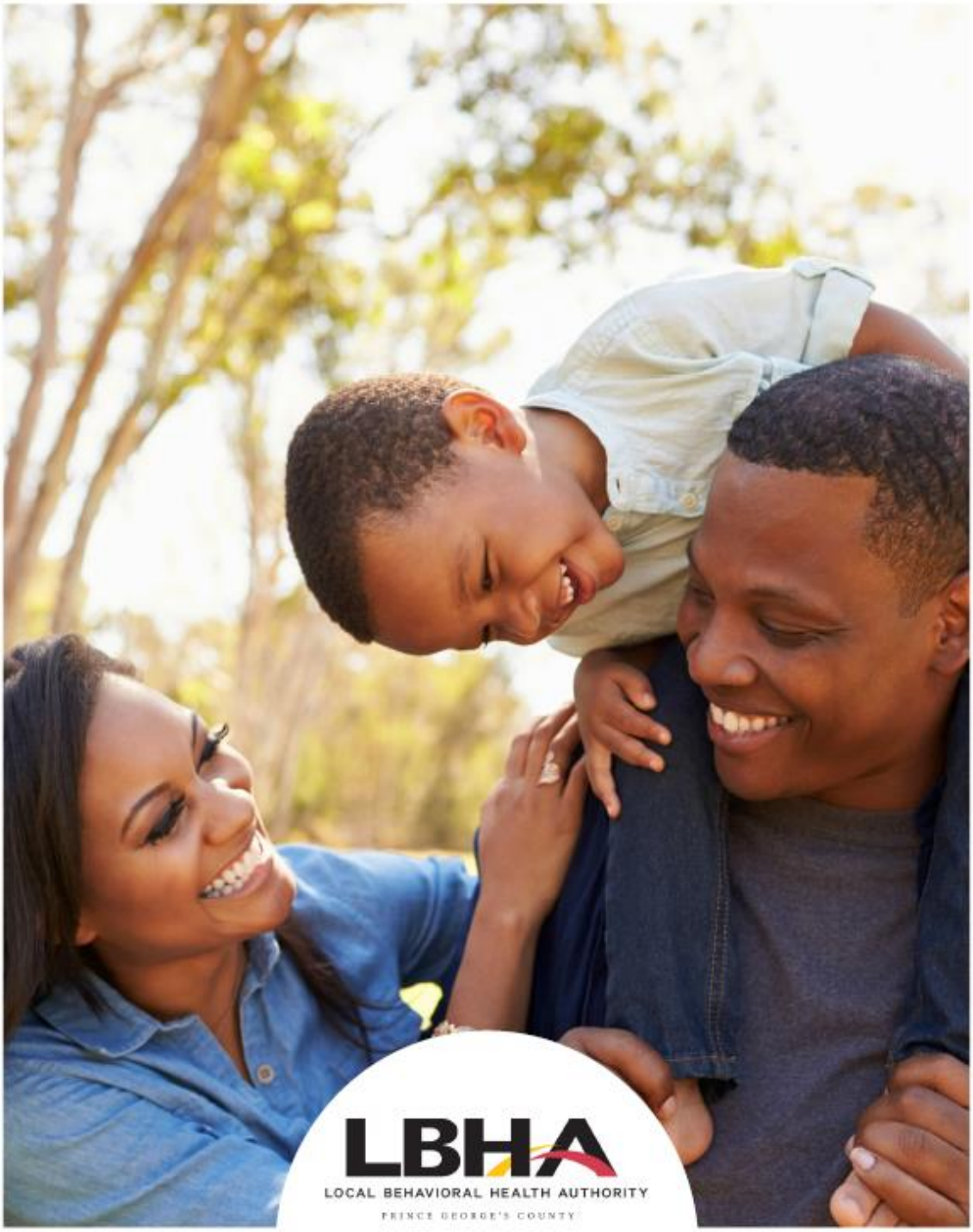
LOCAL BEHAVIORAL HEALTH AUTHORITY

FISCAL YEAR 2023 ANNUAL PLAN



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HEALTH DEPARTMENT
Prince George's County

Prince Georges Proud

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A. INTRODUCTION

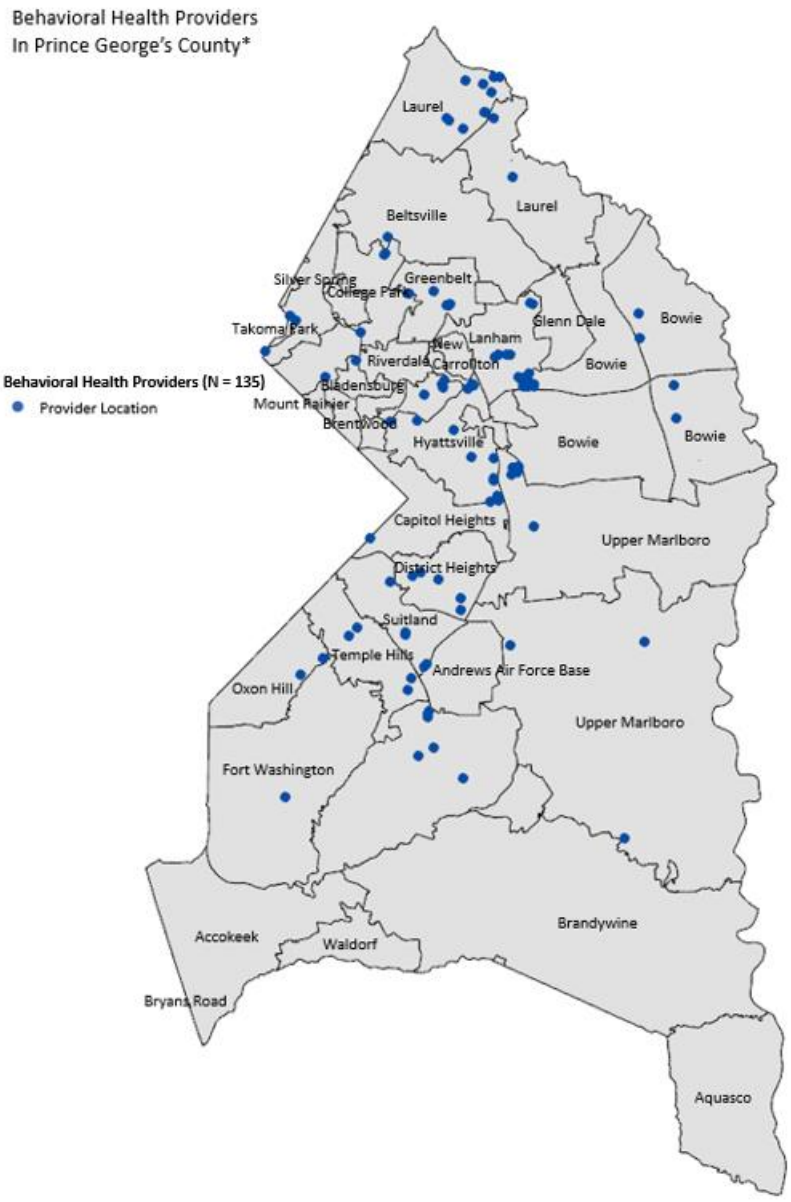
The Local Behavioral Health Authority (LBHA) is a government body, that is located within the Prince George's County Health Department (PGCHD). In collaboration with the Maryland Department of Health (MDH), Behavioral Health Administration (BHA), the LBHA is designated to serve as the local authority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

A primary role of the LBHA is planning, managing, and monitoring the publicly funded behavioral health system within the County. The Public Behavioral Health System (PBHS) is comprised of services that are reimbursable via the Medicaid and State funded fee-for-service system, administered by an Administrative Services Organization (ASO). In addition to PBHS oversight, the LBHA awards and oversees grant-funded behavioral health service contracts. Other responsibilities include identifying programmatic gaps and needs, securing funding and monitoring community behavioral health (BH) providers to ensure they 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 BH needs.

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

- Assertive Community Treatment (ACT)
- Crisis services
- Inpatient services
- Intensive Substance Use Disorder (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.



Data Source: Prince George's County LBHA
Retrieved: March 7, 2022

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 the following services:

- America Sign Language interpreters and signing therapists
- 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 behavioral health
- Medication Assisted Treatment
- Mental Health Court case management
- Spanish-speaking outpatient substance use
- SUD assessment and case management for adults
- SUD crisis stabilization
- Outreach
- Peer support and peer recovery support
- Psycho-geriatric nursing

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

Local authorities were asked to draw from the content of the self-assessment, which is updated annually, 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 #1 – Leadership and Governance;
- Domain #2 – Budgeting and Operations; and
- Domain #3 – Planning and Data-Driven Decision Making

To guide the development of the County's goals, objectives, and strategies, the LBHA has utilized the Behavioral Health Administration's LSMSAT, as well as the Cultural and Linguistic Competency Strategic Plan (CLCSP) located in Appendices A and B.

B. NEW DEVELOPMENTS AND CHALLENGES

The LBHA welcomed opportunities for growth and positive change in Prince George's County amidst unwelcomed challenges, such as the Coronavirus (COVID-19) pandemic and the recent racial justice movement. The expansion of telehealth due the pandemic created an overall change in the health care climate. Although the pandemic has created many challenges and barriers, it has also been a prime opportunity for rapid and intense planning as the pandemic magnified needs, exposed systems gaps, and strengthened partnerships. Since the effects of

the pandemic on the BH system are exhaustive, there will be several mentions in the annual plan that will detail the effects on specific programs.

New Grants and Expansion of Services

The expansion of telehealth due to the pandemic created an overall change in the health care climate. BH providers were able to expand the way services are rendered to consumers, by offering telehealth services. The use of telehealth equipment, increased access to BH services allowing consumers to access services in their homes or other secured locations, preventing the possibility of spreading the virus.

In-person behavioral health programs, such as group-based services, were interrupted during the COVID-19 pandemic and just recently began to start up again. While we do not quite know the full effect of the service disruptions caused by the pandemic, there were some immediate impacts. For example, mental health groups at the detention center were impacted. When the numbers increased, groups were no longer able to convene, and more individual crisis interventions occurred as a result of the pandemic. Another example is the overall decrease in the number of referrals to grant funded programs. More challenges will be identified as programs are highlighted and data is analyzed throughout this document.

Early Intervention

Young children and transition age youth (TAY) were disproportionately affected by the pandemic. This highlighted the need for system changes and increased collaboration which resulted in the need to streamline behavioral health services for TAY.

Efforts continued to implement the First Episode Psychosis (FEP) program in Prince George's County, for FY2021 and FY2022. The FEP program outreach efforts focused on hiring staff and locating a site in within the County. Referrals are ramping up as marketing continues. The program serves youth and young adults, ages 15–30 year-old. A diagnosis of a schizophrenia spectrum disorder, diagnosed in accordance with DSM-5 criteria, for whom the current episode of psychosis is within two years of the first onset of psychotic symptoms. The services and supports are designed to reduce the chronicity of the illness, to prevent the development of long-term disability, and to promote independent and integrated community living.

Planning is underway to provide support to expand a Therapeutic Nursery Program (TNP) in Prince George's County in FY2023. The TNP is a multidisciplinary, integrated early childhood mental health and education program for families with high-risk children ages 3 to 5. It will provide services to the preschool children and their families who are experiencing social, behavioral, emotional challenges. This includes those that are impacted due to trauma and adverse childhood experiences (ACES).

Suicide Prevention

The LBHA designed a communication's plan that utilized public service announcements to help shed light on suicide and the associated risks. This campaign helped bring light to the issues in the African American and Latinx communities. The campaign involved Radio One, which published culturally sensitive radio ads, to engage the community regarding mental health risks associated with suicide.

In June of 2021, the Prince George's County LBHA launched a Suicide Prevention Campaign in partnership with Urban One, Inc. (aka Radio One). Funding for the campaign was courtesy of Maryland Department of Health. The campaign started June 9th and ran through June 30, 2021. This campaign focused on creating awareness and educating the public on suicide prevention, services available and eradicating stigma. It targeted adults 25-44 years old, with a focus on LGBTQ+ community and men. The campaign comprised of three (3) different on-air commercials, that aired on WKYS, Majic 102.3 & 92.7 and Praise 104.1 radio stations and utilized social media for messaging.

Geofencing was used on all three radio stations, as well as their Facebook and Instagram account. RadioOne had a target of reaching 245,000 consumers, however, we reached 300,170. This means 1/3 of the County's population heard about the campaign in some way. The average click-thru rate, which is defined by actual eyes seeing social media, is .05-.07% and the campaign's banner on the station had a rate of .15%. There were 86,947 people that saw the campaign on the social media alone. With a click thru rate of 1.51% (national average is .05-.07%) for all the stations combined. This was a successful campaign overall, which ran for one month, from June 9-30, 2021.

Additionally, the LBHA continued with our suicide prevention training activities included five (5) Mental Health First Aide (MHFA) trainings, two (2) ASK Workshops and one (1) ASIST training.

The Maryland Health Services Cost Review Commission (HSCRC) provided funding to hire a consultant, Dignity Best Practice, to help move the 911 and suicide crisis line call center calls to 988, including mobile crisis response. The funding allowed Dignity Best Practice to work with the stakeholders in the County to complete a workflow on how calls from the community are to be processed. This workflow will help direct calls in the most appropriate way, to deal with behavioral health issues more efficiently. The calls will be determined to need a 988 professional or dispatch of a MCT, with or without a police escort in the community.

Crisis Service Enhancement

In FY2021, opportunities for enhancing, strengthening, and improving crisis response in the County continued to address the limited inventory of services that are essential to immediate stabilization of persons experiencing a behavioral health crisis.

The LBHA/HD work collaboratively with the HSCRC to bring the programs stated in the grant to fruition in the County, which will strengthen its crisis system overall. The HSCRC funding of $23M was granted in FY2021. This funding allowed the agent who manages the funds to put out an Request for Proposals (RFP) for a Crisis Stabilization Center in the County. RI International, who was the author of the Crisis Now model, which was adopted by SAMSHA, was awarded the contract. They have been working with Prince George's County to locate a space for the Crisis Stabilization Center. Currently, they are submitting plans for a site in the Southern part of the County, where services are needed, and there is space for expansion. The Crisis Stabilization Center will have a no-wrong door approach and will receive everyone brought to the facility and process them through for services or referrals as needed. The HSCRC also provides funding for an electronic crisis tracking system, air traffic control system. This will start with one module of the software and will expand over time as the system becomes statewide.

According to the Crisis Now Model, Prince George's County needs eight (8) mobile crisis teams (MCT). Teams were expanded from two (2) to four (4) with the HSCRC funding, which was competitively bid out for additional teams. However, an additional four teams will need to be funded at a cost of $1.4M if we are being compliant with the National model. This will bring the mobile crisis to full capacity to serve a County as large as Prince George's.

The Local Behavioral Health Authority issued a Request for Applications (RFA) on December 15, 2021, for mobile crisis services in the County. The services had been rendered by the same provider for the past 24 years, and their current contract ended in FY2021, but an extension was utilized due to the pandemic. The RFA was inclusive and mindful of the new mobile crisis team, which is supported by the HSCRC. The results of the RFA are currently pending.

The County was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care (SOC) expansion grant for FY2020 to address the needs of the Transitional Age Youth population in the County. Program interventions were intended to provide crisis and stabilization services, peer support services, suicide prevention, and outreach and education to transition age youth (TAY) experiencing behavioral health issues, particularly those experiencing homelessness. Due to significant delays, mostly resulting from the COVID-19 pandemic, programmatic implementation did not begin in earnest until FY2021.

Initially, the major strategy of the grant used a model for mobile crisis and stabilization services for TAY. The mobile team would be dispatched to the field, as a specialty TAY mobile crisis response team. However, realistically that service was already being provided for all ages through the County's Crisis Response Team. Therefore, the focus of the grant shifted to reflect more of a secondary mobile response that provides two peer support specialists and a clinician, who support TAY through follow up after a crisis, stabilization, and referrals to services and other community-based supports available in the County. Understandably, the use of peers versus the use of clinicians to implement these services was a challenge. Integration of peers

required weekly meetings with the vendor leadership to increase their knowledge of peer services and supports and assist them to overcome adaptive and technical challenges.

Additional family/caregiver and TAY peer supports were provided by the Maryland Coalition of Families (MCF) and National Alliance on Mental Illness (NAMI). MCF and NAMI provided family support services to parents, guardians or proxies of youth aged 16-21 years of age. During FY2021, the primary reason for referral was for mental health treatment and resources. Additional reasons for referral were for assisting with transitional issues, school concerns, psychoeducation, advocacy, and developmental disability treatment and resources. Both agencies held virtual parent/caregiver support groups each month, highlighting topics relevant to TAY and families. The family peer support specialists also attended the Local Care Team (LCT) meetings, to serve as a parent advocate for families coming to the table. In FY2022, NAMI has formed a peer led and facilitated support group, for TAY to discuss and address issues determined by them.

The SOC was also able to fund a short-term suicide prevention pilot with Mindoula Health. The suicide prevention component utilized data and predictive analytics, to provide evidence based interactive modalities on a tech-enabled platform through virtual and in person supports for the TAY and their caregiver/proxy. In FY2022, the program will continue to engage partners and expand its outreach efforts.

Finally, the SOC funding, in partnership with the Department of Social Services (DSS) and the Youth Homeless Demonstration Project (YHDP), supported the start-up, initial operation costs, and a TAY Peer Support Specialist for the Sasha Bruce Drop-In Center. The no barrier Drop-In Center for youth and young adults, would provide supportive services (food, shower, resources, telehealth, employment resources, etc.) and limited street outreach. Eventually, the peer led stabilization team will also be located at the site for set time periods each week.

Strengthening Collaborations

Decreases in referrals and the limited ability to implement services due to the COVID-19 pandemic, were just a few challenges faced by many behavioral health programs. While the pandemic presented unforeseen challenges, it also strengthened collaborative efforts. Many behavioral health grant programs experienced a decrease in referrals through FY2021, which prompted programs to get creative by outreach to non-traditional referral sources. These new partnerships have recently helped to increase community referrals and identify populations that will benefit from services.

Administrative Services Organization (ASO) Transition/Optum

The Administrative Services Organization (ASO) continued to be a challenge in FY2021. PBHS providers struggled to get services approved and questions answered. It was the hope that some of the problems that were seen in the launch year of FY2020, would have been resolved.

The providers are hopeful that FY2022, will see less issues as they seek to provide services to County residents.

BH Workforce Retention

The LBHA previously reported on the challenges experienced within the BH workforce which are common across the broader system. However, in the County it has been observed that there is an issue with filling BH positions once the positions are vacated, and retaining staff overall. Many providers are reporting staff vacancies creating challenges to providing BH services to individuals in need. This became more apparent as the Country began to experience the great resignation, during the pandemic. The positions are more challenging due to increase in salaries that are not accounted for in our budget, which prevent us from drawing candidates in a very competitive market. With the COLA increases over the past year, it is anticipated that the adjustment will help fill some of the many vacancies that continue to plague so many in the behavioral health field.

