University of Maryland Center for Infant Study/School Mental Health Program (CIS/SMH)

July 1, 2020- June 30, 2021

Annual Performance Analysis Report

Contents

Program Mission and Vision

The mission of the CIS/SMH on-site and off-site multidisciplinary teams is to offer a full continuum of high quality, effective mental health service to children, youth, and their families. CIS/SMH Program's multidisciplinary teams provide child and family centered care each year to up to 300 infants, toddlers, preschoolers, and youth through age 21 and their families. Staff is trained in evidence-based, developmentally appropriate practices for a range of social emotional challenges and mental health disorders and treatment plans are outcome focused, strengths-based, and family- and youth-driven. The off-site team provides prevention and treatment services to primarily regular education students in 21 Public Schools located in Baltimore City. The CIS/SMH clinicians participate in a wide variety of University related activities, including the training of pre-service mental health professionals through internships and fellowships, certificate programs, as well as presenting and helping to facilitate local, state, and national conferences. Staff members provide consultation and technical assistance to local public schools and are engaged in multiple collaborations through Maryland's System of Care. The CIS/SMH Program works closely with its affiliated National Center for School Mental Health (NCSMH), a national resource center for advancing research, training, policy, and practice in school mental health and the Taghi Modarressi Center for Infant Study, a center of excellence in infant and early childhood mental health for training and consultation at the local, state, and national levels. Partnerships with these two Centers helps to inform and ensure the provision of high quality, sustainable child, and adolescent mental health services.

Program Description

The Center for Infant Study/School Mental Health Program (CIS/SMH), a program within the Division of Child and Adolescent Psychiatry, University of Maryland School of Medicine (UMSOM) operates under the administrative, clinical, and medical direction of Dr. Sarah Edwards. On the University of Maryland's Baltimore campus, the School of Medicine serves as the anchor for a large academic health center which provides high quality medical education, research and client care and community service to Maryland and beyond. On campus, the CIS/SMH Program is affiliated with the University of Maryland Medical Center, one of the nation's oldest academic medical centers. Our faculty and trainees are credentialed through the University of Maryland Medical System. Another key affiliate organization for the CIS/SMH Program is the University of Maryland Faculty Physicians, Inc. (FPI). FPI coordinates and supports the clinical activities of the University of Maryland School of Medicine. In partnership with the administrative team of the Division of Child and Adolescent Psychiatry and the leadership of the Department of Psychiatry, FPI provides administrative support and offers business functions such as program development, finance, information technology, compliance, legal affairs, practice operations support, and reimbursement management.

The Center for Infant Study was founded in 1982 by Dr. Taghi Modarressi, Associate Professor of Psychiatry and a pioneer in early childhood mental health. The Center was unique in that it offered psychiatric care for children three and under and eventually expanded services to children up to age six and their families. The

University of Maryland School Mental Health Program was formed in 1989 under the direction of Dr. Lois Flaherty, a child psychiatrist who would become a leading figure in the school mental health movement. In January 2001, the Center for Infant Study began a partnership with the University of Maryland School Mental Health Program to become the CIS/SMH Program in an effort to broaden the continuum of care and improve administrative efficiencies. In November of 2003, the CIS/SMH was approved through Maryland's Department of Health and Mental Hygiene Office of Health Care Quality as an outpatient mental health clinic. This merger allowed for the CIS/SMH Program to expand public mental health services to young children, youth and families in Baltimore and surrounding counties, both onsite and offsite through partnerships with early education, elementary, middle, and high schools.

Organizational Overview

The information below highlights key programmatic, leadership, structural, and demographic details of the Center for Infant Study/School Mental Health Program (CIS/SMH).

Program Name	Division Name
Center for Infant Study/School Mental Health program (CIS/SMH)	Division of Child and Adolescent Psychiatry

Parent Organization	Administrating Organization
Department of Psychiatry, University of Maryland School of Medicine	Psychiatry Associates P.A, University of Maryland Faculty Physicians, Inc. University of Maryland Medical Center-Risk Management and Medical Staffing Office

Medical Director	Directors
Sarah Edwards, DO	Nancy Lever, PhD and Kay Connors, LCSW-C Jennifer Cox, LCSW-C Brijan Fellows, LCSW-C

Practice Manager	Medical Billing
Tyeisha Johnson	Kim Erskine, MBS, Inc.

State Licensing & Certifying Agencies	
Maryland Behavioral Health Administration	Maryland Office of Health Care Quality

Accreditation
Commission on Accrediting of Rehabilitation Facilities International – CARF International- **3- year accreditation awarded May 2016 and May 2019**

Population Served/Demographics

The CIS/SMH Program works closely with children, youth and their caregivers, relatives or guardians or foster care families, as well as teachers, childcare providers and other collateral providers (e.g., primary care, speech therapists, school employed mental health staff etc.) to provide child, family and community centered care for children and youth displaying mental health problems and/or behavioral problems and in need of early intervention to support developmental growth and well-being. It is our commitment as a program to support growth and development of families from birth to the age of 21 in a seamless child service delivery line by providing quality care that is culturally and developmentally sensitive.

Client Demographics	
Current Program Census: 284	Number of Clients Served: 286

Client Demographics by Gender	
Number of Female Clients: 144	Number of Male Clients: 142

Client Demographics by Race	
African American: 227	Caucasians: 42
Hispanic/Latino: 0	Native American: 0
Asian/Pacific Islander: 6	Oher/Undeclared: 11

Client Demographics by Age Range	
Ages 0 to 5: 75	Ages 6 to 18: 211

Settings

Onsite clinical care is provided on the University of Maryland, Baltimore campus at the Walter P. Carter Center (701 West Pratt Street, 4th Floor) in Baltimore City. Offsite services are provided in 21 elementary, middle, and high schools in Baltimore City using part-time and full-time school- based staffing. In addition to primary clinical staff at the school, psychiatric services are provided in- person at the school as well as through telemental health technology.

