# THREE YEAR STRATEGIC PLAN

*Harford County Local Behavioral Health Authority*

*F Y 2 0 2 4—FY 2026*

***A Vision of Integrated Behavioral Health Systems Management in Harford County***

Office on Mental Health
Core Service Agency of Harford County, Inc.

Public Health
Prevent. Promote. Protect.
Harford County Health Department

Harford County Health Department

# Harford County Local Behavioral Health Authority
# FY 2024-FY 2026 Strategic Plan

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## A. Introduction

Harford County has a unique and complex behavioral health systems management structure. Three entities comprise this structure—Harford County Health Department's Local Addictions Authority, Harford County Government's Office of Drug Control Policy, and the Office on Mental Health/Core Service Agency of Harford County, Inc (a 501(c)(3) organization). The Harford County Health Department's Local Addictions Authority (LAA) and the Office on Mental Health/Core Service Agency of Harford County, Inc. (OMH/CSA) are the designated local behavioral health authorities (LBHA) working together to promote and support the development of accessible, high quality, community-based behavioral health services. As system managers, the OMH/CSA and LAA oversee, develop, monitor, identify community needs, promote resolutions, and advocate for people engaged in the Public Behavioral Health System (PBHS). In addition, both entities provide behavioral health systems development and planning, community and provider education, grant monitoring and management, promotion of behavioral health integration, and technical assistance and support. The OMH/CSA and LAA work alongside the Harford County Office of Drug Control Policy (ODCP) which oversees substance-related prevention management. Harford County's structure is unique, because unlike other counties, Harford County's LAA does not receive prevention funding for the county or oversee prevention initiatives. The Office of Drug Control Policy has historically been responsible for prevention efforts in the county, and this configuration has remained unchanged.

In addition to local behavioral health authorities, there are multiple advisory boards, agencies, community members and direct service providers working together to offer advice, determine community needs, and advocate for publicly funded behavioral health services. Community stakeholders include the local Mental Health and Addictions Advisory Council /Local Health Improvement Coalition-Behavioral Health Workgroup/Opioid Intervention Team (MHAAC/LHIC/OIT) members, the OMH/CSA's Board of Directors, providers, and several multi-disciplinary teams. The LAA and OMH/CSA's strong collaborative and cooperative relationships with these stakeholders allows the community to expand, strengthen, and sustain an integrated and comprehensive behavioral health system.

The local public behavioral health system continues to rely on positive linkages, strategic planning, and robust alliances with community organizations, providers, consumers, and advocates. Harford County has developed a strong system of care, comprised of a variety of diverse services including:

- 24/7 Behavioral Health Crisis Hotline
- 24/7 Mobile Crisis Team
- E-COVID Youth Crisis Expansion
- Behavioral Health Urgent Walk-in Center & Residential Crisis Beds
- Urgent Care Peer Expansion
- Assertive Community Treatment (ACT)
- Targeted Case Management for Adults

- Care Coordination/Youth Targeted Case Management
- Disaster Assistance & Coordination—behavioral health response
- Critical Incident Stress Management (CISM) CSA Team
- Crisis Intervention Team (CIT)
- Homeless Outreach & Engagement case management services
- Forensic/Re-entry case management services
- Inpatient hospitalization (Adult)
- Mental Health Diversion Program (MHDP) through District Court (Adult)
- Intensive Outpatient Program (Adult)
- Psychiatric Rehabilitation Programs
- Residential Rehabilitation Programs (Adult)
- Outpatient Mental Health Centers
- Respite Services for Children & Adolescence
- Behavioral Health Homes (Adult)
- School-Based Mental Health Services in all Harford County Public Schools
- Family Intervention Specialist via Department of Juvenile Services
- Supported Employment
- Safe Start
- Statewide Housing Initiative/State Hospital Discharge Project
- Teen Diversion
- Mental Health Stabilization Services Program in partnership with Department of Human Resources
- Therapeutic Behavioral Services
- Peer-run Wellness and Recovery Center
- School Intervention Specialist (SIS)
- Continuum of Care (CoC) Housing Program
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Program
- DUI Education Programs
- Early Intervention Programs
- Outpatient Treatment Programs
- Partial Hospitalization Programs
- Residential Programs (SUD specific)
- Opioid Treatment Programs
- Withdrawal Management Services
- State Care Coordination (SCC)
- Maryland Recovery Net (MDRN)
- Peer Support Services
- Detention Center MAT Reentry Program
- Overdose survivor outreach
- Opiate Recovery Court (District Court)
- Drug Court (Circuit Court)
- Harm Reduction Services- including naloxone training and distribution, EMS naloxone leave behind program, Fentanyl test strips distribution
- Office-based Buprenorphine therapy

- Adolescent Clubhouse
- Journey to Change
- State Hospital Discharge Initiative/Permanent Supportive Housing Program

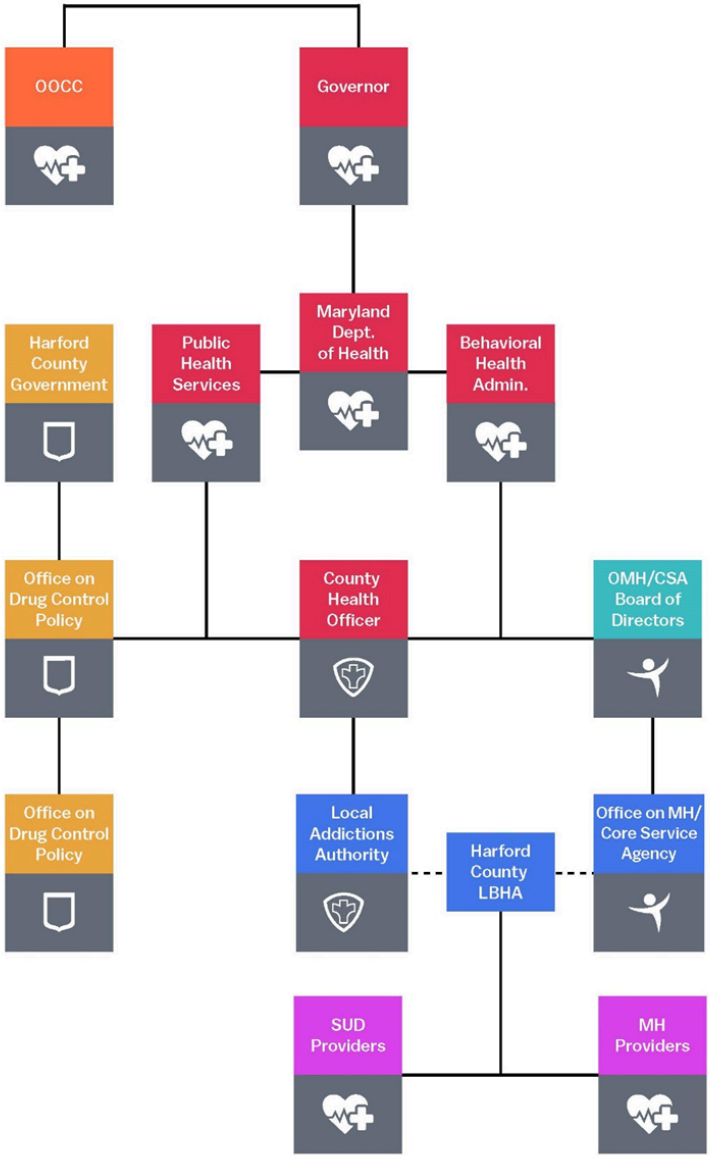
Harford County is a rural county, close to both Pennsylvania and Delaware. It is located along a major highway, I-95, and is relatively close to Baltimore City. According to the United States Census Bureau Population Estimates for 2021, Harford County is home to 262,977 residents. Harford County's population has remained relatively stable since 2020, rising by 2,053 residents (0.8%). There is a marginal amount of racial and ethnic diversity, with 77.9% reporting their race as white, 15.4% African American, 5.1% Hispanic/Latino, 3.1% Asian/Pacific Islander, 3.0% identifying as two or more races, and .3% American Indian/Alaskan Native. In 2021, Harford County's median household income was slightly higher than the state average, with the state average being $91,431 compared to Harford County's median income of $98,495. The poverty rate in Harford County, 6.2%, is significantly lower than the state's, at 10.3%. Harford County has a high school graduation rate of 93.7%, which is slightly higher than the state average of 90.8%. Additionally, Harford County's persons without insurance (4.2%) is significantly lower that the state average (7.1%).

The Harford County Core Service Agency and Harford County Local Addictions Authority are two separate entities with slightly different organizational structures at the local and state level. The Local Addictions Authority is housed within the Harford County Health Department, and they report directly to the Harford County Health Officer. The Harford County Core Service Agency is a private non-profit organization governed by a 13-member Board of Directors consisting of local government and elected officials (including the County Health Officer), advocates, members of local businesses, education, and legal communities, and individuals and family members who have participated in behavioral health services or local advocacy groups. There are several areas where the organizational structures are intertwined, and the two entities have established an integrated approach functioning as the local behavioral health authority (LBHA). The LBHA has taken numerous steps to strengthen and build upon shared visions and priorities to create a unified systems planning and management entity. Efforts have been put in place to coordinate messaging to educate individuals, families, and the community about behavioral health services.

At the local level, the Core Service Agency, Local Addictions Authority, and the Office of Drug Control Policy report to the Mental Health and Addictions Advisory Council (MHAAC), the Local Health Improvement Coalition (LHIC)—Behavioral Health Subcommittee, and the local Opioid Intervention Team (OIT). At the state level and as mandated by the Maryland Department of Health, the Harford County Health Officer reports directly to the Deputy Secretary of Public Health Services. The Local Addictions Authority and the Core Service Agency report to the Deputy Secretary/Executive Director of Behavioral Health at the Behavioral Health Administration (BHA) which provides funding to the local behavioral health authorities. The Office of Drug Control Policy (ODCP) reports to the Office of Public Health Improvement which provides prevention funding to ODCP. The Public Health and Behavioral Health Deputy Secretaries report to the Secretary of Maryland's Department of Health and this Secretary is

held accountable by the Governor of Maryland. The LAA is also responsible for reporting to the Maryland Opioid Operational Command Center (OOCC).

## Harford County
## Local Behavioral Health Authorities' Organizational Chart




**B. FY 2024-FY 2026 Key Priorities/Goals and Objectives**

Goal #1: Increase oversight efforts to improve quality of care

Objective: From FY 2024 to FY 2026, the Harford County LBHA will ensure coordination of behavioral health oversight, complaint resolution, track/monitor licensing and credentialing, and strengthen culturally and linguistically competent behavioral health services of providers.

Strategies:

- Review and update conflict and grievance forms to ensure content is culturally and linguistically competent and health literate
- Educate and promote use of the LBHA universal grievance form to ensure behavioral health complaints are responded to in a consistent and timely manner
- Create and disseminate a satisfaction survey to track and solicit feedback regarding the complaint resolution experience
- Extract components of BHA's audit and monitoring form to refine the LBHA's process of sub-vendor monitoring to strengthen local oversight and ensure compliance
- Develop and implement a provider newsletter to include ASO updates and audit outcome trends, COMAR regulation changes and requirements, best practices, and technical assistance for program licensing and credentialing

Performance Measure: The Harford County LBHA will utilize quarterly satisfaction surveys to capture improved provider quality and client satisfaction.

Performance Target: 75% of disseminated satisfaction surveys will report a positive experience.

Goal #2: Increase public outreach and education efforts

Objective: From FY 2024 to FY 2026, the Harford County LBHA will increase public outreach and education efforts designed to increase awareness and reduce the stigma associated with mental health and substance use issues. The Harford County LBHA will solicit feedback from stakeholders/community members, individuals, and families to measure effectiveness of public outreach and educational events.

Strategies:

- Utilize the Mental Health Addictions Advisory Council (MHAAC), Local Health Improvement Coalition (LHIC) Behavioral Health Workgroup, and the Harford County OOCC Opioid Intervention Team (OIT) to establish a formal platform to ensure public behavioral health communication and materials are coordinated and reduce duplication efforts
- Provide bi-annual educational sessions at the MHAAC/LHIC/OIT on youth and adolescent behavioral health treatment to educate county leadership, law enforcement, health and medical, education, human services, and community organization professionals.

Sessions will include information on navigating specific referrals for youth and adolescent behavioral health services in Harford County.

- ❖ Develop a formal process where the feedback received from individuals, family members, and public and private entities, can be compiled and shared among behavioral health staff. Utilize feedback to adjust and target behavioral health communication strategies. Create a feedback section on the Harford County LBHA's website to help aid in evidence-based decision making.
- ❖ Track website content to ensure user friendliness and monitor utilization to make evidence-based decisions to determine topics for educational forums and public outreach campaigns
- ❖ Create a central access point for community members regarding public training, education, and awareness efforts in Harford County
- ❖ Work collaboratively with community stakeholders to develop monthly training, education, and public awareness efforts to include MHFA, QPR, Talk Saves Lives, CIT

Performance Measure: Annually, the Harford County LBHA will facilitate 12 public education, training, and awareness efforts.

Performance Target: 75% of survey respondents will say their knowledge of behavioral health has increased by attending a public education, training, or an outreach event.

**C. Targeted Case Management (TCM)**

In fiscal year 2021, Harford County's Mental Health Targeted Case Management (TCM) programs mirrored the state's utilization average of 2.3%. Harford County's adult TCM program had a utilization rate of 29% compared to the State's utilization rate of 64%. The adult TCM provider selected for Harford County is Leading by Example (LBE). As an agency, Leading by Example operates in Baltimore City, Baltimore County and Harford County. This provider offers outpatient mental health services, therapeutic behavioral health services, and psychiatric rehabilitation services in all three jurisdictions. During FY 2021, the COVID pandemic caused Leading by Example to encounter multiple challenges within their program, which may have accounted for the lower-than-expected capacity. The workforce shortage has been the biggest challenge to serving individuals in their case management program. The program had seen a decrease in referrals due to individuals engaging and participating more frequently with telehealth services; thus, reducing the need for assistance maintaining and needing linkages to outpatient treatment. The COVID-19 stimulus provided by the federal government also helped individuals maintain their housing and utility bills independently. Individuals were still maintaining social distancing practices, which also contributed to lower numbers being served. Unlike Harford County's adult program, the TCM program for children had a significantly higher utilization rate of 71% compared to the state's utilization rate of 36%. Empowering Minds Resource Center (EMRC) is the child and adolescent provider in Harford County. The high utilization trend can be related to the partnerships with the Harford County Public Schools, as

well as targeting Residential Treatment Centers (RTC), the Harford County Department of Human Services (DHS), inpatient hospitals, and the Local Care Team (LCT) as referral sources.

In fiscal year 2022, Harford County's Mental Health Targeted Case Management (TCM) programs continued to have similar utilization rates as the state's average of approximately 2.2%. However, Harford County's adult TCM program utilization rate of 37% continued to be substantially lower than the State's utilization rate of 64%. Primarily, workforce shortages continue to be an ongoing problem, impacting the number of clients Leading by Example can serve in their TCM services. Leading by Example continues to work on increasing their workforce and in turn, increasing their capacity for TCM clients for the future. Additionally, ongoing communication can be a challenge to maintain service delivery within Targeted Case Management. Often, prospective, or even enrolled clients, have limited access to technology, phones and/or limited minutes on the phones they already have. Although there have been many benefits of telehealth services, many individuals qualifying for TCM services are experiencing homelessness or at risk of homelessness with very low income, if they have any income at all. These individuals typically don't have disposable income they can use to pay for monthly internet services creating additional barriers to ongoing TCM services. Leading By Example is focused on contacting potential participants quicker to reduce communication barriers, resulting in increased number of engagements and retention. Finally, Leading By Example has put forth efforts to increase their enrollment by creating a web-based referral form, in addition to the previous paper form, making it more accessible for providers and individuals who are completing TCM referrals. With these interventions in place, Harford County should be on target to increase capacity into a more comparable position relative to the rest of the state.

