Tri County

BECAUSE WE CARE

CALVERT | CHARLES | ST. MARY'S

Southern Maryland Crisis Services

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Acknowledgements & Executive Summary

The Renaye James Healthcare Advisors team is appreciative of the many key stakeholders in the Southern Maryland region and subject matter experts across the state who took the time to complete surveys and/or meet with the team to provide the valuable information contained in this environmental scan.

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- J. Scott Smith, Superintendent, St. Mary's County Public Schools
- Katie Wandishin, Coordinator, Local Behavioral Health Authority, Calvert County Health Department
- Lori Werrell, Regional Director, Population and Community Health, MedStar St Mary's Hospital/ MedStar Southern Maryland Hospital Center
- Erin Wilkins, Calvert County Crisis Response

Executive Summary

In April 2021, Renaye James Healthcare Advisors of Columbia, Maryland was awarded a contract through the St. Mary's County (Maryland) Health Department to assist in assessing behavioral health crisis services in Southern Maryland. This is in response to a statewide effort to increase the access and provision of behavioral health crisis services in Maryland. The award requirements include conducting an environmental scan and assessment to identify the current status of behavioral health crisis services in the three counties of Southern Maryland (St. Mary's, Charles, and Calvert) to include regional assets, barriers, and gaps of care. In addition to the environmental scan, a separate Crisis Center implementation plan will be developed to guide the region on the steps to develop a comprehensive Crisis Center by county or by region.

Like other jurisdictions in the state and country, the three counties in Southern Maryland have clear challenges with providing comprehensive crisis services. These challenges include the provision of timely services; over-utilization of law enforcement, the criminal justice system and emergency departments; and reduced psychiatric beds at local hospitals (Alaska Mental Health Trust Authority,2019). In order to identify the status of the crisis services in the region, questionnaires, focus group meetings, and individual informant interviews were conducted in May and June 2021. In addition, literature reviews, data queries (state and national) and data analyses were completed to compare and contrast the demographics, health status, and behavioral health status of the region to its state and national counterparts.

With these data points, a detailed SWOT (strengths, weaknesses, opportunities, and threats) analysis was completed. This SWOT analysis, evidence-based crisis center research, and subject-matter expertise contributed to the assessment of regional crisis services as well as the recommendations and discussion for future crisis services for the region.

The environmental scan and assessment illustrate that the regional stakeholders have a clear understanding of the priorities and needs of the area and identified the following as top priorities:

- Child/Adolescent Crisis Services
- Geropsychiatry Crisis Services
- 24/7 access to Crisis Services
- Residential Services- Child/Adolescent
- Residential Services- Geriatric
- Tri-county integrated Crisis Response System

The complete analysis aligns with the regional stakeholder observations and identifies the following gaps in care, barriers to care, or current needs in the region:

- Behavioral health crisis centers with walk-in stabilization capacity
- Outpatient Emergency Department diversion resources
- Mobile crisis services
- Residential crisis services
- Cross jurisdiction collaboration
- Accessibility of services/ Transportation barriers

Understanding the priorities and the existing barriers, the recommendations for Crisis Center Services include offering comprehensive behavioral health crisis services in a hub-and-spoke model that includes a crisis hotline/ call center hub, mobile crisis team, walk-in center, and residential services. Although some counties have identified locations to implement crisis services, recommendations for potential locations to house the crisis services have been recommended based on the commercial real estate availability in the region.

Based on several factors, to include but not limited to funding, technology capacity, geography, and county government infrastructure, a regional approach to the establishment of a singular crisis center may pose a challenge to implement in the short-term; as a result, the discussion in the Additional Considerations and Closing Remarks sections includes options to implement comprehensive services at a local/county level and still consider regional collaboration at the governance level.

