BrightLife
Enhancement Services
Holistic approach to healthcare

Brightlife Enhancement Services
Strategic Plan
2022 - 2025

PURPOSE:
This document serves as Brightlife Enhancement Services Strategic Plan to be utilized for the period of **January 1, 2022 to December 31, 2025**. An extended evaluation of Brightlife Enhancement Services's challenges, services, special projects, critical issues, strengths, weaknesses and opportunities was conducted in an effort to chart the direction essential for Brightlife Enhancement Services to continue to move forward. Program evaluation, need assessment and outcome data are an integral part of this strategic plan.

ASSUMPTIONS:
We made the following assumptions as this strategic plan was created:

- There is a need to seek out alternative funding.
- The resources and level of services are reducing in regard to the reimbursement rate and number of billable hours.
- This document will provide a foundation for the decisions and actions of the agency and staff leadership of Brightlife Enhancement Services over the next 3 years.
- There will be a subset of additional deliberations and actions at the committee and leadership levels to complete each strategy as well as strategic discussions by the board as it monitors implementation of the plan.
- During the implementation of this plan, we assume extensive conversation and information on sharing among leadership and staff to maximize planning efforts.
- This document will be a "living" document, monitored regularly and adjusted accordingly as the implementation of the plan evolves.
- Acted upon correctly, completion of this plan will create the foundation for future strategic initiatives.
- Brightlife Enhancement Services Leadership Team is ultimately responsible for ownership of the implementation of this plan.

ORGANIZATIONAL DESCRIPTON:
Brightlife Enhancement Services is a comprehensive community behavioral health agency that renders services to youth and adults with mental/behavioral problems that may be co-morbid with substance abuse. Brightlife Enhancement Services supports their wellness and recovery journey through the use of the most appropriate treatment modality that is tailored to meet the needs of the individual and their families and assist in the achievement of their individual self-defined treatment goals and wellness needs. Central to our approach is our belief that individuals are in the best position to determine their own treatment needs, and in their uniqueness, are the most qualified determinants of their personal wellness definition.

Commitment to External Partners:
In the delivery of our services Brightlife Enhancement Services will meet or exceed all applicable guidelines promulgated by Office of Health Care Quality), Brightlife Enhancement Services External Review Organization (ERO), Medicaid, Maryland – Community of Mental Health and other governing agencies while enabling all stakeholders to find a workable and realistic way to implement evidence-based practices within the available resources.

Commitment to Brightlife Enhancement Services Staff Members:

The key to the delivery of all our services is our commitment to our Staff Members; for we truly believe that enthusiastic workers, given sufficient resources, effective leadership and proper support can help some very troubled people make enormous and enduring changes in their lives.

Commitment to Individuals and their Families:

Services are organized to meet the needs of the individual with the individual and their family, an integral part of the treatment team... It is our belief that recovery is achieved, and wellness is maintained by the engagement of natural support; therefore, it is our job to teach the skills and establish the linkages necessary for individuals and their treatment partners to maintain resiliency on their own.

MISSION AND VALUES OF BRIGHTLIFE ENHANCEMENT SERVICES

MISSION STATEMENT

Brightlife Enhancement Services is to help adults and children in Hagerstown and surrounding areas facing mental health challenges who require targeted support that addresses their distinct needs by providing behavioral health services and resources tailored to the well-being and development of individuals with mental health needs in the community.

OUR GOAL

Our goal is to help you grow from your struggles, heal from your pain, and move forward to where you want to be in your life.

Brightlife Enhancement Services is organized around core principle of delivering high quality treatment services in a way that is supportive of the person served and that encourages empowerment, self-determination and success.

We take responsibility for QUALITY…
Our services will be "best in class" in terms of value received for dollars paid. We will deliver excellence, strive for continuous improvement and respond vigorously to change. Our services will be provided by highly trained practitioners that deliver evidenced-based practices that are comprehensive, community-based and person centered. Each of us is responsible for the quality of any service we provide.

We deliver CUSTOMER SATISFACTION…
We are dedicated to satisfying our customers. We believe in respecting our customers, listening to their requests and understanding their expectations. We strive to exceed their expectations in accessibility, quality and on-time service delivery.

We provide LEADERSHIP as a company and as individuals…
Brightlife Enhancement Services leadership is founded on talented Staff Members, effectively applying principles that bring out the best in those that we serve. We each lead through our competence, creativity and teamwork.

We act with INTEGRITY in all we do…
We are each personally accountable for the highest standards of behavior, including honesty and fairness in all aspects of our work. We fulfill our commitments as responsible citizens and Staff Members. We will consistently treat customers and company resources with the dignity and respect they deserve.