C. FY 2021 HIGHLIGHTS AND ACHIEVEMENTS

System Management and Coordination Activities

The LBHA plays a vital role in assisting potential community-based providers (in the Medicaid and State funded, fee-for-service Public Behavioral Health System) through the application process for state licensure. The number of behavioral health providers operating PBHS programs continued to grow substantially over the past fiscal year. The LBHA entered into agreements with 23 new programs and completed 41 renewals for addition of services or relocations, significantly increasing the number of providers and the number of PBHS programs available to residents to 422.

Expansion of Service Capacity

The number of behavioral health providers has steadily increased, but there are still low ratios of behavioral health providers to residents, with 146 per 100,000 residents in Prince George's County, compared to the state average of 258 per 100,000 residents. Furthermore, a smaller percentage of Prince George's County residents, than the average for Maryland has health insurance, which can also limit access to care. These statistics emphasize the need for more easily accessible services to better manage behavioral health conditions. The inner beltway and urban areas within the County are saturated with BH providers (see map on page 2). The LBHA continued to provide technical assistance and supported expansion to providers who desired to open programs in more rural, suburban, and southern parts of the County, local hospital systems, behavioral health inpatient facilities, and continues its work with a prospective methadone provider. The FY2021 outreach and technical assistance efforts to potential providers helped to increase to the number of operating licensed PBHS providers by 12% (129 to 145) and programs by 17% (362 to 422) from June 2021 to current.

Through the utilization of BHA grant funds, the LBHA assisted with expanding SBIRT (Screening, Brief Intervention and Referral to Treatment) to Luminis Doctors Community Hospital and Adventist Fort Washington Medical Center to ensure that it was available at all the hospitals in the County. Adventist Ft. Washington is fully staffed for SBIRT, while Luminis Doctor's Community has experienced significant delays in getting their program up and running, due to the BH workforce issue mentioned above.

Luminis Doctors Community Hospital also received $20 million dollars in capital funds from the Prince George's County Executive in FY2021, when funds were diverted from the police capital budget. This funding is being used to expand behavioral health services on the Doctors/Luminis Lanham Campus, which will provide local access to acute care services for patients in mental health and substance use disorder crisis. The building that will be used for Behavioral Health is proximal to the current Emergency Department. The outpatient portion of the building is scheduled to open in the Summer of 2022, with the in-patience facility opening in December 2022.

The facility will include the following services on the 1st floor, which will include: SUD outpatient; Intensive Outpatient Treatment (IOP); Outpatient Mental Health Clinic (OMHC); Psychiatric Day Hospital/Partial Hospitalization Program (PHP); Residential Crisis; and 6-bay walk-in urgent care. The second floor will house the inpatient services, comprising of a 16-bed adult unit.

Lastly, the LBHA was recently contacted by Pyramid Healthcare, who is a large conglomerate in several states, that they are opening a 100-bed inpatient facility to our County. The project is slated for next year, and proposes 20 beds for level 3.7, and 80 beds that will be level 3.5 and 3.1 interchangeably. The facility will also have PHP, IOP and other outpatient services adjacent.

PBHS and Total Number Served

In FY2021, 23,605 individuals with mental health needs and 6,780 with SUD needs, received services in the public behavioral health system (PBHS). The data for FY2020 is not available, but the figures are understood to be comparable. In addition to managing the PBHS, the LBHA monitors key services that are not covered with PBHS funds but funded with grant resources. During FY2021, the LBHA monitored the implementation of 44 grant-funded behavioral health programs, services and projects. A selected few are highlighted below.

Opioid Related Services

Last year, it was shared that the opioid overdose projects were overseen by the LBHA, including the Naloxone training for the County. In FY2021 there were a total of 1,070 people trained on how to use Naloxone, with 847 of those individuals being in law enforcement. Due to the pandemic, only two community events were attended for FY2021. For FY2022, thus far, there have been a total of 833 individuals trained on Naloxone, with 698 of those individuals being in

law enforcement. Staff also have attended 10 community events this fiscal year, as we have moved through the pandemic.

Funding for the Opioid Operation Command Center (OOCC) was continue to be used with information from EMS to geo-map areas of concern. This is useful in continuing to develop a $90,000 Public Service Announcement (PSA) push into the communities, which show the greatest number of overdoses in the County. The County overdoses are decreasing and pushing back toward the 2019 numbers, prior to the pandemic.

The program launched its first harm reduction campaign "Go Slow";.This campaign was implemented in Prince George's County in March 2022 through Radio One, thanks to Overdose to Action (OD2A) funding. This campaign uses radio, Facebook, and Instagram to get the message out that fentanyl is in everything and if people cannot abstain, they should go slow.

The Go Slow campaign was originally created by Bmore POWER with support from the Behavioral Health System Baltimore, the Johns Hopkins Center for Communication Programs and Mission Media, who gave permission for Prince George's County to utilize it. They have the original website of www.goslow.org. However, as part of the campaign a website was developed for Prince George's County, http://health.mypgc.us/GoSlow.

Another campaign that is also funded through the OD2A grant, was the implementation of the Good Samaritan Law campaign with ads developed for the State of Maryland, on their Before It's Too Late website (Videos and Public Service Announcements (PSAs) (maryland.gov). These will be television ads in both English, https://youtu.be/wcxItg6xRd8, and Spanish https://youtu.be/excCHCcNO1M.

The Good Samaritan Law protects individuals from being prosecuted when they call 911 to report that someone has overdosed. The purpose of the Good Samaritan Laws is to help people who are overdosing get the help they need from those that are present, without fear of being prosecuted, or violate parole or probation.

Another major development regarding opioid related services in 2021, is a partnership with the Fire/EMS to start the “Naloxone Leave Behind Program”. The "EMS leave-behind " initiative is a promising method of bringing naloxone to those who need it most, individuals who just overdosed. Through this program, EMS providers give a naloxone kit directly to people who experience an overdose, their social network, and their family immediately after the overdose event. In Prince George’s County, the Fire/EMS have 74 units on which the kits will be placed, including Paramedic Engines, BLS and ALS transport units. Initially, each of the units are stocked with 5 kits. The three EMS supervisors on each shift (12 total) will carry 5 kits each, to assist with supplying units as needed. In addition, they will stock their apex machines located in their seven battalions (7 machines total). Each apex machine can hold up to 6 kits, and the machines are checked and stocked as needed every day. Also, their ePCR (eMEDS through MIEMSS) has been updated to reflect questions surrounding patient distribution of the naloxone kits. On all overdose responses, clinicians will be required to advise whether a kit was left behind and if so indicate how many.

In 2020, we got the clearance from several major law enforcement departments to train their sworn officers in Naloxone, which allows them to carry naloxone in the community. We continued this into 2021 and are now retraining officers that were trained previously and/or their kits have expired. In FY2021, a total of 847 law enforcement personnel were trained. Thus far for FY2022, there have been a total 698 law enforcement personnel trained, through February 2022.

The existing State Opioid Response (SOR II) Medication Assisted Treatment (MAT) program was renewed for FY2021, along with the FY2020 piloted MAT community program, which also continued services in FY2021. Those enrolled in the MAT community program upon release were referred to a program to continue with their medication, individual and group substance abuse counseling, peer recovery specialist support, clinical case management services and medication management. The goal of the program is to provide continuing care to individuals who use opioids when they leave the DOC and to prevent relapse, so they could remain sober. The program administered suboxone to 86 inmates. Additionally, the use of SBIRT was implemented at DOC in September 2020. This is used to evaluate individuals for SUD, and also to begin MAT treatment when they first arrive. Those who are determined to have an opioid or stimulant use disorder are offered the opportunity to participate in the DOC SOR II MAT program, and the community-based program that provides services to detainees upon release from DOC.

Current Crisis Services

The County’s current crisis response system (CRS) includes a crisis hotline/operations center, in-home behavioral health services for children, hospital diversion services and one (1) MCT available during the day, two (2) in the evening, and one (1) team for the overnight shift (12:00 a.m.-8:00 a.m.). The current system is also comprised of Critical Incident Stress Management (CISM) and Crisis Intervention Training (CIT) to first responders.

The Crisis Response System responded opened 2,154 new cases in FY2021. Of the 3,469 calls to the operations center, the vast majority were regarding citizens between the ages of 22 and 60 years of age (799 calls). The second highest number of calls were for individuals 13 to 17 years of age (203 calls). It is important to note that although the number of calls increased drastically from FY2020, the number of calls for youth in this age category decreased by 44 calls. There were 25 calls from individuals who identified as veterans. The mobile crisis teams were dispatched 991 times. As a result, 80% of individuals who received CRS services were able to remain in the community and divert hospital admission and the detention center at end of intervention.

University of Maryland Capital Region Health, Prince George's Hospital provided emergency psychiatric evaluations to 258 uninsured persons and 206 uninsured persons filled the 23-hour crisis beds in the behavioral health unit. Prince George's County was one of the jurisdictions with the highest number of coronavirus positivity rates in the state and consequently, the hospital was severely impacted. As previously reported, the need for beds to address the surge of individuals needing hospitalization to treat the virus had a critical impact on the behavioral health unit.

Efforts to Prevent Homelessness and Provision of Housing and Other Support Services

Assistance was provided to 44 individuals through the PATH program also helps individuals experiencing homelessness (or at imminent risk of homelessness) and who have severe mental illness or co-occurring disorders to secure safe, stable housing and other supports. In addition, through the Outreach with Treatment Services program, assessments were done with 242 individuals who were homeless, and the program evaluated 94 of those individuals for mental health and substance use disorders. Ninety-seven percent (97%) of those evaluated were linked to mental health treatment and 73% were linked to SUD services. Thirty-six (36) participants also obtained housing placements. The Homeless Outreach program developed relationships with three new Warm Nights shelters in Prince George's County. Outreach included providing sleeping bags, gloves, socks, and coats to individuals in need. The program also provided personal protective equipment to staff and program participants. Like other behavioral health program experiences, COVID-19 allowed for more access to new clients and innovative programming. The program conducted thousands of virtual appointments and initiated new treatment groups. Some barriers continue to include the limited number affordable housing opportunities and lack of jobs for individuals who are homeless. These individuals have expressed that the "jobs" that they were able to do prior to the pandemic have ceased or are hard to come by, as many businesses lost money and were not able to pay them to do the odd jobs.

The Continuum of Care (CoC) housing program provides rehabilitative services and supportive services to those with behavioral health diagnoses and forensic backgrounds. Services were provided to 18 individuals and 16 families in FY2021. The program maintained a 94% and above occupancy rate. Also, the program purchased a "worknumber" which helps verify employment and income data and check applicant provided information. This will support the accuracy of

residents' household income, to calculated correct rent payments. The program also worked with a company to set up a rent payment portal for residents with credit and/or debit cards. This will afford tenants the ability to promptly pay rent without purchasing money orders and/or deliver their rent to an office.

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 waitlist. The program also accepts community referrals after state hospital referrals are explored. The LBHA has experienced a shortage of appropriate RRP referrals from the state hospitals and community. It appears that consumer's illnesses are more severe requiring 24/7 supervision, which is not reimbursable. Other issues that complex the situation, include consumers with co-occurring diagnoses, opting out of contributing to their cost of care, and individuals wanting housing instead of a rehabilitation program. Many RRP programs have also experienced staff shortages, which have contributed to some bed slots being placed on hold.

The LBHA worked diligently with the only Maryland Certification of Recovery Residence (MCORR) in the County, to provide housing to individuals who do not otherwise qualify for continued assistance with recovery housing. Unfortunately, after working with the potential provider across two fiscal years, the recovery residence was unable to produce the contract documents required to move forward. In FY2023, the LBHA will redirect their efforts to providing information, support, and technical assistance to other recovery residences in the community.

The Community Case Management program continued making progress by linking residents to services during the pandemic. Services included transportation to and from substance use disorder treatment and doctor's visits, grocery deliveries for residents shut in with no transportation during the height of COVID-19, assisting with applications for State Care Coordination, Metro Access, delivering medication with nursing staff, nicotine replacement therapy, connecting clients to Medical Cab, dental, food stamps, and medical insurance. There was a decrease in referrals due to the COVID-19 pandemic, and the closure of Cheverly Health Center outpatient services. Many of the referrals received for Case Management Services came from outpatient treatment. At the height of COVID-19, some providers limited intake, or closed their offices, which caused a delay in services. It has caused a delay in services, return calls, and emails to obtain information on behalf of clients that we serve. Assisting clients with obtaining housing continues to be a challenge for the Case Managers due to the limited housing resources in the county as well as clients limited skills utilizing smart technology or not have the capabilities to receive virtual services for health appointments. Despite the challenges experienced, Case Managers continued providing services to active and newly referred clients throughout the County during the pandemic. The Case Management team distributed educational literature and incentives to some community providers throughout the County to support their program and expand relationships. Technical Assistance include on-going training through Zoom, Teams, and Google Meet to offer virtual services.

Children, Adolescents, Transition Age Youth Services and Their Families

The In-Home Intervention Program for Children (IHIP-C) had a new provider, Center for Therapeutic Concepts in FY2021. This change delayed Prince George's County residents from utilizing services for the fiscal year, however, by February 2021 clients were being served. By the end of the fiscal year, there were three (3) children participating in the program, with two (2) of them showing overall improvement, improved family relations, and two (2) with no or improved school problems.

The newly chosen Target Case Management (TCM)/Care Coordination Organization (CCO) provider for children and adolescents, Center for Children, experienced a slow start in the provision of services. The provider experienced prolonged delays in the process of obtaining a new Medicaid number for the site established in Prince George's County and were not able to begin accepting referrals until well into July. The program received enough referrals to provide a Care Coordinator with an adequate caseload. However, as the COVID-19 pandemic continued, the referrals were slow, especially since most services were being provided virtually. Unfortunately, Center for Children also experienced staffing issues later in the year as the pandemic continued.

Older Adults and Long-Term Services and Supports

The LBHA continued to provide support to behavioral health programs that assist individuals who are elderly and medically fragile. In FY2021, forty-five (45) older adults were served in the Geriatric RRP, Nursing in RRP and Behavioral Health in Assisted Living Facility programs. Services were rendered to assist forty (40) of these individuals within their RRP homes by ensuring the availability of medically trained staff, a registered nurse, and Certified Nursing Assistants to provide them with individualized medical education and care.

The LBHA continues to refer behavioral health providers whose clients are aging and experiencing behavioral health challenges to the Southern Maryland Pre-Admission Screening and Resident Review (PASRR) Specialist for consultation. The PASSR Specialist provides behavioral health resources with the purposes of diverting older adults from nursing facility admission and/or reducing length of stay in a nursing facility.

Services to Special Populations

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 forty-seven (47) individuals in an Outpatient Mental Health Center, Psychiatric Rehabilitation Program and Residential Rehabilitation Program. American Sign Language (ASL) Interpreters provided 170 hours of ASL interpretation to ensure individuals who are deaf and hard of hearing receive quality services relevant to their needs.

The House Bill 7: Integration of Child Welfare program (HB7) SUD counselor provides referral to treatment and case management/monitoring for families that have an open child protective

serviced (CPS) case and is open to anyone in the family that is referred by CPS. In FY2021, the program screened 176 clients, of which 118 clients were referred to community treatment providers. The Senate Bill 512: Substance Exposed Newborn/Children in Need of Assistance program identifies newborns exposed or addicted to drugs/alcohol and offers the mother and birth father drug treatment, as well as support. In FY2021, the SUD counselors screened 34 new clients and referred 55 clients to community treatment providers. Clients were linked to ancillary services. This included Peer Recovery Support Program, to increase the likelihood of successful linkage to treatment services, and Healthy Beginnings for post-natal care of high-risk co-occurring clients. Both programs successfully provided services to clients using telehealth and telephonic platforms and began training for transitioning to a new electronic medical record (EPIC). Program staff also completed several evidence-based trainings to enhance their service delivery.

The U.S. Census (2016-2020) reports estimate that there are 53,192 veterans in Prince George's County. Although the inquiries for veteran resources have been infrequent, the LBHA continues to stay abreast of the services available to veterans. When residents contact the LBHA and identify as formerly or currently serving in the military, they are also referred to the Maryland Commitment to Veterans Regional Coordinator. The coordinator can also connect them with mental health, SUD treatment and other support services.

Justice-Involved

The Mental Health Court (MHC) located within the District Court serves individuals with mental illness who have misdemeanor charges. Case management services were provided to 122 individuals and 140 referrals were made to housing resources and services, such as substance use treatment, therapy, and anger management. Of the 122 individuals served 84% ended the year without new charges and 67 individuals successfully completed the program. The LBHA provides funding for a part-time clinical social worker position for the District Court of Maryland, to support the ongoing operations of the MHC. In May 2020, the Mental Health Court experienced the loss of the social worker, and the position has been very difficult to fill. Though this loss was critical, the case managers continued to provide services and ensure individuals compliance with their mandates.

Maryland Community Criminal Justice Treatment Program (MCCJTP) is referred to as the backbone of crisis intervention for the inmate population for over 15 years. The mental health services, mainly crisis intervention, are provided outside of the normal working hours, such as evenings, weekends, and holidays. Clients receive case management and aftercare services, and they will be assisted with identifying housing resources and referrals in the community. Housing continued to be a challenge in the community. Staff are involved in mental health court, where release to the community will be conditional to the inmate's compliance to their mental health medication. Also, MHC was very helpful, by court ordering hospitalization to mental health hospitals for seriously mentally ill patients who didn't get better through an intervention. Shortage of mental health hospital beds remains a challenge.

MCCJTP provides service to vulnerable inmate populations such as individuals with substance use disorder, mental illness, homelessness, and veterans. While Trauma Addictions Mental Health and Recovery (TAMAR) provides service exclusively for women with trauma, addiction, mental illness. Thirty-five (35) female inmates participated in the Trauma, Addiction, Mental Health and Recovery (TAMAR) groups within the detention center. Using the TAMAR curriculum, these inmates were able to gain valuable insight into their trauma and learn ways to cope and manage, while in detention and most importantly once they reenter the community. Due to the lockdown of the detention center the TAMAR groups were halted, during which the TAMAR specialist continued to reach out to participants virtually and by phone to provide individual support and counseling. In June 2021, the program held the annual Trauma training for officers which received great feedback.

The TAMAR program for female inmates has been described as "one of the most effective, useful, and most cherished programs" which decreased recidivism by helping inmates cope, both inside the correctional facility and reentering the community. The DOC currently has 870 inmates, of which 836 are men and 34 are women. The DOC trauma specialists recommend implementing a TAMAR program for male inmates. In the past, DOC operated a two-year grant program that was similar to TAMAR, but the target population were the men inmates. It was a 12-week program and as a result, the rate of recidivism was significantly lowered among the men who participated in the program. A main barrier, is the program has not been able to secure peer recovery specialists that can pass the background investigation required to come inside the DOC. The LBHA has shared peer resources from programs within the Health Department to connect with the DOC.