Payer sources

The Center for Infant Study/School Mental Health Program in the Department of Child and Adolescent Psychiatry is licensed as an Outpatient Mental Health Clinic by the Office of Health Care Quality under the Department of Health and Mental Hygiene. The program accesses the public mental health system and private insurance to support its services and is supported, in part, by school contracts and a grant from the local mental health authority, Behavioral Health Systems Baltimore.

Program Hours

On-site therapy appointments are available Monday through Friday from 9:00am – 6:00pm and depend on the schedule of the assigned clinician. Medication management appointments are available on Wednesday from 3:00pm – 4:00pm and as needed for emergency appointments. Our receptionists are available Monday through Friday from 8:00am – 4:30pm to assist with scheduling appointments. Off-site, therapy appointments are available based on the school-based clinician's schedule at given schools sites. Appointments are made typically 7:30-5:00 at the school sites, Monday-Friday. During non-school days (e.g., summer and vacation) school-based clinicians continue to be available at the school, via telemental health or directly in the home or community. Medication management appointments are scheduled through the CIS/SMH Program school clinician and are on Tuesdays from 8:00-11:30 and as needed for emergency appointments.

Since 2000, the University of Maryland, Department of Psychiatry has been working with the State of Maryland to advance telemental health technology to provide mental health care, with an emphasis on psychiatric care. Efforts have included 1) a learning collaborative in psychopharmacology among professionals at the University of Maryland School of Medicine, Johns Hopkins, and State inpatient residential facilities; 2) service provision to Mid-Shore and Western Maryland providers; 3) the development of state Medicaid standards for telepsychiatry; 4) telemental health consultation to programs in Baltimore City and in Prince George's County for youth classified as emotionally disturbed; and 5) psychiatric consultation and medication management for the SMH Program.

Within the United States there is documented shortage of child and adolescent psychiatrists. The shortage is significant and can be considered a crisis in the field. In a study in the journal Pediatrics, (McBain, Kofner, Stein, Cantor, Vogt, and Yu (2019) researchers found that there are now 9.765 psychiatrists per 100,000 children. However, the American Academy of Child and Adolescent Psychiatry recommends a ratio of 47 child psychiatrists per 100,000 children aged 0-19. Related to this workforce challenge, identifying cost-effective strategies to allow psychiatrists to use their time more efficiently is critical. The use of telemental health offers school programs a strategy to maximize psychiatry time. For example, when a psychiatrist is using telemental health equipment they can connect with multiple schools across a given time and will not lose any time for travel and/or going to pick up the student from the classroom.

As a result of the Covid-19 Pandemic the CIS/SMH Program increased the use of telemental health dramatically, starting March 2020. This shift was made to address the needs of our population and accommodate school building closure and anxiety regarding the virus and in-person services. The program was well positioned to make this adjustment due to our history or tele-psychiatry. We had the infrastructure and technology to provide high-quality telemental health treatment and prevention services. Use of telemental health was especially critical from March 2020-August 2021. As the vaccine became available and buildings re-opened, the program has been using telemental health less regularly, but still offer tele options to maximize our psychiatry time and as needed to accommodate clients and families.

Scope of Services

The CIS/SMH on-site program primarily serves families and children ages birth to 6 years old affected by exposure to traumatic events, including grief, loss, and violence, emerging mental health symptoms, and/or caregiver child relational issues. Through the provision of school mental health services, the CIS/SMH off-site program seeks to enhance the learning environment of public schools by helping to reduce the barriers to learning and actively promoting the social-emotional-behavioral well-being of students. Clinicians are dedicated to using evidence-based practices, offering community centered care to reduce barriers to access to care and to create a safe and nurturing learning environment in which youth and families can rapidly access services that promote wellness and academic success.

CIS/SMH Program Services

Assessments and therapies are provided to children and their families either on-site at the University of Maryland Walter P. Carter Center or in a school or community setting.

Mental Health Concerns addressed include, among others:

- Attachment Problems between Caregiver and Child
- Depression
- Anxiety
- Separation Difficulties
- Traumatic Experiences (Abuse, Neglect, and Sexual Abuse)
- Disruptive Behavior
- Problems with Inattention and Hyperactivity
- Grief and Loss
- Difficulty Adjusting to School and Childcare
- Enuresis/Encopresis
- Substance Use and Abuse
- Stress that is Negatively Impacting School and Family Life
- Transitions (such as divorce, moving, starting new school)
- Poor Peer and/or Familial Relationships

Service modalities available include:

- Diagnostic Evaluation
- Family Therapy
- Individual Therapy
- Group Therapy
- Parent-child Therapy
- Medication Evaluation & Management
- Psychiatric Consultation

- School Staff Consultation
- Mental Health Promotion
- Prevention Activities
- Crisis Intervention
- Care Coordination and Referrals

Service Model

The Center for Infant Study/School Mental Health Program's ***Multidisciplinary Treatment Team*** of experts includes psychologists, social workers, professional counselors, and psychiatrists. Clinicians are committed to providing child, family and community centered care that is informed by research to support children's emotional and behavioral development and reduce mental and behavioral health systems through treatment, training, consultation, and accessing resources. Clinicians perform diagnostic assessments, and offer comprehensive treatment plans, as well as actively collaborate with schools, pediatric practices, social services, and other child-serving agencies to coordinate care to enhance the well-being and care of children (ages 0-21) and their families.