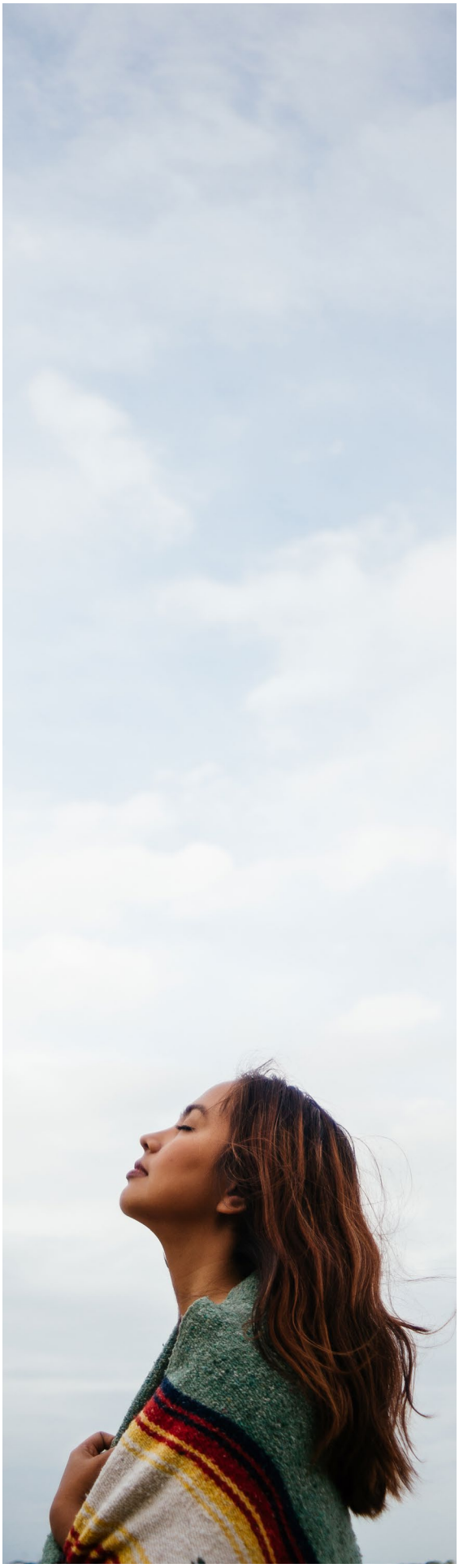
Introduction and Background

PURPOSE

St. Mary's County Health Department engaged Renaye James Healthcare Advisors to complete a Southern Maryland community assessment and an environmental scan to identify behavioral health (mental health and substance use) access challenges in the Southern Maryland region that consists of St. Mary's, Calvert, and Charles Counties. In this report, and as defined by the Substance Use and Mental Health Services (SAMHSA), behavioral health includes "the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities."

This community assessment and environmental scan were completed between May 21, 2021 through June 18, 2021, and appraises the current behavioral health resources in Southern Maryland and evaluates their efficacy in meeting the needs of the population (s) in St. Mary's, Calvert, and Charles Counties. Using state and regional data, stakeholder input, a landscape assessment, and national crisis center research/literature review, this community assessment and environmental scan provide critical information on the gaps in behavioral health services, the unmet behavioral health needs of the population, and the regional coordination challenges that emphasize the need for a Southern Maryland Crisis Center and comprehensive crisis services.

The crisis services that will ultimately result from this endeavor will efficiently and effectively serve individuals experiencing a behavioral health crisis who are at high risk of instability in the community, especially those who are in danger of harm to self or others and at risk of immediate referral to a hospital emergency room. Although some level of crisis services are available in the Southern Maryland region, those services are not fully developed according to evidence-based models summarized in this report and are not available 24/7/365 resulting in individuals accessing inappropriate and inadequate services to address unmet behavioral health crisis needs.



ABOUT RENAYE JAMES HEALTHCARE ADVISORS

Founded in 2017, Renaye James Healthcare Advisors is an outcome–based, healthcare advisory company dedicated to improving the quality, safety, and efficiency of care delivery to those in need. The organization accomplishes this by guiding medical practices and healthcare programs to realize quantifiable improvements in revenue, quality, safety, staff engagement and the patient experience. The Renaye James Healthcare Advisors team has front-line, management, physician and executive experience who work to transform practices into high-quality, efficient, safe and patient-centered venues of care. Past endeavors with health systems and partners include the development of strategic plans, implementation of quality improvement programs, team-based care models, care coordination programs and achievement of operational excellence.

