Broward Behavioral Health Coalition
2023 – 2027
Strategic Plan

CELEBRATING 10 YEARS OF SERVICE

BBHC

BROWARD BEHAVIORAL HEALTH COALITION

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CEO's Message

Silvia Quintana, LMHC, CAP

Our strategic planning process began in the middle of responding to the pandemic, highlighting the importance of having a workforce and community that is equitable, flexible, and creative in its response to the emergent and unfolding behavioral health environment.

We know the need for our services will only increase along with state and federal mandates that are imminent, requiring increased population health coordination, integration, and expanded continuum-of-care services.

This strategic plan was developed to assess and adjust our direction in economic developments, changing demographics and service needs, as well as population health policy changes at the local, state, and national levels.

This plan will guide our organization in navigating these immense changes and serve as a roadmap to more integrated, coordinated, whole-person, and culturally competent behavioral health services. It sets new strategic priorities, focuses resources, aligns system-wide goals, and identifies desired key outcomes.

I want to thank our beneficiaries, staff, contracted providers, and other valuable stakeholders for their ongoing input to this strategic plan. I especially appreciate the courage and perseverance our staff have demonstrated in the face of adversity and uncertainty. I am proud of our collective efforts to support the well-being of our Broward County community.

On behalf of our management team, we are excited to continue our engagement and collaboration with our beneficiaries, families, contracted providers, County partners, our Board of Directors, the Department of Children & Families, and the community at large as we begin to implement this strategic plan.

Introduction

Broward County Behavioral Health Coalition (BBHC) envisions a thriving community where prevention is possible and recovery from mental health and substance use disorders is the expectation. BBHC and its partners are committed to this vision by providing evidence-based prevention, intervention, and treatment services for children, youth, and adults that are innovative, person-centered, well-coordinated, and easy to navigate. BBHC is proud of the services it provides and its recent programmatic accomplishments, including our work to address the opioid epidemic, expand school-based behavioral health services, and create a new 24-hour Community Response Team.

These efforts, while powerful, are not enough. There are nearly daily reminders of the impact that mental illness and substance use disorders are having on individuals, families, and communities across the County. Recent assessments and community engagement efforts have identified the need to reduce fragmentation of services; better integrate mental health, substance use disorder and primary care medical services; and expand access to peer support, trauma-informed care, and recovery support services. Our challenges are clear, and it is no surprise that mental health and substance use disorders are a leading health problem facing the County and our health system.

This Strategic Plan is evidence of our continued commitment to address the challenges we face and transform the Broward County's behavioral health system. Together with our partners, we are making notable progress – but we must continue to innovate and refine our services in ways that promote prevention and early intervention, expand access and engagement in care, improve care coordination and service integration, and foster recovery and resilience. BBHC must also continue to strengthen internal systems to improve communication, promote accountability, and build workforce capacity.

The ongoing strategic planning of the organization considers: expectations of persons served, expectations of other stakeholders, the competitive environment, financial opportunities, financial threats, the organization's capabilities, social determinants of health, demographics of the service area, the organization's relationships with external stakeholders, the regulatory environment, the legislative environment, the use of technology to support efficient operations, effective service delivery, performance improvement and information from the analysis of performance.

This Strategic Plan provides a roadmap for BBHC and its partners to align our collective efforts with our vision and guide BBHC's continued efforts to become a nationally recognized behavioral health system. This five-year plan is a critical step in BBHC's efforts to lead change.

Brief History

Broward County's public behavioral health system is under the jurisdiction of the Florida Department of Children and Families (DCF). DCF privatized its service system through the development and contractual relationships with local Managing Entities to provide the administration, management, support, and oversight of the State and federally funded behavioral health services. In 2011, DCF designated the Broward Behavioral Health Coalition (BBHC) as Broward's local Managing Entity (ME), which is responsible for the contracting, monitoring, clinical quality oversight and performance improvement of the DCF/State funded behavioral health services.

BBHC provides a comprehensive system of care for substance use, mental health, and co-occurring disorders for individuals in Broward County. As a non-profit organization, BBHC also manages local and national grants to develop evidence-based practices and practice improvement for providers and persons served.

Mission, Vision & Values

Central to an effective and community supported strategic plan is a close alignment to a set of core principles. The following have been created by community stakeholders in the establishment of BBHC and serve as the core principles of the Strategic Plan.

BBHC Mission:

"To advocate and ensure an effective and efficient behavioral health system of care is available in Broward County."

BBHC Vision:

BBHC seeks to ensure a responsive and compassionate behavioral healthcare experience for people in our community.

BBHC Values:

The goals and objectives of this Strategic Plan are guided by a set of core values adopted by BBHC in 2011. These values apply at all stages of life, across all cultures, and for all communities in Broward County and encompass the key components of the Strategic Plan:

- Consumer Driven
- Efficient Management
- Cultural Competence
- Innovative System
- Compassionate Service
- Fiscal Integrity

BBHC Accomplishments

BBHC was created 12 years ago as the managing entity for Broward County. The organization has accomplished the following major achievements:

- Developed electronic systems for data collection, trend analysis and reporting which have been instrumental in the identification of needs and system improvements.
- Developed and implemented a robust utilization management program that ensures access to and placement in the least restrictive level of care based on clinical need. As a result, access to all levels of care has been streamlined.
- Quality improvement initiatives have been implemented and sustained to increase clinical expertise, evidence-based services, tracking provider performance and service delivery outcomes.
- Evidence-based practice (EPB) training and technical assistance to enhance workforce skills which impact service delivery at no cost to the community.
- Expansion of cross systems collaboration.
- BBHC's CEO was selected by her peer to be the VP of FAME's Executive Committee.
- BBHC's CEO was appointed by the Surgeon General to represent the Behavioral Health profession as Member of the Statewide Child Abuse Death Review (CADR) Committee.
- BBHC is Commission on Accreditation of Rehabilitation Facilities (CARF) accredited.
- BBHC and its network providers have implemented over 100 evidence-based practices since 2011.
- BBHC is Florida's first member of the International Individual Placement and Support (IPS) Learning Community.
- BBHC has forged partnerships through funding from DCF, Broward County, United Way of Broward County, Health Foundation of South Florida, Children's Services Council of Broward County, Substance Abuse and Mental Health Services Administration, and the U.S. Department of Health and Human Services Children's Bureau.
- BBHC worked closely in collaboration with Carrfour Supportive Housing, NAMI, Footprint to Success, South Florida Wellness Network (SFWN), the City of Pembroke Pines, Broward County, Department of Children and Families (DCF) and the Governor's Cabinet to bring an affordable housing project to Pembroke Pines.
- BBHC developed a permanent/transitional Supportive Housing Program for young adults and adults that are couch surfing, transitioning out of residential treatment or aging out of Foster Care. Henderson's program serves 83 persons and Archways serves 11 persons.
- BBHC began funding a Benefit Acquisition Team at Henderson Behavioral Health that serves homeless individuals throughout the Broward County Shelter System, Residential Treatment Facilities, Community Court, and the Community as a whole and assists them in applying for Social Security Benefits.
- Family CPR in collaboration with BBHC allocated SAMH Block Grant funds for 3 beds at the Village (substance abuse residential) for mothers and children, who have been deemed as in need of immediate residential SUD treatment to avoid a child welfare removal episode.
- The Peer Pilot Program project was developed with the support of Sunshine Health. A major barrier to the institutionalization of peer support within the Child Welfare system is the rate of Medicaid reimbursement.

The Strategic Planning Process

BBHC staff formally began the strategic planning process in early 2022, during the global COVID-19 pandemic. The strategic planning process was led by the CEO and the Managing Director of Administration.

The initial strategic planning process entailed an examination of key data documents and feedback resources, and the completion of a Strengths, Weaknesses, Opportunities and Threats (SWOT) assessment. The plan was created based on these resources.

Given the limitations of in-person collaboration due to the pandemic, stakeholder input was gathered through multiple rounds of surveys, small group meetings, and teleconferencing discussions. During the strategic planning period, stakeholders offered input and feedback.

The strategic plan is organized around six high-level strategic goals, each of which has a specific set of objectives. The key outcomes at the end of the plan outline some of the actions that will be taken over the next five years to achieve the vision and mission. This strategic plan is a living document, which will be updated to reflect changes that occur both externally and internally as the implementation, monitoring, and tracking progresses towards our strategic goals.

The next steps in the strategic planning process will be the creation of detailed implementation plans which will guide the implementation process and help ensure that system-wide efforts are aligned, focused, and well-coordinated. The plans will be developed through a series of targeted collaborative efforts with affected subcommittees and stakeholders.

Environmental Scan of Community Data

Demographic Profile:

A Behavioral Health Needs Assessment was completed in 2022 that compiled primary and secondary data that identified behavioral health needs and available community assets to advance healthcare delivery and improve outcomes for all Broward County residents.

The population in Broward County increased almost 30,000 individuals over the past five years to a total of 1,926,205. Racially, the service area is predominantly White (60.7 percent), followed by the Black population accounting for 28.6 percent and Asian residents made up 3.6 percent. Ethnically, almost 30 percent of the service area population is Hispanic. When compared to Florida, Broward County is much more racially and ethnically diverse. Females accounted for slightly more than half of the service area with 51.3 percent and 41.1 percent of individuals are between the ages of 25-54 years old. Residents, 65 years of age or older, accounted for 16.4 percent of the population.

On average, 65.8 percent of Broward County's population participated in the labor force over the past five years. The 5-year unemployment rate estimate for Broward County is 6.1 percent. The ratio of income to poverty rates of those Broward County residents living >400 percent FPL, were 42.4 percent. The Florida Council on Homelessness reported there were 2,054 homeless individuals in Broward County. Of these individuals, 1,228 (60%) identified as unsheltered .

General Health Status Profile:

- BRFSS data estimates revealed 81.2 percent of adults, ages 18-64 years of age, living in Broward County said their ***overall health*** was "good" to "excellent". This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

- The average percentage of Broward County adults reporting good ***mental health*** over the past three years was 88.6 percent. The number of unhealthy mental days for Broward County residents was 3.7 days in the past 30 days.

- The crude ***suicide death rate*** decreased from 13.7/100,000 in 2018 to 11.4/100,000 population in 2020. This represents a decrease of 2.3/100,000 suicide deaths. Among males, the suicide death rate for Broward County was more than three times the rate among females. The suicide death rate among the White population was more than four times the rate for Black residents in Broward County.

- The rate of total ***domestic violence*** offences decreased in Broward County during the past three years, falling from 297.1/100,000 to 293.5/100,000.

- The rate of children experiencing ***child abuse*** over the past three years has continuously decreased in Broward County. Among children ages 5-11 years, the rate of child abuse fell from 979.9/100,000 to 430.5/100,000.

- ***Child sexual abuse*** rates changed very little during the past three years. In Broward County, the 2019 sexual abuse rate for children 5-11 years was 26.0/100,000.

- The estimated number of ***seriously mentally ill (SMI) adults*** increased by 2.5 percent over the past three years. The estimated number of SMI adults in Broward County was 59,921 in 2020.