Child and Family Centered Care is guided by the strengths, needs and priorities of the youth and their family. Assessment and treatment planning practices emphasize the role of psychoeducation, informed consent and shared decision making. Providers are careful to review the risks and benefits of interventions as well as limits around confidentiality with regards to child protection and eminent safety concerns. CIS/SMH Program protects the confidentiality of information related to clients within standard limits. These limits are discussed with all clients prior to beginning service and clients are asked to sign the orientation welcome letter acknowledging that they have had the limits of confidentiality explained to them. Integrated and coordinated care is central to our philosophy. Our team is committed to partnering with families, educators, medical providers and other health and human service system staff to support the physical, developmental, psychological, and social growth and wellness of our clients. Integrated and coordinated care help to reduce barriers to access to care, including stigma, and increase access to resources that support families and youth's goals of stability and resilience. This approach better supports engage and improve outcomes for youth and families in our program.

Referrals

Caregivers and youth self-refer to clinic intake specialist by calling 410-328-3522. Within the off-site program, caregivers and youth can self-refer and school and community-based individual staff and teams can make referrals to the school-based clinician. Families and students are often made aware of the services by primary care providers and school personnel and through presentations at school events.

Resources for Services

The program's operating budget is $2,331,729. Program Directors and the Medical Director work carefully with the Division Business Manager and Department Business Administrator to manage and monitor the budget through monthly division reviews and quarterly department audits. The University of Maryland's Office of Research & Development is the Chief Administrative unit, and the managers work closely with the Sponsored Program Administration to execute contracts and communicate effectively with sponsors and interface with the Kuali Coeus system to prepare and approve budgets.

The Program Directors coordinate with the Division Business Manager and the Practice Manager to

oversee the purchase and maintenance of essential equipment including phones, computers, and videoconferencing equipment. Off-site providers may require a cell phone (carrier Verizon) to maintain safety and contact with supervisors. Each phone is encrypted by Department of Psychiatry Information Systems (PIS) to ensure client confidentiality. The on-site phones are serviced by University of Maryland Medical Center (UMMC) and the computers are serviced by the Psychiatry Information Systems (PIS) Department. The Division Manager works with PIS to catalogue purchase and confirm encryption. The business management staff also helps to order office supplies and coordinate with UMMC on maintenance needs and building safety protocols.

Commitment to Training and Evidence-Based Practices

Training for program staff is mapped to job descriptions as well as compliance with regulations and professional licensing boards. All staff complete compliance training during the orientation phase of their employment and are required to complete yearly online refresher training on HIPAA and ethical billing practices. Mental health providers and medical providers complete training on the use of electronic medical records usage and medical billing codes and documentation completion and periodic health and safety training, such as first aid and CPR training, fire drills and emergency response procedures.

Staff attends weekly staff meetings and seminars to learn about policies and procedures as well as to advance their knowledge and skills related to core competencies in child and family mental health interventions, including evidence-based screening and assessment tools incorporated into clinical procedures. Through various grants and faculty expertise, staff is offered in-depth training in several evidence-based practices.

Best Practices and Evidenced based Treatments are grounded in an ecological approach to school and community settings and collaborate to access the resources of multi-tiered systems of support. No seclusion nor restraint practices are used in the program, instead the clinical team is trained to apply positive approach to behavioral interventions as well as range of prevention, de-escalation, and interventions strategies. Promising Practices/Programs and Evidence Based Treatments include:

0 to 5 age range	6 to 12 age range	12-14 age range	15-18 age range	Family level
Mom Power	**Botvin LifeSkills**	**Botvin LifeSkills**	**Botvin LifeSkills**	
	Bounce Back/Cognitive Behavioral Intervention for Trauma in Schools	**Cognitive Behavioral Intervention for Trauma in Schools**	**Cognitive Behavioral Intervention for Trauma in Schools**	**Strengthening Families Coping Resources**
Child Parent Psychotherapy	**Good Behavior Game**	**Screening, Brief Intervention, Referral to Treatment (SBIRT)**	**Screening, Brief Intervention, Referral to Treatment (SBIRT)**	**Chicago Parenting Program**

Preschool PTSD	**The Incredible Years**	**Interpersonal Therapy for Adolescents**	**Interpersonal Therapy for Adolescents**	**Circle of Security**
Trauma-Focused Cognitive Behavioral Therapy (TFCBT)	**Trauma-Focused Cognitive Behavioral Therapy (TFCBT)**	**Trauma-Focused Cognitive Behavioral Therapy (TFCBT)**	**Trauma-Focused Cognitive Behavioral Therapy (TFCBT)**	**Strengthening Families Program**
FAN Approach-Fussy Baby Network	**Coping Cat**	**Adolescent Community Reinforcement Approach (A-CRA)**	**Adolescent Community Reinforcement Approach (A-CRA)**	**Parent CRAFT**
Play Therapy				

The CIS/SMH Program is committed to training others. The CIS/SMH Program has staff and faculty who are trainers in the following evidence-based programs:

- Botvin's LifeSkills
- Bounce Back
- Cognitive Behavioral Interventions for Trauma in Schools (CBITS)
- Adolescent Community Reinforcement Approach (A-CRA)
- Smart Choices for Gambling Prevention
- Child Parent Psychotherapy
- FAN- Facilitating Attuned Interactions
- SEFEL-Social Emotional Foundations of Early Learning
- Mental Health First Aid- Adult and Youth
- ACE Interface
- Strengthening Families Program
- Screening, Brief Intervention, Referral to Treatment

Partnerships

The CIS/SMH works closely with the child and their caregivers/guardians, as well as teachers, childcare providers, and other collateral providers (e.g., primary care, speech therapists, school employed mental health staff etc.) to provide child- and family-centered care for children and youth displaying mental health problems and/or behavioral problems and in need of early intervention to support positive mental health and well-being. It is our commitment as a program to support growth and development of families from birth to the age of 21 in a seamless child service delivery line by providing quality care that is culturally and developmentally sensitive.