SERVICE AREA

The service area for this environmental scan includes the geographical boundaries of Charles County, Calvert County, and St. Mary's County known as the Southern region of Maryland. The region's northern boundary passes through Prince George's County and Anne Arundel County, east of Washington D.C. Its eastern boundary is the Chesapeake Bay, and its southern and western boundary is the Potomac River, Maryland's boundary with Virginia. Based on the US Census Bureau, American Community Survey 2015-19 data, an estimated 363,229 people live in the region over a 1,029.68 square mile area. This constitutes an average population density of 353 person per square mile.

Charles County is the most populated jurisdiction with a total of 159,428 people living in its 457.80 square mile area. This is followed by St. Mary's County with a total of 112,290 people who reside in its 358.69 square mile area and Calvert County 91,511 people living in the county's 213.19 square mile area (Community Commons, 2021).

Data Collection Methods

Qualitative and quantitative data were collected from May 7, 2021 through June 14, 2021 to develop a profile of the critical health needs of the service area and the opportunities for improvement. These both provided a foundation for understanding the strengths and weaknesses as well as the threats and opportunities to improve behavioral health and behavioral health access. A SWOT (strengths, weaknesses, opportunities, and threats) analysis was the primary framework used to analyze the data findings. The assessment included a review of available regional and state demographic data, regional and state health data, reports, interviews, survey results, and healthcare/behavioral healthcare literature. Subsequently, the need for an integrated and robust array of crisis care services in the Southern Maryland region was able to be described and quantified.

PRIMARY AND SECONDARY DATA ANALYSIS

To gather primary or firsthand data, three main approaches were adopted to ensure that feedback from a diverse group of individuals that are representative of key stakeholders within each county was obtained. The target audience was based primarily on a list of key partners of each county's Local Health Department (LHD) A questionnaire (see Appendix A) developed through the Survey Monkey platform was deployed first to 102 key stakeholders, which yielded an approximately 57% response rate, including but not limited to local behavioral health authorities, law enforcement professionals, emergency management services, hospital and government agency staff, health department and governmental agencies, community providers, school system leaders, and persons served.

With a total of fifty-eight (58) respondents, twenty-six (26) respondents are from St. Mary's County, twenty-one (21) respondents from Charles County, six (6) respondents from Calvert County, and the remaining four (4) respondents serve in multiple counties.The data obtained from the questionnaire was aggregated and synthesized to identify common trends, priorities, and efficacy of existing resources in the region and by county.

Additionally, focus groups from each county were held to obtain participant feedback based on their experiences and observations in working and/or living in the region. Finally, fifty-eight (58) key informant interviews were conducted with several key stakeholders to obtain additional information and perspectives on the adequacy of current behavioral health crisis services in the Southern Maryland region.