A federally funded Sequential Intercepts Map (SIM) workshop was held in April 2021. The SIM is the gold-standard model that systematically maps access to best practice resources, for those engaged in or at risk for engagement with the criminal justice system with behavioral health conditions. The mapping exercise engaged stakeholders from County public safety entities, healthcare organizations, social service agencies, and the Health Department. Gaps and recommendations in the crisis intervention intercept included but were not limited to the formal creation of Crisis Intervention Team (CIT) department and a Law Enforcement Assisted Diversion (LEAD) program. The importance of a stabilization center was also highlighted.

<u>Evidence-Based Programs/Services</u>

The Assertive Community Treatment (ACT) program is an evidenced based model that provides multidisciplinary, comprehensive, flexible treatment and support to individuals with severe mental illness, as well as those with co-occurring disorders who are at high risk for psychiatric or criminal justice involvement due to their mental illness. The ultimate goal is recovery. Unfortunately, there is only have one evidence-based ACT team in Prince George's County, which is not enough for a county of 900,000 residents. Therefore, we have been in talks with BHA on how best to expand this service in Prince George's County. We are in active discussions with the current provider and have also reached out to another provider who was interested in

starting services in the County. There is a need for operational funding, to help cover the costs of the programs, until they are at full capacity, due to the staffing requirements.

SSI/SSDI Outreach, Access and Recovery (SOAR) assists with expediting the receipt of SSI eligibility benefits for eligible mental health consumers. The SOAR program has faced challenges hiring a coordinator, whose duties have been performed by the SOAR Lead while the position has been vacant and receiving eligible cases. The program is currently working with a PBHS provider, who also provides psychological evaluations for homeless residents, to develop a local psychological evaluation tool that includes the four areas of functional limitations often required by the Department of Disability Services to determine eligibility. The program will integrate these critical criteria with their diagnostic evaluation tool to identify potential SOAR clients.

Using the County's Homeless Management Information System (HMIS), the SOAR program was able to identify some residents in permanent supportive housing programs, who have disabilities without income. Most of the residents have varying degrees of physical health conditions. However, the program currently screens and re-evaluates them to determine their eligibility for SOAR or the SSA Vulnerable Population Application Program.

<u>Wellness, Recovery, Peer Support and Advocacy</u>

NAMI Prince George's County (NAMI-PG) Advocacy and Community Outreach programs has had a positive impact on Prince George's Community residents through planning, implementation, and management of existing and new programming that provided mental health education, support, advocacy, and community outreach programs. NAMI programs are peer-led, evidenced-based, and provided for free to participants. Classes offer information, resources, and community support. They help increase understanding of mental health, improve coping skills, and empower participants to advocate for themselves and their loved ones. NAMI presentations offered audiences the opportunity to hear stories of direct experiences of the impact of mental illness on individuals and their families and to create awareness, reduce stigma, and increase empathy. NAMI support groups offered participants an opportunity to share their experiences and gain support from one another. Additionally, NAMI Prince George's County was chosen for the 2020-21 print edition of the Catalogue for Philanthropy: Greater Washington as "one of the best" community-based nonprofits in our region. Other highlights, accomplishments, achievements for NAMI Prince George's County, included:

- NAMI Helpline: Continued to help residents navigate Prince George's County's behavioral health and social services systems. NAMI Helpline increased awareness and utilization of community programs and services for an estimated 1500 county residents (an average of six contacts a day – Monday through Friday).
- Quarterly Newsletters: Published newsletters and distributed them quarterly to more than 1,000 NAMI members and community partner organizations in November 2020, February, April, and May 2021. The newsletters included news updates, information on

relevant events, information on NAMI programs and services; save-the-date information for upcoming events; staff member spotlights; crisis resources; volunteer opportunities; and much more.

- NAMI-PG hosted six (6) board and membership meetings virtually during the grant period. Meetings addressed governance matters and were a breeding ground for innovation and decision making. The meeting directly benefited over 150 NAMI members, and indirectly benefited the thousands of Prince Georgians across 9 districts impacted by mental illness that NAMI-PG serves.
- Mental Health Education Sessions: NAMI hosted six (6) local education sessions on mental health topics and directly benefited an estimated 180 family members and/or mental health professionals.
- Psychoeducational Sessions: NAMI provided 40- two (2) hour Bipolar Support Groups for individuals with mental illnesses and directly benefited an estimated 12 individuals living with mental illness.
- Community Outreach Events: NAMI participated in more than seven (7) community outreach events to increase mental health awareness and education in the community. These opportunities educated individuals about NAMI's services and helped to erase the stigma surrounding mental health.
- Family Support Groups: NAMI sponsored six (6) family support groups (FSG), that met monthly. NAMI-PG successfully transitioned support groups from in person to online (via Zoom technology). Our Family Support Groups benefited 320 family members.
- Family Education Courses: NAMI sponsored two (2) eight (8) session family education courses to develop understanding and enhance coping skills for supporting individuals/family members with mental illness (NAMI Family to Family, NAMI Basics, NAMI Homefront).
- Consumer Support Groups: Sponsored two (2) NAMI Connections Support Groups (consumer support groups) that focused on recovery and met monthly (every 2nd Saturday, and every 2nd and 4th Monday). These groups benefited an estimated 216 individuals impacted by mental illness.
- Peer Education Courses: Sponsored one (1) eight (8) session peer education course (NAMI Peer to Peer) to promote wellness and recovery. Six (6) individuals living with mental illness benefited directly. The family members and caretakers of these individuals are more than likely to have benefited indirectly, as well.
- Training Sponsorship: Sponsored three (3) trainings (NAMI Peer-to-Peer Mentor Training, Connection Peer Support Group Facilitator Training, and Family-to-Family Teacher Training) to expand and enhance programs and services offered by NAMI-PG to the community. Eight (8) trainees made commitments to teach courses after being trained.
- Printed Mental Health Awareness Outreach Materials: NAMI-PG distributed over 1,000 pieces to mental health consumers, families, and community members.
- Information Packets: NAMI- developed and distributed 600 hospital psychiatric discharge packets to UMD Regional Hospital (Laurel), UMD Capital Region Health, and Medstar Southern Maryland Hospital.

- Satisfaction and Knowledge Surveys: NAMI-PG collected more than 100 participant satisfaction and knowledge surveys and utilized the feedback to evaluate over a dozen trainings, education courses, and support groups.

On Our Own of Prince George's County (OOO-PGC) Wellness and Recovery Center survived the COVID-19 pandemic intact, albeit with limited services. The non-profit, community-based organization assisting people with mental illness and addictions actively pursuing recovery, closed for a year beginning in mid-March 2020. During a year unlike any other in recent history, the Center's scheduled plans were upended in a way no one could have foreseen. Regular activities such as support groups, educational seminars, workshops, outreach presentations, guest speakers, and social activities could not be held. However, the Center continued its work as a community association for people with similar backgrounds, lived experiences, and interests by offering peer support by phone and answering Warm Line calls. The Wellness Center's usual spectrum of services could not be offered.

Despite frequent news reports of the dramatic increase of opioid overdoses during the shutdown, the Center did not receive calls from anyone dealing with an opioid addiction during the pandemic as staff continues to brainstorm on how to reach this 'community.' In FY2021, staff were able to attend nineteen webinars/trainings related to peer support work. Although, the center maintained their library, it was not available to be used. Center staff were able to send information or refer consumers to informational websites, as questions from members were received during peer support conversations. During the past year, the staff worked with On Our Own of MD staff to provide up to date information regarding peer support. and other resources to the Center's members. OOO-PGC was able to provide referrals to housing programs to five individuals. All Center program attendees have stable housing. The Center members range in age from the mid-20s to older than 60 years of age.

The Wellness and Recovery Center provides a safe and comfortable physical space and supportive, culturally sensitive programming for members to assist them in their recovery efforts. The Center also provides socialization opportunities to connect with other members. Staff encourages goal setting and being accountable for choices. Since the program was unable to meet in person, staff encouraged members to connect with one another through ZOOM support group meetings sponsored by On Our Own of Anne Arundel County. OOO-PGC members were invited to join the meetings. Meeting topics addressed the loneliness, anxiety and isolation from family and friends that people were grappling with at that time. Coping skills were discussed often at ZOOM support groups. These meetings began in December 2020. Additional ZOOM support groups topics included the following:

- "Anxiety: Different kinds and How to Manage It"
- "Companionship"
- "Corona Virus and Practicing Good Hygiene"
- "Discussed the Quarantine and how people were managing the isolation.

- “Five Ways Love Changes Us for the Better”
- “How to Stay Sober during the Holidays”
- “How to Say No”
- “Identifying ten coping skills that work for you”
- “Resilience---What it Means and How to Get It”
- “Respect for Yourself and Others”
- “How to recognize Unhealthy Boundaries”
- “When is it Emotional Abuse?”

On Our Own reopened in late March 2021. All COVID-19 protocols were followed to maintain the safety and health of both their staff and members. Members were invited to a special luncheon the first day they reopened. Lunch gave everyone an opportunity to reconnect, as well as a chance to meet the new Executive Director. The Center continues to provide lunch once a month. Activities held weekly include Travel Tuesdays, Poetry and Painting, and a Vision Board Workshop: “Visualizing a Better Me.” Travel Tuesdays is especially popular. Staff show “YouTube” videos from various countries detailing that country’s history and scenery as well as landmarks. Most members have never had the opportunity to travel and have enjoyed this program. Wellness and healthy lifestyle resources for members included developing a Wellness and Recovery Action Plan (WRAP) which includes a daily living plan, that helps maintain balance and wellness. Food and eating well workshops are offered too and in May FY2022 a presentation on diabetes and healthy eating was offered.

Like many other programs On Our Own of Prince George’s County Wellness and Recovery Center experienced one of its most difficult years to date. Early in the pandemic the Governor announced mandated business closures except for “essential businesses.” The Center closed to maintain the safety of both the staff and their members. Late last year, when some programs were reopening**,** the Executive Director had to weigh the importance of reopening the Center too soon. Factors considered for reopening included regular updates from the state and local authorities, about the numbers of citizens diagnosed with COVID-19, the surge in hospitalizations in Prince George’s County, the ability to maintain the Social Distancing requirement of six feet, as well employee apprehensions.

Collaboratively, the Peer Recovery Specialists (PRS) within the Health Department served 1,246 individuals seeking behavioral health support and made 5,346 contacts. Despite the challenges presented by the pandemic, during FY2021, adult Peer Recovery Specialists were able to continue providing supportive services to Prince George's County residents. Each peer renewed their certification as a Certified Peer Recovery Specialist. The peers were also vigilant in their continuing education completing trainings in Harm Reduction, Intersection of Trauma, Process Addiction, Brain Injury, Co-Occurring Behavioral Health, and Peer Leadership. Peers also attended national Alcohol and Narcotic Anonymous Conference in FY2021. Staff continued to host weekly recovery support Zoom meetings with clients. Initially, the peers faced challenges reaching out to individuals by phone during the pandemic. The peers believed that the absence of initial face-to-face contact and not recognizing the peer's telephone number, created the

difficulty of a phone meeting. Housing was also an issue amongst many individuals who were facing homelessness.

The Recovery Support coordinator served 27 unduplicated women in the Pregnancy/ Postpartum Project during FY2021. The women were diagnosed with an opioid and other substance use disorders. The coordinator provided However, recovery support services, resources, and/or referrals to wrap around services for 129 women who were pregnant or postpartum women.

Additionally, the Peer-to-Peer Federal-funded program provided peer recovery support to 75 returning citizens during FY2021. Majority of program participants were referred by the Offender Reentry Program and the Bridge Center at Adam's House. All Reentry Support staff were Certified Peer Recovery Specialists. Staff were impacted by challenges and obstacles due to COVID-19 restrictions/regulations. However, they were able to meet virtually with participants to successfully provide reentry and recovery support, and competently assist participants with access to services and resources in the community including, but not limited to employment and training opportunities; behavioral health treatment; medical treatment; social services; and support groups. All participants had a recovery-oriented, person-centered reentry plan based on results of the Level of Service/Case Management Inventory (LS/CMI) assessment. Of the 75 persons served, approximately 61% completed the program and only three program participants were rearrested during the grant period.

The Adolescent Clubhouse (ACH) is a recovery-oriented program that provides recovery support and continuing care for youth ages 12 – 17 years old. Adolescents appropriate for admission receive SUD treatment, including for opioid use disorders. The ACH program experienced several changes in FY2021. Like many other behavioral health services, ACH transitioned from in-person services to full-time teleworking from home due to the increased positive cases during the COVID-19 pandemic. The program completed details on converting the in-person programs and services into digital format and services to youth and families continued through those challenging times. The ACH program officially moved to the new location and hired two (2) new staff who are also conducting the outreach for the program. The outreach workers responsibilities are instrumental for new enrollments, maintaining contact with our partners, community-based organizations, and families, with regards to helping youth. Brochures about the Adolescent Clubhouse where distributed and information was also provided to the community in an effort to reach the younger generation and educate them on drug abuse. The additional outreach efforts have results in new partnerships and increased enrollment.

Part of the ACH programing is to reward positive behavior and to recognize the good work that youth exemplify. The youth were given holiday gifts to show that they were being thought of during the holiday season. Abstinence of substances, school attendance, and participation in the ACH programs are some of the standard measures for acknowledging growth and development.

The staff coordinated vouchers for food to ACH youth and their families. The families were able to shop for groceries prior to the Thanksgiving holiday. This was a significant event due to many families experiencing economic hardship, associated to events of the COVID-19 pandemic. Staff also participated in a basket distribution sponsored by a local church, delivering 100 food baskets of nonperishable healthy food items. This assistance served as an economic relief and support to many of the ACH families. This was a meaningful opportunity for the staff to network and share information about the ACH.

ACH staff contributed to the development of a social media campaign to deter youth and their peers from underage drinking, marijuana use, vaping, and distracted driving.

The goal has been to develop and increase relationships with community partners, government agencies, Prince George's County Public Schools (PGCPS), and faith-based organizations that will assist with connecting with youth and families. In FY2021, ACH staff conducted several presentations to the Prince George's County Department of Social Services (Child, Adult & Family Services), Prince George's County Public Schools Pupil Personnel Services, Department of Juvenile Services, Prince George's County Library, and Community Crisis Center, Inc. Homeless/Crisis Hotline.

The ACH also completed two (2) Strengthening Families Program (SFP) for Trainers. Both trainings were formulated for virtual delivery. ACH staff started as trainers and successfully conducted their first formal virtual SFP training lessons with youth and families in April 2021. SFP training sessions were concluded with a graduation ceremony and dinner was coordinated and delivered to participant's residences prior to each lesson.

D. Sub Grantee Monitoring

Any entity that delivers behavioral-health related services with the funds award by the LBHA is considered a sub-grantee. Sub-grantees are required to enter into written contractual agreements, inclusive of grant agreements and Scopes of Services, with the LBHA. All conditions of the grant award are covered in the grant agreements and Scopes of Services (also known as Attachment A). As part of the contract, the LBHA Contract Monitor develops the Scope of Services with the Subgrantee, which outlines the program's responsibilities including, but not limited to, program objective(s), service provision, reporting, billing, eligible and ineligible use of funds.

- Site Visits to the provider

Site visits are conducted annually by LBHA Contract Monitors to ensure program compliance. Prior to the pandemic, all site visits were held on-site at the program's location. However, the LBHA has recently expanded to a virtual platform for some programs. These visits include staff and/or program participants interviews, review of client files, and other documentation to support the provision of services. Site visit reports are developed and are specific for each grant-funded program. The template includes all conditions of the award to be monitored by the LBHA.

Of note, if a program has a corrective action plan, additional site visits are often warranted.

- Review of provider progress reports

All sub-grantees are required to submit program reports, on a schedule identified within the Scope of Work. This schedule permits monthly and/or quarterly reports as well as an Annual Activity report. The reports include program activities as identified in the subgrantees contract with the LBHA. The details of the reports are reviewed by the assigned LBHA Contract Monitor to determine if the program is on track to meet their targeted outcomes.

- Review of provider fiscal reports/budgets/invoices

The LBHA requests that sub-grantees submit their program budgets in March, if a recurring grant program, or if a new subgrantee at the time of notification of award. The LBHA reviews each budget to ensure that the budget request is in line with the grant project and only eligible items are included. Once budgets are final, they are forwarded to the Health Department's Contracts Specialists who then forwards all contract documents (i.e., Grant Agreement Scope of Service and budget) through the County's procurement process.

Subgrantees are contracted to submit invoices to their assigned LBHA Contract Monitor each month by the 10th of the following month. For example, July invoices will be due August 10th. Invoices are initially reviewed by the Contract Monitor to ensure it includes the approved program budget, expenditures are in line of what the services are for and supporting documentation such as receipts and program reports correspond with expenditures. Approved invoices are forwarded to the LBHA Manager for signature, then submitted to the HD fiscal office and next processed to the HD Accounts Payable office for remittance. Payment should be made in 30 days or less from the sub vendors submission of an accurate invoice.

- Review of deliverables met/not met; actions to be taken if services have not been delivered

If contract/program deliverables are not met, then the LBHA will increase site visits and/or put in place a corrective action plan (CAP). The CAP be in the form of a letter or email and will contain the following details: 1) the condition(s) of the subvendor's contract that have not been met 2) actions taken by the LBHA to assist the subvendor as applicable 3) date the CAP response is due to the LBHA. Corrective Action Plans are only issued after the LBHA Contract Monitor has provided the Subvendor with adequate technical assistance.

- Review of Provider Audit Reports

Audits are required of all subgrantees awarded contracts for $100,000 or more. The subgrantee must submit a financial audit to the Health Department/LBHA on or before March 1st for the previous fiscal year. The audits are submitted to the HD Audit Manager for review for the presence of conditions that might prevent the sub-vendor from delivering services or fulfilling the terms and conditions of its contract.

Failure to comply with this requirement may result in a delay or reduction in payment to the subgrantee and could result in the HD Audit Manager assigning a Management Consultant to provide the audit and/or the closing fiscal report, financial report at the subgrantee's expense.