Client and Family Centered Approach to Care

The CIS/SMH strives to adopt and implement a client- and family- centered approach to care. The word strive is used intentionally to describe this not only as an active process, but also conveys our mindfulness that this is a process where there is always room for improvement. The foundation to our client- and family-centered approach is the promotion of active involvement of the client and their family members when appropriate, in their own treatment process. Some of the approaches and practices that highlight our commitment to providing client- and family-centered care include the following:

- The promotion of client's active involvement, collaboration, and shared decision- making with respect to their own treatment.
- The provision of treatment interventions and services that address identified needs at both the client and population level.
- The provision of treatment services beyond that of the mental health disorder diagnosis, by looking at the needs of the whole person and providing treatment services accordingly.
- An emphasis on linking and referring clients to needed health and mental health care, education, social services, transportation, and other valued resources in the community.

CARF International Accreditation

Our Programs are CARF International Accredited!

In May 2016, the Center for Infant Study/School Mental Health Program attained an initial 3-year accreditation result from the Commission on Accreditation of Rehabilitation Facilities International (CARF). In May 2019, the CIS/SMH Program was awarded another 3-year accreditation.

The attainment of CARF International accreditation demonstrates our program's ability to substantially meet established and recognized standards. The achievement of CARF accreditation represents our commitment to continuously improve the treatment and services we provide to our clients and their families.

What is CARF?

CARF is an international, not-for-profit organization with a proven track record of accrediting a wide range of Behavioral Health Programs. CARF was founded in 1996 and known at the time as the Commission on Accreditation for Rehabilitation Facilities, which is now known as CARF or CARF International.

What is Accreditation?

From our perspective, accreditation is best described as a rigorous, onsite, peer review process, completed by a team of surveyors who wish to determine a program's conformance and fidelity to the accreditation bodies established standards, as well as the program's commitment and willingness to continuously improve the treatment and services it provides to its target population.

Why Does our Program Seek Accreditation?

It is a requirement that our outpatient mental health clinic (OMHC) obtain accreditation to be certified at both the State and Federal levels to provide treatment services to our client population. More importantly, our involvement in the accreditation process helps our program to both improve and grow.

Recommendations and Updates from May 2019 CARF Survey

SECTION 1

Leadership

1. 1.A.5.b.(3)-5: The organization has a cultural competency and diversity plan; however, it should also include consideration of gender, sexual orientation, and spiritual beliefs

- **a.** ***Update:*** As of July 30, 2019, gender, sexual orientation, and spiritual beliefs were added to our cultural competency and diversity plan. This plan continues to be reviewed carefully and amended as appropriate and in response to our staff, clients, and stakeholders.

2. 1.A.6.a.(6)(c) and (e): It is recommended that the organization's ethical codes of conduct for service delivery also include personal property and the witnessing of legal documents

- ***a.*** ***Update:*** Ethical codes of conduct were addressed regarding the issue of personal property and witnessing of legal documents in our policies and procedures manual.

Human Resources

1. 1.C.1.a-b: It is recommended that the organization's on-going strategic planning also consider the expectations of persons served and other stakeholders
   - a. ***Update:*** Client/Caregiver satisfaction data and feedback is used to develop the strategic plan. The Leadership Team has worked to make surveys more accessible and feedback easier to give to program leadership (i.e., weblinks) by making surveys readily available online.
   - ***b.*** Program leadership regularly seeks feedback from an array of stakeholders and uses this information to inform our strategic plan.
2. 1.C.3.a: The organization should also share its strategic plan, as relevant to the needs of the specific group, with the persons served.
   - a. ***Update***: Program Leadership will develop and share publicly a one-page summary of our Strategic Plan annually.

Health and Safety

1. 1.H.9.a and e: It is recommended that the organization's written procedures regarding critical incidents also include prevention and timely debriefing conducted following critical incidents.
   - ***a.*** ***Update:*** *As of September 30, 2019,* the procedure for critical incidents was amended to include prevention steps and now states that all critical incidents will be debriefed with the clinician and Leadership Team within 24 hours.

Accessibility

1. L.1.3.a-d: Although the organization has reasonable accommodations included in its employee handbook, it is recommended that request for reasonable accommodation be identified, reviewed, and decided upon and documented for persons served.

a. ***Update:*** The Accessibility Plan has been modified to include request for reasonable accommodations, how they will be identified, reviewed, decided upon, and documented for persons served.

Performance Improvement

1. 1.N.3.a (1), b.(1), b.(2), b.(3), c
   The organization should communicate accurate performance information to the persons served according to the needs of the specific group, including the format, content and timeline of the information communicated.
   a. ***Update:*** By the end of the second quarter each year, a one-page document reporting performance indicators evaluated will be made available on our website and posted at our University location.