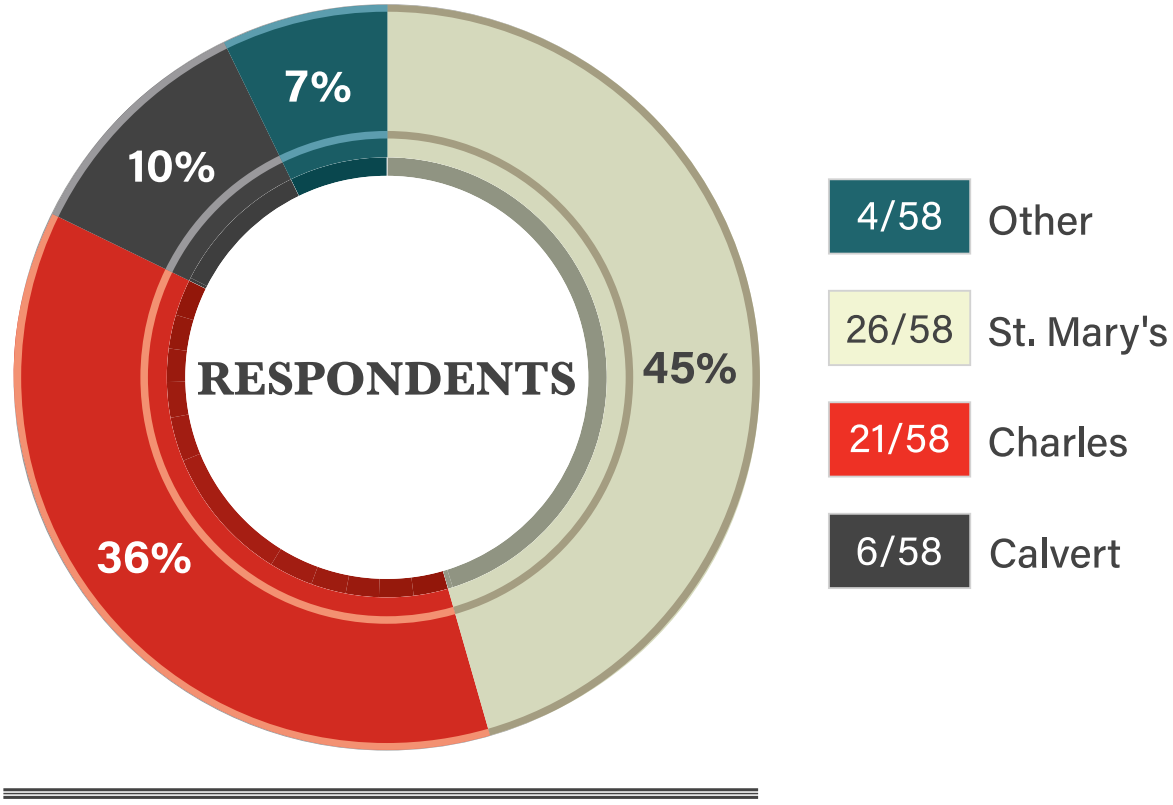


Chart 1

With regards to secondary data, a literature review of crisis service models was conducted using peer reviewed journals and publications; information was accessed from local, state, and national governments' surveillance data repository systems; and Community Commons, a database to review community assets, was accessed. Reports and data from the State Health Improvement Process (SHIP) regarding emergency services and emergency hospital usage for persons with behavioral health needs were examined to determine the populations that could be better served via crisis program services instead of an emergency department. The most recent Community Health Needs Assessment (CHNA) reports from all three counties were also reviewed. In addition, an environmental scan/landscape assessment was completed to determine the best location for a crisis center in each county based on available commercial properties. Real estate experts, stakeholder input, data, and research methods were utilized in determining the recommendations for a physical site that provides accessibility to crisis center services and one that is conducive to optimal health outcomes.

Finally, the National Action Alliance for Suicide Prevention's Crisis System Flow tool was used to evaluate potential monthly crisis potential volumes. Crisis Now's framework for State/ Regional Self-Assessment was used to reveal gaps in current crisis response services.

DATA STRENGTHS AND LIMITATIONS

Strengths

The qualitative and quantitative data gathered provided rich information that were used to inform the priorities identified and recommendations formulated. Given that CHNAs had recently been completed by the three counties and are available publicly, the assessment focused primarily on behavioral health related needs and priorities. Priority was placed on obtaining the most current data, such as the recent county Hospital data. In terms of a literature review, several crisis models have emerged over the last several years that prove successful in adequately serving the behavioral health crisis community. These models were analyzed with regard to the current Southern Maryland region's resources, strengths, needs, conditions, and priorities to develop an optimal crisis model for the region. Additionally, the questionnaire data captures the voice of the Subject Matter Experts (SMEs) within the area, the Southern Maryland region. To provide substantial quantitative data, the majority of the questions were measured on a Likert scale, which can be used as a baseline metric in the future. Additionally, the data was dissected by county, in attempts to find similarities and differences between them. If there is an asset or successful process that is illustrated in one county and not the other, the information can be a valuable best-practice in the region or can be used to reduce or mitigate any ongoing barrier. Lastly, the data was broken down by question to find the averages in agreement or disagreement of each. The open-ended comments and feedback were also analyzed for commonalities to emphasize throughout this assessment.