Again, in FY 2022, Harford County's Youth TCM Program's utilization rate of 63% was significantly higher than the state's utilization rate of 36%. This has contributed to an increase in school based mental health programs; in addition, the provider, Empowering Minds Resource Center entered into contracts to provide services in all 53 Harford County public schools. The need for case management for youth has been in high demand as children transition back to schools and out of home placements due to the stressors of the COVID-19 pandemic.

The OMH/CSA continues to follow the 5-year cycle for procuring Targeted Case Management (TCM) providers. The Request for Proposals (RFP) for youth case management was issued in 2021 with the contract award beginning July 2021. The OMH/CSA plans to RFP this program in the spring of 2026. The RFP for adult case management was issued in spring 2022 and notification to the providers was made in May 2022. The OMH/CSA plans to RFP the adult TCM program in the spring of 2027.

**D. Data and Planning**

The following information presented in the worksheets, graphs, and charts is based upon data provided by the Behavioral Health Administration, The Hilltop Institute at UMBC, CRISP, and other resources. Service utilization information reported for fiscal years 2022 and 2023 is

subject to change as claims can be submitted up to 12 months after service delivery. Additionally, this data is being used to support and guide a system planning process that focuses on the development of a strategic plan and addresses the impact of COVID-19.

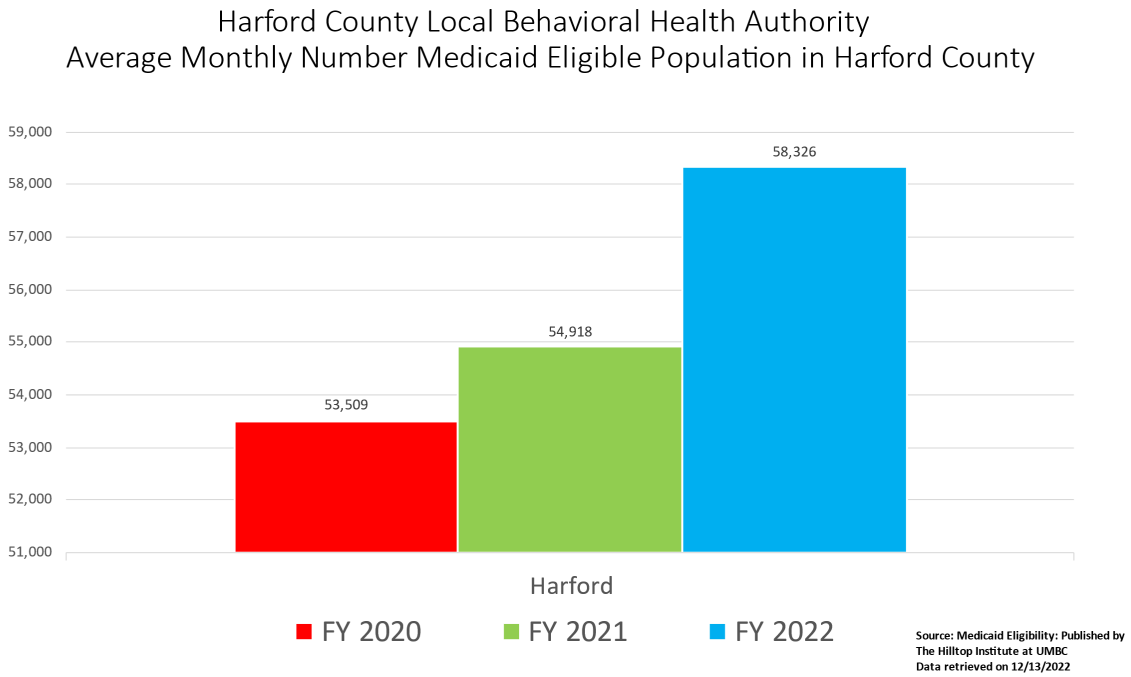



Figure 1

Figure 1 represents the average monthly number of Medicaid eligible population in Harford County for fiscal years 2020 through 2022. From fiscal years 2020 to 2021, the average monthly rate increased by 1,409 individuals (2.6%). From fiscal years 2021 to 2022, there was a substantial increase in the Harford County population eligible to receive Medicaid benefits. An additional 3,408 residents (6.2%) were eligible to receive Medicaid benefits. This increase is most likely contributed to the COVID-19 pandemic because many individuals were unable to retain employment. Of the total population in Harford County, 22.2% of residents were eligible to receive Medicaid benefits in fiscal year 2022.

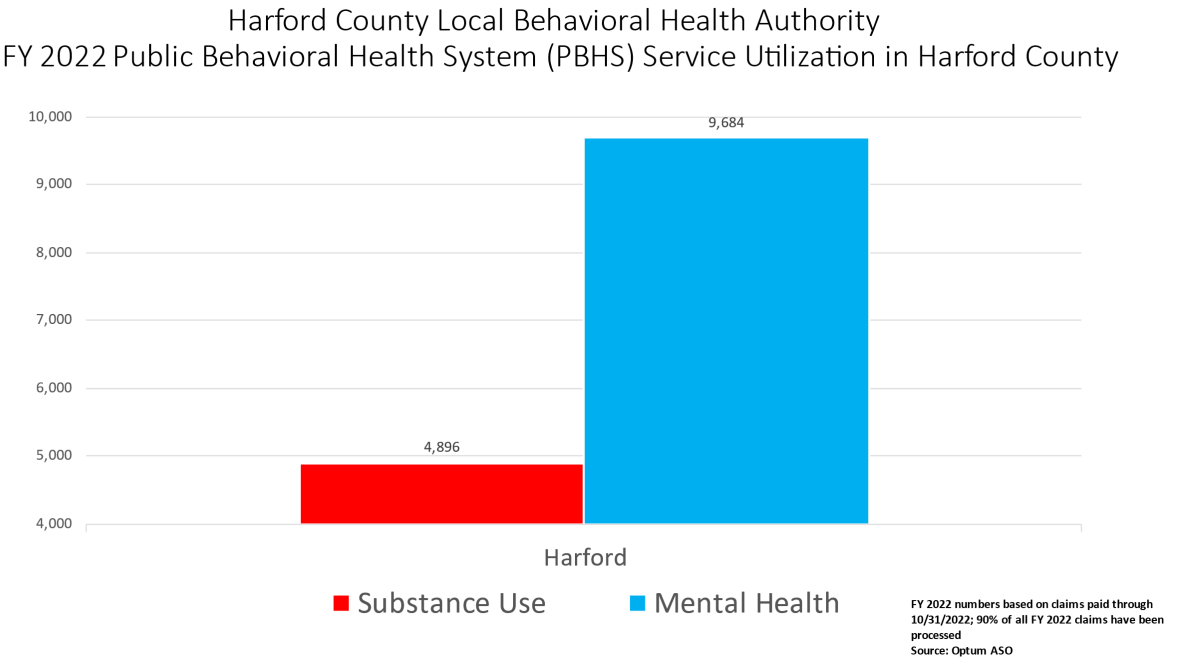



Figure 2

Figure 2 shows the service utilization of public behavioral health system services in fiscal year 2022. Substance use public behavioral health system services were accessed by 4,896 Harford County residents during this period. This number represents a Medicaid penetration rate of 8.4%. Mental health public behavioral health system services were accessed by 9,684 Harford County residents. This number represents a Medicaid penetration rate of 16.6%. Of the 1,783,087 Maryland Medicaid enrollees, substance use public behavioral health system services were accessed by 103,709 Marylanders. This number represents a Medicaid penetration rate of 5.8% which is 2.6% lower than Harford County's penetration rate. Mental health public behavioral health system services were accessed by 242,705 Marylanders. This represents a Medicaid penetration rate of 13.6% which is 3.0% lower than Harford County's penetration rate.

| FY 2021-22 PBHS SUD Statewide & County Comparisons by Age | | | | | | |
|---|---|---|---|---|---|---|
| | Persons Served | | | | | |
| | County | | | State | | |
| | FY 2021 | FY 2022 | % Change | FY 2021 | FY 2022 | % Change |
| **Age 0-17** | 73 | 100 | 37.0% | 2,378 | 2,709 | 13.9% |
| **Age 18+** | 4,660 | 4,796 | 2.9% | 101,682 | 101,000 | -0.7% |
| ****TOTAL** | **4,733** | **4,896** | **3.4%** | **104,060** | **103,709** | -0.3% |

***Data Source: Optum ASO claims data paid through 10/31/2022.
***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.
***Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 3

The graph above shows the Public Behavioral Health System (PBHS) Substance Use Disorder utilization for the State of Maryland and for Harford County by fiscal year. The age 18+ category had a slight 2.9% increase from FY 2021 to FY 2022. From FY 2021-2022, ages 0-17 had a 37% increase. This change surpasses the rate of change for the whole State by 23.1%. It should be noted the numbers for FY 2022 are incomplete and may increase. At first glance, this figure is alarming and may be signaling an upward trend in adolescent substance use. However, these figures represent the number of Harford County residents that have sought and found treatment. Harford County opened its first Adolescent Club House in FY 2022, The Clubhouse by Ashley. The Clubhouse is an after-school and summer program that provides a safe environment for the teens to hang out, try out new board games, cook, read, do homework, and check out events in the area without the use of substances. The Clubhouse offers its participants peer support, activities, snacks, and transportation. Through peer support, program participants may be finding linkages to treatment. Also, the Harford County Health Department—Bureau of Behavioral Health has started a youth and adolescent program to treat residents under the age of 18. Treatment for Maryland residents under the age of 18 in the Public Behavioral Health System can be difficult to find. The availability of more treatment and support services may account for an uptick in utilization.

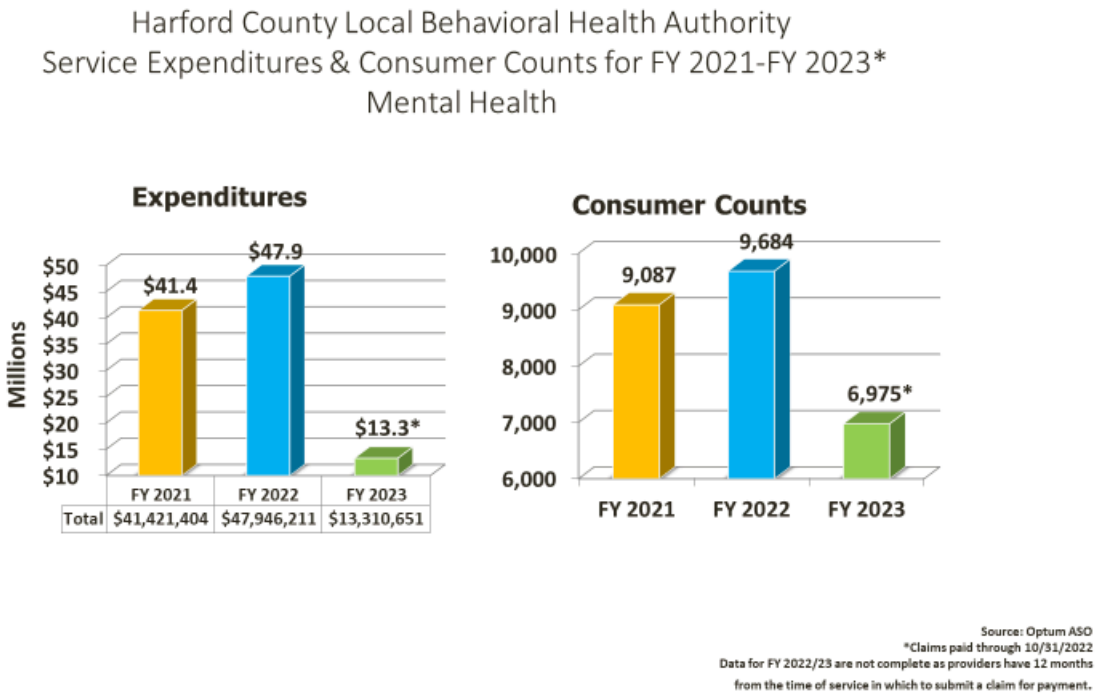



Figure 4

Information in figure 4 is a comparison of expenditures and consumer counts for fiscal years 2021 through 2023. It should be noted this information is based on claims paid through 10/31/2022; therefore, fiscal year 2023 information only contains data for four months. Additionally, providers have 12 months from the time of service to submit a claim for payment. This will likely result in changes to expenditures and consumer counts for both fiscal year 2022 and 2023. Individuals accessing mental health services increased by 597 (6.6%) from fiscal year 2021 to 2022 and expenditures for the same period increased by $6,524,807 (15.8%). The increase in Medicaid eligibility may have contributed to the increase in consumer counts and expenditures.

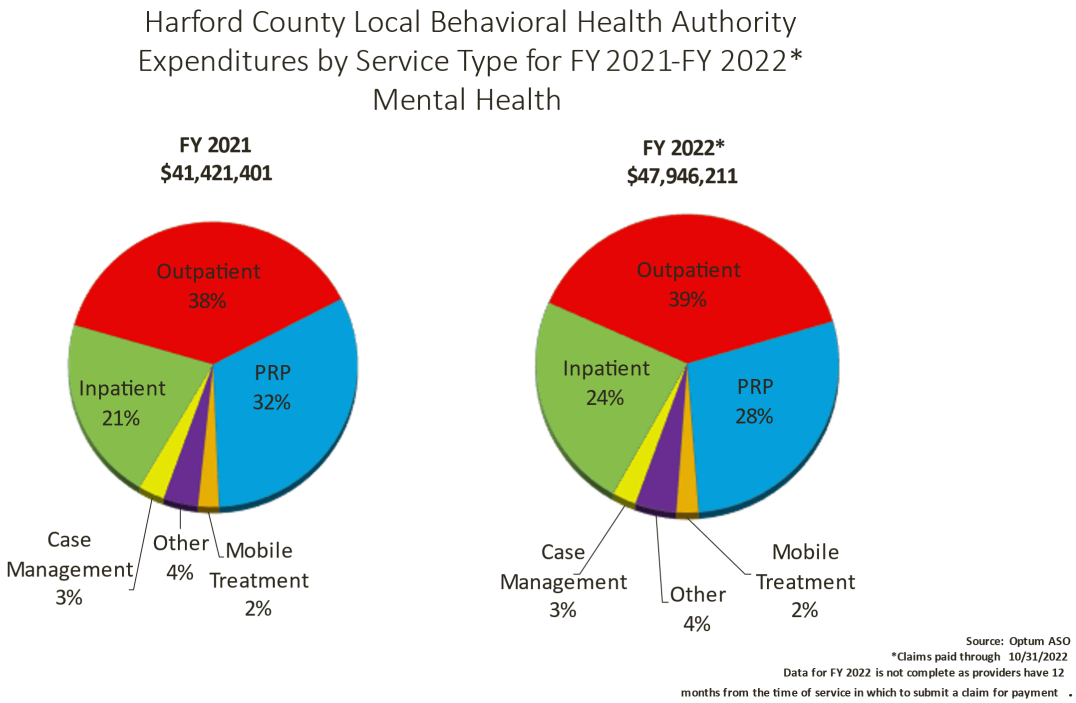



Figure 5

The pie charts above illustrate the percentage of overall expenditures among mental health service types for fiscal years 2021 and 2022. In fiscal year 2022, claims data reported an increase among most mental health service types from the prior fiscal year. The three service types with the largest expenditure percentage increase from FY 2021 to FY 2022 were partial hospitalization programs, residential treatment centers, and inpatient stays. In fiscal year 2022, partial hospitalization increased by $95,848 (107.2%), residential treatment increased by $378,773 (109.6%), and inpatient stays increased by $2,600,163 (29.9%). The increased expenditures in service types involving residential/inpatient care may be attributed to the stressors brought on by the pandemic. Additionally, the fear of receiving treatment in a hospital setting has decreased due to vaccination efforts. Although, these three service types were the largest percentage increase, expenditures for outpatient treatment services were the largest overall dollar amount increase. In FY 2022, outpatient services increased by $2,870,127 (18.3%).