- Among youth, ages 9-17 years, the estimated number of ***youth with emotional/behavioral disability*** increased by 1.4 percent from 2018 to 2020. The Florida Department of Education (FLDOE) reported 0.4 percent of children in K-12 grades had an emotional/behavioral disability in Broward County. These rates have been steady over the past three years.

- BRFSS results revealed the percentage of adults living in Broward County who are current ***smokers*** to be 12.6 percent. Data from the FYSAS indicated that the percentage of middle and high school students who reported never having smoked cigarettes increased from 90.5 percent in 2016 to 92.3 percent in 2020. When students were asked about smoking frequency, 96.3 percent of those living in Broward County did not smoke at all.

- ***Alcohol Use:*** Binge drinking is defined as five consecutive drinks for men and four consecutive drinks for women. The percentage of binge drinkers Broward County was 16.7 percent. The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 61.9 percent in 2016 to 69.8 percent in 2020. The percentages of students in 2020 consuming alcohol on more than 2 occasions ranged from 3.8 percent for 3-5 occasions to 1.9 percent for those consuming alcohol on at least 40 occasions. High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening 0 occasions in their lifetime (2020) in Broward County was 96.8. When looking at previous reported data, this was an increase from the percentages reported in 2016 for Broward County youth.

- The percentages of students who have not used ***marijuana*** in their lifetimes decreased over the past four years in Broward County (76.9 percent-2020). For those who did use marijuana on one to more than 40 occasions, the overall percentages increased in Broward County from 19 percent 20 percent. The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. In Broward County, 6 percent of students had vaped marijuana in the past 30 days.

- In Broward County, 11.2 percent of the noninstitutionalized population is estimated to have a ***disability*** (includes hearing, vision, cognitive, ambulatory, self-care, and independent living).

- 82.3 percent of residents, ages 18-64 years, living in Broward County reported having some type of ***health insurance*** coverage.

<u>Homeless Population Profile:</u>

- In 2022 (the most recent data available), the Florida Council on Homelessness reported there were 2,054 homeless individuals in Broward County. Of these, 826 (40%) individuals were sheltered, and 1,228 (60%) were unsheltered.

- Chronically homeless, defined as continually homeless for over a year, decreased from 914 people in 2019 to 388 in 2022. Homelessness among veterans decreased from 219 in 2019 to 117 in 2022.

- Four hundred-one (401) families experienced in 2022. The number of homeless students, at 4,903 in the 2017-2018 school year has decreased to 3,264 during the 2021-2022 school year. Of those students who were homeless in 2021-2022, 76 percent (2,482) were in a sharing housing arrangement, 8% (265) were in shelters, almost 12% (385) were living in motels and nearly 8% (251) were unaccompanied youth.

BBHC Consumers Served Data

Demographic Profile:

BBHC funded organizations served 14,118 clients in FY 2021-2022. Nearly all clients (99.85%) resided in Broward County (14,096 clients). Clients who reported living in another county accounted for 0.15% (22 clients). Among adult clients served, 51.91% of adults were enrolled in the Adult Mental Health (AMH) program and 41.18% of adults served were enrolled in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program, at 5.61%, and the Child Substance Abuse (CSA) program at 1.31%.

Males represented more than fifty percent of all clients in the AMH, ASA, CMH and CSA programs ranging from 52.0 percent in the ASA program to 71.0 percent in the CSA program. Females accounted for 45.0 percent of clients in AMH program but only 36.0 percent of those in the ASA program. There were 10.0 percent more women enrolled in mental health programs (45 percent) then in substance abuse programs (35 percent).

The majority of BBHC clients were White (45.0 percent). Black BBHC clients accounted for 40.0 percent of the total client population. The racial diversity among AMH clients was greater when compared to ASA clients where 57.0 percent of the population was White, and 31.0 percent were Black. Clients in child programs followed the same trend with a more diverse racial distribution among CMH clients when compared the CSA clients.

The percentage of Hispanics/Latino in the BBHC client population was 19.7 percent. This was less when compared to the Hispanic population in Broward County at 29.8 percent. When comparing the ethnic distribution among programs, clients in the CMP program closely matched Broward County demographics where Hispanic/Latino clients accounted for 28.0 percent.

Adults, ages 25-44 years of age, accounted for 45.1 percent AMH clients and 59.2 percent of ASA clients. Among these, adults ages 25–34 years, made up the largest proportion of both AMH and ASA clients when comparing age ranges. Children under age 5 years accounted for less than 0.5 percent of CSA clients but 11.0 percent of CMH clients. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA (76.2 percent) program when compared to those in the CMH program (42.8 percent).

A higher percentage of AMH clients lived independently alone (18.5 percent) when compared to ASA clients at 12.2 percent. Eighty percent of clients in the CSA program lived dependently with relatives. This was higher when compared to the percentage of clients in the CMH program where 55.5 percent lived dependently with relatives.

Among BBHC adults, 33.3 percent of clients were high school graduates who did not go on to further education. Over forty percent of the total client population had less than a high school education. Among adult programs, 38.7 percent of AMH clients and 36.5 percent of ASA clients did not attain more than a high school education. The percentages of adult BBHC clients who earned an associate degree or bachelor's degree ranged from 13.1 for AMH clients to 10.7 percent for ASA clients.

Unemployment ranged from 42.3 percent of AMH clients to 55.6 percent among ASA clients. Full-time workers accounted for 10.0 percent of AMH client and 17.4 percent of ASA clients. For all BBHC clients, 8.9 percent were employed part time.

BBHC Homeless Consumers Profile:

A total of 2,492 homeless clients were enrolled in adult and child programs in FY 2020-2021. Of these, 59.6 percent were in the AMH program and 40.0 percent in the ASA program. Clients enrolled in child programs accounted for less than one half of one percent. It should be noted that there may be a small percentage of overlap with some clients enrolled in both programs.