SECTION 2

Program service structure

1. 2.A.22.e.(2): The organization is urged to ensure that team members document the results of team meetings. This could be through a meeting summary or outcomes report
   a. ***Update:*** In April of 2019, the CIS.SMHP Clinical Team Meeting Report Form was developed for start of use beginning May 1, 2019.
2. 2.A.25.f.,h.,I.: Although the organization provided through ongoing supervision of clinical or direct service personnel there should be documentation evidence that supervision address the issues of ethics, legal aspects of clinical practice and professional standards, including boundaries, cultural competency issues and model fidelity, when implementing evidence-based practices. This could be supported by making these areas of discussion clearer on the existing forms.
   a. ***Update:*** In April of 2019, the CIS.SMHP Clinical supervision note was developed for start of use May 1, 2019. This note had been modified from previous notes to more clearly address the issues noted in the recommendation.

Screening and access to services

1. 2.B.8.d.(1)(d)(viii): It is recommended that the orientation of each person served also include an explanation of the organizations standards of professional conduct related to services. This could be added to orientation material. The organization might consider providing some of the orientation information using different media, such as video tape, comic books, and pictures. This could make orientation more age appropriate.
   a. ***Update:*** The Leadership Team will oversee development of new client orientation materials that will provide information that is age-appropriate and culturally sensitive so that that new client and their families will have a better understanding of the organization's standards of professional conduct.

Person-Centered Plan

1. 2.C.1.c.(3) and (4): The person-centered plan should also be consistently based on person's abilities and preferences in addition to strengths and needs.
    a. ***Update:*** As of October 30, 2019, ability and preferences were added to the diagnostic evaluation to be used to create the person-centered treatment. All person-centered treatment plans are informed by our diagnostic assessment.
1. 2.D.3.g.(4): The organization has strong transition planning in place; however, it is recommended that the written transition plan also consistently include preferences.
    a. **Update***:* As of October 30, 2019, a prompt for preferences was added as mandatory line on the transition and discharge documents.

Quality Records Management

1. 2.H.4.b., 4.g.(1), 4.g.(2): Although the organization has a comprehensive review of records and service process, it is recommended that the records review also address whether confidential information was released according to applicable law and regulations and actual services reflect the appropriate level of care for a reasonable duration.
    a. Update: The CIS/SMH Program Quarterly Quality Review Form was updated, October 2019, to include areas that assess if confidential information was released in accordance with the ethical laws and regulations and if treatment reflects the appropriate level of care for a reasonable duration.

SECTION 5

Children and Adolescents

1. 5.D.1.q.(3): It is recommended that the assessments of each child or adolescent served also include his/her parents'/guardians' preferences.
    a. Update: As of October 30, 2019, the Diagnostic Evaluation Form was updated to include a section on parent/caregiver preferences.

Report on data collected

(Accessibility, Cultural Competency and Training, Risk Management, Technology, Performance Improvement and Risk Management Plans)

Effectiveness

Programmatic Goal 1

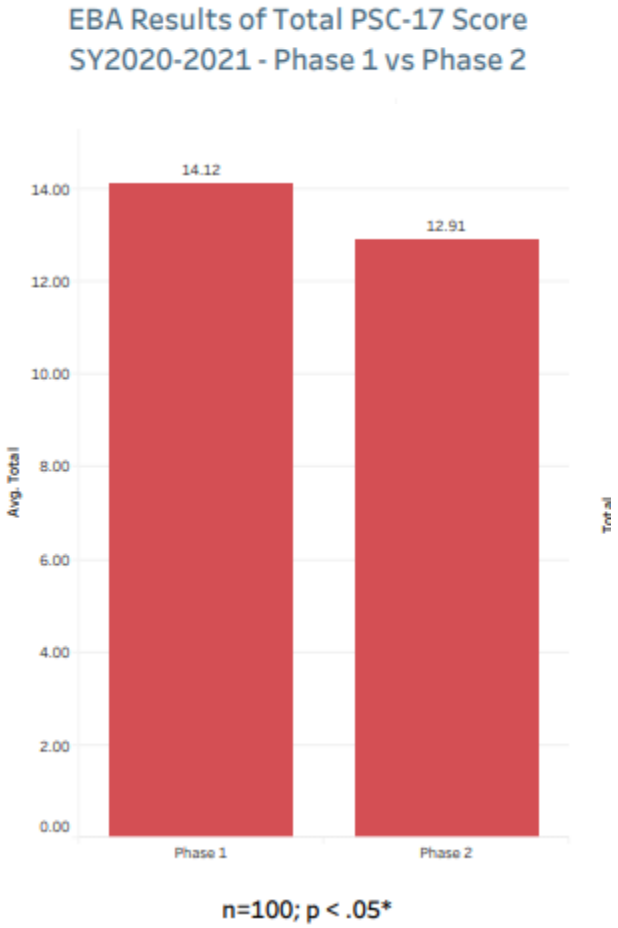
The CIS/SMH Program will provide effective clinical supports and treatment.

Rationale:

This programmatic goal is consistent with our program mission and meets the needs of the client population we serve.

Objective 1

The program will use Evidence-Based Assessment (EBA) results from the PSC-17, data from our funders to track effectiveness of our program. Our goals are to have a statistically significant reduction of symptoms from phase 1 to phase 2.



Analysis (note characteristics of person served and any extenuating or influencing factors): From the data collected, we had demonstrated reductions in clinical symptomatology from the first to second phase of the evaluation for clients served. Seeing these decreases in our symptomatology numbers from Phase 1 to Phase 2 is encouraging, especially given the circumstances of COVID-19.

Action Plan: With the addition of new staff, we need to continue our focus training all new staff in telemental health and our new technology. Telemental health training will be added to our training plan for all new staff, and it will be completed within 6 months of hire dates. We will continue to monitor EBA data and look at other areas of improvement within the EBA report from funders.

Efficiently

Programmatic Goal 1:

The CIS/SMH Program will have efficient data collection.

