce
Performance Measures *(How will success be measured):* • Provide ongoing CLC training opportunities
Intended impact *(What is the intended impact for addressing the prioritized/selected Standard):* • Attract a diverse workforce to meet the needs of the population that exist.