The number of homeless male clients (1,708) were more than double the number of homeless women (785). Males accounted for 67.0 percentage of clients in the AMH and 72.0 percent of ASA homeless clients. There was a higher percentage of homeless male clients, at 69.0 percent, when compared to the general client population where males accounted for 58.0 percent of all clients. Among child programs, females accounted for 67.0 percent of CMH and 100.0 percent of CSA clients. It should be noted that the number of homeless clients in the CMH & CSA was very small so results should be interpreted with caution.

Black homeless clients accounted for 45.7 percent of those in the AMH program while White homeless clients accounted for 44.0 percent. White homeless clients represented the majority of ASA clients at 66.6 percent. Black homeless clients accounted for 83.3 percent of CMH participants. The percentage of homeless Hispanic/Latino clients in the AMH program, at 9.8 percent, was lower when compared to the Hispanic/Latino clients in the ASA, at 15.0 percent. This was lower when compared to the general client population where 19.7 percent were Hispanic.

Adults, ages 25-44 years, accounted for 60.4 percent of ASA clients and 47.5 percent of AMH clients. Homeless clients 65 years and older accounted for less than three percent the total homeless client population.

Among the homeless clients, close to forty percent did not have a high school education and 33.6 percent completed their education at the high school level. Less than ten percent of homeless clients were employed (part or full time) and 65.3 percent were unemployed.

Stakeholder Survey Results

Stakeholder respondents were asked questions regarding awareness, access to care, and barriers to behavioral health resources. More than 85 percent of stakeholders were aware of the behavioral health resources available in their county and over 95 percent had knowledge of the 2-1-1 informational resource. However, they did not feel that the overall community possessed the same level of awareness; only 57 percent rated awareness as good to excellent. Fortunately, of those who reported having used the 2-1-1 resource, the majority (55 percent) found it to be useful. Like consumers, stakeholders felt that linkages to services were well coordinated and accessible but were less confident in other aspects of the program. Stakeholders cited the lack of reliable transportation as the top barrier for access care. Long wait lines was number two and being unsure of where to go was the third biggest barrier to care. This identifies the need for additional resources to support the flow of consumers across the healthcare system. Respondents reported that housing needs, transportation needs, staff shortages, mental health resources, and more knowledge of available programs are needed resources and services.

Results from the survey identified the following resources and services that have improved quality of life for individuals:

- Access to food
- 211 Broward
- Case Management Services
- Broward Addiction Recovery Ctr
- Memorial CATS Program
- Peer Services
- Agencies like Jubilee
- Care Coordination Services
- Section 8/HUD Housing
- Memorial Youth & Family Services
- Adult SUD Treatment
- Drop-In Centers
- South Florida Wellness Network
- Therapy Services
- Broward Housing Solutions
- Memorial Family TIES
- Child Mental Health Services
- MAT in Emergency Departments

Results from the survey identified the following barriers for accessing services in the community (rank ordered):

1.Did not know where to go for services	2. No or very limited transportation	3.Long wait lists
4.Could not afford services	5. Did not meet eligibility criteria	6. Stigma
7. Language/Cultural differences	7. No evening or weekend appts.	8. Services not available in the county
9. No outreach to people who are homeless	10. Housing/Shelter availability is not enough & it is too complicated of a process	

Results from the survey identified the following needs and gaps within the system of care:

▪ Transportation	▪ Housing	▪ Childcare
▪ Reduce waitlists	▪ More inpatient facilities	▪ Residential SUD treatment
▪ CMHCs for uninsured	▪ Knowing how & where to go for services	▪ More Case Management Service locations to assist people applying for HUD/Section 8 Housing

Consumer Survey Results

Awareness of where to find services when needed was a challenge for about 17 percent of consumers. However, word of mouth was the most prominent method of learning of programs. More than half of the consumers indicated that they learnt of the services they needed from family members, friends, or another person who used the services. Overall, more than 60 percent consumers did identify that they received services when they needed them. Over sixty percent of consumers were aware of the 2-1-1 resource in their community. Most consumers also reported that they believed provided services were accessible. According to the responses, long wait lines, not knowing where to go for services, strict eligibility requirements, lack of transportation, stigma, and affordability were all top barriers for receiving necessary resources.

Recovery Community Survey Results

Adults living with co-occurring mental health and substance use conditions were the largest group of respondents in this survey, making up 47 percent of responses. Adults with lived mental health conditions are the second largest respondent group, followed by adults with lived substance use conditions and family member/friend of someone with lived mental health conditions.

Almost one-third of respondents worked/volunteered in either adult mental health services or substance use services; 23 percent were employed/volunteered with peer support services. Forty percent of respondents have been employed/volunteered with the agency for more than 3 years. Personal fulfillment was a main reason for maintaining employment with the agency for over a quarter of respondents. Commitment to recovery principles and flexible work schedules were also among top reasons for maintaining employment. Top barriers in the hiring process included salary, and the exemption/background screening process.

A large majority of responses indicated that agencies utilized peer support services, adhered to recovery support best practices and reduced stigma by promoting person centered recovery language. Most respondents also identified that peers were included in program development stages as well as recovery management and board meetings. However, respondents were most aware of only a select few recovery partnerships.

Cultural Health Disparities Survey Results

A cultural health disparities survey was sent to clients in CDC identified vulnerable areas. They were asked a series of questions related to behavioral health care services and told to choose from responses ranging from strongly agree to strongly disagree. Question types ranged from demographic information to feelings/perception regarding behavioral health care services. There was a total of seventy-two survey respondents; 73 percent of the respondents were female. Most responses portrayed positive attitudes towards behavioral health care services, but there were some questions with varied responses. When asked how they would rate their trust in the behavioral health care system to treat them with respect, 45 percent did not have trust.