Rationale:

This programmatic goal is consistent with our program mission and meets the needs of the client population we serve and to provide accurate outcome information.

Objective 1:

Our goal has always been to have at least 90% of cases with a documented screening and/or assessment measures to inform diagnosis and/or treatment progress. Our focus over the past few years has been on two screening in particular, the Vanderbilt and Preschool Pediatric Symptom Checklist (PPSC). With assistance from our department, we will seek to increase the access to data collection for 2-3 additional assessments (i.e., CES-DC, Spence, and/or UCLA-5).

Analysis (note characteristics of person served and any extenuating or influencing factors): Screenings are regularly collected for all cases and demonstrate improvement for onsite and offsite services. Efficiency of accessing data from our electronic medical records in aggregate has been challenging. We need to improve our ability to be able to access the data in aggregate that is entered into the EMR system. Due to COVID-19, progress in this area was limited. While data was collected within the EMR, to date we have not been able to efficiently and/or effectively access this data in aggregate from the Department.

Action Plan: The CIS/SMH Program Leadership Team is working with the Department of Psychiatry and the Quality Improvement Team and our online electronic management system to develop flowsheets within client charts that will simplify the data collection and analysis of screening data.

Service Access

Goal 1: Overcoming barriers and increasing access to clinical care.

Rationale: We can only help families who are able to access our services and must work to address barriers that prevent them from initiating and obtaining care such as stigma, transportation, childcare, and financial concerns. COVID-19 has caused the additional barrier of limited to no access to schools and our university offices at times during the pandemic.

Objective: Increase ease of initiating care and subsequent access to care by offering multiple modes of paperwork completion and delivery of services options.

Analysis (***note characteristics of person served and any extenuating or influencing factors***): Clients and families need a less time-consuming process to initiate services, particularly regarding the paperwork required and need a way to complete paperwork outside of the office/school building.

Action Plan: The CIS/SMH Program has worked with our Department and Division to identify and develop an electronic system for paperwork that is HIPAA compliant and user friendly to allow for improved access to electronic documents and the completion of intake paperwork online. The new process will be fully implemented over the course of the next year. All Clinicians will be registered in the online system and trained in its use.

Satisfaction Measurement

Programmatic Goal 1

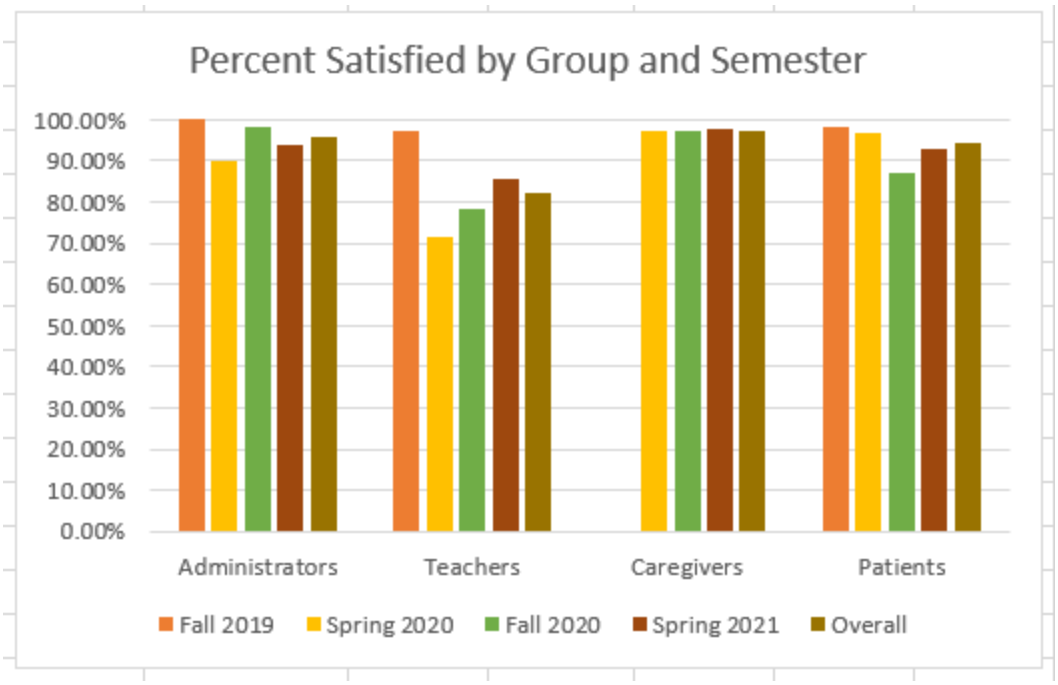
The CIS/SMH Program will measure cross stakeholder satisfaction by youth, families, educators, and principals with CIS/SMH Program services.

Rationale:

This programmatic goal is consistent with our program mission to provide quality services that are client centered.

Objective 1: Collect satisfaction surveys listed below and achieve an 80% positive response rate for the extent to which they agreed or strongly agreed that they were satisfied with services provided.