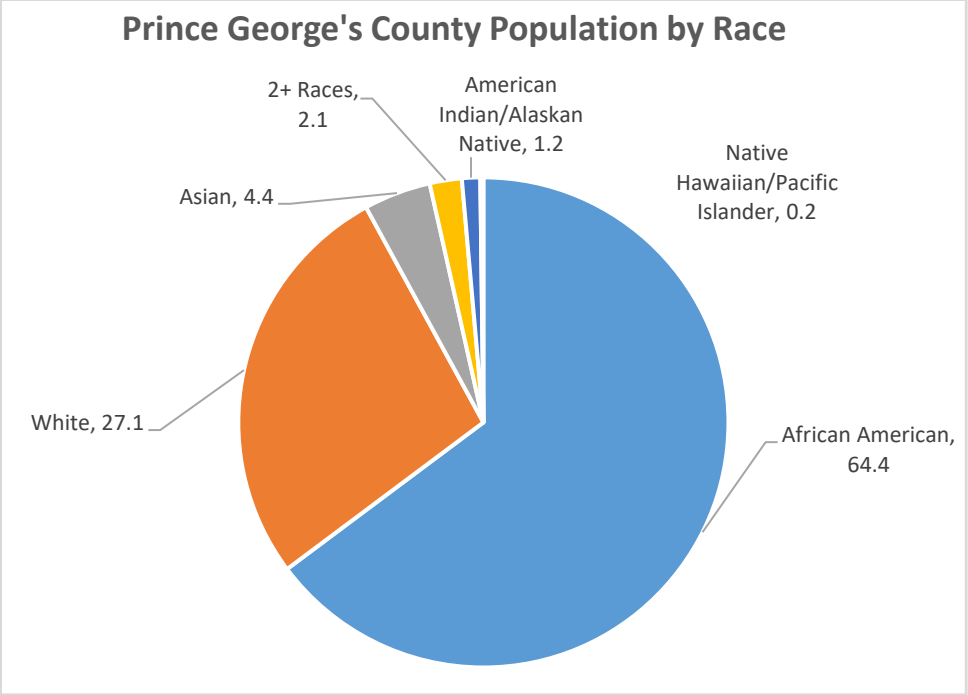
E. DATA AND PLANNING

The data section of the Annual Plan includes information that has guided the system planning process. It includes data on County demographics, social determinants of health, Medicaid enrollment and penetration, suicidality, overdose events, crisis response and the County's response to the COVID-19 Pandemic. As the LBHA plans intervention and prevention efforts to address behavioral health in our County, we will continue to consider the unprecedented impact of COVID-19.

1. Population and Demographics

Prince George's County has approximately 967,201 residents, of which 22 percent are under 18 years of age, and nearly 14 percent are 65 years and over. It is also the second most populous County in the state of Maryland (after Montgomery County). According to the U.S. Census Bureau, the median household income in Prince George's County is $86,994 which is slightly higher than Maryland's median income of $86,063 and $17,473 greater than the US median household income of $67,521, respectively. Although the County's median household income is well above the U.S. median overall, it is important to note that the incomes range greatly from area to area.

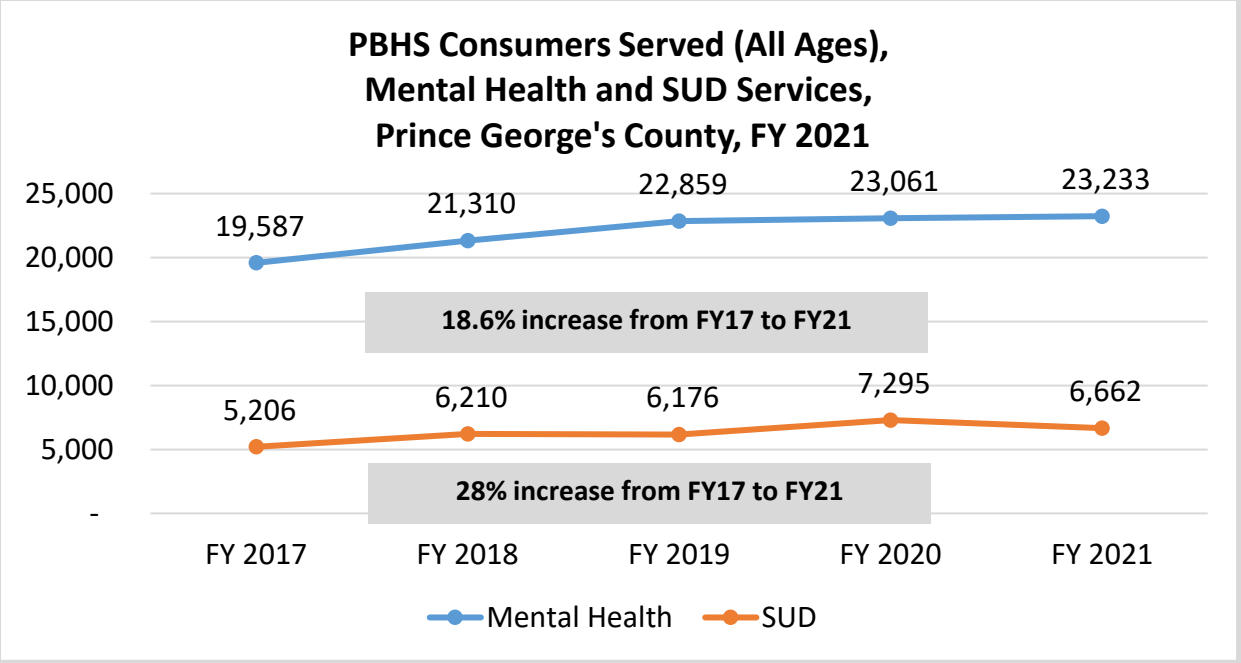
Prince George's County is considered one of Maryland's most diverse counties. Minority groups account for more than 73% of the population. According to the 2020 U.S. Census Bureau, Blacks, Hispanics, and Asians make up 64.4%, 19%, and 4.4%, respectively. As reported by the Census Bureau American Community Survey, the County's total foreign-born population in 2020 was 23%. The top three immigrant communities living in the County are Latin American, African, and Asian.



Data Source: American Community Survey 1-Year Estimates, 2020

2. PBHS Utilization

Number of Individuals with MA Receiving Services in the PBHS during FY 2017 to FY 2021					
Prince George's	2017	2018	2019	2021	2021
Mental Health	19,587	21,310	22,859	23,061	23,233
Substance Use	5,206	6,210	6,176	7,295	6,662



Data Source: FY 2017-2019 based on PBHS Utilization. Claims paid through 10/31/2019. FY 2020-FY 2021 based on Claims paid through 10/31/2022. Data for FY 2021/22 are not complete as providers have 12 months from the time of service in which to submit a claim for payment.

The overall number of individuals receiving PBHS services in Prince George's County continues to grow. In FY2021, 23,233 consumers accessed mental health services, and 6,662 consumers accessed SUD services.

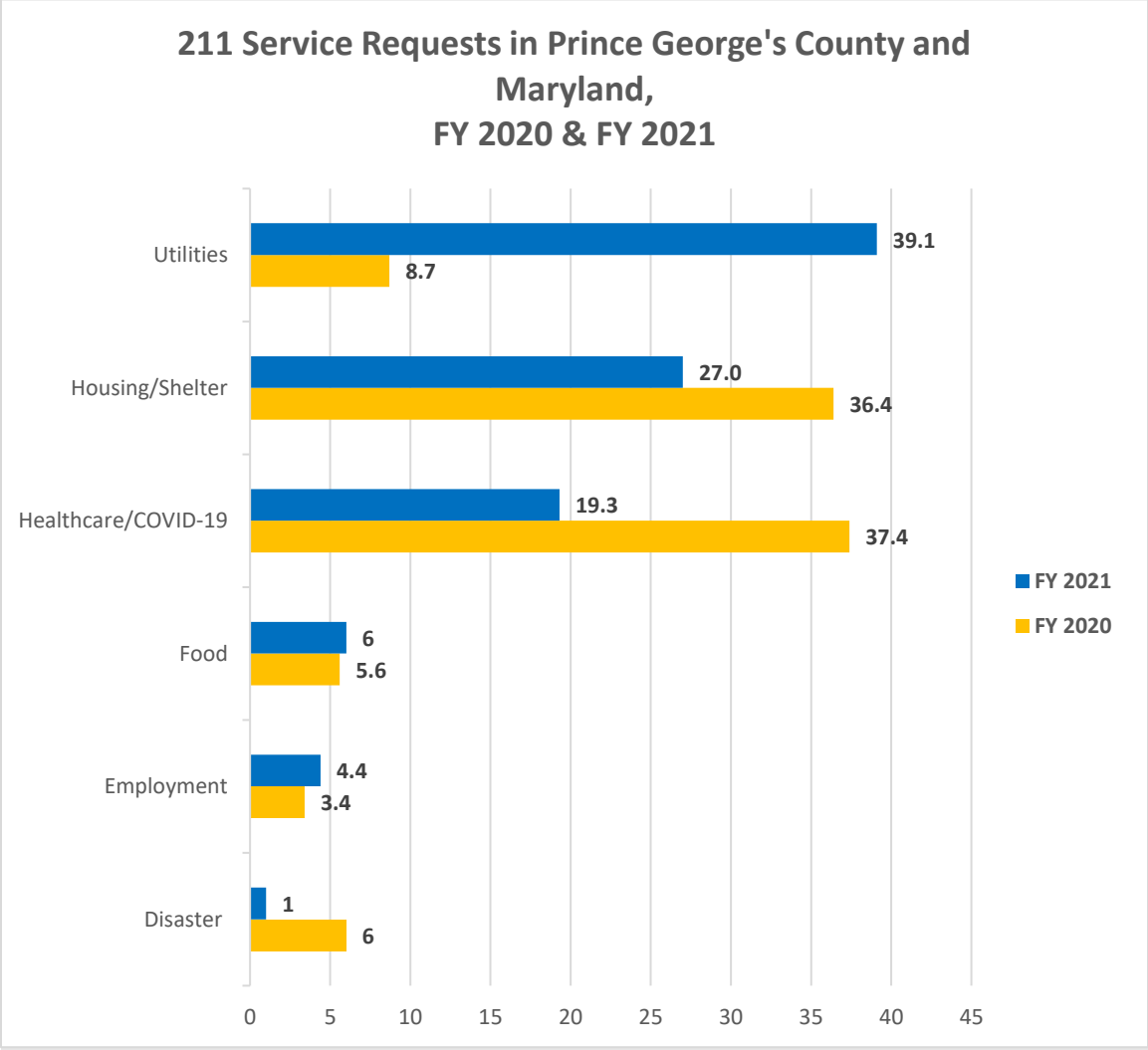
Noticeably, while the number of consumers receiving mental health services continuously increases each fiscal year, the number of those accessing SUD services fluctuates. After an increase in the number of individuals accessing SUD services from FY2019 to FY2020, there was an 8.68% decreased (7,295 to 6,662) from FY2020 to FY2021. Of note, this decrease occurred during the COVID-19 pandemic, when hospitals reported an increase of individuals seen in behavioral health units.

As mentioned previously, there are approximately 135 PBHS programs operating in the County to serve the needs of 23,233 mental health consumers and 6,662 SUD consumers. To meet the BH needs of our large, growing County, it is important for the LBHA to continue to address network adequacy to help make certain that there are enough available programs.

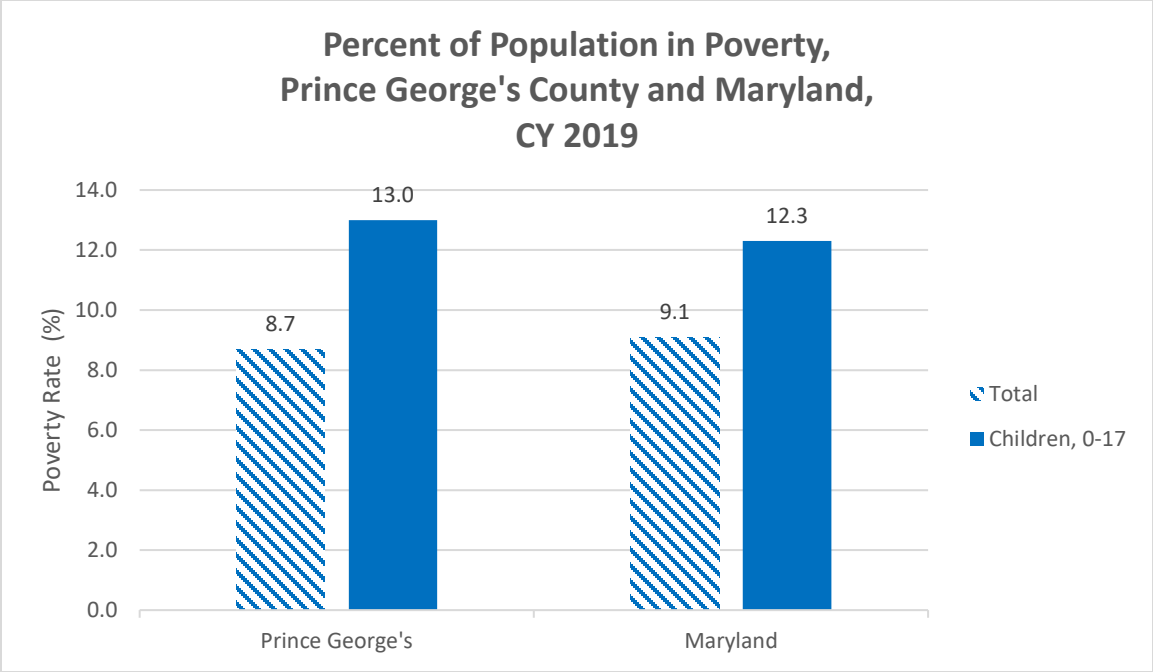
3. Poverty Rates and Rankings

Although Prince George's County has a reputation as the most affluent African American community in Maryland, there are areas of continued socioeconomic need. Socioeconomic factors such as lack of affordable housing are significant stressors that negatively impact the behavioral health of individuals. Access to healthcare in Prince George's County, including behavioral health care, is limited, creating an additional barrier for access to quality healthcare.

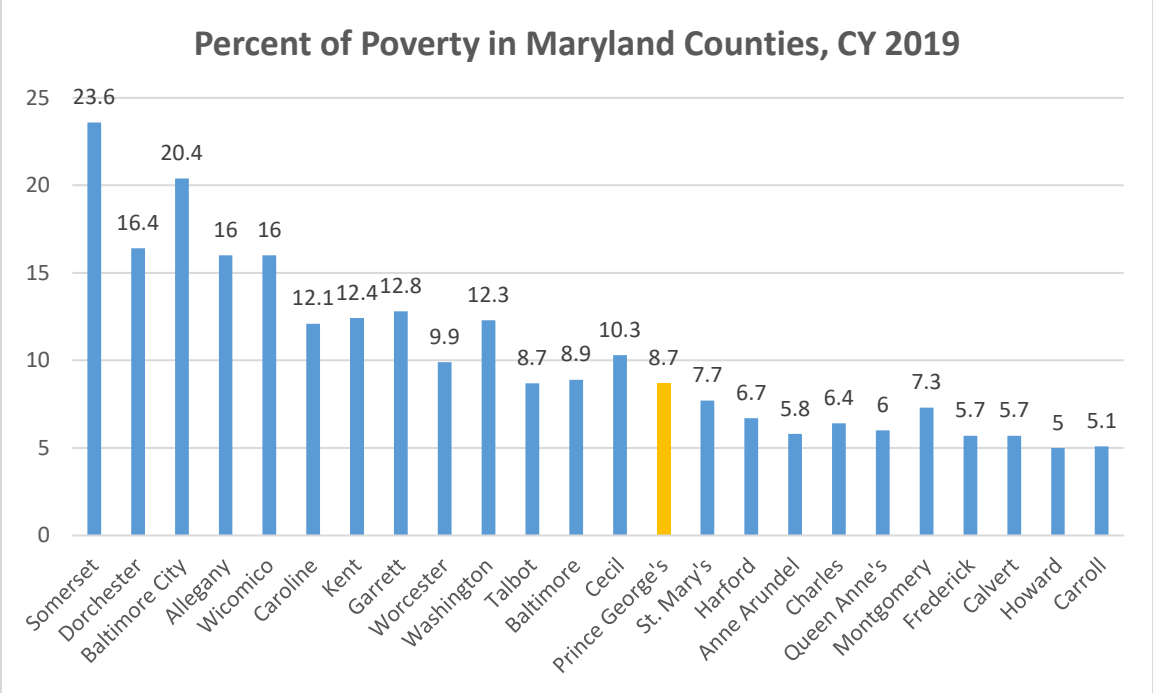
Data retrieved from MD 2-1-1 for fiscal years 2020 and 2021, showed that the top requests for Prince George's County residents included assistance for utilities, housing/shelter and healthcare/COVID-19. Information requests for utilities, food and employment increased from FY2020 to FY2021, with utility assistance experiencing the most significant increase. During the same period, requests for information for housing/shelter decreased by 8% and information for healthcare/Covid-19 also significantly decreased by 36%.