Limitations

It is important to note some limitations that exist within our primary and secondary data. First, there is inconsistency shown in the sample size throughout each county. As a result of the small sample size of the respondents in Calvert County, although informative, the significance of the data is low due to there only being six respondents, as opposed to over twenty respondents in Charles and St. Mary's Counties. Additionally, there may appear to be discrepancies in the questionnaire data received, since the questionnaire was given solely to stakeholders who are aware of resources that already exist, rather than assessing the current needs of the community. For example, in St. Mary's County, they listed public transportation as both a barrier and asset, which both are true due to stakeholders having more awareness than the average community member.

In addition, due to time limitations in conducting the environmental scan, the accessible data feeds are based on current trends with no historical trends to review. Given the nature of crisis centers, there are no accredited national benchmarks to compare the data to for reference outside of the available Emergency Department (ED) data.

Lastly, some measures such as the opioid prescriptions rate and depression prevalence were centered on available Medicare data at the county, state, and national levels and did not include Medicaid's managed care beneficiaries. It is also estimated that the Medicare data may be representative of just about 12% of the total population (Community Commons, 2021).

Regional Behavioral Health Status

MENTAL HEALTH CONDITIONS

In St. Mary's County, 17.7% of the Medicare fee-for-service population have been diagnosed with depression. This is followed by 17.2% in Calvert County and 13.7% in Charles County. These rates are lower than the state aggregate (18.0%) and the United States (18.4%).

In the most recent Community Health Needs Assessment (CHNA) for St. Mary's County (2020), 63.4% of respondents reported substance use and 54.3% reported depression, anxiety, and trauma/post trauma stress as major health issues affecting the county. In Calvert County's most recent CHNA (2020), respondents reported the need for more behavioral health services, particularly for youth aged individuals. Furthermore, adolescent suicide and self-harm hospitalization rates in Calvert County were more than double the Maryland state rates from 2013-2015. Most recent Charles County CHNA (2018) data reveals that 27.3% of county residents reported an unstable mental health status in the past month. Furthermore, from 2009-2013, Charles County ED visits due to mental health conditions increased.

All three counties reported increased concerns around depression and anxiety for residents during the COVID-19 pandemic echoing the impact of social isolation, financial loss, and reduced access to behavioral healthcare services in the region.

Mental health court dockets are needed; as many people in need of mental health treatment are ending up in jail.