- UM CIS/SMH Client and Caregiver Satisfaction Measure -adapted from the Client Satisfaction Questionnaire
- UM CIS/SMH Principal and Teacher Survey-adapted from the Client Satisfaction Questionnaire



Analysis (note characteristics of person served and any extenuating or influencing factors): Over the last 2 years, we have reached our goal of having at least 80% client, family, and principal satisfaction. Due to COVID-19, we know some clients and caregivers had difficultly accessing services due to internet and technology needs and we worked with those families to assist as we could. We are thrilled that we were able to maintain satisfaction rates among clients, families, and administrators during this challenging time. We were much more isolated and distanced from our teachers and put measures in place to better connect during temporary building closures however, we did see a dip in satisfaction rates amount teachers which needed to be addressed in the Spring of 2020. We also hypothesize that this dip was compounded by additional stress, increasing job demands, and the resulting lower job satisfaction that teachers experienced trying to meet student needs during the pandemic. However, we recognized that we needed to more intentionally reconnect and support teachers when buildings fully reopened. Since the reopening of schools, satisfaction rates have been increasing and we exceeded our 80% goal in the Spring of 2021 but have not recovered to pre-pandemic satisfaction rates.

Action Plan: As we continue to monitor our satisfaction rates, we will modify our satisfaction surveys to reflect the ways services are being rendered to better assess the effectiveness of both in-person and tele services. Additionally, as we support teachers in returning to full-time open buildings, we will prioritize efforts to reconnect with teachers and solidify those relationships to better support their students' mental health and wellbeing. We are participating in a first 30-days of school re-engagement initiative which includes a focus on staff support and well-being.

Business Function Performance

Goal 1: Program funding will sufficiently cover staff salaries, including promotions, and all business expenses.

Rationale: We need to ensure all business cost are covered in order to best provide services.

Objective: 100% of program staff will be fully covered by fee for service or grant based contracts

Analysis (***note characteristics of person served and any extenuating or influencing factors***): Despite the impact of COVID staff have been able to be fully covered by fee-for-service, our grants, and other special projects. Program leadership and staff have been able to adjust to the "new normal" and our funding has not been negatively impacted. We must continually look for funding services as the needs are great in our communities for services both prevention and treatment. We provide services in highly stressed communities that experience high rates of trauma so all tiers of intervention are needed.

Action Plan: The CIS/SMH Program has work with our Department and Division continue to identify sources of funding to keep to our mission to provide treatment as well as prevention services (not billable) to our population.

CIS/SMH Program Highlights

Human Resources:

- Worked with Department and Division Business Manager to update and improve hiring processes, new points of contact were assigned to HR duties.

Environment of Care:

- Clinicians put in significant effort and training and policies were developed for the delivery of telemental health. Online tools and intervention were shared across the program.
- Clients and families were given the choice to engage in telemental health to ensure access to care.

Client Outreach and Cultural Competency:

- Online/electronic tools have been (and are in continued state of being) implemented and regularly evaluated to make services more easily accessible (referral forms, use of QR Codes, DocuSign, My Portfolio, Tele Port, Tiger Connect, etc.)
- The programs offered and staff attended safe and accountable spaces to process multiple events related to race and culture. There was a significant increase in support provided peer to peer and supervisors to peers.
- A subset of staff has engaged in Diversity, Equity, Inclusion, Anti-Racist (DEIA) training related to delivering services in a culturally sensitive and relevant way.
- Trainings were revised, updated, and created to ensure delivery of and content within training is culturally relevant.
- The division and department created and continued subcommittee meeting specifically focusing on DEI-A.

Evidenced Based Practice:

- Offsite clinicians were trained and implemented Coping with Covid, Botvin's LifeSkills and were

trained in and utilized the evidence-based practices in the Practicewise and MATCH materials.

- Two Senior Clinicians became trainers Strengthening Families Intervention
- On-site clinicians continue to be trained in Child-Parent Psychotherapy and Chicago Parent Program
- Clinicians and Trainees were trained in Screening, Brief Intervention, Referral to Treatment and Adolescent Community Reinforcement Approach

Increase Access to Care:

- The teams continue to build on and improve the telemental health program with the goal of increasing access to psychiatrists in the schools as well as offering multiple modes of delivery

CIS/SMH SWOT Analysis

FY 2020-2021

The completion of our Annual SWOT analysis provides our organization with a chance to complete a situational analysis, highlighting our organizations strengths, weaknesses, opportunities, and threats. For the purposes of our SWOT analysis, organizational strengths and weaknesses are identified by looking internal characteristics, processes, issues, and experiences while opportunities and threats are looked at through an external lens trying to better understand and appreciate how external factors can impact an influence or organization.

The initiation of our SWOT analysis begins with completing and inventory of organizational strengths and weaknesses. Once this process is completed our attention turns to the examination and identification of potential external opportunities and threats that have the potential to impact and influence the CIS/SMH Program.

The primary purpose of completing our SWOT analysis is to view and examine our organization in an objective manner that may lend itself to assisting program leadership and staff in making decisions about making program improvements, modifications, and even the developing of new programs and initiatives. Completion of the SWOT analysis also provides program leadership to examine our fidelity to our written program mission.

Strengths:

A consistent strength of the University of Maryland Center for Infant Study/School Mental Health Program has been our staff and our organizations commitment to enhance staff retention for both faculty and staff. Although we have said goodbye to a few of our longest-term staff this year related to career advancements and family decisions, we believe that our retention will continue to stay strong. We have replaced at least one of our staff with a former trainee in our program- a trend we continue to consistently have and are proud of. When possible, we actively try to recruit trainees who have succeeded in our programs to reduce the onboarding knowledge needed and to go with a known effective individual. We are committed to offering professional development, growth opportunities, strong supervision, coaching and individualized support to help each staff member excel. The University of Maryland Center for Infant Study/School Mental Health Program staff is both seasoned and experienced and brings a wealth of

knowledge and skills to the workplace. The University of Maryland Center for Infant Study/School Mental Health Program's training programs have offered both training of the future workforce and a pathway for employment opportunities for individuals with proven skillsets. The University of Maryland Center for Infant Study/School Mental Health Program executive leadership has had little turnover since its inception offering historical perspectives while being open to adapting to changing structures and policies. Our team has cultivated a level of proficiency, competency, and experience that has proven helpful in navigating a wide range of challenges related to providing services both onsite and in the community.