Results from focus groups with consumers identified the following needs and gaps:

- Importance of being heard
- Decrease stigma and judgement
- Trauma & Sensitivity Training
- Reduce waitlists
- Limited resources due to lack of insurance or individuals experiencing homelessness.
- More staff are needed
- Promoting safe spaces
- Provide group, individual & virtual therapy to meet the needs of the person
- Penalizing persons for arriving late when they are dependent upon public transportation.
- Community education
- More drop-in centers
- Discharge planning/supportive services
- Lack of provider availability
- Need for smaller groups/ individualized treatment
- Job connections for persons with disabilities
- Job and life training
- Strength-based/ judgement free zones

No Wrong Door Survey Results

This assessment conducted among the BBHC providers revealed the mission to make all doors the right doors or even eliminate doors completely. This survey consisted of eighty-one respondents; over 20 percent of respondents worked in adult outpatient programs, followed by recovery support (20 percent) and adult detoxification units (14 percent). A large majority of participants thought the "No wrong door" access and their organization had a successful relationship.

Results from focus groups with BBHC providers identified the following needs and gaps:

- Training for fundamental behavioral health services for peers and professionals who can triage and support.
- Ongoing sensitivity training
- Additional staff is needed
- Socioeconomic understanding
- Availability of resources/beds
- Community resource directory explaining services offered
- Referral coordination
- Insurance plan barriers
- Stigma
- Engaging the school system
- Telehealth
- Lack of funding
- Lack of resources

BBHC Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis Results

In addition to the documents and data reviewed earlier in this plan, the community completed a SWOT analysis specifically focused on the functioning of BBHC. One hundred thirty-six (136) individuals within Broward County participated in focus groups and surveys facilitated via the Consumer Advisory Subcommittee, the Recovery Oriented Systems of Care Subcommittee, and the BBHC Board of Directors. Across these committees, voices representing providers, consumers of service, community advocates, allies and other stakeholders were heard. Results of the SWOT analysis by stakeholder group are presented in the following pages.

STAKEHOLDER GROUP IDENTIFIED STRENGTHS: *Strengths* are *internal* BBHC characteristics that are unique, special, highly valued, and positive relative to BBHC.

BBHC Board of Directors & Staff	Evidenced By
• Leadership Team, CEO, Board of Directors & Staff	• CARF Accreditation • Collaboration with federal, state, & local systems • Representation in state & local policy committees • Commitment of BOD • Commitment Across Disciplines and Stakeholders
• System Innovation & Network Expansion	• Doubling budget • Achieving all Performance Outcomes • Doubling Service Array • 100+ EBPs across the SOC
• Communication with SoC	• Expansion of Cross Systems Collaboration • Advocacy

Providers	Evidenced By
• Leadership Team, CEO, Board of Directors & Staff	• Clear Mission & Committed Leadership • CARF Accreditation • Advocacy for Broward SoC Providers
• System Innovation & Network Expansion	• Advocacy for cultural competence • Recovery Oriented, Client-Centered Services • Creating New Services & Resources
• Communication with SoC	• Provider & Client Advocacy • Communication with Providers

Consumers	Evidenced By
• Leadership Team, CEO, Board of Directors & Staff	• Elevation of consumer voice in business decisions, & program development • Developed & sustained peer/consumer run services
• System Innovation & Network Expansion	• Elimination of Access Barriers • Peer Employment Opportunities
• Communication with SoC	• Positive Cultural Shift within Service Systems in how Consumers & Families are viewed • Advocacy for peers, consumers & families

Advocate/Ally/ Stakeholder	Evidenced By
• Leadership Team, CEO, Board of Directors & Staff	• Unification of BH Providers • Responsive to provider and consumer needs
• System Innovation & Network Expansion	• Utilizing funding opportunities • Accountability of Provider Network • Creativity in Meeting Community Needs
• Communication with SOC	• Community Care Collaboration • Connection with Network Providers & Community Organizations • Training within the SoC

STAKEHOLDER GROUP IDENTIFIED WEAKNESSES: *Weaknesses are internal challenges that BBHC faces or limitations to achieving our mission and goals.*

BBHC Board of Directors & Staff	Evidenced By
• Composition of Board of Directors	• BOD lacks diversity reflective of the community, including youth
• Data-Driven Knowledge & Funding	• Use of data to inform service accountability and cost of care • Lack of data from other service systems • Aligning Persons Served with Appropriate Level of Care
• Communication	• Limited understanding of BBHC staff activities and oversight areas • Advocacy for culturally & linguistically Competent Services • Community lack of awareness of BH services

Consumers	Evidenced By
• Lack of funding	• Need for services for uninsured/underinsured • Lack of medications
• Lack of Provider Knowledge of Peer Role	• Peers asked to do activities outside of their roles • Peer services different at different providers
• Communication	• Marketing the BBHC network • Marketing Role of Peers & Consumer Voice

Providers	Evidenced By
• Data-Driven Knowledge & Funding	• User-Friendly Data System • Changes in billing/reporting impact achieving objectives • Complicated integrations with state systems • Need for real time data to assess performance & identify trends • Need provider training in utilizing data
• Communication	• Community awareness of BH services & programs & system navigation • Transparency of Decision-Making • Follow-up with consumers • Lack of requesting provider feedback

Advocate/Ally/ Stakeholder	Evidenced By
• Data-Driven Knowledge & Funding	• Funding limitations or Restrictions • Transparency with Allocations of Funds • Lack of data from other systems such as jails
• Provider Network	• Integrate providers from other systems • Specialty Services • Provider Accountability
• Communication	• Lack of Solid Marketing/Communication Plan • Collaboration with BSO, 211, NAMI, MHA