Data Source: https://md-dc.211counts.org/

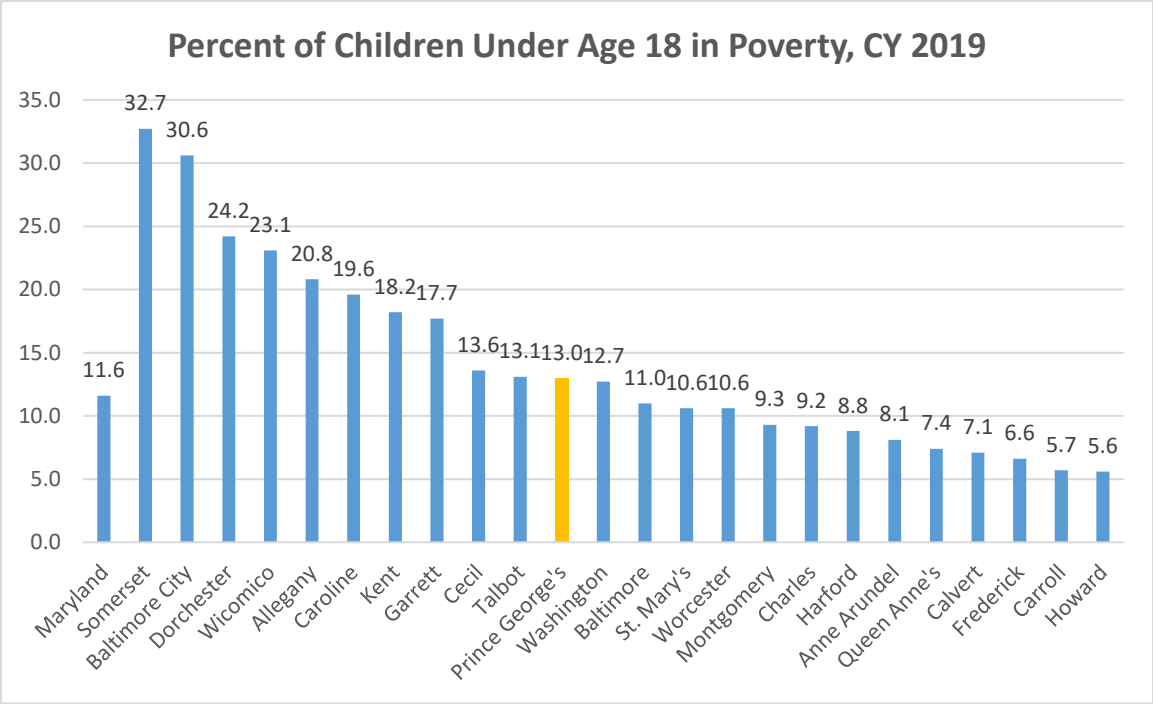


Data Source: http://ers.usda.gov/data-products/county-level-data-sets/poverty.aspx



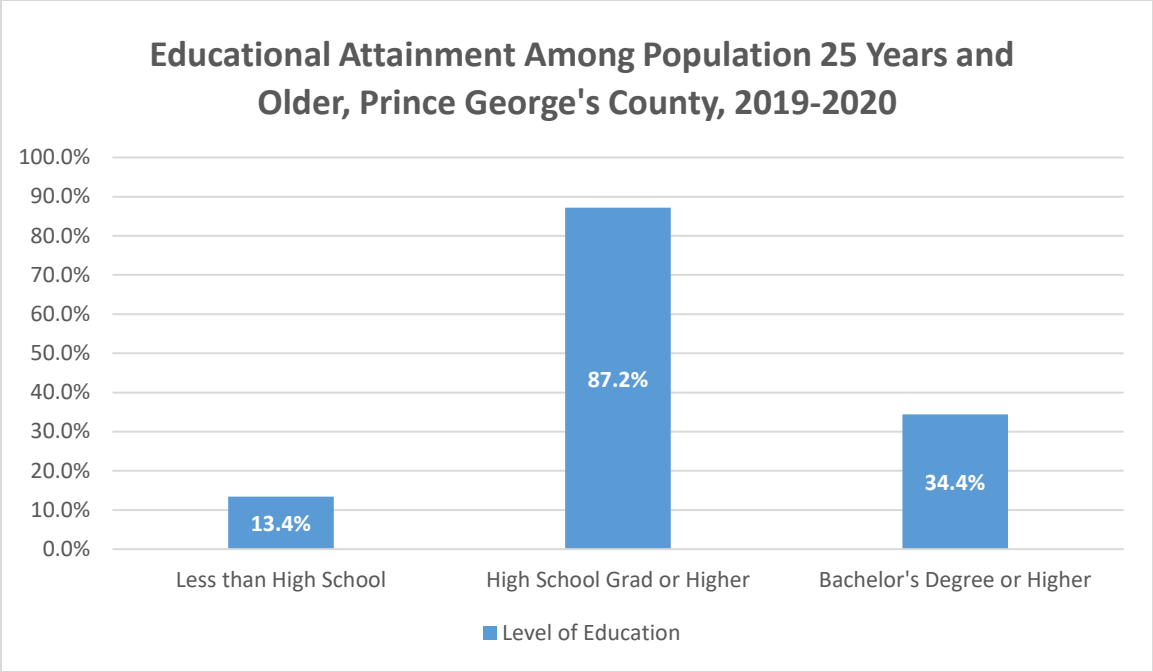
Data Source: http://ers.usda.gov/data-products/county-level-data-sets/poverty.aspx

According to the above chart, which pulled information from the USDA Economic Research Services (2019), Prince George's County ranks slightly above Maryland in poverty rate. Prince George's County has a total of 76,853 consumers in the County below the poverty level and ranks 14 overall in the State, which ties with Talbot County at 8.7.



Data Source: http://ers.usda.gov/data-products/county-level-data-sets/poverty.aspx

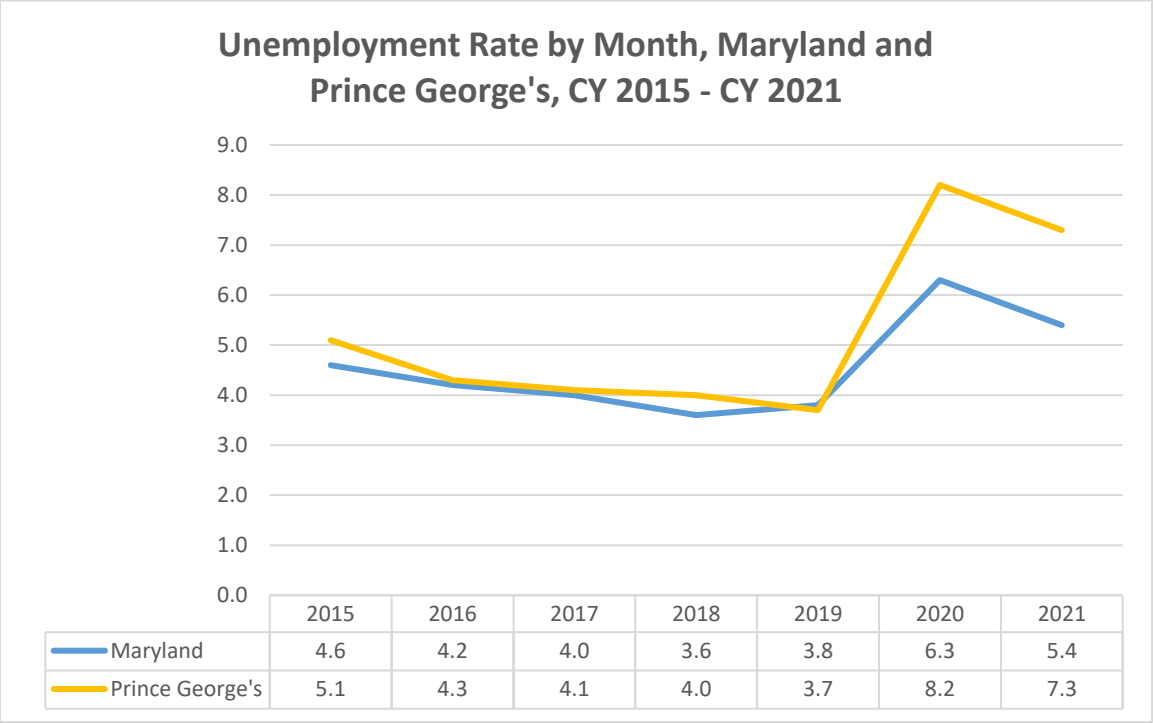
The percentage of children in living in poverty in Prince George's County is slightly higher than the state of Maryland's percentage, and lands in the middle among the 23 counties and Baltimore City. The rate of poverty in children under 18 was 13 for Prince George' County and 12.3 statewide. The LBHA plans to focus efforts to support additional services to address the needs of young children.



Data Source: American Community Survey 1-Year Estimates, 2019

The above chart illustrates the level of education among Prince George's County residents, ages 25 years and older. Of the survey respondents, 87.2% at minimum graduated from high school, 34.4% earned a bachelor's degree or higher and 13.4% had less than a high school diploma. The data shows that the majority of County residents are at least high school graduates, with a little over a third of those residents having a college education. Populations with lower rates of higher education and higher rates of poverty often have higher rates of Deaths of Despair (i.e., suicides, drug overdoses, alcohol poisoning).

4. Unemployment



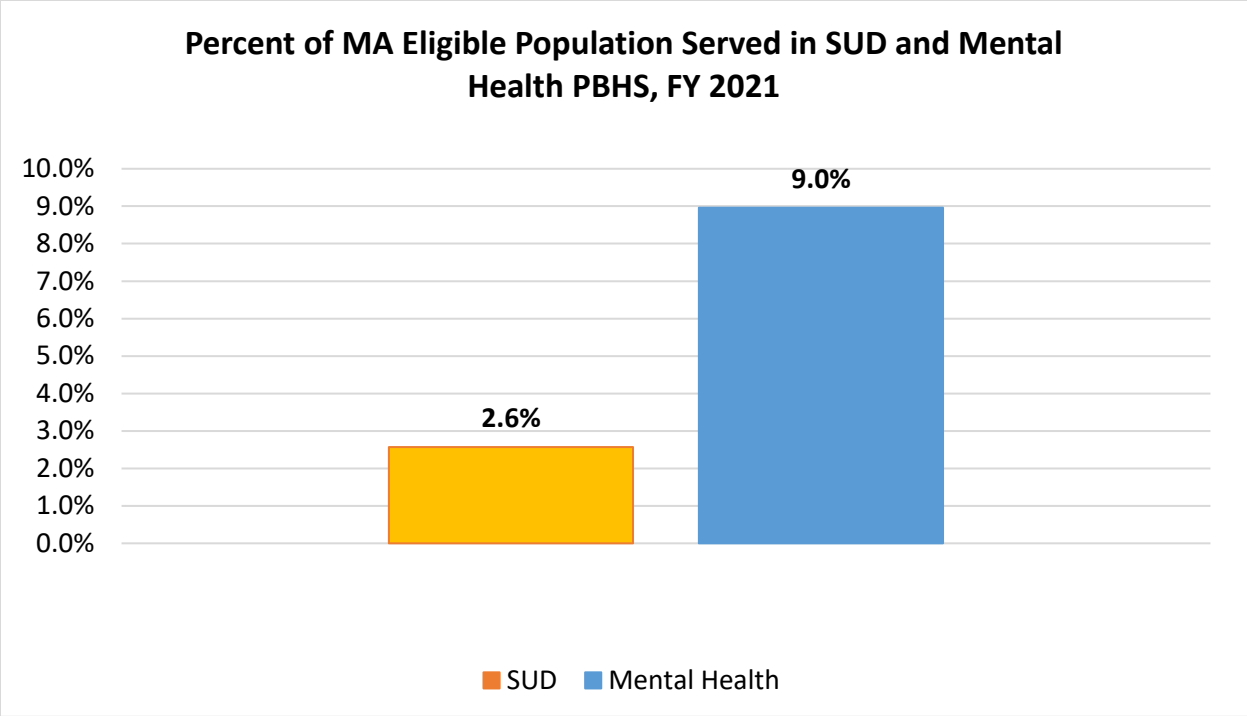
	2015	2016	2017	2018	2019	2020	2021
Maryland	4.6	4.2	4.0	3.6	3.8	6.3	5.4
Prince George's	5.1	4.3	4.1	4.0	3.7	8.2	7.3

Data Source: Bureau of Labor Statistics. Publisher: MD Office of Workforce Information and Performance. Retrieved 3/19/2022

The unemployment rate in Prince George's County mirrored the statewide average from 2015 until the COVID-19 pandemic began. Although the unemployment rate has decreased from 2020 to 2021, the County continues to trail behind the statewide recovery in employment. Data also shows that when there is an increase in unemployment rates there is also an increase in suicide rates. Efforts to address workforce development and retention are underway to include training opportunities to address burnout, workplace stress and professional development.

5. Medicaid Enrollment and Penetration

According to FY2021 data, approximately 26.8% (259,138/967,201) of Prince George's County residents were Medicaid (MA) eligible. The County's MA eligible population represented 18% (259,138/1,405,552) of the total number of those who were MA eligible statewide.



Data Sources: PBHS Utilization claims data through 10/31/2021; Medicaid Eligibility: Published by The Hilltop Institute at UMBC https://md-medicaid.org/eligibility/new/index.cfm.

The Medicaid penetration rate in FY2021 for consumers accessing mental health services was 8.96%, and the Medicaid penetration rate for consumers accessing SUD services was 2.57%.

The LBHA will continue to target outreach efforts to ensure residents are aware of the services that are available to them. Prince George's County has 23% of its residents born outside of the U.S., and 27.8% speak a language other than English at home. In fact, 17.83% of residents speak Spanish as their primary language. It is important that all PSAs and outreach materials are also cultural and linguistically diverse to overcome any language barriers that may exist.

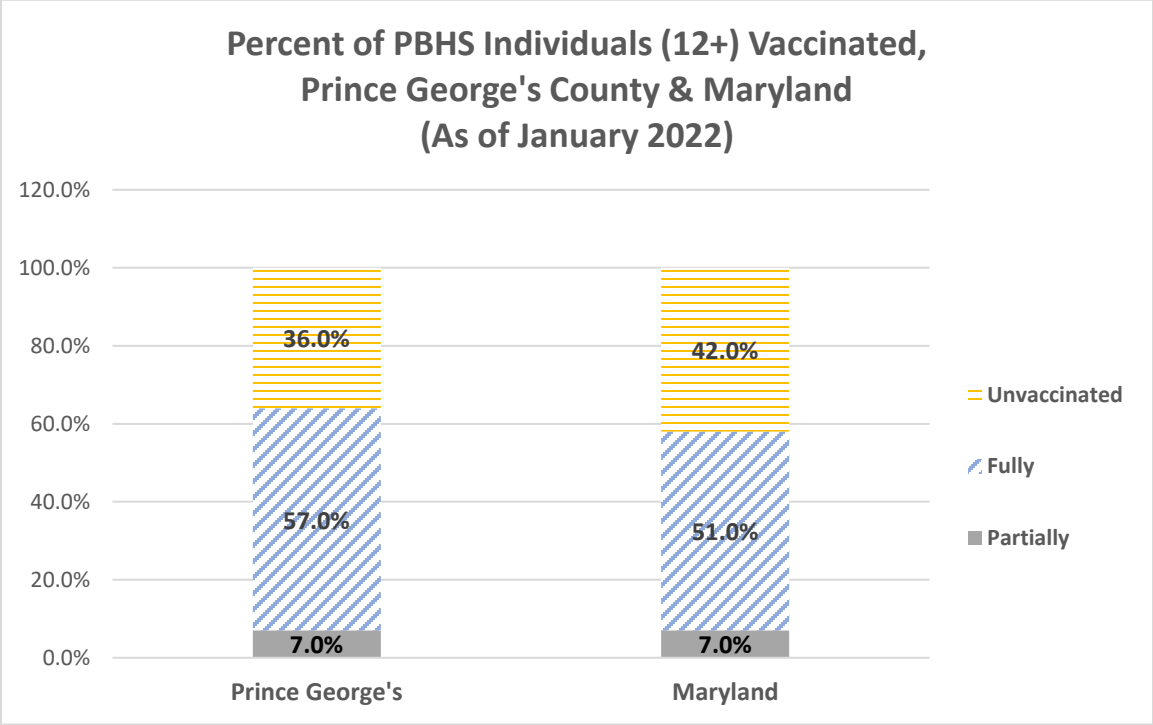
6. **Impact of COVID-19**

- Strategies the LBHA and providers have used to increase rates.

Aside from providers implementing telehealth in their practices, behavioral health providers in Prince George's County incorporated very creative ideas to increase referrals and improve client engagement. Many of these activities have been included in the highlight section of this Annual Plan document. COVID-19 messaging from BHA, SAMHSA and PGCHD was also shared with providers, and program monitors encouraged providers to adjust their policies and procedures to be in line with Center for Disease Control (CDC) guidance to help prevent the spread. Providers were encouraged to review the information and resources which contained recommendations around behavioral health treatment. LBHA Program Monitors met with licensed providers to review protocol and provide direct contact information to the Health Department's lead COVID-19 Disease Control Reporting System. The LBHA assisted all providers

with the knowledge on reporting any suspected COVID-19 outbreaks and assisted them once an outbreak occurred. Additionally, the LBHA continued its overdose response, but increased naloxone distribution efforts throughout the community during the pandemic.

As of January 2022, BHA has reported that 51% (87,852) of the 171,524 individuals 12 years old and older, served in the Maryland PBHS has been fully vaccinated. There were 14,825 PGC residents 12 years of age and older that received PBHS services, of which 57% (8,472) were fully vaccinated and another seven percent received at least one vaccine.



Data Sources: Individuals (Age 12+ As of 01/19/2022) Served in the PBHS since January 2020 by Vaccination Status. Count by Individuals Jurisdiction Based on Claims Paid through 11/21/2021

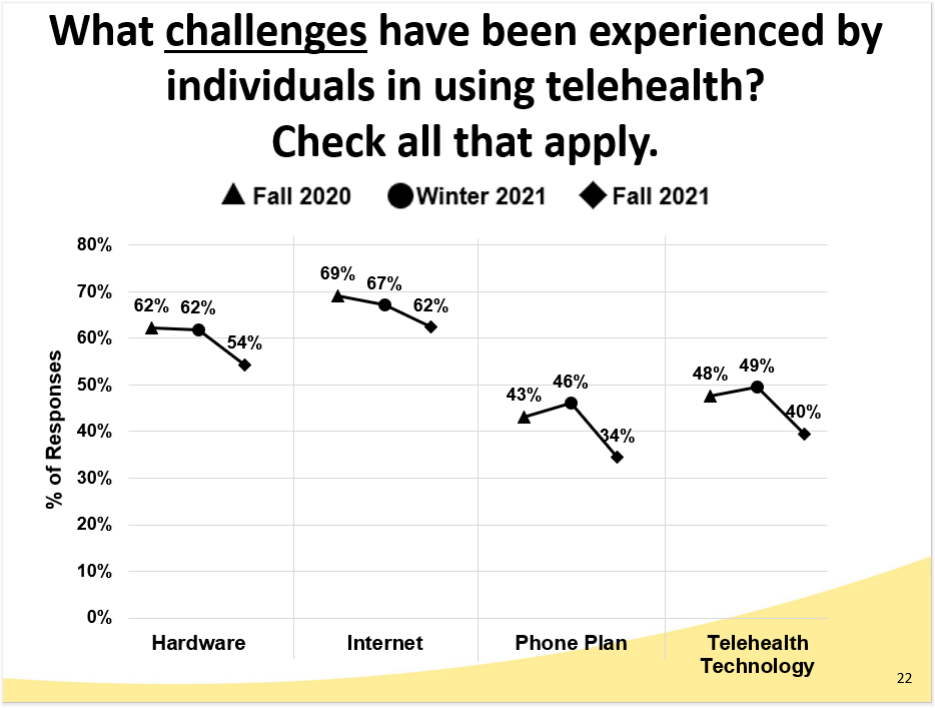
- Identification of barriers, challenges, or resource needs to improve rates.

The beginning of the pandemic presented many unforeseen challenges for behavioral health care. Many of these challenges were overcome with ingenuity of existing resources and did not require additional reinforcements. Providers were unable to meet with clients face-to-face, experienced a reduction in referrals, and groups were done virtually or even canceled. Peers and case managers found it difficult to reach and engage new clients. Some BH professionals spent time showing clients how to operate devices and acclimate to new technology. Others did not have adequate technology to participate in services. These barriers and others contributed to difficulties accessing and continuing health services.

The feedback gathered from local providers corresponds with the data presented by the University of Maryland Systems Evaluation Center on the Effect of COVID-19 on Behavioral Health in Maryland Fall 2020 Survey, which received 592 responses from its fourth COVID-19

survey. The survey showed that half of respondents viewed telehealth technology as a challenge. Of note, the data also showed that in fall 2021, less individuals found obtaining and/or use of hardware, internet, phone plans and telehealth technology as challenging that in the previous winter season. The chart below was extracted from the UMD Systems Evaluation Center presentation. Of the 592 respondents surveyed, 49% reported that they experienced challenges with use of telehealth technology in winter 2021. By fall 2021, this percentage had decreased by 9%. The decline can be attributed to the heightened resources made available to the public during this time to include educational materials, programs, and financial assistance.