– Brandon Foster
Director of Corrections,
Charles County Detention Center

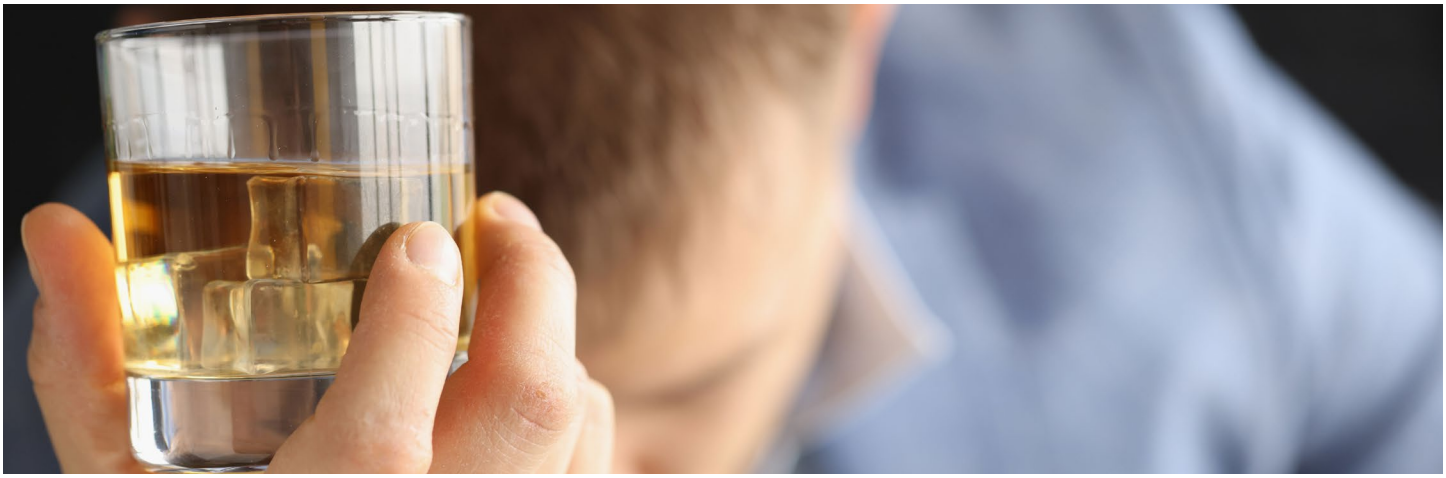
COMMUNITY RISK FACTORS

Suicide Mortality

This indicator measures the number of suicides per 100,000 population, per year. Suicides continue to be a public health crisis and were the tenth-leading cause of death in the United States in 2019, responsible for more than 47,500 deaths (National Center for Injury Prevention and Control, 2021). Although there is not one determining cause for suicide, at the individual and community levels, feelings of hopelessness, depression, family history, inadequate community connectedness, lack of access to providers and medications are preventable factors that can negatively increase suicide rates (Stone et al., 2017). As seen on chart 2 below, for this indicator, Calvert County was highest in the region at 14.5% followed by St. Mary's County (11.8%), and Charles County (11.6%). The average rate for the region (12.6%) was higher than the state and U.S rates of 9.3% and 12.4% respectively (Community Commons, 2021).

The high rate within the region could be attributed to prevailing risk factors that are also significantly higher than the state averages in some cases as per the 2018 Youth Risk Behavior Survey (Appendix B). Based on this data, 23.2% of high school students surveyed reported having lived with anyone who was an alcoholic or problem drinker, used illegal street drugs, took prescription drugs to get high, or was a problem gambler. This rate was significantly higher within students who self-identified as gay, lesbian, or bisexual (33.8%). Also, 27.5% of students within the region reported having lived with anyone who was depressed, mentally ill, or suicidal; in addition, 24.5% reported someone in their household has gone to jail or prison; and 21.2% of students reported a parent or other adult in their home regularly swears at them, insults them, or puts them down.

Chart 2



Excessive Drinking

Alcohol misuse can lead to behavioral health concerns and is also a risk factor for other avoidable health conditions such as depression, suicide, accidental injuries, and chronic diseases. The excessive drinking indicator measures the percentage of the population who report consuming five or more drinks for men and four or more for women within a month. Also included within this measure are men who report consuming more than two drinks per day and women who report consuming more than one drink per day for women within a 30-day period (Centers for Disease Control and Prevention, 2020).

Based on 2014 data, for this indicator, St. Mary's County was highest in the region at 20.0% followed by Calvert County (19.9%), and Charles County (15.4%). The average rate for the region (18.4%) was higher than the State and U.S rates of 16.70% and 17.7% respectively. This higher prevalence within the region is also reflected in the 2019 data from the Maryland.

The Behavioral Risk Factor Surveillance System (BRFSS) that showed the region at a rate of 56.2% significantly higher than the State aggregate of 53.6% (Appendix C). An average of 86.2% of the respondents were asked about alcohol consumption and only 22.8% in the region were offered advice on harmful or risky drinking behaviors during their last routine checkup (BRFSS, 2019).