STAKEHOLDER GROUP IDENTIFIED OPPORTUNITIES: *Opportunities occur when the external environment is closely aligned with a BBHC strength.*

BBHC Board of Directors & Staff	Evidenced By
• BBHC/SOC Branding/Marketing Efforts	• Increase Social Media Presence • Marketing plan • Cultural Competency • Communicating what BBHC does within the Provider Network
• Technical & Data Systems	• Increasing Technical Systems to Support Staff • Sharing Data and Resources Across Systems (e.g., CSC Pilot) • Provider use of EHR • Sharing of Data Monitoring Purposes
• Expanding Workforce & Provider Network	• Need to address service gaps due to staff shortages • Immediate & appropriate access to services • Aligning Universities to Expand Workforce
• Funding	• Improved Medicaid Rates and Service Coverage • Collaboration with other MEs and MMA/Medicaid plans • Management of funds • Advocacy to Expand Medicaid Eligibility in FL • Pilot Project of ME managing braided funding

Consumers	Evidenced By
• BBHC/SOC Branding/Marketing to Persons Served	• Need marketing to persons served throughout Broward & state
• Expanding Provider Network	• Need to address service gaps due to staff shortages • Use of telehealth across state lines
• Creating a Welcoming Culture Within Provider Network	• Need to train front-desk & support staff • Train providers in Person-Centered Care & Assess Fidelity of Model
• Improve Communications Between Providers & Consumers	• Implement & Monitor regional ROSC plan to provide consistency across providers • Competitive wages & education opportunities for staff
• Implementing Organizational & System of Care Wellness Programs & Activities	• Implement Requirement for Provider Organization Wellness Plans • Provide Refresher WRAP Trainings & Staff Wellness Plans

Providers	Evidenced By
• BBHC/SOC Branding/Marketing Efforts	• Provider Advocacy • Build community trust in BH providers • Increase Social Media Presence
• Technical & Data Systems	• Using Data to Drive Decision-Making & Identification of Successful Programs • Improved Objective Provider Accountability Measures
• Expanding Provider Network	• Housing providers • Improved Provider Relations • Job Placement providers • Expand Innovative Services • Provider Accountability
Funding	• Advocacy for Medicaid to Cover Services that BBHC pays for to address gaps • Capitalize on federal funding • Coordination of funding across service systems

Advocate/Ally/ Stakeholder	Evidenced By
• Bidirectional communications with community	• System supported advocacy • Communicate Provider Needs to State Leadership
• Expanding Provider Network	• Include Other Systems such as Jail Diversion, BSO, Specialty Providers, Faith Community • Partnerships with primary care providers
• Increasing Technical Systems to Support Staff	• Track Data & Performance Outcomes More Closely • Improved connected data systems between across systems • Improve Provider Accountability
• Funding	• Cover Crisis Services such as 988, CSUs, & Mobile Response • Advocacy for Medicaid to Cover Services that BBHC pays for to address gaps • Maximize Federal Funding & Braided Funding Across Systems

STAKEHOLDER GROUP IDENTIFIED THREATS: *Threats occur when the external environment actually or potentially reduces or eliminates a capability or need for a capability of BBHC.*

BBHC Board of Directors & Staff	Evidenced By
• Funding	• MMA/AHCA • Funding Cuts • People Losing Medicaid at the end of the COVID Public Health Emergency
• Political Environment & Impact to Service System	• ME Procurement • Election Outcomes • Consolidation of MEs by DCF • Closure of Baker Act Receiving Facilities • Loss of Forensic Beds at State Hospital
• Cost of Living	• Increasing number of uninsured/underinsured individuals • Housing Costs • Food Costs • Inflation • Healthcare Costs
• Workforce Shortages	• High turnover • Background Screening Backlogs Due to Regulatory Requirements • Staff burnout/high workloads • Lack of Qualified Staff • Providing Competitive Wages • Cultural Shift in Work/Life Balance

Consumers	Evidenced By
• Funding	• Cuts leading to lack of service capacity & qualified providers
• Political Environment	• Senate Bill 282 & Adequately Trained & Certified Peer Support Staff • State DCF Not Supportive of MEs • Chasm Between MH & SUD Providers • Community Culture not Facilitating Safe Spaces
• Cost of Living	• Housing Costs • Provider Staff Accessing Safety-Net Services • Rationing of meds
• Workforce Shortages	• Living Wage • Lack of psychiatry • High turnover, inability to recruit • Staff burnout/high workloads • Lack of staff wellness • Lack of welcoming environment at network & provider level

Providers	Evidenced By
• Funding	• Medicaid HMOs competing for state funding • Lack of diverse funding
• Political Environment	• State legislation & changing regulations • State leadership not aligned with local community needs • State DCF Not Supportive of MEs • Negative media coverage of BH
• Cost of Living	• Housing Costs • Healthcare Costs
• Workforce Shortages	• Providers are underfunded to compete with other employers • High staff turnover leading to lack of service access • Lack of Qualified Staff • High workloads • Sacrifice of EBP fidelity

Advocate/Ally/ Stakeholder	Evidenced By
• Funding	• Lack of Medicaid Expansion • Medicaid Criteria
• Political Environment	• State Legislature • Lack of Shared Data Across Systems • Legislation creating barriers to service access • State DCF Not Supportive of MEs
• Cost of Living	• Lack of Supportive Housing
• Workforce Shortages	• Availability of Services • Staff Retention • Limited Providers • Living Wage