Residential Rehabilitation Programs and Respite Care were the only mental health services to experience a decrease in expenditures from fiscal year 2021 to 2022. Residential Rehabilitation Programs expenditures decreased by $45,470 (-6.6%), and respite care expenditures decreased by $2,277 (-17.3%). In fiscal years 2021 and 2022, Residential Rehabilitation Programs (RRPs) discharged participants at the same rate as prior years, but it has taken longer to fill the beds due to workforce shortages, both at the state hospitals and the RRPs. Additionally, while state hospital clients have priority for the RRP vacancies, it is taking longer to arrange for their transfer to the community RRP beds. In some cases, placement can take two months or longer. This means the bed, while “approved” for an individual, is still vacant and cannot be billed.

There have also been barriers placing individuals with a criminal history and intensive needs. These factors prolong the placement process as additional supports or services are explored before placing the individual in the community, which leaves beds vacant while working towards a successful and appropriate placement. The decrease in respite expenditures for fiscal year 2022 could be attributed to families not being comfortable sending their children on weekend stays or community outings during the COVID pandemic. The program continues to see a decline in referrals as individuals are still accessing telehealth services and obtaining parents signatures for additional services has been a barrier.

**FY 2021- FY 2023 PBHS SUD Service Type Utilization Comparisons by Expenditures: County Comparison**

| | Expenditures | | | | |
|---|---|---|---|---|---|
| **Service Type** | **FY 2021** | **FY 2022** | **% Change** | **FY 2023** | **% Change** |
| **Gambling** | $3,838 | $3,073 | -19.9% | $2,747 | -10.6% |
| **SUD Inpatient** | $502,881 | $576,726 | 14.7% | $103,044 | -82.1% |
| **SUD Intensive Outpatient** | $2,184,062 | $2,779,316 | 27.3% | $1,091,298 | -60.7% |
| **SUD Labs** | $1,318,375 | $1,599,441 | 21.3% | $408,664 | -74.4% |
| **SUD MD Recovery Net** | $45,620 | $92,880 | 103.6% | $41,730 | -55.1% |
| **SUD Opioid Maintenance Treatment** | $7,794,232 | $7,975,806 | 2.3% | $2,541,836 | -68.1% |
| **SUD Outpatient** | $2,165,079 | $2,517,276 | 16.3% | $792,917 | -68.5% |
| **SUD Partial Hospitalization** | $1,273,231 | $1,925,189 | 51.2% | $851,548 | -55.8% |
| **SUD Residential - Court Ordered Placement** | $108,890 | $235,789 | 116.5% | $107,752 | -54.3% |
| **SUD Residential - Women with Children/Pregnancy** | $125,142 | $88,532 | -29.3% | $21,965 | -75.2% |
| **SUD Residential All Levels** | $2,880,934 | $4,017,671 | 39.5% | $1,602,300 | -60.1% |
| **SUD Residential ICFA** | $0 | $0 | $0 | $0 | $0 |
| **SUD Residential Room and Board** | $682,005 | $1,051,751 | 54.2% | $415,478 | -60.5% |
| **SUD Residential Room and Board - Court Ordered Placement** | $40,088 | $77,364 | 93.0% | $37,571 | -51.4% |
| **SUD Residential Room and Board - Women with Children/Pregnancy** | $97,806 | $89,721 | -8.3% | $26,877 | -70.0% |
| ****TOTAL** | **$19,222,183** | **$23,030,535** | **19.8%** | **$8,045,727** | **-65.1%** |

***Data Source: Optum ASO claims data paid through 10/31/2022.

***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.

***Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.

***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 6

## FY 2021- FY 2023 PBHS SUD Service Type Utilization Comparisons by Expenditures: Statewide Comparison

| | Expenditures | | | | |
|---|---|---|---|---|---|
| **Service Type** | **FY 2021** | **FY 2022** | **% Change** | **FY 2023** | **% Change** |
| **Gambling** | $85,472 | $128,894 | 50.80% | $46,018 | -64.30% |
| **SUD Inpatient** | $11,790,209 | $11,175,067 | -5.22% | $2,624,025 | -76.52% |
| **SUD Intensive Outpatient** | $63,536,352 | $83,362,833 | 31.20% | $32,422,004 | -61.11% |
| **SUD Labs** | $37,174,042 | $39,427,214 | 6.06% | $11,356,658 | -71.20% |
| **SUD MD Recovery Net** | $1,537,386 | $2,741,108 | 78.30% | $1,049,814 | -61.70% |
| **SUD Opioid Maintenance Treatment** | $118,734,493 | $115,295,626 | -2.90% | $35,414,492 | -69.28% |
| **SUD Outpatient** | $67,604,287 | $74,716,453 | 10.52% | $22,683,264 | -69.64% |
| **SUD Partial Hospitalization** | $24,200,906 | $41,984,646 | 73.48% | $15,538,928 | -62.99% |
| **SUD Residential - Court Ordered Placement** | $8,598,206 | $11,628,511 | 35.24% | $3,351,711 | -71.18% |
| **SUD Residential - Women with Children/Pregnancy** | 2,423,091 | 1,964,520 | -18.93% | 326,419 | -83.38% |
| **SUD Residential All Levels** | $111,522,824 | $139,642,956 | 25.21% | $48,197,959 | -65.48% |
| **SUD Residential ICFA** | $201,953 | $116,969 | -42.08% | $35,621 | -69.55% |
| **SUD Residential Room and Board** | $28,397,432 | $37,545,265 | 32.21% | $13,675,325 | -63.58% |
| **SUD Residential Room and Board - Court Ordered Placement** | $2,846,497 | $4,194,749 | 47.37% | $1,104,768 | -73.66% |
| **SUD Residential Room and Board - Women with Children/Pregnancy** | $2,207,821 | $1,884,760 | -14.63% | $434,723 | -76.93% |
| ****TOTAL** | **$480,860,971** | **$565,809,571** | 17.67% | **$188,261,729** | -66.73% |

***Data Source: Optum ASO claims data paid through 10/31/2022.

***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.

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Figure 7

As seen in the tables above, trends in expenditures related to SUD services in Harford County were in line with the state trends. The trends related to expenditures roughly correlated with the utilization by number of people served trends. Of note from FY 2022, was the robust increase in expenditures in MD Recovery Net. MD Recovery Net spending in Harford County increased 103.6%, which outpaced the statewide increase of 78.3% over the same period. While most metrics in expenditure SUD utilization were similar to the statewide trends, one unexpected exception was a 116.5% increase from FY 2021 to FY 2022 in Court Ordered Placement expenditures compared to just a 35.2% increase statewide in Court Ordered Expenditures over the same period. The LBHA is unaware as to why this rose so sharply over that time and looks forward to seeing if that trend continues into FY 2023.

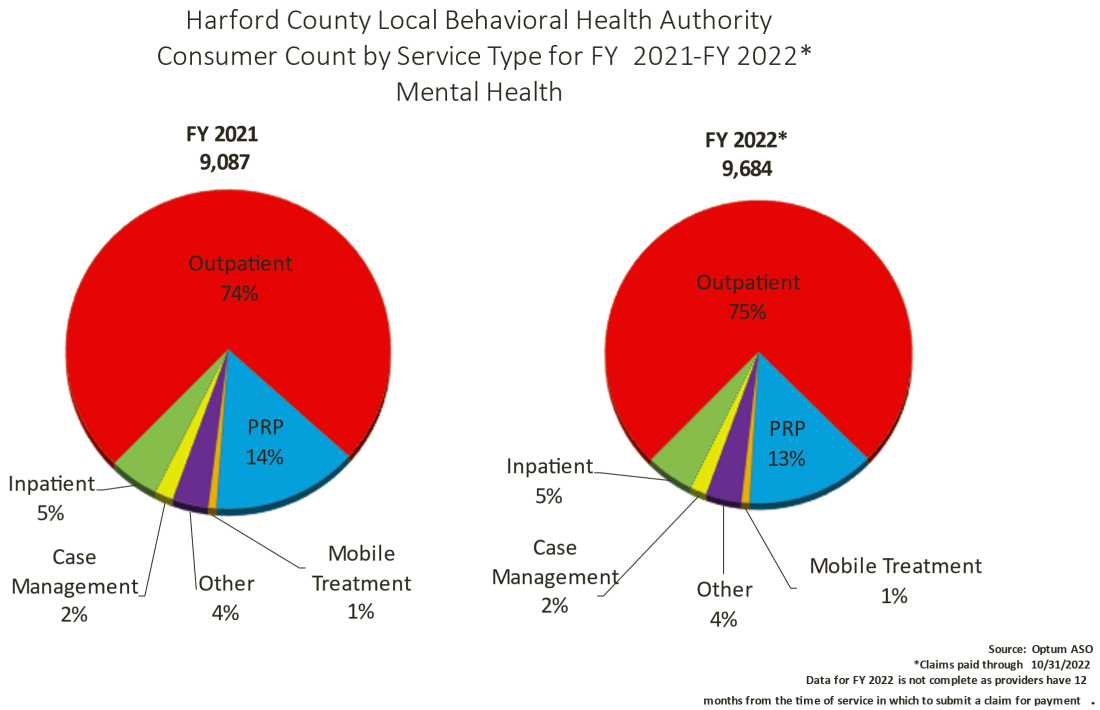



Figure 8

The pie charts above represent a fiscal year comparison of consumer counts by service type. In fiscal year 2022, there was an increase of 597 individuals accessing behavioral health services from the previous fiscal year. This represents an increase of 6.6%. Most mental health service types reported consumer count increases between fiscal years 2021 to 2022. From FY 2021 to FY 2022, partial hospitalization had an increase of 23 individuals (164.3%), residential treatment reported an increase of six individuals (100%), crisis services consumer counts increased by 30 individuals (16.8%), and mobile treatment services increased by nine individuals (9.7%). Inpatient and outpatient treatment, supported employment, and case management also reported increased consumer counts in FY 2022.

Three mental health service types reported a decrease in consumer count from fiscal year 2021 to fiscal year 2022. Respite care reported the largest percentage decrease of participants among the various service types. Respite care served six individuals during fiscal year 2022; this was eight less individuals than fiscal year 2021. This represents a decrease of -57.1%. Residential rehabilitation programs also reported a decrease from the prior fiscal year. In fiscal year 2022, 167 individuals accessed this service versus 176 in fiscal year 2021. This is a decrease of -5.1%. Psychiatric rehabilitation programs reported a minimal decrease in consumer count. This program served 1,637 individuals versus 1,658 in the prior fiscal year. This represents a decrease of -1.3%.

# FY 2021-2023 PBHS SUD Service Type Utilization Comparisons by # Persons Served: County Comparison

| | Persons Served | | | | |
|---|---|---|---|---|---|
| **Service Type** | **FY 2021** | **FY 2022** | **% Change** | **FY 2023** | **% Change** |
| **Gambling** | <11 | <11 | <11 | <11 | <11 |
| **SUD Inpatient** | 132 | 136 | 3.0% | 34 | -75.0% |
| **SUD Intensive Outpatient** | 604 | 659 | 9.1% | 323 | -51.0% |
| **SUD Labs** | 2,561 | 2,826 | 10.3% | 1,269 | -55.1% |
| **SUD MD Recovery Net** | 44 | 68 | 54.5% | 29 | -57.4% |
| **SUD Opioid Maintenance Treatment** | 1,897 | 1,784 | -6.0% | 1,448 | -18.8% |
| **SUD Outpatient** | 1,899 | 1,924 | 1.3% | 1,057 | -45.1% |
| **SUD Partial Hospitalization** | 231 | 304 | 31.6% | 156 | -48.7% |
| **SUD Residential - Court Ordered Placement** | 13 | 14 | 7.7% | <11 | <11 |
| **SUD Residential - Women with Children/Pregnancy** | 12 | 12 | 0.0% | <11 | <11 |
| **SUD Residential All Levels** | 369 | 463 | 25.5% | 234 | -49.5% |
| **SUD Residential ICFA** | 0 | 0 | 0 | 0 | 0 |
| **SUD Residential Room and Board** | 368 | 462 | 25.5% | 233 | -49.6% |
| **SUD Residential Room and Board - Court Ordered Placement** | 15 | 14 | -6.7% | <11 | <11 |
| **SUD Residential Room and Board - Women with Children/Pregnancy** | 13 | 13 | 0.0% | <11 | <11 |
| ****TOTAL** | **4,733** | **4,896** | **3.4%** | **4,807** | **-1.8%** |

***Data Source: Optum ASO claims data paid through 10/31/2022.

***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.

***Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.

***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 9

| FY 2021- FY 2023 PBHS SUD Service Type Utilization Comparisons by # Persons Served: Statewide Comparison | | | | | |
|---|---|---|---|---|---|
| | Persons Served | | | | |
| Service Type | FY 2021 | FY 2022 | % Change | FY 2023 | % Change |
| Gambling | 92 | 110 | 19.57% | 46 | -58.18% |
| SUD Inpatient | 3,649 | 3,221 | -11.73% | 897 | -72.15% |
| SUD Intensive Outpatient | 13,055 | 14,656 | 12.26% | 8,112 | -44.65% |
| SUD Labs | 58,520 | 59,716 | 2.04% | 30,250 | -49.34% |
| SUD MD Recovery Net | 1,243 | 1,728 | 39.02% | 683 | -60.47% |
| SUD Opioid Maintenance Treatment | 31,016 | 28,445 | -8.29% | 22,554 | -20.71% |
| SUD Outpatient | 47,058 | 48,416 | 2.89% | 26,501 | -45.26% |
| SUD Partial Hospitalization | 4,417 | 5,896 | 33.48% | 2,609 | -55.75% |
| SUD Residential - Court Ordered Placement | 495 | 598 | 20.81% | 265 | -55.69% |
| SUD Residential - Women with Children/Pregnancy | 208 | 172 | -17.31% | 49 | -71.51% |
| SUD Residential All Levels | 12,239 | 14,433 | 17.93% | 6,722 | -53.43% |
| SUD Residential ICFA | 18 | 16 | -11.11% | 6 | -62.50% |
| SUD Residential Room and Board | 12,189 | 14,317 | 17.46% | 6,671 | -53.41% |
| SUD Residential Room and Board - Court Ordered Placement | 516 | 602 | 16.67% | 253 | -57.97% |
| SUD Residential Room and Board - Women with Children/Pregnancy | 230 | 189 | -17.83% | 58 | -69.31% |
| **TOTAL | 104,060 | 103,709 | -0.34% | 64,770 | -37.55% |

***Data Source: Optum ASO claims data paid through 10/31/2022.

***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.

***Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.

***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 10

Figures 9 and 10 compare both local and statewide SUD utilization by number of people served over a three-year period. Of interest is the slight increase in total utilization of all SUD services from FY 2021 to FY 2022 as compared to the slight decrease statewide. The data, while incomplete, for FY 2023 shows an even more stark contrast. Harford County is trending to serve more people with SUD services than it has in the previous two years and is outpacing the statewide trend. To date, total utilization statewide for FY 2023 has reached 64.5% of FY 2022 utilization and Harford's total FY 2023 utilization has already reached 98.2% of FY 2022 total utilization. The higher total SUD service utilization growth in the county compared to the state can be attributed to the consistent increase in services being made available countywide. Particularly notable is the increase in the utilization of all residential SUD services from FY 2021 to FY 2022. Harford County was similar to the statewide trend in total utilization of residential services in that total individuals served increased over the period and grew at a slightly higher rate. While FY 2023 information is still incomplete, the LBHA is excited to see if the growth in residential SUD services continues in FY 2023. The trends in total SUD utilization by people served are similarly reflected in the tables reflecting SUD utilization by expenditures.