Prince George's County PBHS clients also will receive support from the Telehealth Equipment Pilot Project RFP that was issued by BHA in FY 2021. Two large providers were awarded funding to help clients in their programs obtain equipment, internet access and training on how to use devices for telehealth services.



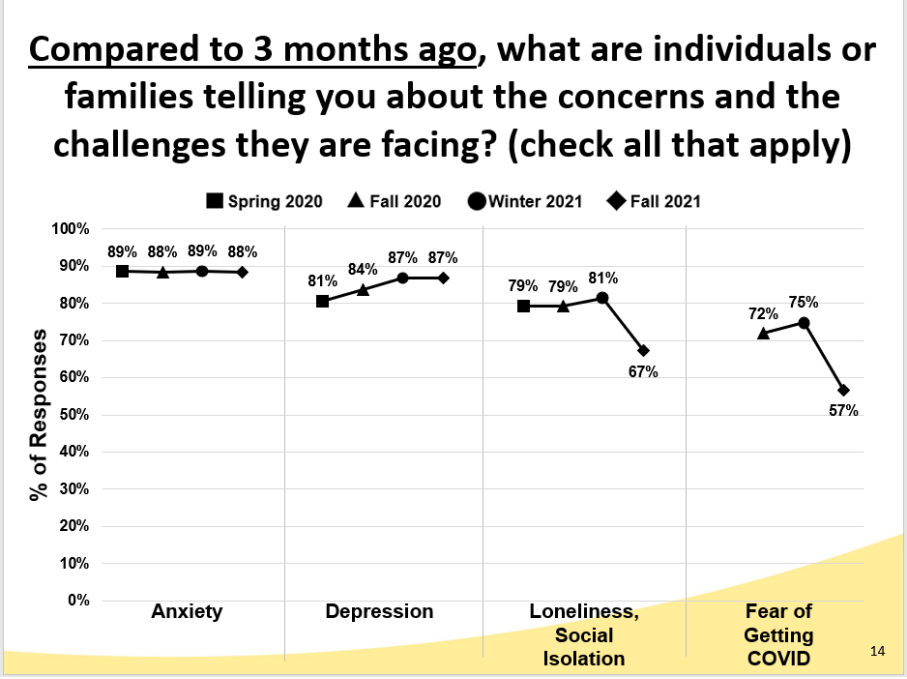
Data Source: Effects of COVID-19 on Behavioral Health in Maryland: Fall 2021 Survey, Systems Evaluation Center University of Maryland Baltimore. February 2022

- Significant changes observed from last year.

The pandemic has raised awareness regarding the overall importance of mental health. It is expected that the increased exposure to stressors related to the pandemic may significantly impact behavioral health. As a result, the LBHA has been awarded additional grant opportunities and has been charged with managing more grants than ever before. Many providers and consumers are now reporting to be more comfortable with the use of telehealth equipment and rendering services virtually, even as some providers have resumed in-person groups.

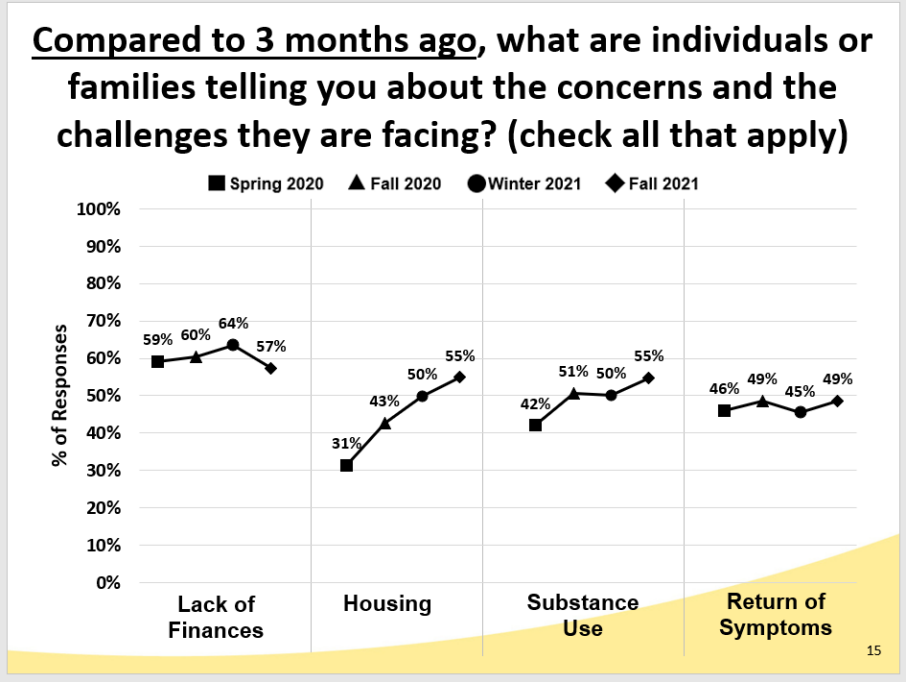
- Review of the data to support successes and challenges.

The data from the COVID-19 4th survey showed a tremendous decline in individuals receiving BH services/supports needing telehealth equipment from Fall 2020 to Fall 2021. The data also showed a decrease from Winter 2021 to Fall 2021, in the number of individuals concerned with fear of loneliness and isolation (79% to 67%) and getting COVID-19 (72% to 57%).



Data Source: Effects of COVID-19 on Behavioral Health in Maryland: Fall 2021 Survey, Systems Evaluation Center University of Maryland Baltimore. February 2022

As the COVID-19 confirmed cases decline, many families are attempting to recover from the challenges it brought about. Some experienced financial challenges due to job loss or health-related issues and others struggled with their recovery efforts. The data shows that half or more of the respondents reported housing, substance use concerns and return of BH symptoms as areas of concern for them. With each percentage increasing from Winter 2021 to Fall 2021 . The decline in percentage of those reporting lack of finances as a concern, may be due to more people finding jobs as seen in the Maryland unemployment rate data which shows a reduction in unemployment from 2020 to 2021. The increase in individuals finding it difficult to locate housing has been seen across peer, case management and homeless support programs. Each program has communicated with the LBHA regarding the challenges BH staff are experiencing with providing individuals with adequate affordable housing resources.



Data Source: Effects of COVID-19 on Behavioral Health in Maryland: Fall 2021 Survey, Systems Evaluation Center University of Maryland Baltimore. February 2022

7. Overdose (OD) Events

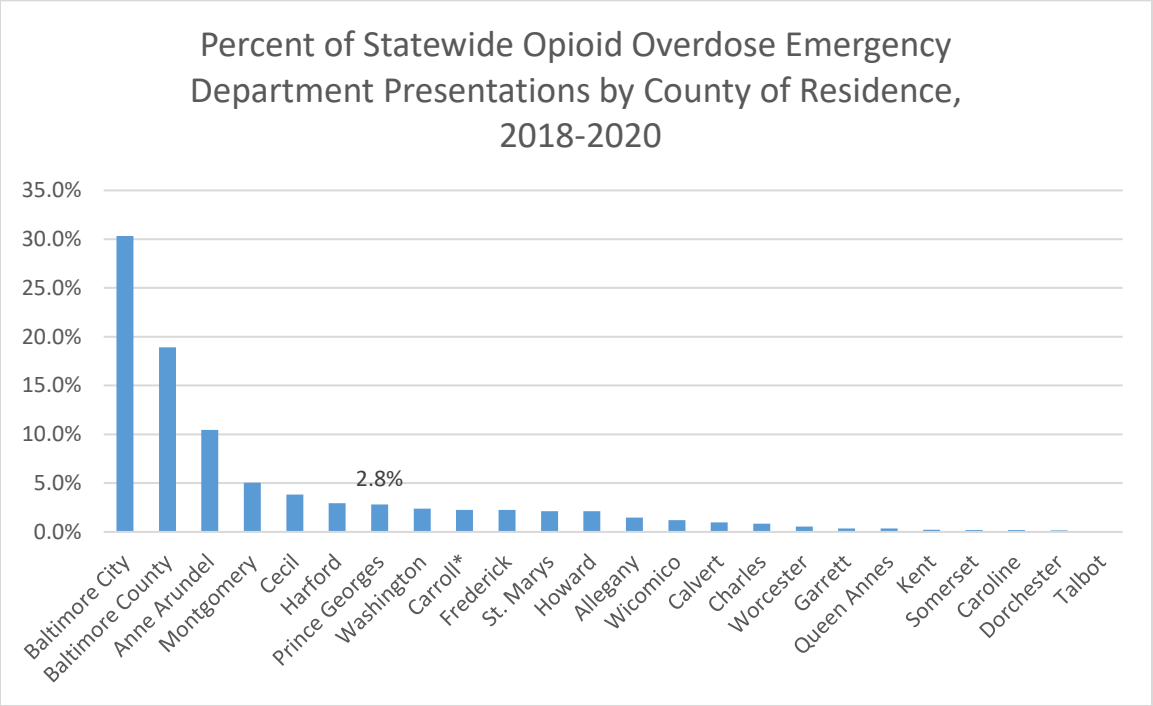
Data on overdose events is often obtained from the ESSENCE database system. However, data for non-fatal overdoses is currently inaccessible. Considering the data retrieved for FY2021 showed that that the number of overdose deaths has declined, a strong assumption can be made that the number of non-fatal overdoses may have also declined and/or the County reached naloxone saturation, and it was responsible for the decrease in numbers. Either way, this is a strong assumption in the absence of real data. Data in this section will reflect information previously reported in the FY2022 LBHA Annual Plan.

Unfortunately, beginning in late 2019, there was an increase in the Prince George's County overdose rates, which has continued throughout much of 2020, and much of that increase has coincided with the 2020 COVID-19 pandemic. There has been a significant increase in illicit fentanyl in the community drug supply, including in combination with non-opioid drugs. This could be even more fatal to unsuspecting opioid-naïve individuals who desired to take other drugs, such as stimulants, and unfortunately died because they unknowingly used a drug laced with fentanyl.

There is also a high degree of mental health comorbidity in this population. In 2018, over one third of the overdose decedents in the Capital Region had a mental health condition according to the State Unintentional Drug Overdose Reporting System.

Opioid-Overdose Presentations by County

ESSENCE Opioid Overdose Presentations for Calendar Years 2018-2020 by County of Residence				
	Year 2018	Year 2019	Year 2020	Total
Prince George's	153	201	157	511
Maryland	6,767	6,515	4,844	18,126

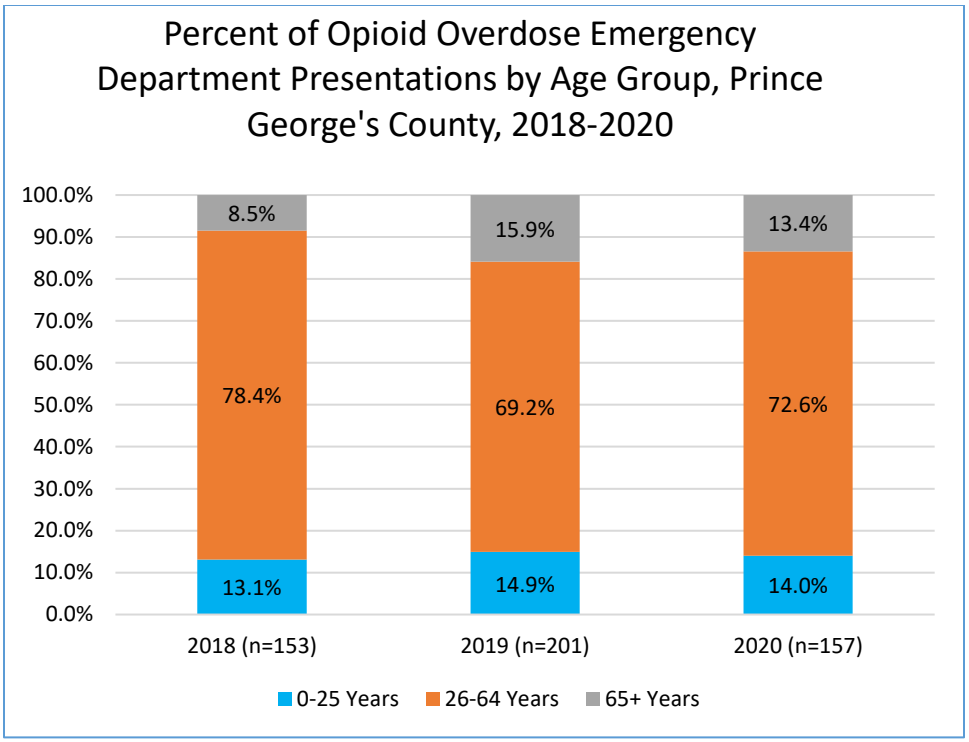


Data Source: ESSENCE. Baltimore, MD: Maryland Department of Health; October 31, 2020

There were 18,126 emergency department opioid overdose encounters from 2018 through 2020 in Maryland and 511 of the encounters were presented in Prince Georges' County. Even though Prince George's County accounts for 15% of the state's population, it accounted for less than 3% percent of opioid overdose encounters in emergency departments from 2018-2020.

Opioid Overdose Presentations by Age Group

Although data is not yet available, it has been reported that emergency departments in Prince George's County saw a decline in the number of opioid overdoses from 2020 to 2021 as shown in the chart below. This can be attributed to COVID-19, the cancellation or delay for non-emergency surgeries, and the County's overdose prevention efforts.



Data Source: ESSENCE. Baltimore, MD: Maryland Department of Health; October 31, 2020

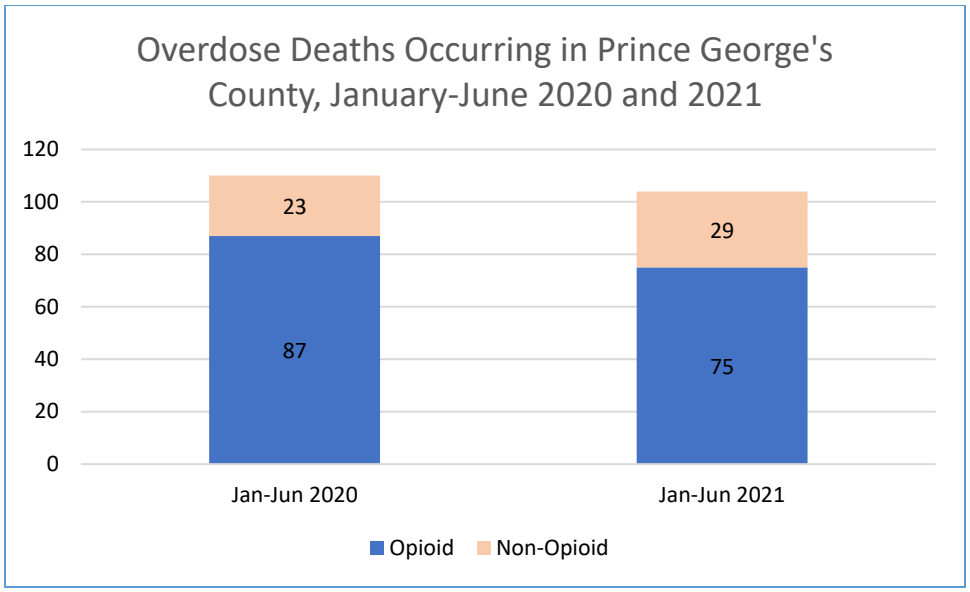
The proportion of ED encounters for opioid overdose among those 25 years and younger remained steady during the three-year period. However, those 65 years and older made up a larger proportion of encounters in 2019 and 2020, compared to 2018. Data indicates that individuals aged 65 and older, are prescribed opioids at a higher rate than other age groups.

8. Overdose Deaths by Jurisdiction

The overdose rates in Prince George's County, have declined from January – June 2020 to January – June 2021, from 110 deaths to 104 deaths. This is a decrease of six deaths overall for total drug and alcohol related deaths for the period. Opioid related deaths went from 87 to 75 in the same period, for a decrease of 12 in total. This includes a decrease of heroin related deaths from 30 in 2020, to 17 in 2021 for a total decrease of 13. Additionally, fentanyl related deaths declined from 85 in 2020, to 71 in 2021, for a total decrease of 14.

OD Deaths	All Substances				Opioid Related			
	Year 2018	Year 2019	Year 2020 Jan-June*	Year 2020 Jan-June*	Year 2018	Year 2019	Year 2020 Jan-June*	Year 2021 Jan-June*
Prince George's	127	146	110	104	94	102	87	75
Maryland	2,406	2,379	1,351	1,358	2,143	2,106	1,204	1,217

Data Source: OCME-VSA Monthly Unintentional Intoxication Death Data updated through second quarter CY 2021.



Data Source: Unintentional Drug- and Alcohol-Related Intoxication Deaths* in Maryland Preliminary data update through 2nd quarter 2021 (Maryland Department of Health, 2021). Retrieved March 22, 2022.

The decrease in overdose deaths can be attributed to the measures put into place in 2020, where geo-mapping was utilized with information from EMS to identify the areas of concern. This was useful in developing a $90,000 Public Service Announcement (PSA) push into those communities with the highest number of overdoses reported (both non-fatal and fatal), which almost immediately began to show a decrease in the opioid overdose numbers. The County is trending in the right direction at the time of this report.