To fulfill these values, Brightlife Enhancement Services adheres to and believes in the following guiding principles:

Family integrity is of paramount importance. Needs for security, permanency and cultural ties in family relationships should pervade all planning. Families should participate fully in all decisions concerning planning, placement, program and discharge.

Brightlife Enhancement Services shall work with other social service agencies within its services area to achieve the best possible outcome for consumers.

Brightlife Enhancement Services consumers shall participate fully in all service planning decisions. The uniqueness and dignity of the consumer shall govern service decisions. Individualized Recovery Plans shall reflect the consumer's developmental needs, which include family, emotional, intellectual, physical, social and cultural factors.

Culturally competent services will be guided by the concept of equal, responsive and nondiscriminatory services matched to the consumers' population. Cultural competence involves working with natural, informal support and helping networks within minority communities. Inherent in cross-cultural interactions are dynamics, which must be acknowledged, accepted and adopted.

Cultural competence extends the concept of self-determination to the community.

Brightlife Enhancement Services recognizes that minority populations are at least bi-cultural and that this status creates a unique set of mental health and substance abuse issues, which the system must be equipped to respond. Thus, the system must sanction, and in some cases, mandate the incorporation of cultural knowledge into practice and policy-making.

1. Consumers who have mental illnesses and/or substance abuse problems shall be treated with dignity and respect, as they have the same needs, rights and responsibilities as other citizens. Thus, these individuals should have the same access to opportunities, supports and services to help them live successfully in the community.

2. Brightlife Enhancement Services service's shall help consumers to empower themselves, focus on strengths, maintain a sense of identity and enhance self-esteem. Services should help people develop their potential for growth and movement towards independence.

3. Brightlife Enhancement Services service's shall meet the special needs of people with mental illness and/or substance abuse problems who are also affected by one or more of such factors as: old age, physical disability, homelessness, the AIDS virus and/or involvement in the criminal justice system.

Strategic Plan

SERVICES AVAILABLE

- Psycho-social Rehabilitation Services
- Money Management
- Outpatient
- Physical Health/Sobriety
- Illness management
- Health and Wellness Education
- Transportation Services

SWOT ANALYSIS

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TRENGTHS

- The staff has extensive knowledge in the field of behavioral health
- Use of Person-centered Treatment Planning in all phases of treatment.
- Full range of mental/behavioral health services available to support individuals in various stages of recovery and Core Services.
- Team approach in service delivery.
- Flex scheduling

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EAKNESSES

- Competing in new areas with new state governmental guidelines
- Meeting all regulatory requirements

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PPORTUNITIES

- Increase Community Outreach to attract more referrals
- To actively serve areas in the surrounding areas with Community Healthcare Programming.
- To help the Behavioral Health population

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HREATS

- ❖ Other established treatment centers within the Community
- ❖ Staff training

BRIGHTLIFE ENHANCEMENT SERVICES
STRATEGIC GOALS: 2022-2025

- Recruit and maintain a Directcare Treatment Services Team according to CARF standards.
- Recruit and maintain a Specialty Team for Behavior Health and Outpatient Services according to CARF standards.
- Stabilize the organization's finances and build the organization's operating capital and cash reserves;
- Develop and implement new methods that will ensure the clinical and administrative systems are continuously in place to keep the organization operating at its optimum; meaning that quality/quantitative services are being provided, prepared for audits, etc.
- Obtain 3-Year Accreditation from CARF

GOAL I: Create the internal capacity to support the Vision and Mission of Brightlife Enhancement Services.

STRATEGY	ACTION STEPS	WHO IS RESPONSIBLE	BY WHEN	PRIORITY
Strategy A: Create and implement a plan to retain and hire quality staff.	1. Create salary/benefit structure designed to retain and hire qualified staff. a. Complete a review of current salary and benefits. b. Integrate incremental changes in annual budgets. 2. Create and implement an educational/training component for Staff Members. 3. Recruit a Chief Executive Officr/Rehabilitation Specialist	Program Director Medical Director	6/2023 Hired 5/2023	High
Strategy B: Review/create active committee structure to evaluate available reimbursable Programs	1. Review other Specialty Programs that are provided by the state and evaluate the ability of Brightlife Enhancement Services to provide the services. 2. Recruit staff members with expertise in the identified Specialty	Program Director	1/2024 Continuing to hire	Medium

provided by the State	Programs that Brightlife Enhancement Services offers to the community.			
Strategy C Review role and define responsibilities of identified Specialty Programs	1. Survey current members. 2. Review needs of organization.	Executive Leadership Team	3/2023 Decided not to have OMHC accredited	Medium

GOAL II: Sustain and create programs and services which meet standards of the best practice.