## FY 2021- FY 2023 PBHS SUD Utilization Comparisons by Funding Group: County Comparison

| | Persons Served | | | | | Expenditures | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | FY 21 | FY 22 | % Change | FY 23 | % Change | FY 21 | FY 22 | % Change | FY 23 | % Change |
| **Medicaid** | 4,517 | 4,744 | 5.0% | 2,988 | -37.0% | $16,553,023 | $18,324,558 | 10.7% | $6,354,043 | -65.3% |
| **State** | 738 | 790 | 7.0% | 343 | -56.6% | $2,394,511 | $4,368,063 | 82.4% | $1,562,410 | -64.2% |
| **Uninsured** | 160 | 107 | -33.1% | 54 | -49.5% | $274,446 | $337,915 | 23.1% | $129,274 | -61.7% |
| **Unknown** | <11 | 0 | <11 | 0 | <11 | <11 | $0 | <11 | $0 | <11 |
| ****TOTAL** | **4,733** | **4,896** | 3.4% | **3,385** | **-30.9%** | **$19,222,183** | **$23,030,536** | **19.8%** | **$8,045,727** | **-65.1%** |

***Data Source: Optum ASO claims data paid through 10/31/2022.
***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.
***Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 11

## FY 2021- FY 2023 PBHS SUD Utilization Comparisons by Funding Group: Statewide Comparison

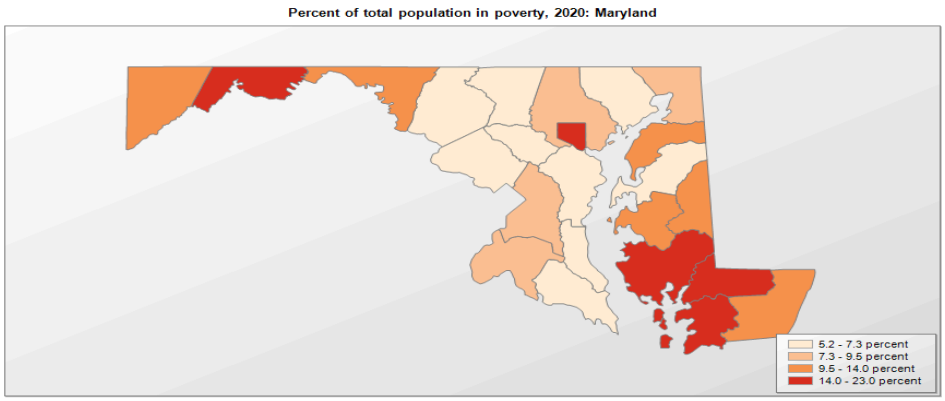
| | Persons Served | | | | | Expenditures | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | FY 21 | FY 22 | % Change | FY 23 | % Change | FY 21 | FY 22 | % Change | FY 23 | % Change |
| **Medicaid** | 99,462 | 99,304 | -0.16% | 62,285 | -37.28% | $377,989,773 | $394,859,011 | 4.46% | $136,414,462 | -65.45% |
| **State** | 17,782 | 18,715 | 5.25% | 8,067 | -56.90% | $91,758,400 | $156,060,816 | 70.08% | $46,781,039 | -70.02% |
| **Uninsured** | 3,052 | 3,176 | 4.06% | 1,464 | -53.90% | $11,098,134 | $14,889,745 | 34.16% | $5,066,230 | -65.98% |
| **Unknown** | <11 | 0 | <11 | 0 | <11 | $14,664 | $0 | -100.00% | $0 | <11 |
| ****TOTAL** | **104,060** | **103,709** | -0.34% | **64,770** | -37.55% | **$480,860971** | **$565,809,572** | 17.67% | **$188,261,731** | -66.73% |

***Data Source: Optum ASO claims data paid through 10/31/2022.
***Data for FY 2022/23 are not complete as providers have 12 months from time of service in which to submit a claim for payment, however, based on this data run approximately 90% of all FY 2022 claims have been processed.
***Consumer count totals are unduplicated and is not the sum all services as an individual may receive more than one service or funding type throughout the fiscal year.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 12

Referring to the tables above (FY 2021-FY 2023 PBHS SUD Utilization Comparison by Funding Group: County Comparison and FY 2021-FY 2023 PBHS SUD Utilization Comparison by Funding Group: State Comparison), local trends are similar to statewide trends in that the Medicaid funding group has the highest utilization rates (approximately 80% in FY21, 22 and 23) and the Uninsured group has the lowest (approximately 3% in FY21, 22, and 23). Expenditures for these funding groups produce similar results; however, in FY 2021 the Unknown category accounts for

the lowest amount. Between FY 2021 and FY 2022, there was a 33.1% decrease in the Uninsured group local; however, there was a 4.1% in the same group statewide. The LBHA expected the data that was presented in the tables above as this is a trend that has occurred in past fiscal years.




| Percent of Total Population in Poverty, Calendar Year 2020 | | | |
|---|---|---|---|
| Jurisdiction | All | Children 0-17 | Ranking Total Population in Poverty |
| Statewide | 9 | 11.2 | |
| Allegany | 14.7 | 18.6 | 4 |
| Anne Arundel | 5.2 | 6.3 | 24 |
| Baltimore | 8.9 | 11.2 | 13 |
| Calvert | 5.3 | 5.3 | 22 |
| Caroline | 12.4 | 17.9 | 7 |
| Carroll | 5.2 | 5.6 | 23 |
| Cecil | 8.8 | 12.4 | 14 |
| Charles | 7.4 | 9.3 | 15 |
| Dorchester | 14.9 | 23.8 | 3 |
| Frederick | 6.2 | 7.2 | 20 |
| Garrett | 12.8 | 16.7 | 6 |
| Harford | 6.2 | 7.2 | 19 |
| Howard | 5.5 | 5.8 | 21 |
| Kent | 12 | 17.2 | 9 |
| Montgomery | 6.7 | 7.6 | 18 |
| Prince George's | 9.5 | 12.7 | 12 |
| Queen Anne's | 6.9 | 7.9 | 17 |
| St. Mary's | 7.3 | 9.2 | 16 |
| Somerset | 22.2 | 26.6 | 1 |
| Talbot | 9.6 | 14.7 | 11 |
| Washington | 12.3 | 16.9 | 8 |
| Wicomico | 14.2 | 19.2 | 5 |
| Worcester | 11.7 | 18.6 | 10 |
| Baltimore City | 20 | 26.8 | 2 |

Source: Economic Research Service; U.S. Department of Agriculture
http://www.ers.usda.gov/data-products/county-level-data-sets/poverty.aspx

Figure 13

The map and table in figure 8 show the total percentage of county residents in poverty, the total percentage of children 0-17 living in poverty, and a ranking of total population in poverty broken down by county. The ranking is from 1 through 24 with 1 having the highest percentage of poverty and 24 having the lowest percentage. In calendar year 2020, Harford County had a representation of 6.2% of the total population living in poverty. This is a small decrease from calendar year 2019 where 6.7% of the Harford County population were living in poverty. 7.2% of youth between the ages of 0-17 are recorded as living in poverty in calendar year 2020. This is a decrease from calendar year 2019 which reported 8.8%. Overall, Harford County has a poverty ranking of 19th, which is an improvement from 17th for calendar year 2019.

Maryland Unemployment Percentage Rates 2019-2021

| | 2019 | 2020 | Change (2019 to 2020) | 2021 | Change (2020 to 2021) |
|---|---|---|---|---|---|
| **MARYLAND** | 3.5% | 6.8% | 3.3% | 5.8% | -1.0% |
| Allegany County | 5.1% | 7.8% | 2.7% | 6.4% | -1.4% |
| Anne Arundel County | 3.0% | 5.8% | 2.8% | 4.7% | -1.1% |
| Baltimore City | 5.0% | 8.8% | 3.8% | 7.6% | -1.2% |
| Baltimore County | 3.6% | 6.8% | 3.2% | 5.7% | -1.1% |
| Calvert County | 3.1% | 5.2% | 2.1% | 4.6% | -0.6% |
| Caroline County | 3.5% | 5.5% | 2.0% | 4.7% | -0.8% |
| Carroll County | 2.8% | 5.1% | 2.3% | 4.2% | -0.9% |
| Cecil County | 3.9% | 5.9% | 2.0% | 5.2% | -0.7% |
| Charles County | 3.5% | 6.7% | 3.2% | 5.7% | -1.0% |
| Dorchester County | 4.5% | 6.7% | 2.2% | 5.6% | -1.1% |
| Frederick County | 3.1% | 5.9% | 2.8% | 4.8% | -1.1% |
| Garrett County | 4.3% | 6.6% | 2.3% | 5.2% | -1.4% |
| Harford County | 3.2% | 5.8% | 2.6% | 4.8% | -1.0% |
| Howard County | 2.7% | 5.2% | 2.5% | 4.3% | -0.9% |
| Kent County | 3.9% | 6.6% | 2.7% | 5.5% | -1.1% |
| Montgomery County | 2.9% | 6.3% | 3.4% | 5.5% | -0.8% |
| Prince George's County | 3.7% | 8.2% | 4.5% | 7.5% | -0.7% |
| Queen Anne's County | 3.0% | 5.5% | 2.5% | 4.4% | -1.1% |
| St. Mary's County | 3.3% | 4.8% | 1.5% | 4.5% | -0.3% |
| Somerset County | 6.0% | 8.3% | 2.3% | 7.6% | -0.7% |
| Talbot County | 3.4% | 6.0% | 2.6% | 5.3% | -0.7% |
| Washington County | 3.8% | 6.7% | 2.9% | 5.4% | -1.3% |
| Wicomico County | 4.6% | 7.5% | 2.9% | 6.1% | -1.4% |
| Worcester County | 7.2% | 11.2% | 4.0% | 8.2% | -3.0% |

Source: https://msa.maryland.gov/msa/mdmanual/01glance/economy/html/unemployrates.html

Figure 14

The chart above provides data on unemployment rates from calendar years 2019 through 2021 for all counties in the state of Maryland. As expected, there were some significant changes in unemployment rates for the entire state, as well as Harford County in calendar year 2021. In calendar year 2021, Harford County reported an unemployment rate of 4.8%, which is a decrease of 1.0% from calendar year 2020. This could be attributed to the state getting a better handle on the COVID-19 pandemic, increased vaccination rates, and people wanting to return to work.

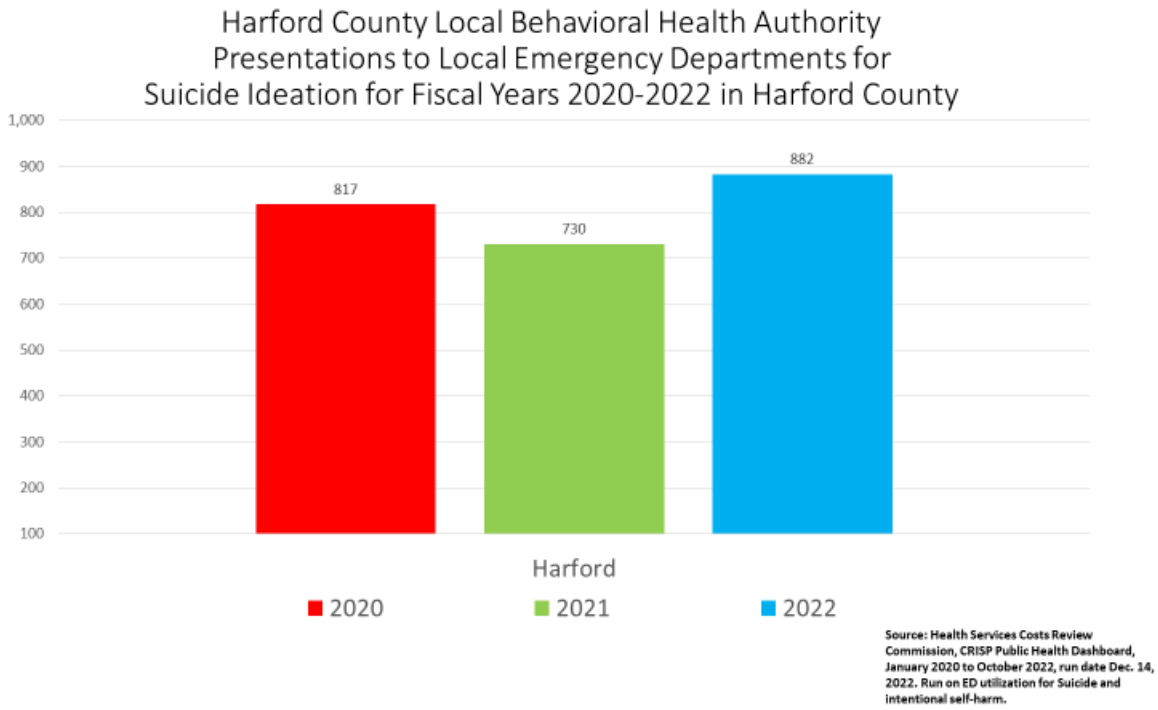



Figure 15

The bar graph above provides data on suicide ideation occurring in Harford County for fiscal years 2020 through 2022. From fiscal year 2020 to 2021, there were 87 (-10.6%) less emergency department presentations for suicide ideation in Harford County. This decrease may be attributed to the impact COVID-19 had on hospitals, where individuals were less likely to access the emergency department due to fears of being exposed to coronavirus. There was an uptick of suicide ideation presentations from fiscal year 2021 to 2022. This uptick of 152 more presentations (20.8%) could be related to pandemic changes (loss of loved one to virus, end of emergency mandates and restrictions, vaccinations).

As the COVID-19 pandemic continues, children and adolescents have returned to in-person learning. Harford County Public Schools (HCPS) reported an increase in symptoms of anxiety and depression among students. For the 2021-2022 school year, HCPS reported a significant increase in the number of suicidal ideation reports. However, having a 24/7 hotline and mobile

crisis team, as well as the Klein Family Harford Crisis Center, has been a factor in diverting youth from the emergency departments.