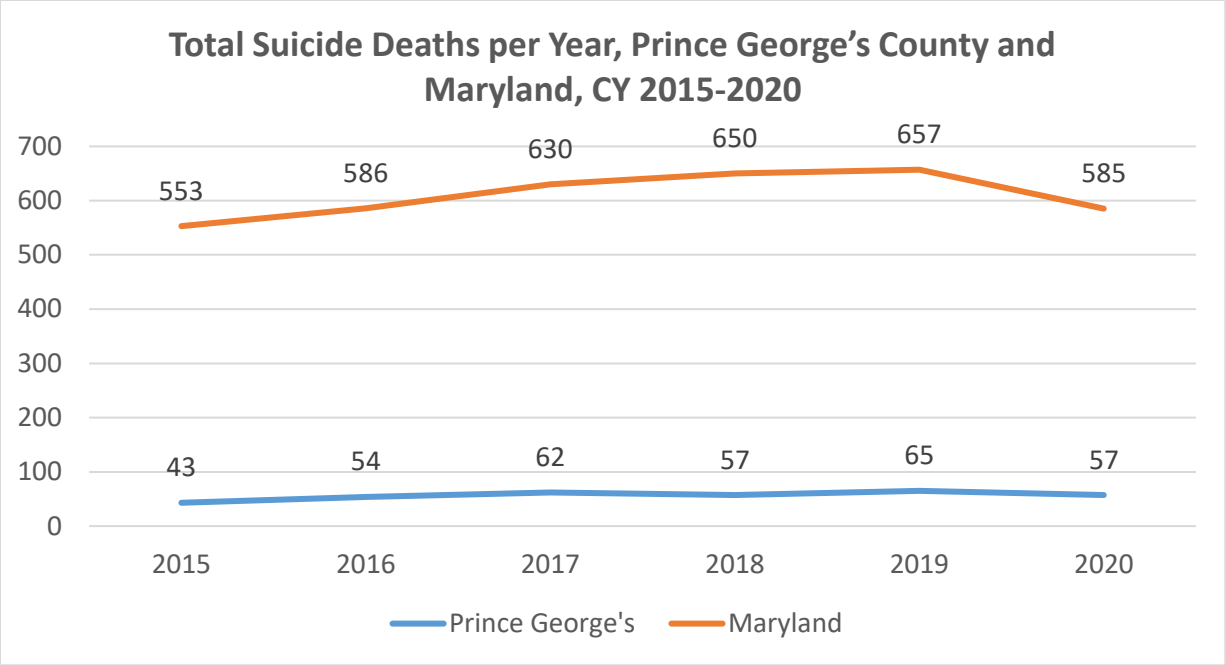
9. Suicide Mortality

Suicide Mortality by Select Demographics, Prince George's, and Maryland, 2018-2020

	Prince George's		Maryland	
	Count	**Percent**	**Count**	**Percent**
Total Deaths	**179**	--	**1,892**	--
Gender				
Male	136	76.0%	1,488	78.6%
Female	43	24.0%	404	21.4%
Race/Ethnicity				
Black, NH	95	53.1%	329	17.4%
Hispanic	17	9.5%	87	4.6%
White, NH	60	33.5%	1,392	73.6%
Asian or Pacific Islander, NH	**	**	81	4.3%
Age Group				
Under 15 Years	**	**	21	1.1%
15-24	22	12.3%	231	12.2%
25-34	40	22.3%	313	16.5%
35-44	34	19.0%	287	15.2%
45-54	21	11.7%	303	16.0%
55-64	29	16.2%	342	18.1%
65-74	16	8.9%	216	11.4%
75-84	10	5.6%	118	6.2%
85+ Years	**	**	61	3.2%

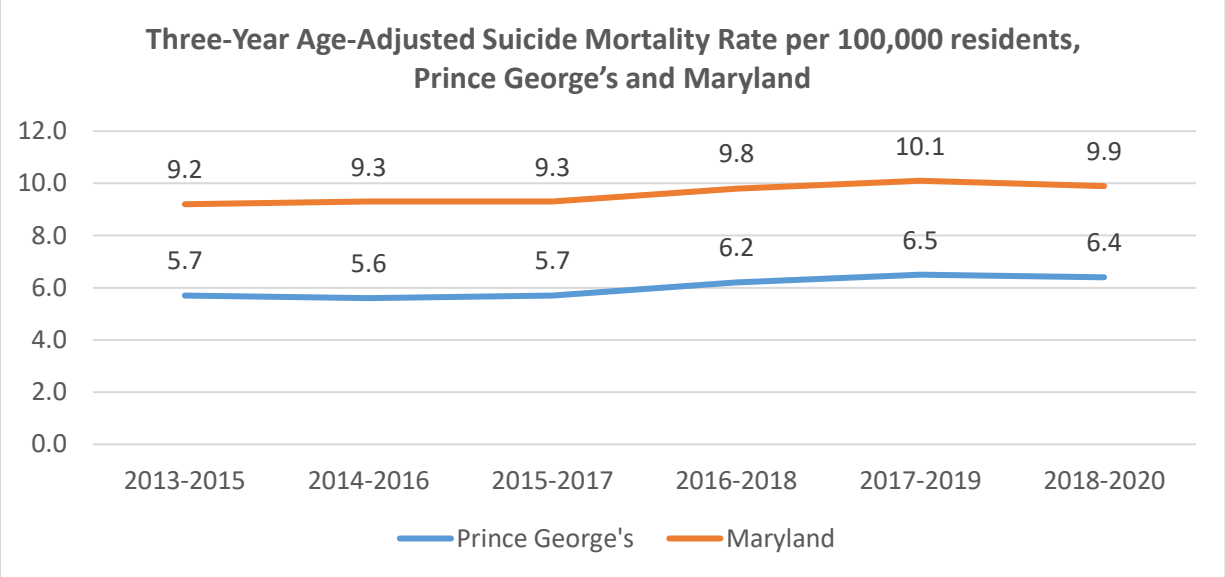
**Data not presented due to small sample size.
Data Source: Centers for Disease Control and Prevention (CDC) Wonder Database; Accessed 3/28/2022

The above table shows that suicide mortality in the County is similar to the State by Gender, with males comprising approximately three out of every four deaths. The percent of suicides for Black, non-Hispanic residents for Prince George's is lower (53.1%) compared to the County population of 59.1% and is also low for Hispanic residents (9.5%, County population of 21.2%), while White, non-Hispanic residents are higher (33.5%) compared to the County population of 11.3%. In the County, ages 25-44 comprise 41% of all suicides while in the state they comprise 31.7%; this will be important as we disseminate information pertaining to targeted age groups for suicidality.



Data Source: Centers for Disease Control and Prevention (CDC) Wonder Database; Accessed 3/28/2022

Both Prince George's County and Maryland saw more than a 10% decrease in the number of suicide deaths in 2020 compared to the prior year as shown in the table above.



Data Source: Centers for Disease Control and Prevention (CDC) Wonder Database; Accessed 3/28/2022

While both Prince George's and Maryland saw few deaths in 2020 the three-year mortality rate only declined slightly as shown in the table above. For Prince George's for 2018-2020, ages 25-34 years had an age-specific rate of 10.1 per 100,000 and ages 35-44 years an age-specific rate of 9.3, followed by 55-64 years at 8.1, demonstrating that these age groups experience higher suicide mortality rates.

There is heightened concern that the recent COVID-19 crisis, the incidents of racial injustice, and police brutality events will have an adverse impact on the mental health of the general public. The data displayed will look at the prevalence of suicide ideations and deaths in Prince George's County and Maryland.

In FY2021, the LBHA utilized the suicide prevention grant took training and public messaging approach for community-based prevention. The goal was to reach at least 245,000 people, but instead the campaign reached 300,000. There were 16 social media posts which received over 86,0.00 social media impressions (likes, shares, etc.) The plan is to continue to allocate resources, when possible, to support individuals at risk and promoting access to suicide and crises resources.

10. <u>Crisis Response and Prevention</u>

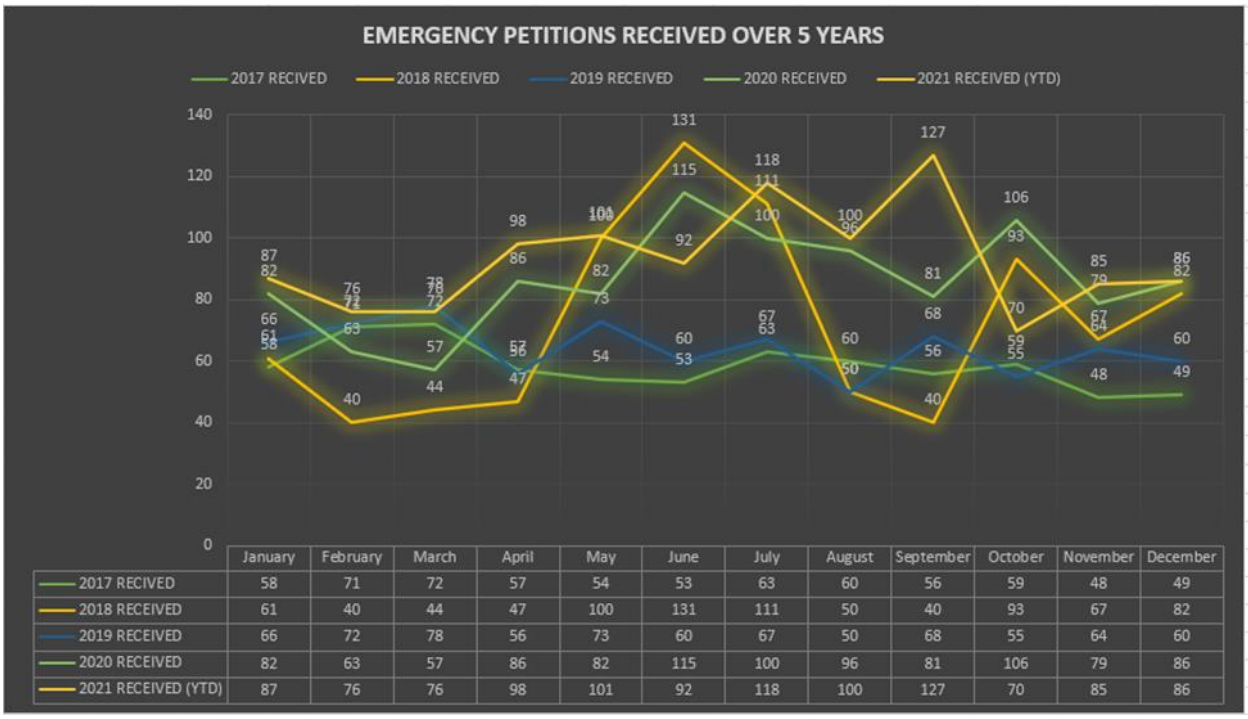
The LBHA/HD have identified the need for programmatic enhancement and expansion of existing crisis services that are already available within Prince George's County. Over the past year, a concerted effort to address the gaps in crisis services in Prince George's County has been a priority. The LBHA/HD has applied for grant funds, provided TA to providers looking to expand upon crisis services, reestablished and strengthened community partnerships.

EMERGENCY PETITION STATISTICAL DATA (2017-2021)

	2017		2018		2019		2020		2021	
MONTH	RECEIVED	SERVED	RECEIVED	SERVED	RECEIVED	SERVED	RECEIVED	SERVED	RECEIVED	SERVED
January	58	58	61	61	66	53	82	64	87	76
February	71	71	40	40	72	53	63	55	76	66
March	72	72	44	44	78	71	57	53	76	76
April	57	57	47	47	56	70	86	66	98	79
May	54	54	100	66	73	71	82	69	101	75
June	53	53	131	61	60	60	115	87	92	79
July	63	63	111	67	67	57	100	85	118	103
August	60	60	50	47	50	56	96	79	100	78
September	56	56	40	40	68	76	81	65	127	93
October	59	59	93	66	55	59	106	88	70	54
November	48	48	67	74	64	44	79	58	85	59
December	49	49	82	67	60	59	86	74	86	67
YEARLY TOTALS	700	700	866	680	769	729	1033	843	1116	905

Emergency petitions (EP) are a source of emergency department psychiatric evaluations for individuals when someone is a danger to themselves or others and are creating a strain on the limited behavioral health inpatient resources. Prince George's County has seen an increase in Emergency Petitions of 59% from 2017-2021, for a total of 905 EP's served in FY2021. Prince George's Police Department has repeatedly facilitated a County-wide diversion of EP from the UMCRH ED for both FY2020 and FY2021, because the psychiatric boarding was overwhelming

the hospital's capacity to manage the somatic and behavioral health needs of patients in the emergency department.



	January	February	March	April	May	June	July	August	September	October	November	December
2017 RECIVED	58	71	72	57	54	53	63	60	56	59	48	49
2018 RECEIVED	61	40	44	47	100	131	111	50	40	93	67	82
2019 RECEIVED	66	72	78	56	73	60	67	50	68	55	64	60
2020 RECEIVED	82	63	57	86	82	115	100	96	81	106	79	86
2021 RECEIVED (YTD)	87	76	76	98	101	92	118	100	127	70	85	86

In 2020 and 2021, UMCRH served 75% of the EP's in the county. This high volume has overcrowded the ED and challenged the ability to provide high quality care, as the ED may not be the most appropriate environment for an individual's treatment. This is a strong motivator to expand crisis services in the county.

The need for Crisis Services was addressed in FY2020 and FY2021 when $20 million was diverted from Police to a facility at Luminis Doctor's Hospital, which is slated to start a phased opening before the end of this calendar year. Additionally, grant funds from the HSCRC of $23 million was utilized to establish a crisis center, which currently is projected to open in the Southern part of the County next calendar year. Lastly, the LBHA received a substantial award as a result of HB 1092 for approximately $750,000 to begin an SUD Crisis Stabilization in the County and are hoping this will be open prior to the end of the fiscal year, as the LBHA is working with a vendor on the contract for these services.

The County currently has one residential facility with ten (10) beds. However, the LBHA has been in communication with a prospective national provider that is looking to bring a one hundred (100) bed residential facility to the County in FY2023. The LBHA is also in talks with a vendor for a possible adolescent SUD residential facility. All of these efforts have been on-going as the LBHA, and the HD have been working collaboratively together with stakeholders to bring the appropriate resources to fill the most pressing gaps in services.

H. FY 2022 GOALS & OBJECTIVES

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 #1) Leadership and governance; 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 (LSM) Self-Assessment Tool as well as the updated Cultural and Linguistic Competency Strategic Plan (CLCSP).

The Prince George's County LBHA goals, objectives and strategies forFY 2022 address the continued efforts to support the transformation of the PBHS in our County and are as follows:

FY 2022 LBHA Goals	
I	**Develop and implement a recovery-oriented, integrated system of care**
II	**Maintain and expand capacity to provide sufficient behavioral health services to address the needs of individuals in care and their families. This includes prevention, intervention, treatment, and recovery services and supports.**
III	**Expand the behavioral health crisis continuum**

GOAL I: DEVELOP AND IMPLEMENT A RECOVERY-ORIENTED, INTEGRATED SYSTEM OF CARE

Objective 1.1: Collaborate with behavioral health care providers, somatic care providers, and other agencies to further develop a mechanism to promote integrated health care by June 30, 2021

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)

Performance Measures: The LBHA will coordinate a minimum of (1) one Dual Diagnosis Capability/co-occurring training opportunity for behavioral health providers and disseminate information to encourage provider participation (LSM Self-Assessment Domain #6)

- **Target:** 10% of the somatic care providers will engage with community BH providers to provide integrated care to their clients. This will be measured utilizing a pre- post training assessment at3- and 6-monthh post training.

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

Objective 2.1: Expand availability and improved access to services that address the behavioral health needs of County residents by June 30, 2021

Strategy 2.1-A: Meet with existing BH providers to expand their program in the County and identify providers in other jurisdictions who meet the needs of our population

Performance Measure: Identify at least one (1) provider who specializes in each service area: TAY, ACT, and recovery residence services, to engage them regarding expanding into the County

- **Target:** Expand BH providers in the County by 10% for FY2023

GOAL III: EXPAND THE BEHAVIORAL HEALTH CRISIS CONTINUUM

Objective 3.1-A: Expand crisis services and access to crisis services in the County with a "No-Wrong Door" approach who are knowledgeable in the "Crisis Now" model for County residents. This will be done by providers that specialize in crisis and attracting them into the County bu June 30, 2021

Strategy 3.1-A: Perform outreach to providers who specialize in the Crisis Now model to increase the number of crisis providers and stakeholders in the County

Performance Measures: Identify at least one (1) new provider who specializes in the "Crisis Now" model, to expand in the County.

- **Target:** Expand overall "Crisis Now" providers in the County by one (1) for FY2023

I. 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.

During 2019, there was a push for the integration of the LDACC and MHAC. The recommendations were sent to the County Executive, but it was right around the time that COVID-19 became the focus for all County resources. Therefore, there has been a delay in onboarding new members and integrating the Local Drug and Alcohol Advisory Council (LDAAC) and Mental Health Advisory Committee (MHAC) during COVID-19. There have also been changes in staff and shifts in responsibilities for individuals that previously could assist with this project. The County has a new Associate Director of Behavioral Health Services, as of March 2022, and this has been presented to her as a priority, as we move into stabilizing as a County after the pandemic. She has been apprised of the situation and the necessity to resolve this in the near future.

APPENDIX A: FY 2022 CULTURAL AND LINGUISTIC COMPETENCY STRATEGIC PLAN UPDATES

Updates to the Cultural and Linguistic Competency (CLC) Strategies is a requirement as part of the local authority's FY 2023 Plan Submissions to assist with advancing CLC efforts.

(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):** Dr. O'Tilia Hunter
E-mail: ovhunter@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

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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):* • Utilize all provider meeting to discuss CLC and provider expectations • Create a platform for sharing information and resources
Performance Measures *(How will success be measured):* • Coordinate (1) event annually bringing all BH providers together **Update:** The LBHA created a separate email address to disseminate information to all behavioral health providers within the County very easily. The purpose of these changes is to ensure that providers and residents can easily access/obtain resources and information. The LBHA held an all BH Provider meeting in August 2020 to discuss the MDH LEP Policy and introduce the providers to CLC paradigm. Future meetings will be scheduled to further discussions about provider expectations and at least one training will be offered.
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):*

- 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 LBHA 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 quarterly updates for LBHA website
- Coordinate at least 1 meeting annually with neighboring local authorities to share available resources for populations where services are lacking or nonexistent within PGC

Update: Quarterly updates were made to the provider resource lists that are distributed to constituents and community partners. The LBHA will again completely update their website in Fall FY 2022. A meeting was not held with a neighboring local authority; however, information is shared ongoingly amongst all jurisdictions.

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

Update: GeoMaps of services were developed originally in FY2019 and the latest version in FY2022. Due to the ASO changes, and then the state data breach, consumer data was not able to be obtained.

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 HD Strategic Planning committee

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

- (1) Health Dept. Strategic Plan developed TBD and participation in local strategic planning efforts

Update: LBHA staff were participating in the strategic planning committee. However, due to the HD being the lead agency in the COVID-19 response, the planning was interrupted. The committee will reconvene later. Of note, the LBHA has been involved in the SOC planning workgroup and Sequential Intercept Model (SIM) workshops which developed local strategic action plans.

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

Update: The LBHA continues to promote the delivery of on-going cultural and linguistic competency (CLC) training of the BH workforce. The LBHA will plan, host and/or sponsor ongoing cultural competency trainings. The LBHA sponsored a 10-session core competency training series for BH providers who support the needs of TAY in FY 2021-2022. Staff also completed diversity training in FY2022.

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.