STRATEGY	ACTION STEPS	WHO IS RESPONSIBLE	BY WHEN	PRIORITY
Strategy A: Develop performance standards for all programs.	1. Create and implement specific benchmarks to mark progress/success in key areas of performance. 2. Review annually	Corporate Compliance Officer Program Director Medical Director	6/2023 Reviewed monthly	High
Strategy B: Develop and implement a plan for long-term programming.	Develop and implement a system to monitor accountability and productivity of all personnel to reduce cost and create more efficient and productive use of all staff.	Executive Leadership Team	6/2023 EMR tracks needed outcome information	Medium

GOAL III: Create and implement a plan to build sustainable, diversified funding.

STRATEGY	ACTION STEPS	WHO IS RESPONSIBLE	BY WHEN	PRIORITY
Strategy A: Create a baseline comprehensive multi-year financial forecast to help direct the decisions and direction of the organization.	1. Include projections for staffing, new programs and building on expense	Program Director Medical Director	6/2023 On-going	High
Strategy B: Identify and Recruit staff for identified Specialty Programs	1.Recruit staff to provide PRP and Outpatient Services	Program Director Medical Director	5/2023 On-going	High

Strategy C: Collaborate with the .	1. Submit applications to Medicare, Tricare, Blue Cross/Blue Shield, CMO's (and others insurance carriers serving Region 1)	Program Director Medical Director	3/31/2022 On-going	Medium

GOAL IV: Create and implement a plan to improve communications and community perceptions of the agency.

STRATEGY	ACTION STEPS	WHO IS RESPONSIBLE	BY WHEN	PRIORITY
Strategy A: Develop and implement a comprehensive community outreach plan designed to build and strengthen relationships with specific constituencies (e.g. court system, criminal justice, business, FBO and CBO, hospitals), address stigma issues and promote relationship between mental health and physical health.	1. Develop and present current public relations activities to Community Stakeholders. 2. Establish KPI's (key performance indicators) for public relations. 3. Train Marketing team on the challenges facing individuals with mental disabilities in our community.	Program Director Medical Director	8/31/2022 On-going	Medium

Finances

The organization has sat down with a financial adviser and constructed a Projected budget for a 15-month period which demonstrates that the organization has the potential to make a profit after being approved by CARF and COMAR.

Financial Threat

If the organization loses clients, that will affect the financial bottom line. Weather disasters, acts of terrorism may prevent services from being delivered which will affect the financial stability of the organization as well. This may also affect the organization with losing revenue as well. The organization operates in the community and this will also present a problem in regard to staff having the means to adequately provide services on a consistent basis.

Financial Trend

The organization has been and should continue to be financially stable provided that there are not any major budget cuts or reduction in the fees for services and able to maintain a census of 30 clients per month.

Environmental Analysis

1. **Legislative/Regulatory Environmental Analysis**
    1. **National.**
        i. The one positive impact we have seen so far from healthcare reform is an increase in the number of 18 to 25-year-old patients. Under HC reform children are able to remain on their parent's insurance until they are 26 without regard to whether they are in college. This is allowing them to enter treatment and remain in treatment for continuing care.
        ii. The one negative we have seen from HC Reform is an increase in the number of high deductible insurance coverage programs. This has negatively affected treatment in two ways. First, we believe that since it has made outpatient treatment more expensive. We believe this has caused a reduction in new patients to existing offices. Second, we believe that it has contributed to a reduction in our completion rate. As patients progress through our program they are building financial balances that are larger than in the past and may be contributing to a larger than expected drop-out rate.
        iii. It now seems clear that HC reform has actually decreased the number of commercially insured patients. We think the problem that has occurred is for patients that show little to no real income. This could be for either patients that are young or perhaps own their own business. Under Maryland's HC reform system, the individual is first asked about financial resources. This tends to direct people to the medical assistance type coverages. We saw a dramatic drop in patients starting in November/December 2013 just as HC reform was being rolled out. We have also seen many patients come to the program that have not been able to get the services they need through MA and they are coming to us as private pay.
    2. **Local.** There are three major changes we are monitoring.