Thus far in the 2022-2023 school year, HCPS reports suicidal ideation reports remain the same as last year which is a significant increase from pre-pandemic. To support youth in the school setting, the Harford County LBHA has worked with HCPS to decrease any barriers youth have accessing behavioral health services. For the 2022-2023 school year, an additional outpatient mental health provider was added to fifteen schools with another sixteen in the works. Youth crisis services have been at the forefront of program development in Harford County. In FY 2022 and FY2023, the LBHA assisted Harford Crisis Response with establishing a youth specific Mobile Response and Stabilization Service (MRSS), which not only responds to crisis events, but continues to provide the youth and family support for up to eight weeks. During this period, the youth MRSS team connects the family to resources and works with them to manage behaviors both at home and in the school, as well as offers support from a peer/family advocate.

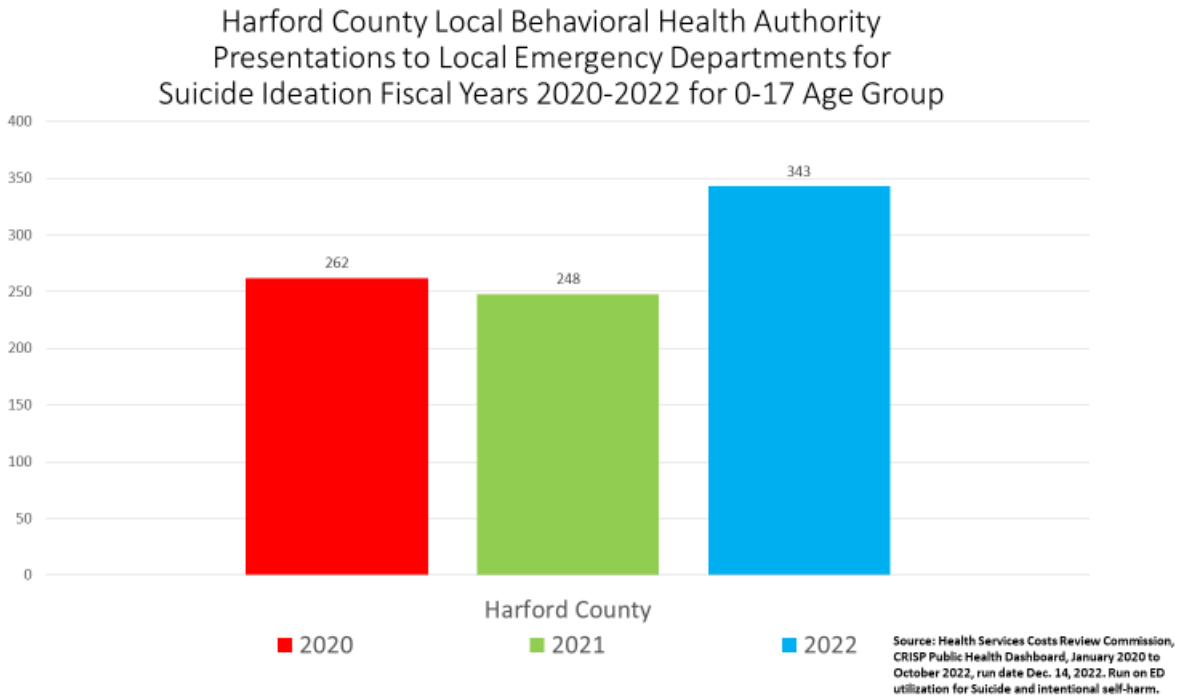



Figure 16

The bar graph above is a fiscal year comparison of suicide ideation presentations in Harford County for youth 0-17 years old. From fiscal years 2020 to 2021, suicide ideation presentations among youth decreased by 14 incidents (-5.3%); whereas fiscal year 2022 reported an increase from fiscal year 2021 of 95 incidents (38.3%). This increase is higher than the overall increase reported among all age groups for the same time span (17.5%).

With the opening of the Klein Family Harford Crisis Center (KFHCC), children and adolescents have been able to be diverted from the emergency department and connected with outpatient

mental health treatment. Although the KFHCC intended to serve adults, they took a "no wrong door" approach when it came to meeting the needs of the community. The KFHCC continues to coordinate care for youth as young as five in the walk-in center and the outpatient mental health center. During the COVID-19 pandemic. families have been able to access mental health services via telehealth, and according to local behavioral health professionals, there has been an increased need for outpatient therapy. During the pandemic's peak, HCPS and many child serving agencies were virtual. Because of this, adults who would typically be informed by youth about suicidal ideations were not as connected to those youth.

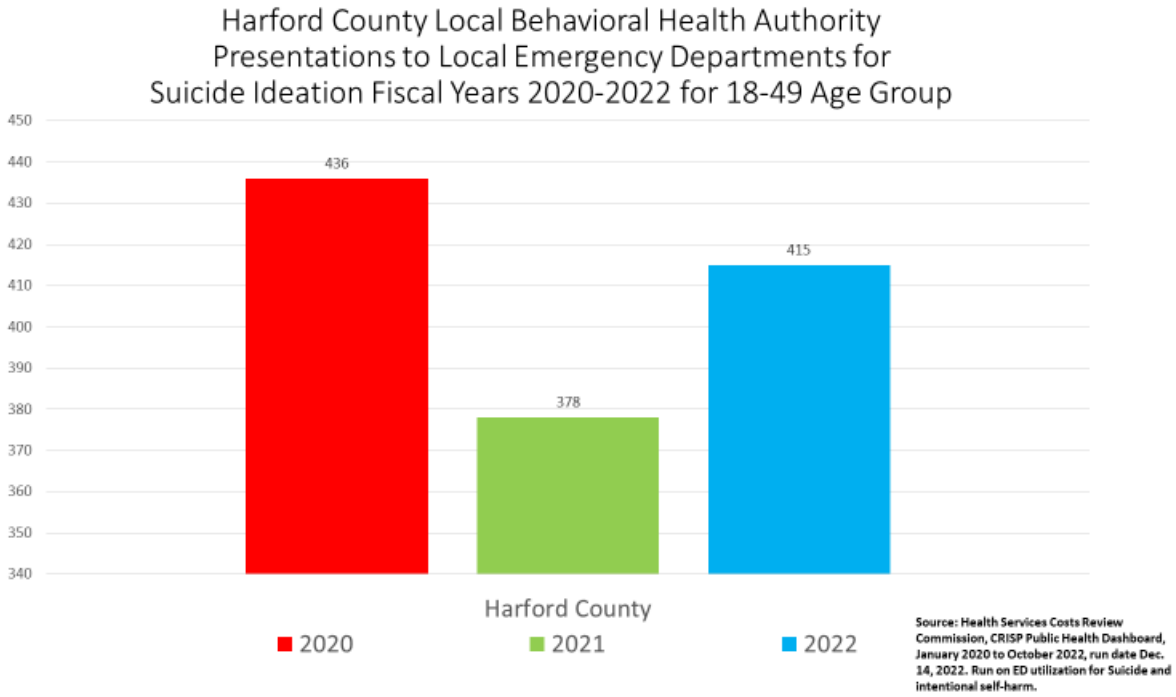



Figure 17

Like the 0-17 age group, the 18-49 age group reported a decrease in suicide ideation presentations between fiscal years 2020 to 2021 and a substantial increase from fiscal years 2021 to 2022. There was a reduction of 58 presentations (-13.3%) between 2020 to 2021 and an increase of 37 presentations from 2021 to 2021 which represents an increase of 9.8%. The decrease in suicide ideation presentations in fiscal year 2021 may be attributed to the suicide prevention initiatives occurring throughout Harford County, including widespread marketing for 1-800-NEXT-STEP (crisis hotline). In 2020, the Office on Mental Health transitioned crisis response services under the agency's umbrella, creating Harford Crisis Response. Harford Crisis Response operates the crisis hotline and mobile response teams. The team made every effort to meet with people in person, something the previous provider was not doing during the pandemic. By encouraging the mobile response teams to conduct face-to-face dispatches, it is believed this increased engagement within the system and the likelihood individuals would follow through on referrals to outpatient treatment and community resources.

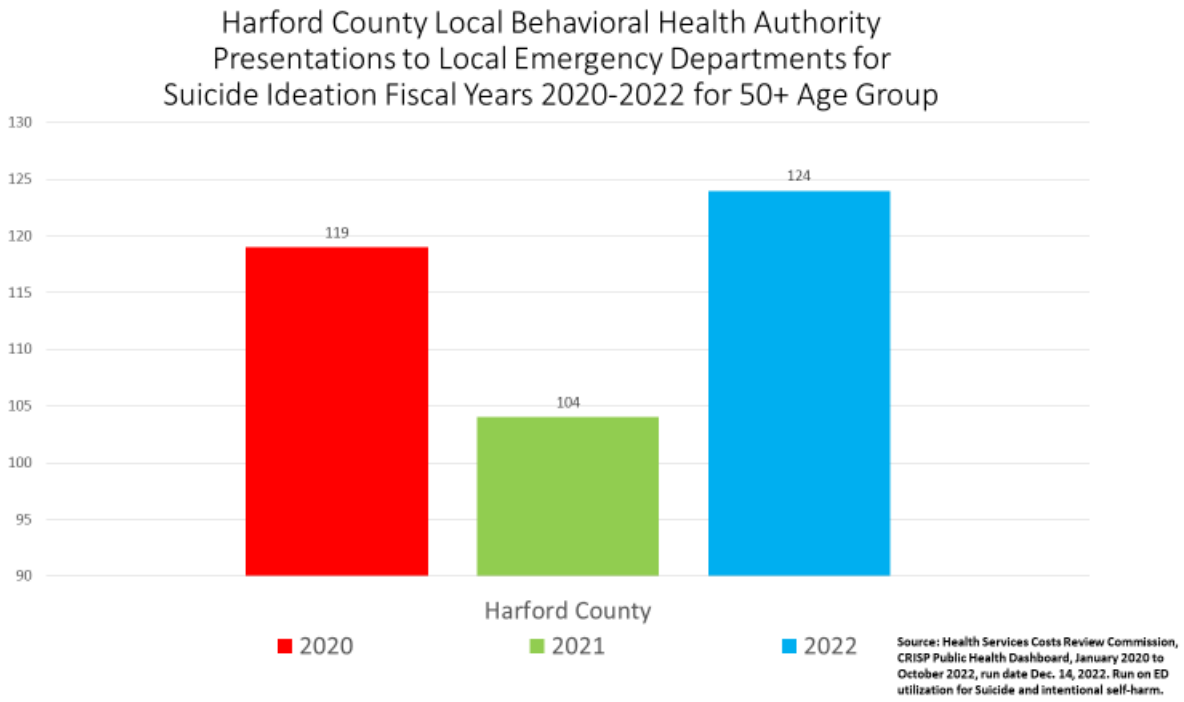



Figure 18

Figure 18 shows suicide ideation presentations for fiscal years 2020 to 2022 for the 50 and over age group. Like the 0-17 and 18-49 age groups, the 50+ age group reported a decrease in suicide ideation presentations from 2020 to 2021 and an increase in presentations from fiscal years 2021 to 2022. From fiscal year 2020 to 2021, there was a reduction of 15 presentations (-12.6%); however, from fiscal year 2021 to 2022, the number of suicide ideation presentations increased by 20 presentations. This number represents a 19.2% increase of suicide ideation presentations for people 50+. This increase is likely attributed to the COVID-19 pandemic and feelings of isolation and hopelessness. Initially, this group consisted of ages that were more vulnerable to becoming seriously ill and increased rates of death from the coronavirus. After a substantial amount of time being confined and restrictions easing, individuals in this age group may have felt safer (from COVID-19) entering a hospital. Many people in this age group could be living alone, unable to visit with friends and family, thus contributing to the feelings of isolation, hopelessness, and increased anxiety due to being an at-risk population.

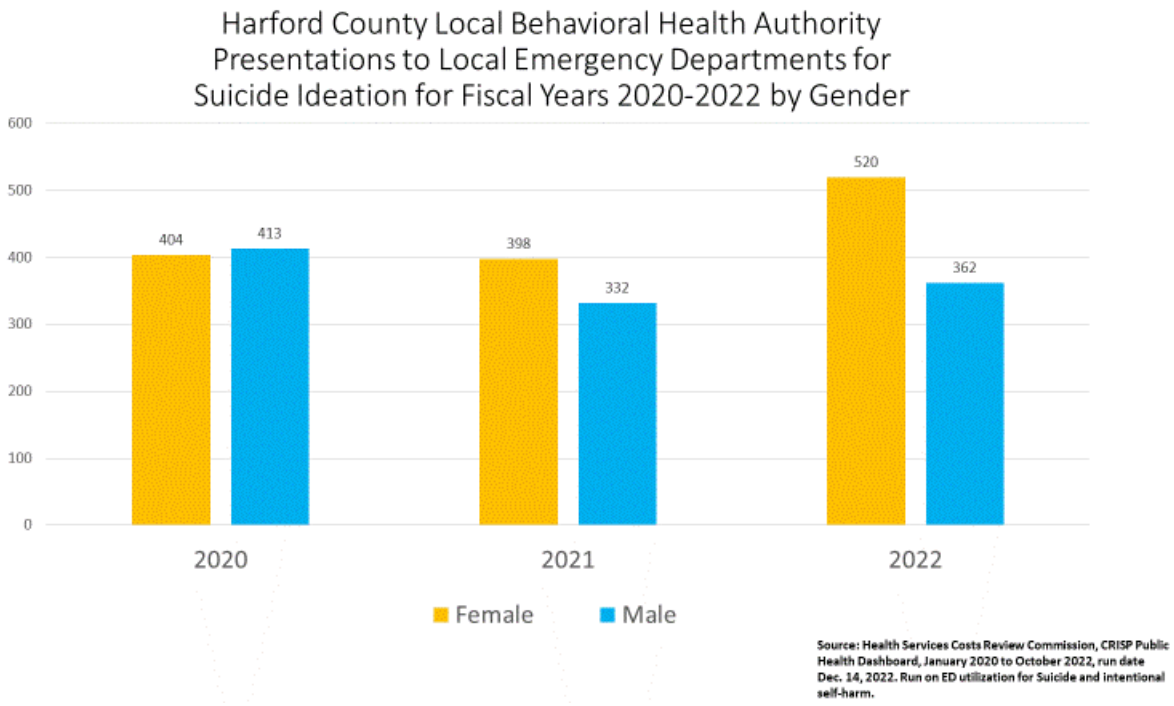



Figure 19

Figure 19 provides data on suicide ideation presentations for fiscal years 2020-2022 by gender. For females, data shows a minimal decrease from 2020 to 2021 (six incidents/-1.5%) followed by an increase of 122 incidents (30.7%) from fiscal years 2021 to 2022. Suicide ideation among males differed slightly. There were 81 less incidents reported from fiscal year 2020 to 2021, which is a reduction of -19.6%. From fiscal year 2021 to 2022, there was a slight increase of 30 incidents, representing an increase of 9.0%.

The consistent decrease among genders in fiscal year 2020-2021 could be due to COVID-19 and many people avoiding hospitals or medical offices unless necessary. Recognizing the impact COVID-19 may have on mental wellbeing, the Local Behavioral Health Authority increased suicide prevention efforts and focused on outreach and increasing Question, Persuade, Refer (QPR) trainings. The slight increase from FY 2021-2022 can be attributed to COVID restrictions being lifted and individuals feeling more comfortable reporting and seeking treatment for self-harming behaviors.