The data presented thus far in this report represents surveys, small group meetings, and discussions in which community stakeholders were invited to share their feedback on areas of strengths and areas of improvement. BBHC's Board of Directors also reviewed findings from the community health needs assessment and the environmental scan of community and BBHC-specific data and reports presented in this report to identify any Political, Economic, Social, Technology, Legal, Environment/Climate, Security/Safety, Religion, Regulatory, and Demographic (PESTLE+) factors. The following SWOT analysis, informed by the PESTLE+ emerged:

System of Care Aggregate SWOT Analysis

Strengths	Weaknesses
❖ Proactive, dedicated, compassionate, knowledgeable, and committed staff ❖ Depth and quality of client-centered services ❖ Diverse programs to meet the needs of consumers ❖ Community partnerships and interagency collaborations ❖ Strong stakeholder collaboration ❖ Adaptable and flexible systems ❖ Commitment to creative, innovative, and proactive approaches to service ❖ Commitment to continuous quality improvement processes ❖ Knowledgeable leadership committed to organizational success ❖ Compliance with state and federal mandates	❖ Workforce shortages ❖ Consumer barriers to accessing services including stigma/fears of discrimination, awareness of services, transportation, availability of services, and location of services ❖ Need more support services such as housing ❖ Lack of community understanding and support for behavioral health needs ❖ Current data and reporting system ❖ Transparency of decision making, allocation of funding, provider accountability ❖ Lack of diversified funding ❖ Limitations of current provider network
Opportunities	**Threats**
❖ Increase cultural understanding, decrease bias, and stigma. ❖ Increase types and location of services. ❖ Increase provider network ❖ Increase recruitment efforts for peers, and qualified staff ❖ Increase organizational efficiency and quality through technology and technical training ❖ Improve performance outcome and data tracking ❖ Improve technology systems to support reporting and data driven decision making ❖ Seek non-traditional and other grant funding sources	❖ The ME Procurement ❖ Political environment ❖ Impending funding cuts ❖ Uninsured population ❖ Increased need for services with potential inability to hire to meet those needs ❖ Staff morale, wellness, and capacity ❖ Cost of living ❖ Lack of appropriate or adequate funding and competing for funding

Strategic Goals at a Glance

The following six, high-level strategic goals will guide our multi-year behavioral health system planning process, including participation by community stakeholders in services and program design toward a coordinated and integrated system of care.

1. **Client and Community Engagement**: Actively engage, empower, and build trust through culturally appropriate services and marketing competencies, partnering with consumers, their families, and the community for their care and well-being.

2. **Service Excellence and Innovation**: Provide an enhanced continuum of care through system and community-wide integration, drawing on evidence-based, trauma and culturally informed practices, innovative technologies, and appropriate levels of services leading to a consumer-driven service delivery system.

3. **Quality**: Expand care management quality and effectiveness through data-driven, metrics-based management facilitated by a robust data strategy, continuous process improvement, training, education, and stakeholder engagement.

4. **Growth and Access**: Serve as a behavioral health leader and community partner through accessible, timely, appropriate, and comprehensive care.

5. **Staff Engagement and Leadership Development**: Develop and sustain a skilled, collaborative, and motivated workforce who have a passion for service and quality at all levels of the organization.

6. **Financial Stability and Performance**: Ensure efficient, responsible, and strategic use of resources for long-term growth-oriented sustainability that facilitates competitive payer partnerships.

Strategic Goals and Objectives

The plan draws on the core philosophy of a recovery-oriented system of care and "No Wrong Door" so we can actively engage and meet our clients and community members where they are and when they are in need. The following Strategic goals and objectives outline our efforts.

Strategic Goal #1: Client and Community Engagement: Actively engage, empower, and build trust through culturally appropriate services and marketing competencies, partnering with consumers, their families, and the community for their care and well-being.

Objectives:

- Expand cultural competency training of service providers by providing one training per quarter as evidenced by compliance with the CLAS Standards.
- Assess the capacity of the network to provide services in at least Spanish and Creole languages via an annual survey to make recommendations to meet the needs of the community.
- Create educational messages targeting at least two different cultural groups in the community through outreach, using various communication channels, annually.
- Present at one venue per quarter to support the above.
- Create marketing flyers in Spanish and Creole, minimally, and disseminate in applicable neighborhoods.
- Increase perception of satisfaction, access to care, and quality of care by soliciting input from the Consumer Advisory Council, Federation of Families, OCP3, NAMI, and other consumer support agencies as evidenced by an increase to 90% on the CPSSS tool annually.
- Conduct two focus groups and/or surveys annually with the above consumer organizations/partners.

Strategic Goal #2: Service Excellence and Innovation: Provide an enhanced continuum of care through system and community-wide integration, drawing on evidence-based, trauma and culturally informed practices, innovative technologies, and appropriate levels of services leading to a consumer-driven service delivery system.

Objectives:

- Monitor 20% of providers on fidelity of selected evidence-based practices, annually.
- An annual survey will be conducted to assess trauma service availability and cultural/linguistic capacity.
- Finalize implementation of the BBHC portal phase one as evidenced by it being operational for all programs.
- Start development and implementation of phase two as determined by the management team.
- Implement Carisk incidental portal for all incidental requests.
- Utilize annual Enhancement Plan to update the Needs Assessment.

- Continue monitoring lengths of stay quarterly to ensure they do not exceed a 20% additional request of the original authorization.

- Meet with at least 50% of Broward legislators who are involved on the behavioral health committees, to gain support for the needs identified in the BBHC Enhancement Plan.

Strategic Goal #3: Quality: Expand care management quality and effectiveness through data-driven, metrics-based management facilitated by a robust data strategy, continuous process improvement, training, education, and stakeholder engagement.

Objectives:

- BBHC Data Submission Report will show a discrepancy of less than 5% by next year.

- Increase discharge data submission by 20%.