2. **Other Environmental Issues.** The odd thing that seems to be occurring in the community is a sudden increase in competition in multiple ways.
    1. **Similar private programs**. All of these programs are either targeting the exact same population, working insured, or they are looking for the same population but servicing on a private pay basis
    2. **Expansion of residential providers**. A more concerning competitive trend is the rapid expansion of the number of National and local residential treatment programs. CRC was a large national entity that was building and buying residential substance abuse treatment centers. They were able to successfully sell the combined entity to a larger entity, Acadia. Based on the success of this venture we have seen a large increase in the amount of venture capitalists trying to pursue this same model. These entities are competing with us in 3 ways. First, they have very well-funded marketing efforts targeted at recruiting local patients to their facilities. These efforts are both through intricate internet strategies as well as boots on the ground. Two national players actually have developed more than 10 phantom websites each that appear to be general websites to help patients. These websites direct patients back to major call centers that encourage patients to go to their facilities. The second thing we are finding is that the days of the 28-day treatment are gone. Once these residential treatment centers attract a new patient they are generally being treated for 30, 60 and 90 plus days. Patients are utilizing their residential, partial and IOP benefits before they are returned to their community. Finally, many of the facilities are developing outpatient capacity in markets to help attract patients back to their facilities. Several National players have announced their intent to engage in this strategy (Hazelden, Beatty Ford and Foundations Recovery Network). Some have expressed an interest in our market.

3. **Sober Living Facilities.** On the one hand, we have seen the residential facilities expanding to provide partial and IOP, on the other hand we have seen an expansion of the traditional sober living facilities to get licensed to provide partial, IOP and traditional outpatient treatment. There are several in our market that we used to use in conjunction with our treatment that are now competing with us for the insured patients.
4. **Traditional State Funded Programs.** Historically, the vast majority of providers in our community were grant funded by the State and other entities. These programs generally provided services to the medical assistance, uninsured and underinsured populations. Due to the conversion by the State to a fee-for-service funding model, many of these entities are pursuing the commercially insured patients to bolster their financial condition. This includes many County Health Departments that are funded by the State and County governments.

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Technology

Technology will continue to assist the agency with creating and maintaining its workload in an efficient manner. The organization will as it grows look to interview EMR companies and look to have one in place by the official opening of its Program.

Demographics and Needs of the Service Area

Brightlife Enhancement Services service area of Baltimore needs increased access to quality healthcare, affordable and clean housing, safe communities, and jobs.

The population that Brightlife Enhancement Services serves is burdened by living in communities with disproportionate rates of crime, poverty, substance use disorders, traumatic injury, homicide, chronic disease, HIV/AIDS, and mental illness. Adults are compelled to combat the many pressures of economic blight daily, causing them to postpone or ignore the health concerns of their children, their elderly relatives, and themselves. These characteristics affect access to primary medical care, health care utilization, and health status as described, *infra*.

Almost 63% (62.8%) of Baltimore City residents are African American.4 Race and poverty status (as well as insurance coverage) are critical factors related to the health status of the predominant low-income African American target population within the proposed service area. These barriers to primary health care access for poor racial/ethnic minorities are among those cited in *Healthy People 2021*, the United States Surgeon General's public health plan for the country. Further, the framework for *Healthy People 2030* approved in June 2021 by the US Department of Health and Human Services mirrors these same critical factors.5 The vast majority of clients of Brightlife Enhancement Services are at risk for poor health, given their race, poverty status, and lack of health insurance.

Ethnic and Racial Groups in the Target Population: The percentage of racial/ethnic groups in Baltimore City was: Whites (30.3% in 20216 as compared to 31.6% in 20207); African Americans or Blacks (62.8% in 2020 versus 63.3% in 2021); American Indians 0.3% as compared to 0.4% in 2020); Asian Americans (2.6% in 2020 and unchanged from 2021); and Hispanic/Latino Americans (5.0% in 2020 as compared to 4.6% in 2021).

Age and Gender Groups: The breakdown of age and gender groups in Baltimore City is broken down in Table 1, *infra*:

Table 1. Age and Sex Distribution8

Age or Sex	Baltimore City
0 – 17 years	21.2%
18 – 24 years	11.3%
25 – 44 years	30.1%
45 – 64 years	25.3%
65+ years	12.1%
Male	**47.1%**
Female	**52.9%**

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Income Levels, Insurance Status, Employment Status: The percent of Baltimore City residents at or below 200 percent of poverty is 22.4%.9 The median household income (2019-2021) in Baltimore City is $46,641, as compared to $71,810 for nearby suburban Baltimore County and

$78,961 for the state of Maryland. In Baltimore City, 23.8% of persons live below the poverty level, as compared with 9.8% statewide, and 8.2% in Baltimore County.