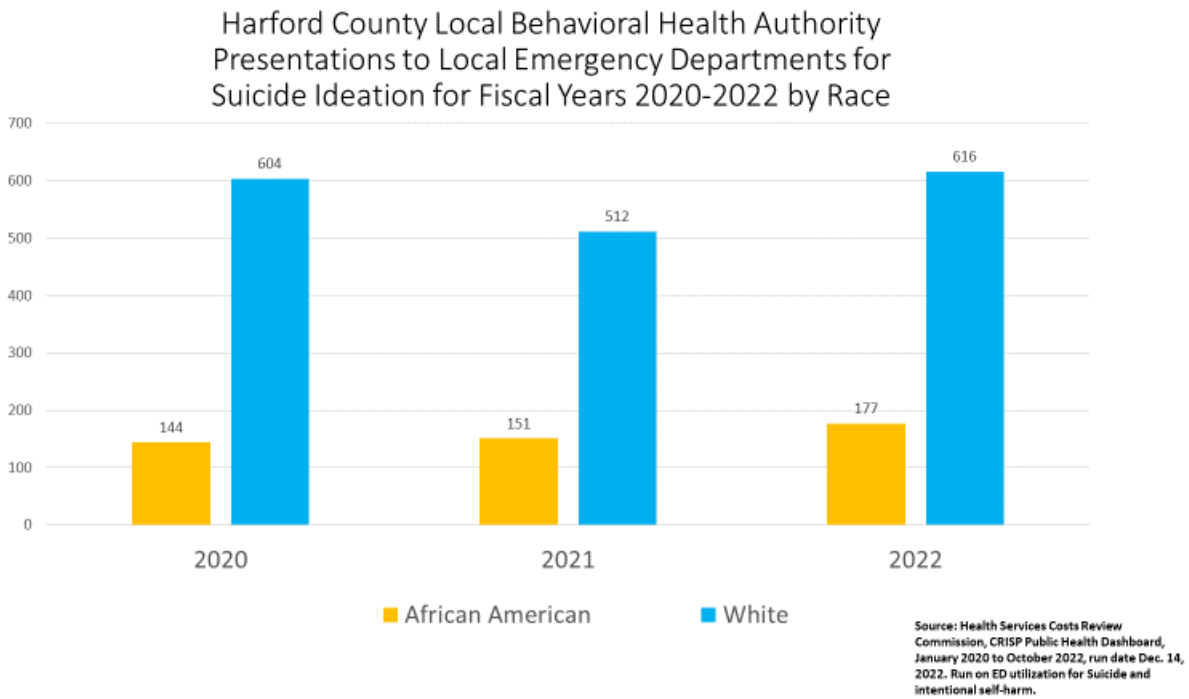



Figure 20

The bar graph above highlights data on suicide ideation for fiscal years 2020 through 2022 separated by race. From fiscal year 2020 to 2021, there was an increase among African Americans (seven incidents/4.9%) presenting to the local emergency department with reports of suicide ideation versus a decrease among individuals identifying as white (92 incidents/-15.2%). Both races reported an increase of suicide ideation presentations from fiscal year 2021 to 2022. African American individuals reported an increase of 26 presentations which is an increase of 17.2%. White individuals reported an increase of 104 presentations which is an increase of 20.3%. The increase of suicide ideation presentations in 2021-2022 may be related to the lasting effects of COVID-19 impacting an individual regardless of race (i.e., unemployment, loss of a loved one, separation from a spouse).

| CY 2020- CY 2022 Overdose Hospital Presentations by Race in Harford County | | | | | |
|---|---|---|---|---|---|
| | Hospital Presentations | | | | |
| **Race** | **CY 2020** | **CY 2021** | **% Change** | **CY 2022** | **% Change** |
| **White** | 257 | 256 | -0.39% | 211 | -17.58% |
| **African American** | 106 | 74 | -30.19% | 53 | -28.38% |
| **Other** | 0 | 11 | 0.00% | 0 | -100.00% |
| ****TOTAL** | **363** | **341** | **-6.06%** | **264** | **-22.58%** |

***Data Source: Health Services Cost Review Commission, CRISP Public Health Dashboard, January 2020 to October 2022, run date Dec. 14, 2022. Run on ED utilization for Overdose Hospital Events.

Figure 21

The figure above provides data on hospital presentation events for opioid overdose for calendar years 2020-October 2022 broken down by race. During calendar years 2020-2022, hospital presentations for opioid overdose has fluctuated. The data for CY 2022 is only until October 2022 and is not a complete picture for the entirety of 2022. Overdose hospital presentations among Non-Hispanic African Americans saw a -30.2% decrease from CY 2020 to 2021 and a -28.9% decrease from calendar year 2021 to 2022. Overdose hospital presentations among Non-Hispanic White individuals showed a -0.4% decrease from CY 2020 to CY 2021 and a -17.6% decrease from CY 2021 to CY 2022. The other category had less than (11) eleven total cases in 2020 and 2022 so that data has been redacted.

According to the 2020 US Census, Non-Hispanic White make up 74.6% percent of Harford's population and account for 71% of total overdoses in 2020. Presentations for the white population is in line with the total population of the county. Non-Hispanic Black make up 13.9% of Harford County population, but this demographic accounts for 29.2% of the total presentations in 2020. There is a disproportionate number of presentations of non-Hispanic black residents presenting to hospitals in Harford County for opioid overdose. This is also true for the state of Maryland as a whole. According to CRISP, this phenomenon is not localized to just Harford County. The number of presentations compared to the total percent of population of non-Hispanic black Maryland residents is disproportionate at the state level. The number of white residents in Maryland is more than three times the number of black residents, but black residents have almost the same number of presentations as white residents with white residents accounting for 49% of total presentations and black residents accounting for 45% of total presentations in CY 2020.

| CY 2020- CY 2022 Opioid Overdose Hospital Presentations by Age In Harford County | | | | | |
|---|---|---|---|---|---|
| | Opioid Overdose | | | | |
| **Age** | **CY 2020** | **CY 2021** | **% Change** | **CY 2022** | **% Change** |
| **<25** | 24 | 13 | -16.61% | 0 | -100.00% |
| **25-34** | 68 | 64 | -5.88% | 49 | -23.44% |
| **35-44** | 53 | 66 | 24.53% | 38 | -42.42% |
| **45-54** | 52 | 37 | -28.85% | 36 | -2.70% |
| **55+** | 169 | 163 | -3.55% | 136 | -16.56% |
| ****TOTAL** | **366** | **343** | **-6.28%** | **259** | **-24.49%** |

***Data Source: Health Services Cost Review Commission, CRISP Public Health Dashboard, January 2020 to October 2022, run date Dec. 14, 2022. Run on ED utilization for Overdose Hospital Events.

Figure 22

The above figure breaks down total overdoses in Harford County by age per calendar year. The 24 and under age group had a -16.6% decrease from 2020 to 2021. There were less than (11) eleven presentations for this group in 2022 so the data has been redacted. The 25-34 age group had a -5.9% change from 2020 to 2021 and a -23.4% change from 2021 to 2022. The 35–44 age group had 24.5% increase from 2020 to 2021 and a -42.4% change from 2021 to 2022. The 45-54 age group had a -28.9% change from 2020 to 2021 and a -2.7% change from 2021 to 2022. The largest category includes residents aged 55 to end of life. This group had a -3.6% change from 2020 to 2021 and a -16.6% change from 2021 to 2022. The data for 2022 is incomplete, and the totals are expected to rise.

A notable finding in the above table is the number of presentations for the 55+ category. This group encompasses a significantly larger percent of the population, and this may be why the number of overdoses in this category are so much higher. However, there have been studies looking at the 55+ age group and opioid overdose. A study that was held from 1999-2019 by the Department of Emergency Medicine, Northwestern University Feinberg School of Medicine, Chicago, Illinois found that in those 10 years, 79,893 people in the U.S. died from an opioid overdose. The annual overall death rate per 100,000 persons for this population ranged from a low of 0.9 in 1999 to a high of 10.7 in 2019 and increased annually from 2000 on. These results suggest a need for increased screening for substance use disorder among older adults along with outreach and treatment models adapted to their unique circumstances.

| CY 2020- CY 2022 Opioid Overdose Hospital Presentations by Gender in Harford County | | | | | |
|---|---|---|---|---|---|
| | Opioid Overdose | | | | |
| **Gender** | **CY 2020** | **CY 2021** | **% Change** | **CY 2022** | **% Change** |
| **Male** | 196 | 207 | 5.61% | 133 | -35.75% |
| **Female** | 179 | 137 | -23.46% | 138 | 0.73% |
| ****TOTAL** | **375** | **344** | **-8.27%** | **271** | **-21.22%** |

***Data Source: Health Services Cost Review Commission, CRISP Public Health Dashboard, January 2020 to October 2022, run date Dec. 14, 2022. Run on ED utilization for Overdose Hospital Events.

Figure 23

The figure above provides data on hospital presentation for overdose calendar years 2020 through October 2022 broken down by gender. During calendar years 2020-2022, hospital presentations for opioid overdose showed a 5.6% increase for males from 2020 to 2021 and a -33.8% decrease from 2021 to 2022. There was a -23.5% decrease for females from 2020 to 2021 and a 0.7% increase in 2022. The data for CY 2022 is incomplete, and Harford's LBHA expects the totals for both males and females to increase. Looking at the data for CY 2022, currently, there is an anomaly in that there are more female overdose presentations than male. It has been documented that Harford County males are more likely to experience an overdose than women. This is also true on the state level. This is the first time females have had more presentations than males. According to the National Safety Council, seven out of 10 preventable opioid overdose victims are male with 45,991 overdoses compared to 18,192 females in 2020. Since 1999, female opioid overdoses have increased at a faster pace than males at a rate of 1,326% for females versus 901% for males.

| CY 2020- CY 2022 Intoxication Deaths Comparison by Cause of Death: County Comparison | | | | | |
|---|---|---|---|---|---|
| | Intoxication Deaths | | | | |
| **Cause of Death** | **CY 2020** | **CY 2021** | **% Change** | **CY 2022** | **% Change** |
| **Opioid Related** | 101 | 110 | 8.91% | 85 | -22.73% |
| **Heroin** | 20 | 23 | 15.00% | <11 | <11 |
| **Prescription Opioids** | 94 | 19 | -79.79% | 24 | 26.32% |
| **Fentanyl** | 21 | 102 | 385.71% | 73 | -28.43% |
| **Cocaine** | 37 | 55 | 48.65% | 34 | -38.18% |
| ****TOTAL** | **273** | **309** | **13.19%** | **216** | **-30.10%** |

***Data Source: MDH-VSA based on data through 12/21/2022.
***Data for CY 2021/22 are not complete and are subject to change.
***Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum the total number of deaths.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 24

Referring to Figure 24, the most notable change occurred in calendar year 2021, as there was a 385.7% increase in the number of fentanyl intoxication deaths. Presently, we are unable to compare this significant change to statewide data; however, when the Maryland Department of Health-Vital Statistics Administration (MDH-VSA) releases its 2021 Unintentional Drug and Alcohol-Related Intoxication Death annual report, the LBHA will use this information to guide, support, and make changes to local system planning processes. This increase is comparable to state totals in calendar years 2015 and 2016 when there was a 229.1% increase in fentanyl intoxication deaths. After seeing the number of fentanyl related intoxication deaths in calendar years 2021 and 2022, it appears Harford County is experiencing a trend where most of its intoxication deaths are fentanyl related. The increase in the number of fentanyl-related intoxication deaths was expected as the number of fentanyl-related intoxication deaths has rapidly increased statewide since 2013; however, the rate of increase was not expected.

Another significant change that occurred in 2021 was a 79.8% decrease in the number of prescription opioid intoxication deaths. This too, appears to be a trend as the number of prescription opioid intoxication deaths is also decreasing in calendar year 2022. As mentioned in the paragraph above, the LBHA is waiting for the 2021 Unintentional Drug and Alcohol-Related Intoxication Death annual report to see if this trend is comparable to statewide data.

| CY 2020- CY 2022 Intoxication Deaths Comparison by Race/Ethnicity: County Comparison | | | | | |
|---|---|---|---|---|---|
| | Intoxication Deaths | | | | |
| Cause of Death | CY 2020 | CY 2021 | % Change | CY 2022 | % Change |
| NH Asian Pacific Islander | <11 | <11 | <11 | <11 | <11 |
| NH Black | 21 | 26 | 23.81% | 17 | -34.62% |
| Hispanic | <11 | <11 | <11 | <11 | <11 |
| NH Other | 0 | <11 | <11 | <11 | <11 |
| NH White | 88 | 95 | 7.95% | 77 | -18.95% |
| **TOTAL | 109 | 121 | 11.01% | 94 | -22.31% |

***Data Source: MDH-VSA based on data through 12/21/2022.
***Data for CY 2021/22 are not complete and are subject to change.
***Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum the total number of deaths.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 25

The above data compares local intoxication deaths by race/ethnicity over a three-year period. The data shows that Non-Hispanic (NH) Whites and NH Blacks account for most of the intoxication deaths in Harford County. This trend is similar to statewide trends in that at least 95% of all intoxication deaths (statewide) between the calendar years 2011 and 2020 have been experienced by individuals in the NH White and NH Black categories. Another trend that has been occurring in both Harford County and the State is an increase in the number of NH Black intoxication deaths yearly. Statewide, each year, between the calendar years of 2011 and 2020, the number NH Black intoxication deaths have increased by various percentages, ranging 4.8% to 46.5%. Referring to the table above, one can see Harford County has been experiencing this same yearly trend. However, this trend seems to have been interrupted. The decrease in the number of NH White and NH Black intoxications deaths in calendar year 2022 was not expected; however, the LBHA understands calendar year 2022 data is not complete and subject to change. The LBHA looks forward to comparing this unexpected change with statewide data for calendar year 2022.