The University of Maryland Center for Infant Study/School Mental Health Program benefits from a multidisciplinary workforce that includes physicians, social workers, psychologists, counselors, and administrative staff which brings a range of perspectives and knowledge related to high quality, comprehensive service delivery.

The longevity of the University of Maryland Center for Infant Study/School Mental Health Program in part can be attributed to both its staff and the organization's ability to adapt and grow despite that many challenges and changes that have occurred over the years, particularly related to funding and COVID-19.

Another considerable organizational strength is the structure and oversight by both UMMC and UMB which ensure that the program is supported and complies with its overarching policies, procedures, and initiatives which provide protections and support to clients and families, ensuring high quality of care.

The University of Maryland Center for Infant Study/School Mental Health Program excels in serving underserved, vulnerable youth and families in Baltimore City and surrounding communities. Our program is fortunate to learn from the National Center for School Mental Health at UMB, a national resource center for advancing research, training, policy, and practice in school mental health as well as the Center of Excellence in Infant and Early Childhood Mental Health at UMB. Both centers provide clinical training and help to inform policy and best practice and are in turn, informed by our clinical programs.

In this ever-changing year, we must also note our ability to "pivot", to be flexible, and to do what needs to be done to meet the needs of our clients and families. COVID-19 has presented us with many challenges from school-building closures to increasing our use of technology and managing our contracts with our funders. Our leadership at the program, division, and department levels have supported our program through multiple changes with flexibility and creativity which has allowed us to continue to provide high-quality care.

Weaknesses:

As mentioned in previous reports, our retention of staff and faculty has led to more advanced staff who have earned pay raises and COLAs. With flat contracts and no increases for fee-for-service, maintaining funding our current staff can be challenging. Another challenge for our program is that being part of University results in high assessments (taxes) on revenue generated through fee-for-service. Currently this rate is over 50%. For contracts, that depend on fee-for-service dollars to fully fund staff, this creates a need for increased deliverables that can be difficult to attain.

Having off-site locations can be challenging related to technology and administrative support. Our clinicians who are school based, contend with technology challenges related to older buildings and limited funding to support technology advancement in the schools. Consistently accessing the internet for clinician notes, email and telepsychiatry can be problematic. The off-site program staff also have no access to on-site clerical support such as answering phone, greeting clients, or assisting with client paperwork. This has led to the development of creative remote strategies to support both IT and administrative needs.

A final weakness that we identified relates to capacity in our high-need environments. While we are very proud of our work, there are many more youth and families who could benefit from our services. To help address this challenge, we are committed to training pre-service students and to train teachers and other school staff on basic mental health identification, support, and referral to treatment and to providing mental health promotion and prevention to help support youth and families before problems interfere with daily functioning.

Opportunities:

Related to the national shortage of child and adolescent psychiatrists, capacity issues for psychiatry time, and COVID-19 the UM CIS/SMH is increasingly utilizing telehealth. Telehealth had previously been successfully integrated into our off-site program for the purposes of consultation, psychoeducation, and medication management so we were well-positioned to transition the program to other types of tele services when it was needed. During COVID-19, the on-site program was able to benefit from the learned experience that off-site program had gained, and this continues to be a trend as the CIS/SMH Program modifies services for the current climate and is more open to hybrid strategies to care

Other opportunities for our program include building training capacity of our current staff to serve as trainers in evidence-based programs. For example, we have successfully trained our staff as national trainers in Botvin's LifeSkills, Strengthening Families Intervention, Fussy Baby, FAN model, A-CRA, Child-Parent Psychotherapy, ACE Interface, and Smart Choices (a gambling prevention program).

Related to diversity, equity, inclusion, and anti-racism (DEIA), the Division and Department have taken steps to actively address racism in all forms. This has led to an increase in opportunities to be part of this work, engage in courageous conversations and more closely examine our workplace and clinical work/engagement with clients. We believe this work will lead to continued improvements in staff recruitment, retention, and client care.

Additionally, as COVID-19 continue to increase the need for mental health services, and mental health is highlighted on the national stage, there may be opportunities to seek additional funding to meet this need and retain high quality clinicians through salaries and incentives.

The UM CIS/SMH also benefits from being part of an academic institution and two highly regarded centers of excellence related to school mental health and early childhood. These relationships offer access to new knowledge and skills and opportunities to participate in national and regional trainings. This promotes a scientist-practitioner model of care that integrates current research with best clinical practice.

Threats:

Our greatest threat to our program continues to be funding. Without guaranteed line items in state budgets and a need to stay fiscally viable, our program must meet all costs each year, leaving little opportunity to invest in innovation and expansion. While we have successfully had our program in existence for over 21 years and have a long history of continuing state and local contracts, each year we contend with securing these funds.

Another threat to our program is losing our highly qualified and talented staff to other organizations who can offer higher salaries. While we promote excellent paid leave time and other state benefits, it is still hard to compete with Washington, DC and other organizations and programs with less restrictive budgets.

Summary:

In summary the CIS/SMH Program's utilization of its internal strength's and addressing its identified weaknesses can assist in the successful management of identified opportunities and threats. Our organizational stance and philosophy relative to meeting challenges and threats has been to take a solution oriented/problem-solving approach. The leadership remains determined to apprise faculty and staff of the challenges that our organization confronts, innovatively addresses challenges and builds on strengths, and remains poised and able to take advantage of opportunities