The unemployment rate in Baltimore City is 5.9%, as compared to a statewide rate of 3.9%. Even with the implementation of the Affordable Care Act, it is estimated that about 11.7% of

adults 18 years and older who are Baltimore City residents are still. With the high unemployment rate in Baltimore City and those residents who work only part-time (with limited or no health insurance), the uninsured and underinsured rates combined approximate 31%.

Educational Attainment: About 84.0% (84.2%) of the Baltimore City population aged 25 years and older is a high school graduate or higher, as compared to 89% statewide. However, those with a Bachelor's degree or higher is 30.4%, as compared to 37.3% statewide.

Lesbian, Gay, Bisexual, Transgendered, and Queer Populations: The Lesbian, Gay, Bisexual, Transgendered, and Queer (LGBTQ) community comprises 3.9% of the Baltimore metropolitan area. Members of the LGBTQ community are often the victims of discrimination. "Research has linked discrimination to a higher incidence of substance abuse, suicide and suicidal ideation, psychiatric disorders, and limited health-seeking behavior. Social stigma and negative stereotypes have been linked with frequent experiences of violence and victimization against LGBT people." LGBTQ people are often victims of hate crimes due to their perceived sexual orientation and gender identity. Further, "it is important to note that, for the purposes of research and advocacy, the LGBT populations have been combined into one entity. However, the groups within this umbrella term are distinct and have their own specific health care needs. Many members of the LGBT communities are also part of other communities that face additional challenges and disparities. Their experiences are not uniform; they are shaped by race, ethnicity, primary language, socioeconomic status, geographical location, age, disability status, and other factors. Therefore, they may be vulnerable to the cumulative negative health impacts associated with these factors. For example, LGBT people of color must navigate additional layers of discrimination based on racism, ethnicity, and language." "In addition to higher rates of violence, LGBT people also bear the chronic stress associated with systemic discrimination and barriers to access of necessary health services. It is estimated that the ratio of uninsured Gay and Lesbian adults to heterosexuals in America is two to one. Lack of legal recognition of same-sex relationships prevents coverage of same-sex partners under some employee health plans. Coupled with lack of support for alternative family structures, LGBT people and their families are more likely to be without health insurance coverage. They may therefore be financially limited in receiving basic, preventive care services. For transgender people, many private insurers and state Medicaid and Medicare plans exclude the provision of transition-related care despite statements from the American Medical Association (AMA) that transition-related care is medically necessary. Furthermore, since transgender people may require additional specialty treatments that are often not standard with traditional care, it may be virtually impossible for them to obtain insurance coverage in the private sector." 20

Behavioral Health, Homeless, Veteran, and Persons Living with HIV/AIDS Populations**:** In Baltimore City, the prevalence of substance use disorders for 2021 is 10.72% and the prevalence of mental health disorders is 18.02%. About 22% (22.5%) of Baltimore City residents accessed both mental health and substance use services in 2020. The opioid overdose epidemic has been overwhelming in Baltimore City. Since 2021, the number of overdose deaths in Baltimore City has more than doubled, largely driven by opioids. There were 760 overdose deaths in Baltimore City in 2021, 573 of those deaths involved fentanyl. Prescription opioid-related deaths in Baltimore City have dramatically and steadily increased from 51 in 2020 to 81 through September 2021. Baltimore City's numbers far exceed all the other Maryland counties. For example, in Baltimore County for the same period, there were 151 deaths, as compared to 86 deaths in 2021.

The Behavioral Health System Baltimore (BHSB) (2021) assessed the capacity of substance related disorder treatment in Baltimore City, focusing on opioid treatment programs and Buprenorphine providers. BHSB estimated that the number of individuals potentially in need of medication-assisted treatment is 24,887 opioid users, of which 18,916 are heroin users. With 26 opioid treatment programs in Baltimore City (with an additional 62 non-opioid treatment programs that prescribe buprenorphine) and an additional 10 treatment facilities in neighboring Baltimore County (with an additional 22 non-opioid treatment programs), the capacity of

Baltimore City's substance related disorder (SRD) treatment exceeds its current need by approximately 3,000 persons.

Homelessness continues to be a social, economic, and public health problem in Baltimore City. It is estimated that 9% of the Baltimore City population is chronically homeless and at least 50% of this population suffer with both substance abuse and mental illness. Efforts to quantify the target population are difficult, due to the transient nature of this populace. In January 2021, the City of Baltimore counted 1,962 persons experiencing homelessness, of which 28% were women (with about one-third of these women having children with them in the shelters), 72% 66% were men, and 0.1% were transgendered. Other data for homeless persons in Baltimore City revealed that 77% were African American, and 51% were between the ages of 41 and 60 years.