Of particular importance is NH Blacks are experiencing fatal intoxication deaths at a disproportionate rate when compared to NH whites. Below is a table to demonstrates Harford County's intoxication death mortality rate (per 100,000 population) by race and ethnicity.

| CY 2020-CY 2022 Intoxication Deaths Mortality Rate (per 100,000) Comparison by Race/Ethnicity: County Comparison | | | |
|---|---|---|---|
| | Intoxication Deaths | | |
| **Cause of Death** | **CY 2020** | **CY 2021** | **CY 2022** |
| **NH White** | 45 | 45 | 39 |
| **NH Black** | 54 | 65 | 44 |
| ****TOTAL** | **111** | **125** | **99** |

***Data Source: US Census Bureau based on Harford County population estimates through July 2022.
***Data Source: MDH-VSA based on data through 12/21/2022.
***Data for CY 2021/22 are not complete and are subject to change.
***Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum the total number of deaths.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 26

| CY 2020- CY 2022 Intoxication Deaths Comparison by Gender: County Comparison | | | | | |
|---|---|---|---|---|---|
| | Intoxication Deaths | | | | |
| **Cause of Death** | **CY 2020** | **CY 2021** | **% Change** | **CY 2022** | **% Change** |
| **Male** | 73 | 97 | 32.88% | 84 | -13.40% |
| **Female** | 38 | 28 | -26.32% | 15 | -46.43% |
| ****TOTAL** | **111** | **125** | **12.61%** | **99** | **-20.80%** |

***Data Source: MDH-VSA based on data through 12/21/2022.
***Data for CY 2021/22 are not complete and are subject to change.
***Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum the total number of deaths.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 27

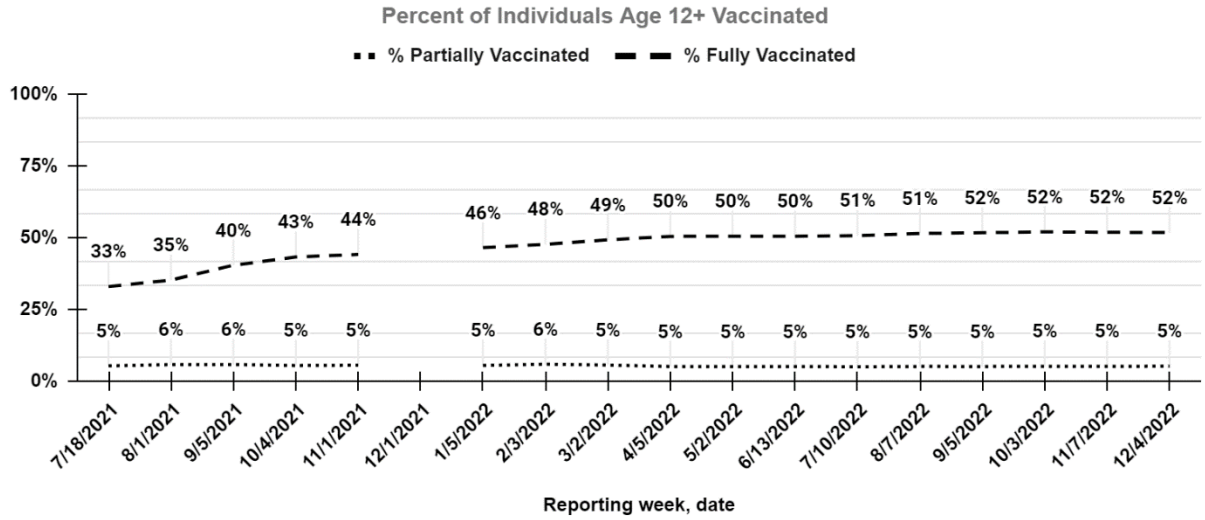
As seen in the table above males have experienced more intoxication deaths than females. Between calendar years 2020 and 2022 local data shows men account for approximately 75 percent of all intoxication deaths. Calendar year 2022 data, which is not final and subject to change, is showing that 84.9% of all local intoxication deaths were experienced by males. Furthermore, there was a significant decrease (-60.5%) from CY 2020 to CY 2022 in the number of intoxication deaths experienced by females. Harford County's LBHA was expecting males to encounter intoxication deaths at a higher rate than females; however, the LBHA did not anticipate the notable decrease in the number of intoxication deaths experienced by females.

| CY 2020- CY 2022 Intoxication Deaths Comparison by Age: County Comparison | | | | | |
|---|---|---|---|---|---|
| | Intoxication Deaths | | | | |
| Cause of Death | CY 2020 | CY 2021 | % Change | CY 2022 | % Change |
| **<25** | <11 | <11 | <11 | <11 | <11 |
| **25-34** | 36 | 35 | -2.78% | 24 | -31.43% |
| **35-44** | 33 | 29 | -12.12% | 22 | -24.14% |
| **45-54** | 18 | 25 | 38.89% | 20 | -20.00% |
| **55+** | 19 | 28 | 47.37% | 27 | -3.57% |
| **Blank** | 0 | 0 | 0.00% | <11 | <11 |
| ****TOTAL** | **106** | **117** | **10.38%** | **93** | **-18.80%** |
| | Average | | | | |
| **<25** | <11 | <11 | | <11 | |
| **25-34** | 33.96% | 29.91% | | 25.81% | |
| **35-44** | 31.13% | 24.79% | | 23.66% | |
| **45-54** | 16.98% | 21.37% | | 21.51% | |
| **55+** | 17.92% | 23.93% | | 29.03% | |
| **Blank** | 0.00% | 0.00% | | 0 | |
| ****TOTAL** | 100.00% | 100.00% | | 100.00% | |

***Data Source: MDH-VSA based on data through 12/21/2022.
***Data for CY 2021/22 are not complete and are subject to change.
***Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum the total number of deaths.
***Due to Potentially Identifiable Information (PII), any numbers between 1-10 are suppressed and represented as "<11".

Figure 28

The table above compares local intoxication death data by age. The data shows that between calendar years 2020 and 2021 there was an increase in the age groups of 45-54 and 55+. These groups accounted for approximately 45% of all local intoxication deaths in calendar year 2021. This is similar to statewide data in which these age groups accounted for approximately 51% of all intoxication deaths statewide. The increases in these age groups (45-54 and 55+) have balanced out the percentages in all age groups other than <25, making each group account for approximately 20% to 30% of all intoxication deaths. Another notable change can be seen between calendar years 2021 and 2022. Between these calendar years, intoxication deaths decreased in all age groups. This change is the result of an overall decrease in the total number of local intoxication deaths. The LBHA attributes the decrease in the total number of intoxication deaths to local initiatives including, (1) Overdose Education and Naloxone Distribution (OEND) efforts, (2) an increase in the number of behavioral health treatment providers and peer support services, (3) overdose survivor outreach programming, and (4) recommendations implemented by the Local Overdose Fatality Review Team (LOFRT).

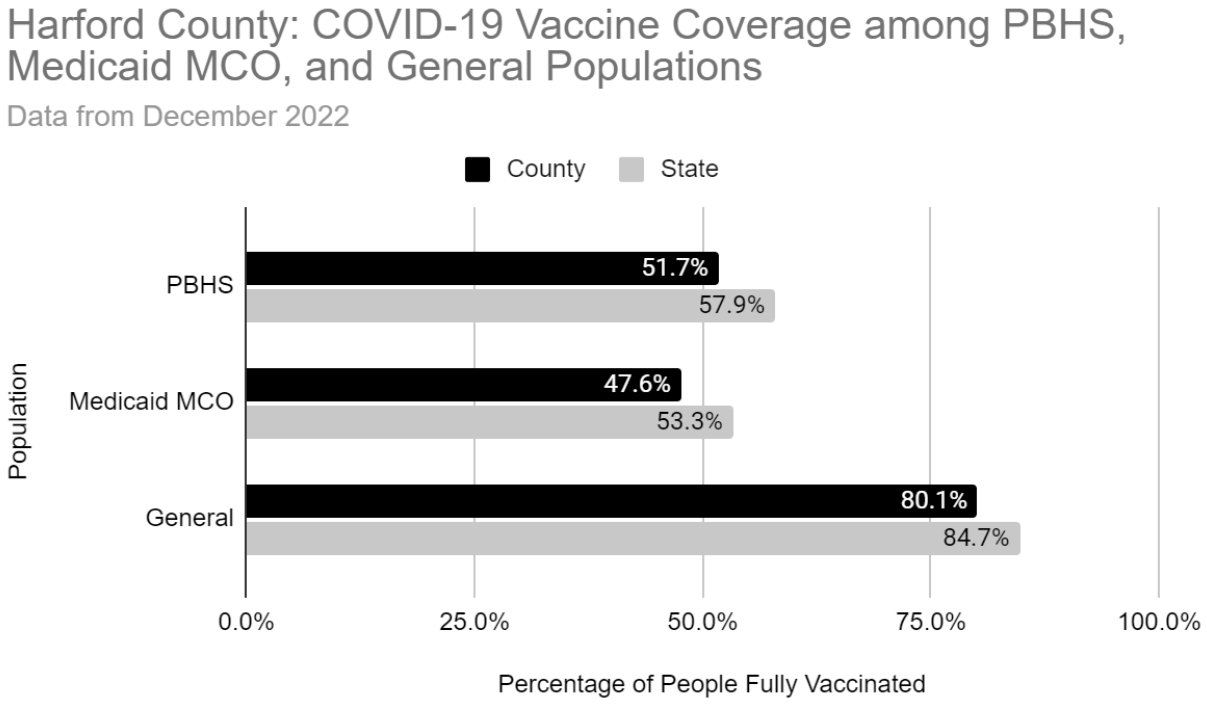



***Data Source: Optum ASO claims data through 12/4/2022.
***Excluding Out of State Individuals, Out of State Providers and Individuals with Only Assessment/Evaluation, Inpatient, Emergency Room, Laboratory Services.

Figure 29

The above graph illustrates trends in COVID-19 vaccination coverage over time for PBHS service recipients (age 12+) in Harford County. The graph shows that between July 2021 and December 2022, there has been a 19% increase in the number of PBHS recipients who have become fully vaccinated. However, this increase becomes stagnant around April 2022, and since that timeframe rates have increased by only 2%. Claims data also identified local PBHS providers with the lowest vaccination percentages (min 25 unvaccinated as 12/9/2022), all of which are SUD providers. The LBHA expected fully vaccination rates to be low, as studies have found that people affected by SUD express hesitation to get the COVID-19 vaccine[1].

[1] Alexandra M. Mellis et al., "Trust in a COVID-19 Vaccine among People with Substance Use Disorders," *Drug and Alcohol Dependence* 220 (March 2021): 108519, https://doi.org/10.1016/j.drugalcdep.2021.108519.




***Data Source: Optum ASO claims data through 12/4/2022.
***Excluding Out of State Individuals, Out of State Providers and Individuals with Only Assessment/Evaluation, Inpatient, Emergency Room, Laboratory Services.

Figure 30

Figure 30 compares vaccination percentages across PBHS, Medicaid MCO, and general populations. At first glance, one can see the differences between County and State percentages are minimal. Although differences between County and State vaccination rates are minor, the LBHA would like to see an increase in the number of PBHS service recipients who are vaccinated. For this reason, the LBHA will continue to work with the BHA's Vaccine Equity Team.

In April 2022, the Harford County LBHA began collaborating with the Vaccine Equity Team to increase COVID-19 vaccination rates in the local PBHS. During this time, the LBHA assisted in connecting the Vaccine Equity Team with local behavioral health treatment providers who were identified as having high percentages of unvaccinated patient populations. To this date, the LBHA had worked with the Vaccine Equity Team to provide connections to four OTPs and one Residential program. The Vaccine Equity Team connected these providers to pharmacies that established pop-up vaccination clinics at the treatment facilities' location. Further collaboration between the LBHA and Vaccine Equity Team occurred during the September 2022 Harford County All Provider Meeting. At this meeting, BHA's Vaccine Coordinator presented opportunities for partnerships between local behavioral health treatment providers and pharmacies. Going forward, the LBHA will continue to work with the Vaccine Equity Team to help reduce the burden of COVID-19 on local behavioral health treatment providers.

## E. Systems Management Integration

**F. Cultural and Linguistic Competence (CLC)**

## NATIONAL CLAS STANDARDS SELF-ASSESSMENT TOOL (LAA)

| **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) | | | | 3 |
| 2 | We have established culturally and linguistically appropriate goals, management accountability and infused them throughout the organization's planning and operations. (Standard 9) | | | | 3 |
| 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) | | | 2 | |
| | | | | | |
| **GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS OF BEHAVIORAL HEALTH SERVICES** | | | | | |
| 1 | We offer language assistance to individuals with limited English proficiency (LEP) and/or other language and communication needs including individuals who use American Sign Language, at no cost to them, to facilitate timely access to behavioral health services. (Standard 5) | | | | 3 |
| 2 | We inform all individuals of the availability of spoken, signed, and written professional language assistance services in their preferred language or form of communication. (Standard 6) | | | 2 | |

| | | | | | |
|---|---|---|---|---|---|
| 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) | | | | 3 |
| 4 | We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community. (Standard 8) | | | | 3 |
| | | | | | |
| **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) | | | | 3 |
| 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) | | | | 3 |
| | | | | | |
| **GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS SERVED IN MARLYAND'S PBHS** | | | | | |
| 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) | | | | 3 |
| 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) | | | 2 | |
| 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) | | 1 | | |

## *COVER PAGE*

**(a) Name of Agency/Organization:** Harford County Health Department (HCHD), Behavioral Health Bureau, Local Addictions Authority (LAA)

**(b) Address:** 120 S. Hays St., Bel Air, Maryland 21014

**(c) Region (MDH/BHA designated region):** Harford County

**(d) Name of contact person (Agency/Organization Lead or Designee):** Shawn Martin

**(e) Brief overview of services provided by agency/organization(***no more than 95 words***):**

The Harford County Local Addiction Authority (LAA) provides oversight, management, and direction for publicly funded behavioral health services in the Harford County. The LAA coupled with the Office on Mental Health/Core Service Services Agency of Harford County, Inc (CSA) comprise the Local Behavioral Health Authority (LBHA). The LAA provides behavioral health systems development and planning, substance use disorder (SUD) provider education, grant monitoring and management, community education, promotion of behavioral health integration among providers, and technical assistance.

**(f) Agency/organization mission statement:** To protect, promote, and improve the health, safety, and environment of Harford County residents.

**(g) Agency/organization vision statement:** To make Harford County the healthiest community in Maryland.

**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 local behavioral health advisory and All Provider Meeting to communicate the LAA's progress in implementing and sustaining CLAS, highlighting available programs that incorporate cultural and linguistic competency

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

- # of All Provider Meetings addressing CLAS
- # of local behavioral health advisory council meetings addressing CLAS

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*

- Stakeholders, constituents, and the general public will be educated about the role of the LAA and CLC appropriate services available.

**Goal 2: Eliminate cultural and linguistic barriers to access 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 inform all individuals of the availability of spoken, signed, and written professional language assistance services in their preferred language or form of communication. (Standard 6)

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

*prioritized standard):*

- Evaluate existing written materials to verify that all individuals are informed of the availability of language assistance services.
- Develop written materials and signage informing individuals of the availability of language assistance services for initial encounters and entrances respectively.

- Written materials will be in the individuals' preferred language.
- Review HCHD LEP Tracking Form to identify emerging trends related to emerging language access needs.

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

- # of written materials and signage developed that inform individuals of language assistance
- # of request for language services yearly
- Review HCHD LEP Tracking from quarterly to identify emerging trends related to emerging language access needs.

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*

- Facilitate access to language assistance services to ensure that language is not a barrier to services

**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 a 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):*

- The LAA will collaborate with HCHD's Population Health Bureau to compile accurate and reliable demographic data specific to Harford County
- Identify locations and availability of local PBHS services
- Utilize gathered data to ensure that the cultural and linguistic needs of the community are being met and identify any gaps in services
- Collaborate with local advisory council and behavioral health service providers to implement initiatives addressing any unmet needs locally.

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

- # of meeting held with HCHD's Population Health Bureau
- # of meeting held with local advisory council and behavioral health service providers

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*

- Analyze service delivery through the lens of accurate and reliable data in order to more accurately and efficiently deliver services

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

***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 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):*

- Cultural and linguistic goals, objectives, and performance measures will be integrated into LAA programs.
- Review all programs annually to ensure that CLAS-related goals, objectives, and performance measures are being met.

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

- % of LAA programs with CLAS-related goals, objectives, and performance measures
- % CLAS-related goals, objectives, and performance measures that are being met

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*

- Allows LAA to integrate cultural and linguistic competency as a standard in all programs

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

***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 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)

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

- Working in conjunction with the HCHD, the LAA will arrange training in cultural and linguistic competency, as well as health equity for member of our governing body, leadership, and staff.