- Ensure BBHC's Network Providers complete the quarterly performance evaluations to ensure all performance outcome measures have data by at least the third quarter.

- Deliver EBP training to the network at least four times per year.

- Deliver operational/administrative trainings to the network at least four times per year.

Strategic Goal #4: Growth and Access: Serve as a behavioral health leader and community partner through accessible, timely, appropriate, and comprehensive care.

Objectives:

- Review the access to care data quarterly to ensure persons served are placed at the appropriate level of care.

- Participate in at least one multi-agency staffing per quarter as scheduled.

- Participate in at least two monthly community meetings engaging partners to address system issues.

Strategic Goal #5: Staff Engagement and Leadership Development: Develop and sustain a skilled, collaborative, and motivated workforce who has a passion for service and quality at all levels of the organization.

Objectives:

- Support BBHC's staff to enhance career development by attending training opportunities, annually.

- BBHC staff will be recognized at the monthly staff meeting based on accomplishments, awards, and/or life events as appropriate.

Strategic Goal #6: Financial Stability and Performance: Ensure efficient, responsible, and strategic use of resources for long-term growth-oriented sustainability that facilitates competitive payer partnerships.

Objectives:

- Monitor program utilization and data validation, bi-annually.
- Encourage stakeholder participation and feedback for strategic use of resources, as scheduled and evidenced by minutes from the respective meeting.
- Increase financial capacity to enhance the system of care by reviewing and/or applying for additional funding as appropriate, annually.
- Increase provider network contracts based on needs in the community as appropriate, annually.

Monitoring and Reporting Progress

Key Outcomes

BBHC expects the following key performance outcomes will help us demonstrate progress towards and achievement of the goals and objectives in this strategic plan. In addition to the performance outcomes, we will identify specific activities, tactics, and/or approaches in the implementation plan for each goal. Some of the key outcomes may be relevant to more than one strategic goal. Where applicable, key outcomes will be compared to existing baseline data and/or baselines will be established. Additional methodologies will be utilized, as needed, to identify and track success.

Strategic Goal #1: Client and Community Engagement: Actively engage, empower, and build trust through culturally appropriate services and marketing competencies, partnering with consumers, their families, and the community for their care and well-being.

- Increased client experience of “No Wrong Door.”
- Increased retention of clients being served while also, when appropriate, increasing clients moving to lower levels of care.
- Increased number and percentage of clients in unserved, underserved, and marginalized populations.
- Increased client satisfaction in services on items related to cultural and linguistic appropriateness of care.
- Increased the number of community members who are knowledgeable and aware of mental health and substance use challenges and how to get help.
- Increased the number of community forums that are knowledgeable about services and can become bridges to help individuals get the help they need.

- Increased outreach and engagement activities, each year, to unserved, underserved, and marginalized populations as compared to baseline data.
- Expanded number and types of trainings and education for staff focused on cultural competency.
- Increased community partnerships.

Strategic Goal #2: Service Excellence and Innovation: Provide an enhanced continuum of care through system and community-wide integration, drawing on evidence-based, trauma and culturally informed practices, innovative technologies, and appropriate levels of services leading to a consumer-driven service delivery system.

- Increased client support through coordination of care.
- Increased client satisfaction with the care and services received.
- Reduced number of high-cost clients, where a decrease would be appropriate.
- Increased rate of timely access to services.
- Reduced rehospitalizations.
- Improved quality of life, including measures of recovery and resilience.
- Increased number of multi-disciplinary treatment teams.
- Reduced incidence of justice involvement.
- Increased availability of translated materials and use of interpretation services.
- Decreased utilization review disallowances.

Strategic Goal #3: Quality: Expand care management quality and effectiveness through data-driven, metrics-based management facilitated by a robust data strategy, continuous process improvement, training, education, and stakeholder engagement.

- Increased performance measures tracking and establishment of critical baselines.
- Increased and improved “timely access” to services.
- Increased bilingual capacity of providers.
- Increased data-driven process improvement projects that include internal and external stakeholders.
- Reduced paper workflows with improved electronic processes.
- Increased institutional knowledge retention through cross training and procedure development.

Strategic Goal #4: Growth and Access: Serve as a behavioral health leader and community partner through accessible, timely, appropriate, and comprehensive care.

- Reduced wait times across the system to transition to appropriate levels of care.
- Increased client experience of programs that are welcoming, culturally competent, and relevant for the community they serve.
- Increased housing support.
- Increased support for families of clients.
- Increased coordination with other systems significantly impacting children and youth (especially educational, juvenile justice and child welfare systems), and individuals and families experiencing homelessness or housing insecurity.
- Increased rates of service to vulnerable populations.
- Maintain positive contracted provider collaboration.

Strategic Goal #5: Staff Engagement and Leadership Development: Develop and sustain a skilled, collaborative, and motivated workforce who have a passion for service and quality at all levels of the organization.

- Increased professional development opportunities at all levels.
- Increased diversity, equity, and inclusion (DEI) trainings for all staff at all levels.
- Increased staff recognition.
- Increased supervision and management leadership trainings.

Strategic Goal #6: Financial Stability and Performance: Ensure efficient, responsible, and strategic use of resources for long-term growth-oriented sustainability that facilitates competitive payer partnerships.

- Enhanced program utilization and data validation.
- Development and implementation of key processes to facilitate stakeholder participation and feedback for strategic use of resources.
- Improve cost analysis to ensure proper program cost allocation.
- Increased provider network contracts based on needs in the community.

Implementation Plans

The execution and implementation of the strategic plan will be overseen by the BBHC Board of Directors and BBHC leadership and staff through implementation plans, which will include detailed action steps to carry out the key goals and objectives with identified stakeholders and timelines.