The opioid epidemic affects individuals experiencing homelessness in ways often not noticed and possibly different from how it affects those who are homed. These individuals have difficulty accessing ambulatory health care and integrated service delivery due to perceived and actual stigma and face structural barriers that make establishing ongoing care challenging. They also have disproportionately high rates of co-morbid conditions that place

them at risk for developing opioid use disorder. Mental health conditions, use of substances other than opioids, and acute and chronic pain conditions are all highly prevalent among persons experiencing homelessness.

Baltimore City continues to far exceed other Maryland jurisdictions in HIV/AIDS new diagnoses and living cases. Although HIV diagnoses in the Baltimore Metropolitan Statistical Area deceased by 52% from 2015 to 2021, Baltimore City had a higher number of new HIV diagnoses (205 cases), as compared to surrounding Baltimore County (199 cases) and Anne Arundel County (50 cases). The Baltimore-Columbia- Towson, Maryland Metropolitan Statistical Area (MSA) has the fourth largest number of living HIV diagnoses in the United States (rate of 607.4 per 100,000 population) as compared to Philadelphia-Camden-Wilmington MSA (393.6 per 100,000) and Washington-Arlington-Alexandria MSA (325.8 per 100,000). Of the persons diagnosed with HIV in the Baltimore MSA, 71.6% are retained in HIV care and 59.8% are virally suppressed (suppressed viral load). Of the 17,394 people aged 13 years and older living with HIV on December 31, 2018, 76% were Non-Hispanic Black, 13% were Non-Hispanic White, 6% were Non-Hispanic Multiracial, and 5% were Hispanic, with statistically small percentages for Non-Hispanic American Indians/Alaskan Natives (9 cases for 0%) and Non-Hispanic Asians (97 cases for 0%). Age of diagnoses of new 2018 HIV cases in the Baltimore MSA between the ages of 20 – 29 years was approximately 33%, 27% for 30 – 39 years, 14% for 50 – 59 years, 13% for 40 – 49 years, 7% for 60+ years, 5% 13 – 19 years, and 1% for less than 13 years. Persons living with HIV are older, with 33% of persons living with HIV being between the ages of 50 – 59 years, 23% being 60 years and older, and 18% being between the ages of 40 – 49 years. For HIV diagnoses exposure in the Baltimore MSA in 2018, Men Who Have Sex with Men (MSM) had 250 diagnoses, followed by Heterosexuals (200 diagnoses), Intravenous Drug Users (IDU) (49 diagnoses), and MSM/IDU (1 diagnosis). For Hispanics in the Baltimore MSA in 2018, there were 443 new diagnoses (6.1% of all diagnoses), with 100% being linked to HIV care within one month, and 88.2% being virally suppressed (as compared to 59.8% in the MSA).

Health Disparities: It is impossible to discuss health issues in Baltimore City without addressing the significant racial and ethnic health disparities that exist as a result of structural discrimination, racism, poverty, and historical practices of exclusion. Despite the City of Baltimore's and state of Maryland's progress toward reducing health disparities, racial and ethnic minorities continue to face significant health disparities. Lead by data and best practices, three conditions that disproportionately impact minorities in Maryland and Baltimore City have been targeted by health authorities: infant mortality, asthma, and diabetes/pre-diabetes.

Black rates of infant mortality are 2.5 to 3 times as high as non-Hispanic White rates. Many factors contribute to the three leading causes of infant death in Baltimore City: pre-term birth, low birthweight, and unsafe sleep. About 84% of baby unsafe sleep deaths are due to smoking during pregnancy. Other factors leading to infant death include the health of the mother and father before conception, medical and supportive services during pregnancy, and post-partum access to critical health education information and services. Although the Baltimore City Health Department's (BCHD) B'More for Healthy Babies initiative reported a 50% reduction in sleep-related infant deaths and a 32% reduction in teen birth rates, a priority area of the BCHD is to decrease the infant mortality rate by 10% from 2015 to 2021. In Baltimore City, the infant mortality rate was 10.4 per 1,000 live births in 2021, as compared to 11.0 in 2020.