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

- # of training conducted

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*

- Will ensure a culturally competent workforce and leadership sensitive to the cultural and linguistic needs of the community

## NATIONAL CLAS STANDARDS SELF-ASSESSMENT TOOL (CSA)

| **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 **X** | 3 |
| 2 | We have established culturally and linguistically appropriate goals, management accountability and infused them throughout the organization's planning and operations. (Standard 9) | | | **X** | |
| 3 | Our organizational governance and leadership promote and use CLAS standards in policies, practices, and allocation of resources. (Standard 2) | | | **X** | |
| 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) | | | **X** | |
| 5 | We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (Standard 15) | | **X** | | |
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| **GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS OF BEHAVIORAL HEALTH SERVICES** | | | | | |
| 1 | We offer language assistance to individuals with limited English proficiency (LEP) and/or other language and communication needs including individuals who use American Sign Language, at no cost to them, to facilitate timely access to behavioral health services. (Standard 5) | | | **X** | |
| 2 | We inform all individuals of the availability of spoken, signed, and written professional language assistance services in their preferred language or form of communication. (Standard 6) | | **X** | | |
| 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) | | **X** | | |
| 4 | We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community. (Standard 8) | | | **X** | |
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|---|---|---|---|---|---|
| **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) | | **X** | | |
| 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) | | **X** | | |
| | | | | | |
| **GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS SERVED IN MARLYAND'S PBHS** | | | | | |
| 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) | | | **X** | |
| 2 | We partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. (Standard 13) | | | **X** | |
| | | | | | |
| **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) | | | **X** | |
| 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) | | | **X** | |
| | | | | | |

## *COVER PAGE*

**(a) Name of Agency/Organization: Office on Mental Health/Core Service Agency of Harford County, Inc. (OMH/CSA)**

**(b) Address: 2231 Conowingo Road, Suite A, Bel Air MD 21015**

**(c) Region (MDH/BHA designated region): Harford County**

**(d) Name of contact person (Agency/Organization Lead or Designee): Jessica Kraus**

**(e) Brief overview of services provided by agency/organization (***no more than 95 words***):**
The Office on Mental Health/Core Service Agency of Harford County, Inc. (OMH/CSA) is a private non-profit organization, developed in 1997, to promote and support the development of accessible, high quality, community-based behavioral health services. As a systems manager, the OMH/CSA oversees, develops, monitors, identifies community needs, promotes resolutions, and advocates for people engaged in the public behavioral health system.

**(h) Agency/organization mission statement:**
The mission of the Office on Mental Health is to plan, promote, monitor, and work collaboratively to ensure quality behavioral health services throughout Harford County.

**(i) Agency/organization vision statement:**
The OMH/CSA works towards a comprehensive, community-based, culturally sensitive, and recovery-oriented behavioral health system.

## 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):*

*The OMH/CSA staff will attend Master Classes provided by the DEI consultant. Staff will develop and improve awareness and skills to work ethically, efficiently, and effectively with people from diverse cultures and ethnic groups.*

***Performance Measures*** *(How will success be measured)*
*OMH/CSA staff will complete at least 20 hours of cultural and linguistic competency training per fiscal year, regarding new ideas and successful approaches to implementing the National CLAS Standards.*

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*
*To build and sustain communication on CLAS priorities and foster trust between behavioral health providers, the CSA, and the general public. Convey information about the OMH/CSA's efforts and accomplishments on addressing the needs of diverse individuals or groups.*

**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 provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community. (Standard 8)*

***Strategies to build competency*** *(What tasks and activities will be implemented to build competency for the prioritized standard):*
*The OMH/CSA will host focus group discussions with stakeholders and participants of behavioral health services to help identify content and material that may be considered offensive and gather suggestions on alternative language to be used. The OMH/CSA will issue plain language guidance and create documents that demonstrate the best practices in clear communication and information design. Forms will be revised to ensure they are easy to fill out and provide contact information if assistance is needed.*

***Performance Measures*** *(How will success be measured):*
*On a bi-annual basis, the OMH/CSA will collect and analyze community feedback regarding the access, utilization, and appropriateness of materials and forms.*

***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*
*The OMH/CSA's materials and forms will be easily accessible, make a positive impact on service utilization, and reduce stigma associated with accessing behavioral health services.*

| **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):*<br>*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.*<br>*(Standard 12)* |
| ***Strategies to build competency*** *(What tasks and activities will be implemented to build competency for the prioritized standard):*<br>*The OMH/CSA will conduct community needs assessments to identify behavioral health services available, as well as review gaps in services in Harford County. The needs assessment will focus on meeting the cultural and linguistic needs of under-served and diverse populations.* |
| ***Performance Measures*** *(How will success be measured)*<br>*Data from the community needs assessments will be collected and analyzed to determine what services need to be provided and create strategies for implementation.* |
| ***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*<br>*Evaluate services and identify gaps to create accessible and competent behavioral health services, focused on meeting the needs of under-served and diverse populations.* |

| **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):*<br>*We partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. (Standard 13)* |
| ***Strategies to build competency*** *(What tasks and activities will be implemented to build competency for the prioritized standard):*<br>*Develop a forum and/or conduct focus groups with EBP service providers to identify where disparities and disproportionalities exist in the public behavioral health system. Partner with behavioral health service providers to develop a learning collaborative to share information, build initiatives, empower the community, and improve services to diverse populations.* |
| ***Performance Measures*** *(How will success be measured):* |

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|---|
| *Results gathered from the annual community needs assessment will be analyzed to determine if disparities are being reduced and eliminated among EBP and behavioral health service providers.* |
| ***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*<br>*Evidence-based practices are culturally and linguistically appropriate to meet the needs of diverse populations being served.* |

| **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 orientation CLAS Self-Assessment Tool):*<br>*We provide 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)* |
| ***Strategies to build competency*** *(What tasks and activities will be implemented to build competency for the prioritized standard):*<br>*The OMH/CSA will incorporate cultural competency and CLAS into staff evaluations. The OMH/CSA will allocate resources to train current staff in cultural competency to include ongoing in-service trainings, to effectively meet the unique needs of diverse populations.* |
| ***Performance Measures*** *(How will success be measured):*<br>*Staff progress will be evaluated to determine success in achieving cultural, linguistic and health literacy competency. Training evaluations will be used to determine effectiveness, capacity building, and impact on behavioral change.* |
| ***Intended impact*** *(What is the intended impact for addressing the prioritized/selected Standard):*<br>*To institute cultural and linguistic competence where staff demonstrate the attitudes, knowledge, and skills necessary to work effectively with diverse populations.* |

### *Cumulative Assessment of Progress to Date*

*CSAs, LAAs and LHBAs receiving funding from the MDH/BHA have been required to submit Cultural and Linguistic Competency Strategic Plans (CLCSP) as part of their overall fiscal year planning process. This process began in FY 2020-2021 and continues to be a requirement.*

*As agencies begin establishing goals for the FY 2024-2026 CLCSP, consider assessing what has been the impact and/or progress made regarding goals established with your 2022-2023 CLCSP. This will assist in the process for determining key areas for further capacity building that can and should be reflected in the current process for CLCSP. Below is offered some critical questions to ask:*

1. *What has been accomplished?*

The OMH/CSA has begun utilizing a learning management system and modules related to Cultural Competency and Diversity, which all staff complete annually. Additionally, in FY 2022, the OMH/CSA hired a consultant, Dr. Gold, to assist with strengthening Diversity, Equity, & Inclusion (DE&I) practices within the agency. Dr Gold is an educator, higher education administrator, ordained minister, and highly sought-after consultant in the equity and inclusion marketplace. The initial step of the initiative was to have all OMH/CSA staff participate in a kickoff event to provide clarification on the agency's mission, vision, and goals. Next, an anonymous survey was developed and disseminated amongst all staff to gauge the climate of the agency's internal practices. Once staff completed the survey, Dr. Gold gathered the data and facilitated a series of open dialogue sessions to discuss the survey results and code themes, in order to suggest action items and professional development trainings. Dr. Gold also reviewed OMH/CSA's personal policies and procedures to provide feedback and recommendations regarding the use of gender-neutral language and inclusive practices. In FY 2023, Dr. Gold and her consulting team will be leading various workshops and master classes on topics such as inclusion essentials for interrupting bias, concepts concerning various types of privilege, community cultural wealth, multicultural perspectives, and concepts concerning demystifying binary approaches to gender and socioeconomic disparities. The leadership team with OMH/CSA will take an additional course relating to aspiring DEI organizational changes. Dr. Gold will assist the leadership team with development and implementation of a sustainability plan, so OMH/CSA can continue to strengthen its practices by utilizing multi-perspective approaches in future decision making within the agency.

2. *What has been the impact?*

All OMH/CSA staff have been included in participating and providing valuable feedback to leadership in order to make necessary changes to create a more inclusive work environment. This has made staff feel appreciated and invested in being part of the change. The OMH/CSA will incorporate cultural competency and CLAS into staff evaluations to ensure the training offered is being put into practice. The OMH/CSA will continue to allocate resources to train new and current staff in cultural competency to include ongoing in-service trainings, to effectively meet the unique needs of diverse populations.

3. *What has not been accomplished and why?*

The OMH/CSA still needs to develop a forum and/or conduct focus groups with EBP service providers to identify where disparities and disproportionalities exist in the public behavioral health system. While the OMH/CSA does meet with all service providers monthly, a forum still

needs to be developed to focus on EBP. While some progress has been made, it has not been accomplished as the OMH/CSA has placed on priority on the other strategies.

*4. What still needs to be addressed and why?*

OMH/CSA still needs to build and sustain communication on CLAS priorities and foster trust between behavioral health providers and the general public. OMH/CSA will provide information about the OMH/CSA's efforts and accomplishments on addressing the needs of diverse individuals or groups. This has not been addressed with community providers and general public because OMH/CSA had to evaluate and master their own internal processes before relating information outside the organization.

Another area still needing to be addressed is to evaluate services and identify gaps to create accessible and competent behavioral health services, focused on meeting the needs of under-served and diverse populations. This has not been addressed because OMH/CSA staff need the proper training in these areas, so they can effectively assess and evaluate programs. The master classes offered this year should give staff the knowledge and tools to identify gaps and barriers within the behavioral health services among diverse populations.

*5. How will it be addressed relative to the 2024-2026 CLCSP?*

The OMH/CSA will host focus group discussions with stakeholders and participants of behavioral health services to help identify content and material that may be considered offensive and gather suggestions on alternative language to be used. The OMH/CSA will issue plain language guidance and create documents that demonstrate the best practices in clear communication and information design. Forms will be revised to ensure they are easy to fill out and provide contact information if assistance is needed.

The OMH/CSA will conduct community needs assessments to identify behavioral health services available, as well as review gaps and barriers to meeting the cultural and linguistic needs of under-served and diverse populations in Harford County.

**G. Sub-Grantee Monitoring**

The Harford County Local Behavioral Health Authority (LBHA) remains committed to monitoring sub-grantee providers and other service providers to ensure compliance with the Conditions of Award/Scope of Work (COA/SOW) and with the Administrative Service Organization data entry and reporting requirements. This year, the Harford County LBHA will resume in person monitoring of all documentation and other criteria related to the Conditions of Award/Scope of Work. Additionally, a representative from the fiscal department will accompany the coordinators to the site visits to conduct a more thorough real time review of the provider's general ledgers. In FY 2023, the OMH/CSA added a Grants Specialist position to the administrative team. The primary duties of this position are to complete regular on-site monitoring visits, review all measures listed in the Conditions of Award and Scope of Work to ensure compliance, and provide technical assistance and support as needed. The Grants

Specialist will be responsible for completing internal Scope of Services forms which capture all elements from the COA/SOW, as well as write narratives to detail all site visits.

At a minimum, the Harford County LBHA conducts annual on-site monitoring of sub-grantee providers and other service providers, such as Targeted Case Management for Adults and the Care Coordination Organization. On-site monitoring visits allow for the coordinators to review all items in the Conditions of Award/Scope of Work to determine compliance. The coordinators complete a Scope of Services form, capturing all the elements from the COA, and write a narrative to detail the site visit. In addition to capturing progress made on performance measures the coordinators and the grants specialist review other areas for compliance. These areas include ensuring proper licenses, certifications, and accreditations are current, programs are on target to meet outcomes, and verifying proper use of grant funding. Should there be a need, the coordinators are responsible for providing technical assistance, conducting follow-up site visits, providing additional training, and/or completing a Corrective Action Plan. There may be cases where service termination is necessary for non-compliance. This would occur when the provider is unable to meet performance measures, misappropriation of grant funding, noncompliance with corrective action plans, and unable to fulfill contract requirements. Copies of these reports are forwarded to the provider and the Behavioral Health Administration (BHA).

In addition, the Harford County LBHA reviews the Maryland Department of Health 438 Form which the sub-grantee providers submit monthly. If there are any line items on the 438 that are significantly over or under expended, the responsible coordinator will contact the provider to gain additional information. The coordinators also ensure the sub-grantee is submitting reports on time, which the coordinator will then forward to the appropriate BHA Program staff. If the provider submits inaccurate or late reports, the coordinators will not approve the 438 forms until resolved. The approved 438 forms are then given to the Finance Department for payment as outlined on the draw payment schedule. The Harford County LBHA follows a six-draw payment schedule for the sub-grantee providers. The contracts between the Harford County LBHA and sub-grantee state providers must submit all required forms by the 35$^{th}$ day after month end for payment.

For other service providers, the Harford County LBHA conducts site visits to ensure compliance with the Code of Maryland Regulations (COMAR). Monitoring tools and narratives are also completed for these site visits and then forwarded to the provider and the BHA Program staff. Providers responsible for entering data into the Administrative Service Organization website are also reviewed, and providers are contacted when discrepancies exist. The Harford County LBHA reviews Residential Bed hold requests for Residential Rehabilitation Programs, crisis residential bed authorizations, and uninsured requests. If there is an issue, the Harford County LBHA immediately contacts the provider for additional information. This information is recorded in the authorization request.

To avoid a potential conflict of interest, a current conflict of interest, or the appearance of a conflict of interest as a result of locating both direct service provision and system management functions of the LAA within the Health Department, the Office on Mental Health/Core Service

Agency (OMH/CSA) reviews and analyzes client-level data for levels of care provided by both the Health Department and community providers, investigates complaints and grievances, attends program audits, and reviews uninsured authorizations requested that the Health Department cannot or should not do.

## H. Plan Approval

Mental Health & Addictions Advisory Council

Public Health
Prevent. Promote. Protect.
Harford County Health Department

HARFORD COUNTY LHIC

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**Stephanie Slowly**
**Deputy Director Systems Management**
**Behavioral Health Administration**
**Spring Grove Hospital Center**
**55 Wade Ave., Dix Building**
**Catonsville, MD 21228**

**January 27, 2023**

**Dear Ms. Slowly,**

**The Harford County Local Behavioral Health Authority presented their Three-Year Strategic Plan to the Harford County Mental Health and Addictions Advisory Council (MHAAC). The Harford County MHAAC is a comprehensive collaborative of community behavioral health stakeholders including Local Health Improvement Coalition (LHIC) Behavioral Health Workgroup members, behavioral health service providers, families affected by behavioral health challenges, Addictions Connection Resources, law enforcement, public schools, local hospitals, and others.**

**After reviewing the Local Behavioral Health Authority's Annual Plan, the MHAAC supports the implementation of this plan for FY 2024-2026 and looks forward to continued collaboration with the Harford County Local Behavioral Health Authority to address mental health, substance, and recovery in Harford County.**

**Respectfully,**

Bari Klein

**Bari Klein**

**MHAAC Chairperson**

**Harford County Health Department**
**Division of Behavioral Health**
**120 S. Hays Street**
**Bel Air, MD 21014**
**410-877-2340**

**Harford County Government**
**Department of Community Services - ODCP**
**125 N. Main Street**
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**Office on Mental Health**
**Core Service Agency of Harford County**
**2231 Conowingo Rd., Suite A**
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**410-803-8726**