APPENDIX B: SELF-ASSESSMENT TOOL

DOMAIN #1: LEADERSHIP AND GOVERNANCE (vision, community engagement, management, policy advocacy, innovation)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ LAA and CSA[1] have separate governing bodies; visions to drive local systems management; community advisory councils[2]; and, hiring and management. Interaction between CSA and LAA is routinely or as needed, yet no formal structure connects the LAA and CSA leaders. Community advisors mostly focus on oversight of either MH or SU/A.	☒ LAA and CSA, or LBHA[3], address MH and SU/A separately, yet leaders have a formal structure to collaborate on some activities via integrated meetings of senior management and leaders, joint meetings of advisory councils, joint work on strategic planning, policy advocacy and innovation, etc. Leaders see systems management integration as important for the local BH system and have begun bringing key functions together.	☐ LBHA leaders and senior management are accountable for outcomes of the local BH system, and formally drive the vision and strategic direction of all local systems management functions. The joint community advisory committee[4] takes a comprehensive view of and offers guidance for the local BH system.

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment See examples to cite)

- Organizational chart that demonstrates a clear means for decision-making that ensures a focus on integrated system planning and management
- There is active implementation of the integrated LBHA Annual Plan and Behavioral Health Work Group's Strategic Plan, including workgroups and integrated LBHA provider meetings. Last year, the LBHA developed outcome-based programming which was a result of plans and meeting with the providers. This fiscal year, the LBHA is working on developing stronger collaborative efforts with County agencies and the HSCRC/TLC-MD to develop and implement innovative programs, including expanding the crisis programming in the County.

[1] Local Addictions Authority (LAA) and Core Service Agency (CSA)
[2] Local Drug and Alcohol Abuse Council and Local Mental Health Advisory Committee
[3] Local Behavioral Health Authority (LBHA)
[4] Joint Mental Health and Substance-Related Committee

- LBHA Manager and staff participation/membership in BH meetings, committees, and workgroups with subject matter experts in both mental health and SUD have helped to create an integrated approach. In addition, the LBHA public service announcements have been revamped to include integrative verbiage and artwork inclusive of both areas. In 2021, there was a push for bilingual and LBTQ+ inclusion for all PSA's and artwork to ensure that the Community at large was represented in the messaging.
- The LBHA continues to explore marginalized populations, to ensure cultural competency within the community. As the LBHA moves away from pandemic-related messaging, and on to how to cope post-pandemic, we see the need the ensure inclusivity.

2) **(Required)** If you selected Level 1 or Level 2:

   a) Which specific aspects are you working on to move to the next level of integration?

   The final integrative piece for leadership is to work on establishing a joint community advisory committee.

   b) What challenges do you perceive regarding achieving the next level of integration?

   Everyone's time is so limited as many individuals are experiencing several issues related to the pandemic, that getting individuals to focus on BH only issues has been a challenge. As we move towards the end of the pandemic, it is the hope that with our increase in collaborations and community engagement that individuals will look to become more inclusive.

3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.

   The LBHA Manager has increased involvement in additional workgroups to be inclusive in all BH activities in the County, and also to be part of the solutions that are moving forward with new projects impacting behavioral health needs of residents.

4) Provide additional comments, if desired.

DOMAIN #2: BUDGETING AND OPERATIONS (financing and billing, technology infrastructure, resource, and expense sharing)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort

☐ Plans for programs, budgets and staffing for the CSA and the LAA are separately developed and submitted to the BHA,[5] which grants separate awards to each. Generally, LAA and CSA interact independently with the ASO and providers on budget or operations issues. Whether the LAA and CSA communicate with each other routinely or as needed, there is no formal structure to coordinate on budgeting or operations.	☒ LAA and CSA, or LBHA, have a formal structure to coordinate across MH and SU/A on aspects of development and submission to BHA of program plans, budgets, and staffing. Coordinated interaction with ASO and providers on MH and SU/A issues is routine. Some shared BH staff, or SU/A and MH staff work together. Sub-vendor contracts may be structured with joint funding for delivery of integrated services or support.	☐ LBHA uses a formal structure to develop and submit to BHA a plan for BH programs, budget, and staffing, with combined funding where possible, with little or no duplication of administrative functions. Interaction with ASO and providers on BH is routine. Shared staff focus on BH, and all SU/A or MH staff work together. Sub-vendor contracts are structured with joint funding for delivery of integrated services or support, when appropriate.

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment for examples to cite)
   - CSA and LAA merger within the HD allowed for most budget and operating functions to be integrated within one local entity which reduced the duplication of work to maximize efficiency and reduce costs. The funding for MH and SUD services are provided by separate funding streams as dictated by the State and Federal levels. We are working to integrate the two as able to do so within the funding constraints.
   - The Health Department's organizational chart has erased the divide between SUD and MH and is fully integrated in terms of operations.
   - The LBHA combined provider meetings and introduced the idea of community providers working together on grants in an integrated fashion.

2) **(Required)** If you selected Level 1 or Level 2:
   a) Which specific aspects are you working on to move to the next level of integration?

   In our integrated LBHA meetings, we have initiated discussions with providers regarding subvendor contracts which will be structured with integrated services and support. The LBHA is continuing to identify ways to further integrate the LBHA admin budget and enhance staffing capacity.

   b) What challenges do you perceive regarding achieving the next level of integration?
   - Overall issues with the ASO will need to be resolved to move forward.

3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.
   - The use of integrated approaches to the provision of contract oversight and program planning during LBHA planning meetings.

4) Provide additional comments, if desired.

[5] Behavioral Health Authority within the Maryland Department of Health (MDH)

DOMAIN #3: PLANNING AND DATA-DRIVEN DECISION MAKING (data analysis, community needs assessment, network adequacy, program outcomes)		
Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ LAA and CSA engage in a separate Community Behavioral Health Planning process, aligned with the State Behavioral Health Plan, and each plan is endorsed by separate governing bodies and advisory councils and submitted separately to the BHA. CSA and LAA coordinate informally on some aspects of planning, data analysis, and/or assessing and improving network adequacy and program outcomes.	☒ CSA and LAA, or LBHA, have a formal structure for the Community Behavioral Health Planning process to address MH and SU/A, aligned with the State Behavioral Health Plan. Involvement of governing bodies, advisory councils, community, and staff may be coordinated, but SU/A and MH plans are mostly separate. Formal structure exists to coordinate on aspects of planning, data analysis, and/or assessing and improving network adequacy and program outcomes.	☐ LBHA uses a formal structure for the Community Behavioral Health Planning process, aligned with the State Behavioral Health Plan, and submits one plan using integrated approaches whenever possible. Formal structure exists for integrated or tightly coordinated BH planning, data analysis, and assessing and improving network adequacy and program outcomes, with little or no duplication of these systems management activities.

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment for examples to cite)
   - A local integrated LBHA Annual Plan, Prince George's Health Action Committee (PGHAC), Community Health Improvement Plan, Prince George's County Health department 5-Year Strategic Plan and Behavioral Health Advisory Group (BHAG)
   - All advisory groups and/or plans utilized data to address gaps in services and identity areas where additional resources were needed. Work groups were implemented as part of the strategic plan to model outcomes.
   - Utilized PBHS data to assess and improve network adequacy.
2) **(Required)** If you selected Level 1 or Level 2:
   a) Which specific aspects are you working on to move to the next level of integration?
   - Utilizing available resources for data collection and analysis to monitor provider services, including duplication of services, and gaps.

   b) What challenges do you perceive regarding achieving the next level of integration? Lack of available data due to ASO transition.

3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.
   - Revisiting grant-funded program performance measures and restructuring data-collection procedures.

4) Provide additional comments, if desired.

DOMAIN #4: QUALITY (provider training, client experience, complaints, performance improvement, licensing, and credentialing)

Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ CSA and LAA engage in separate quality oversight and improvement activities. Generally, each interact with the ASO and providers separately on quality issues, including cultural and linguistic competency, though there may be informal coordination between the LAA and CSA on some aspects of quality oversight, provider training and education, assessment of client experience, handling complaints, or ensuring compliance with provider or program improvement plans.	☐ CSA and LAA, or LBHA, engage in some formally coordinated quality oversight and improvement for BH. Interactions with the ASO and providers on quality issues, including cultural and linguistic competency, are conducted jointly, or coordinated as possible. A structure is in place to ensure coordination on aspects of BH quality oversight, provider training and education, assessment of client experience, handling complaints, or ensuring compliance with provider or program improvement plans.	☒ LBHA has a formal structure for BH quality oversight and improvement activities. Interactions with the ASO and providers are routine and focused on BH quality, including cultural and linguistic competency. All aspects of quality oversight, provider training and education, assessment of client experience, handling complaints, or ensuring compliance with provider or program improvement plans, address BH whenever possible with little or no administrative duplication.

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment for examples to cite)
   - Ongoing all provider meetings whereas provider trainings are also offered.
   - Provide technical assistance to all providers regarding best practices on emerging topics, including assisting providers with emerging issues in behavioral health.
   - Regular interaction with individuals who receive services and organizations representing individuals and families through our information line/walk-ins, program monitoring, Systems of Care (SOC) family and peer activities and Mental Health Advisory Committee (MHAC) meetings.

- Utilize provider meetings as a mechanism to routinely seek and get feedback from providers regarding individuals who receive services.
- Participation on PGHAC, BHAG, SOC Team meetings to interact with agencies, public and private, with an interest in behavioral health.
- Licensed and grant-funded program site visits and participation in site visits for other BH programs being implemented in the County.

2) **(Required)** If you selected Level 1 or Level 2:
   a) Which specific aspects are you working on to move to the next level of integration?
   b) What challenges do you perceive regarding achieving the next level of integration?
3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.
   No substantial changes.
4) Provide additional comments, if desired.

DOMAIN #5: PUBLIC OUTREACH, INDIVIDUAL & FAMILY EDUCATION (messaging, communication, feedback)

Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ LAA and CSA generally develop separate messaging and materials for MH and SU/A and engage in independent, culturally, and linguistically appropriate communications with individuals, families, and the public. Client or public feedback must be sent to the CSA or to the LAA, although the organizations may share feedback received. CSA and LAA coordination of outreach and communication efforts is informal.	☐ CSA and LAA, or LBHA, use a formal process to coordinate messaging and materials across MH and SU/A, and engage in coordinated, culturally and linguistically appropriate communication and outreach with individuals, families, and the public about BH when possible. Feedback from clients or the public is regularly compiled and shared with MH, SU/A, and shared staff, if any.	☒ LBHA is formally structured to ensure that messaging, materials, and outreach take an integrated, culturally, and linguistically appropriate approach to BH issues. Individuals, families, and the public receive consistent messaging and information via newsletters, public awareness activities, social media, etc. Feedback from clients or the public is routinely compiled and shared with staff. Such efforts are tightly coordinated to avoid administrative duplication.

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment for examples to cite)

- Weekly meetings with Health Department's Public Information Officer (PIO) and marketing to develop public service announcements (PSAs), newsletters pertaining to behavioral health and post across several Prince George's County social media platforms (i.e., Instagram, Facebook). Service announcements are available in Spanish and English to represent our population. Established a single point of contact for all public messaging regarding BH.

2) **(Required)** If you selected Level 1 or Level 2:
   a) Which specific aspects are you working on to move to the next level of integration?
   b) What challenges do you perceive regarding achieving the next level of integration?
3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.
   - The utilization and weekly meetings with the PIO for consistent and informative PSAs in the County.
4) Provide additional comments, if desired.

DOMAIN #6: STAKEHOLDER COLLABORATION (with providers of BH, somatic care, community services, and other partners)

Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ CSA and LAA focus on interacting either with MH or SU/A providers, respectively. Each engage in some collaboration with providers of somatic care and/or community services and supports to encourage effective coordination of culturally and linguistically appropriate services. The LAA and CSA informally work together on aspects of their interaction and collaboration with providers that impact the health of individuals and families involved in the behavioral health system.	☐ LAA and CSA, or LBHA, have a formal structure to coordinate interactions with MH and SU/A providers to reduce duplicated efforts, potential knowledge gaps or confusion due to differences in expectations and to support the provision of culturally and linguistically appropriate services. Collaboration on care coordination with somatic and community service providers, who impact the health of individuals and families involved in the local behavioral	☒ LBHA is structured so interactions with BH, MH and SU/A providers are integrated or tightly coordinated to ensure consistency and clear points of contact, avoid duplication and confusion, and support the provision of culturally and linguistically appropriate services. Collaboration with somatic and community service providers is done from an integrated perspective to improve coordination among providers who impact the health of individuals and families involved in the behavioral health system.

	health system, is often done from an integrated BH perspective.	

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment for examples to cite)
   - LBHA participation in the Behavioral Health Work Groups (BHWG) and Prince George's Healthcare Action Coalition (PGHAC) workgroups are used as mechanisms for collaborating with entities that can either benefit from a strong local behavioral health system and/or can contribute to strengthening the local behavioral health system.
   - Prince George's County Health Department has established several workgroups and committees (e.g., BHAG, PGHAC) where LBHA staff are currently active participants
   - The LBHA is in regular communication with all hospital systems in the county to coordinate between somatic and BH, including participation in high utilizer meetings to provide wrap-around services for individuals who previously taxed the healthcare system.
2) **(Required)** If you selected Level 1 or Level 2:
   a) Which specific aspects are you working on to move to the next level of integration?
   b) What challenges do you perceive regarding achieving the next level of integration?
3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.
   Planning for additional outreach to somatic care providers at local hospital systems ad PCP offices by coordination with community case managers and Prevention program staff.
4) Provide additional comments, if desired. As additional PCP offices open, the LBHA will continue outreach efforts to bridge somatic and behavioral health efforts in the County.

DOMAIN #7: WORKFORCE (recruitment, training and development, retention)

Level 1: Coordinated Communication (*Approaching*)	**Level 2: Formal Collaboration (*Capable*)**	**Level 3: Integrated (*Enhanced Ability*)**
1: Basic collaboration and communication on an informal basis	2. Collaboration with some formal structure that may include shared functions	3. Merged, integrated, or tightly coordinated functions, with little or no duplicated effort
☐ LAA focuses on SU/A workforce capacity, licensing and credentialing issues and meeting training needs for providers and systems management staff. CSA does the same for	☐ CSA and LAA, or LBHA, approach MH and SU/A separately when addressing workforce capacity, licensing and credentialing issues and training for providers and systems	☒ LBHA tightly coordinates or is structured to ensure that workforce capacity, licensing and credentialing, and training for providers and systems management staff reflect an integrated

MH. Some coordination of activities occurs between the CSA and LAA on an informal basis.	management staff. However, formal structure is used to coordinate across SU/A and MH on certain activities, including intentionally promoting and supporting integration of BH services for individuals and families. Cross-training of staff is prioritized, along with efforts to hire shared BH staff.	approach to BH systems management, with priority on integration of BH services for individuals and families. Systems management staff use integrated approaches to BH to avoid duplication of effort and are cross trained on MH and SU/A terminology, treatment philosophy and approaches.

1) **(Required)** What concrete evidence did you use as the basis for selecting your current level of integration above? (See attachment for examples to cite)
   - Local leaders and employees have education, knowledge, demonstrated interest and/or experience in BH
   - All LBHA position descriptions were enhanced to include cross training towards inclusion to support BH integration efforts.
   - LBHA Manager and staff actively participate on all known local behavioral health workgroups.
2) **(Required)** If you selected Level 1 or Level 2:
   a) Which specific aspects are you working on to move to the next level of integration?
   b) What challenges do you perceive regarding achieving the next level of integration?
3) **(Required)** Describe any substantive changes in your integration activities since completing the FY2021 local integration Self-Assessment.

   No substantial changes.
4) Provide additional comments, if desired.

APPENDIX C: ACRONYMS

ACES	Adverse Childhood Experiences
ACH	Adolescent Clubhouse
ACT	Assertive Community Treatment
ACM	Assessment and Case Management Unit
ASIST	Applied Suicide Intervention Skills Training
ASL	American Sign Language
ASO	Administrative Service Organization
BH	Behavioral Health
BHA	Behavioral Health Administration
BHAG	Behavioral Health Advisory Group (Prince George's County)
BHWG	Behavioral Health Work Group
CCO	Care Coordination Organization
CDC	Center for Disease Control
CISM	Critical Incident Stress Management
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CLASP	Center for Law and Social Policy
CLC	Cultural and Linguistic Competency
CLCSP	Cultural and Linguistic Competency Strategic Plan
CoC	Continuum of Care
COVID-19	Coronavirus Disease 2019
CPS	Child Protective Services
CRS	Crisis Response System
CSA	Core Service Agency
DOC	Department of Corrections
DSS	Department of Social Services

EP	Emergency Petition(s)
EPIC	electronic medical record
EPS	Emergency Psychiatric Services
FEP	First Episode Psychosis
FQHCs	Federally Qualified Health Centers
FSG	family support groups
FY	Fiscal Year
HB7	House Bill 7
HD	Health Department
HMIS	Homeless Management Information System
HSCRC	Maryland Health Services Cost Review Commission
IHIP-C	In-Home Intervention Program for Children and Adolescents
IOP	Intensive Outpatient Treatment
LAA	Local Addiction Authority
LBHA	Local Behavioral Health Authority
LCT	Local Care Team
LDAAC	Local Drug and Alcohol Abuse Council
LEAD	Law Enforcement Assisted Diversion
LEP	Limited English Proficiency
LS/CMI	Level of Service Case Management Inventory
LSM	Local Systems Management
LSMSAT	Local Systems Management Levels of Integration Self-Assessment
MAT	Medication Assisted Treatment
MCCJTP	Maryland Community Criminal Justice Treatment Program
MCF	Maryland Coalition of Families
MCT	Mobile Crisis Team
MHAC	Mental Health Advisory Committee
MDH	Maryland Department of Health

MHAC	Mental Health Advisory Committee
MHC	Mental Health Court
NAMI	National Alliance on Mental Illness
NAMI-PG	National Alliance on Mental Illness, Prince George's County Chapter
OD2A	Overdose to Action
OOCC	Opioid Operation Command Center
OOO-PG	On Our Own-Prince George's County
PASSR	Pre-Admission Screening and Resident Review (PASRR)
PATH	Projects for Assistance in Transitioning from Homelessness
PBHS	Public Behavioral Health System
PGCHD	Prince George's County Health Department
PGCPD	Prince George's County Police Department
PGCPS	Prince George's County Public Schools
PHP	Partial Hospitalization Program
PIO	Public Information Officer
PRP	Psychiatric Rehabilitation Program
PRS	Peer Recovery Specialist
PSA	Public Service Announcement
PSAs	Public Service Announcements
RFA	Request for Applications
RFP	Request for Proposals
RRP	Residential Rehabilitation Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, Referral and Treatment (SBIRT)
SIM	Sequential Intercept Mode
SOC	System of Care (Grant)
SOR	State Opioid Response
SSI/SSDI	Supplemental Security Income/Social Security Disability Insurance

SUD	Substance Use Disorder
TAMAR	Trauma, Addiction, Mental Health and Recovery
TAY	Transitional Age Youth
TBD	To Be Determined
TCM	Targeted Case Management
TLC	Total Linking Care
TNP	Therapeutic Nursery Program
UMCRH	University of Maryland Capital Region Health
WRAP	Wellness Recovery Action Plan
YHDP	Youth Homeless Demonstration Project