Further, homelessness (and associated food insecurity) among pregnant women in Baltimore City remains a problem. Women with unstable housing have nearly three times the rate of preterm births (19.4% versus 6.3% of births) and seven times the rate of low birthweight babies (10.9% versus 1.6% of births), as compared with women with stable housing. Moreover, mothers with behavioral health disorders often had experiences during pregnancy that increased their stress levels; these women have a 25-60% higher risk for preterm delivery, hypertension, preeclampsia, and a variety of health factors such as unhealthy eating and smoking. Gaps in services and disparities exist in prenatal care, interception care (care between pregnancies), and treatment for behavioral health issues that must be addressed with health care providers on system change to improve birth outcomes.

Non-Hispanic Blacks or African Americans children are 13% more likely to suffer from asthma than non-Hispanic Whites. Black emergency department visit rates for asthma range from approximately 4 times as high as non-Hispanic White rates. For asthma, Asian and Hispanic rates are the same or lower than White rates. Accordingly, there is no disparity for these racial and ethnic groups. Due to the small American Indian or Native American population in Maryland and Baltimore City, data is not statistically stable and has not been presented in Maryland Department of Health reporting. Age-adjusted emergency room visits per 100,000 population was 4.3% higher for non-Hispanic Blacks than for non-Hispanic Whites in 2021, as compared to 3.6% higher in 2020. These results show some improvement in minority health and health disparities, with more work to be done.

Diabetes and pre-diabetes are serious conditions that can lead to complications, including heart disease, stroke, vision loss, amputations, and kidney disease. About 15% (14.5%) of non- Hispanic Blacks or African Americans and 10.5% of non-Hispanic Whites in Baltimore City reported that a primary care physician had informed them that they had diabetes. Among those without diabetes, 10.5% have been told by a primary care provider that they

have pre-diabetes, a serious health condition where blood sugar levels are higher than normal, but not high enough to be diagnosed as Type 2 diabetes. According to the Federal Centers for Disease Control and Prevention, 9 out of 10 people with prediabetes do not know they have the condition.

Persons with prediabetes have an increased risk of developing Type 2 diabetes, heart disease, and stroke. Age-adjusted emergency room visits for diabetes per 100,000 population was 433% higher for non-Hispanic Blacks than for non-Hispanic Whites in 2021, as compared to 3.0% higher in 2021.

Cardiovascular disease (CVD) is still the leading cause of death in Baltimore City among Blacks or African Americans, Asian Americans/Pacific Islanders, and American Indians, and the second leading cause of death among Baltimore City Latinos. The major risk factors for cardiovascular disease are diabetes, smoking, high cholesterol, hypertension, physical inactivity, and being obese and overweight.

As previously stated, smoking contributes to CVD. Baltimore City has consistently had a higher smoking prevalence rate for adults (about 33%) than the state of Maryland (about 16.6%). Youth smoking prevalence rate is 14%, with a tripling of e-cigarette use nationally among middle and high school students over the past three to four years. Maryland youth are four times more likely than adults to use multiple tobacco products at the same time, which increases exposure to nicotine and toxic chemical found in these products. This exposure increases the addictiveness and negative health impacts to tobacco users. In Baltimore City, 17% of high school students and 12% of middle school students reported using tobacco products for the first time. Effective October 1, 2021, Maryland law changed requiring that the statewide tobacco products sales age increase from 18 to 21 years for all tobacco products, including electronic smoking devices (e-cigarettes, vapes, pod-based devices and their e-liquids, and component parts and accessories).

Tobacco use rates differ among racial and ethnic groups. In 2020, for youth and adults, Asian Americans had the lowest tobacco use rate (5.4%). Among adults, American Indians/Alaskan Natives have the highest use rate (42.6%); among youth, Native Hawaiian/Pacific Islanders have the highest tobacco use rate (29.7%). Tobacco-related disparities also exist: although Black/African American youth (12.3%) and adults (16.9%) have lower smoking rates, Black/African Americans die from lung and bronchus cancer at similar rates to Whites – probably due to high menthol cigarette use in Black/African American communities.

Hepatitis C is a liver infection caused by the Hepatitis C virus (HCV). Hepatitis C is a blood-borne virus. Today, most people become infected with the Hepatitis C virus by sharing needles or other equipment to inject drugs. For some people, hepatitis C is a short-term illness but for 70%–85% of people who become infected with Hepatitis C, it becomes a long-term, chronic infection. The majority of persons living with Hepatitis C might not be aware of their infection because they are not clinically ill. There is no vaccine for Hepatitis C. In 2017, the Baltimore City Health Department identified a total of 877 individuals with no evidence of care who either had a positive HCV test or an antibody positive test with no confirmed HCV RNA test. A majority of the individuals that were out of care were born between 1945 and 965, and identified as Black/African American. The rate of Hepatitis C (number of cases per 10,000 residents per year, based on residence of case) in Baltimore (citywide) is 35.0.

In the proposed target population, the top causes of death underscore the health disparities and the need for health equity, as indicated in Table 2, *infra.* This table details the top causes of death in Baltimore City:

Table 2. Top Causes of Death in Baltimore City

Cause of Death	Baltimore Citywide
Heart Disease	24.4%
Cancer	21.2%
Stroke	5.0%
HIV/AIDS	1.8%

Cause of Death	Baltimore Citywide
Chronic Lower Respiratory Disease	3.6%

Homicide	3.3%
Diabetes	3.0%

Moreover, violent crime in Baltimore City (including murders, rapes, robberies, and aggravated assaults) and the health consequences for its surviving victims remains a public health issue. The homicide rate of Baltimore City in 2018 was 50.5 per 100,000 population, as compared to a national rate of 5.7 per 100,000 population. For decades, Baltimore's families have faced the reality of violent deaths due to senseless crime. There were 309 homicides in Baltimore in 2020; Baltimore's homicides in 2021 outpaced 2020 numbers: as of December 1, 2021 there were 300 homicides in Baltimore City.

Hardship Index: The Baltimore City Health Department (2021) uses a data indicator called the "Hardship Index." The "Hardship Index" combines data from six socioeconomic indicators – housing, poverty, unemployment, education, income, and dependency. The index ranges from 100 (most hardship) to 1 (least hardship). Table 4 details the "Hardship Index" for select areas of Baltimore City, and the city of Baltimore (citywide):

Table 4. Hardship Index

	Cherry Hill	**Brooklyn/Curtis Bay/ Hawkins Point**	**Baltimore City**
Hardship Index	74	76	51

Emergency department use is disproportionately high among low-income, underinsured, and uninsured persons in Baltimore City. The use of emergency departments by uninsured persons as their primary care sites contributes to spiraling costs and overcrowding and diverts resources from patients with life-threatening conditions. Because the behaviors and diseases (e.g., diabetes, hypertension, addiction, and HIV) that drive many of these residents to the emergency department are essentially preventable, the need for health education,

screenings, regular preventative care, and culturally congruent health care is great. For those already diagnosed, regular medical attention and affordable medications are crucial.

Another unique characteristic among Baltimore City residents is the percentage of grandparents who are raising their grandchildren due to their adult children's substance use disorder problems, incarceration, mental health issues, or death. About 13% of grandparents in Baltimore City (compared with 7% for Maryland as a whole) have responsibility for raising their grandchildren. About one-third of these custodial grandparents (4% of the total amount of custodial grandparents) are aged 65 years and older. Many custodial grandparents find that the combined challenges of aging and of raising a family create a new form of stress, aggravating health issues that must be addressed.

Technology

Technology will continue to assist the agency with creating and maintaining its workload in an efficient manner. The organization currently utilizes Kareo as its Electronic Medical Record.

It is noted that Kareo assists the organization with storing our clinical health information. It also assists the organization with gathering information for efficient operations, effective service delivery and performance improvement. The information gathers from the reports from Kareo assist the organization with our Annual Performance Analysis, which in turn assist us with our Performance Improvement Plans.

Finances

The organization has set up a budget which demonstrates that the organization has the potential to continue to stay a viable organization in the upcoming years.

Status of Finances at time of CARF Survey

Brightlife Enhancement Services is currently operating through an era in which a Pandemic for the Corona Virus has occurred. The organization is slowly being reimbursed for its

services, however constant contact with our funding sources has allowed us to eventually recuperate the majority of funds billed.

The organization is able to pay all bills and provide the needed services to the community and will continue to do so throughout the Calendar Year of 2023.

Financial Threat

If the organization loses clients, that will affect the financial bottom line. Weather disasters, acts of terrorism may prevent services from being delivered which will affect the financial stability of the organization as well. This may also affect the organization with losing revenue as well. The organization operates in the community, and this will also present a problem in regard to staff having the means to adequately provide services on a consistent basis.

Social Determinants of Health:

SDOH are the conditions in the environment where people are born, live, learn, work, play and worship that affect a wide range of health functioning/outcomes, risks and quality of life outcomes.

Domains include:

- Food
- Housing
- Economic stability
- Education access & quality
- Healthcare access & quality
- Social relationships & community

Brightlife Enhancement Services addresses the identification of social determinants of health through screenings, assessments, community data, self-report surveys and utilizes the information in developing and carrying out treatment plans and services.

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