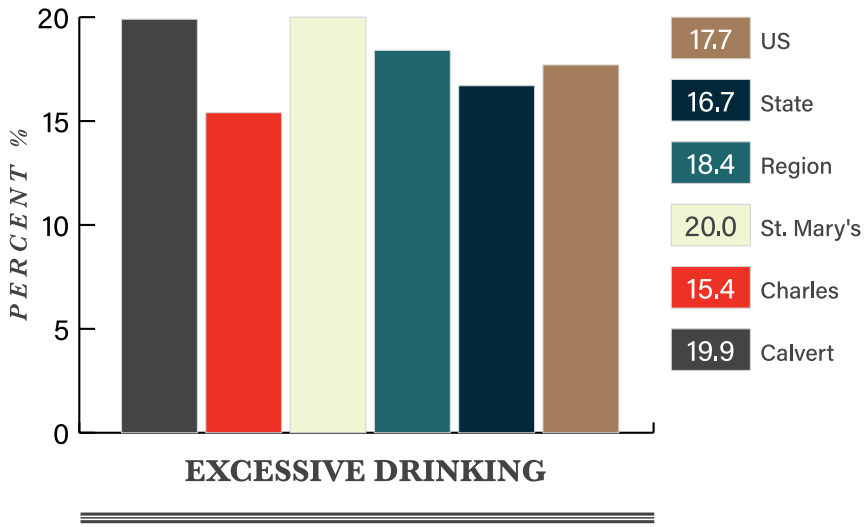


Chart 3

Poisoning Mortality

This indicator reviews the number of deaths with poisoning as the primary cause per 100,000 population, per year. Both pharmaceutical and illicit medication abuse can lead to death which can be categorized as unintentional deaths due to drug overdose. Community Commons data for the 2008-2014 period shows that Calvert County had the highest rate of poisoning mortality in the region at 18.6% followed by Charles County (11.7%), and St. Mary's County (11.4%). The average rate for the region (13.9%) was lower than the state and U.S rates of 14.8 % and 14.9% respectively. Disparities are likely to occur with this measure as death from poisoning is likely to impact males and individuals ages 45-54 (Lippold et al., 2019).

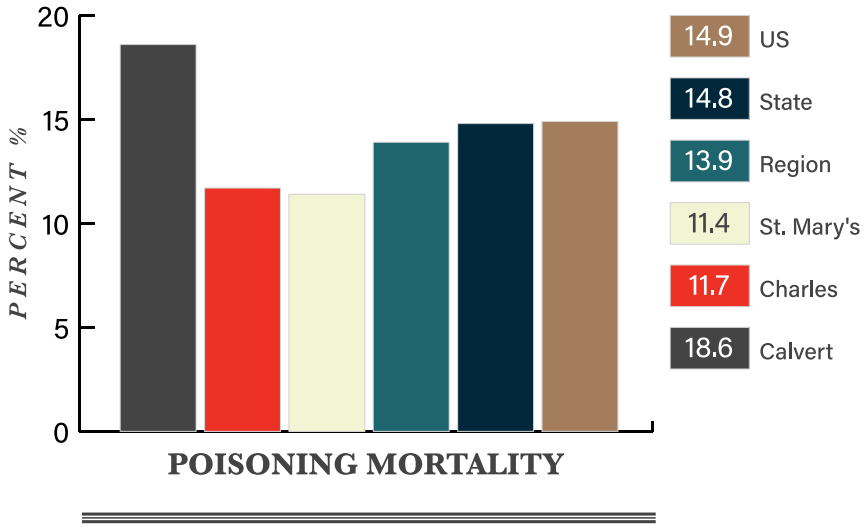


Chart 4

Opioid Prescriptions

This indicator is important as the misuse of, and addiction to opioids continues to be a critical national crisis affecting the socioeconomic welfare of the population. An estimated 90% of drug overdose deaths involved opioids in 2018 with a rate of 45.1 opioid prescriptions for every 100 persons (National Institute on Drug Abuse, 2021). The rate of opioid prescriptions (i.e., natural analgesics, semi-synthetic, and synthetic) is often used as an indicator to assess the level of opioid use at the county level. Accessible data was used to review the percentage of all opioid prescriptions filled in 2013 by fee-for-service Medicare beneficiaries. The rate of opioid prescriptions in Charles County was highest in the region at 7.2% followed by Calvert County (5.5%), and St. Mary's County (4.3%). The average rate for the region (5.7%) was higher than the state and U.S rates of 5.0% and 5.3% respectively (Community Commons, 2021).

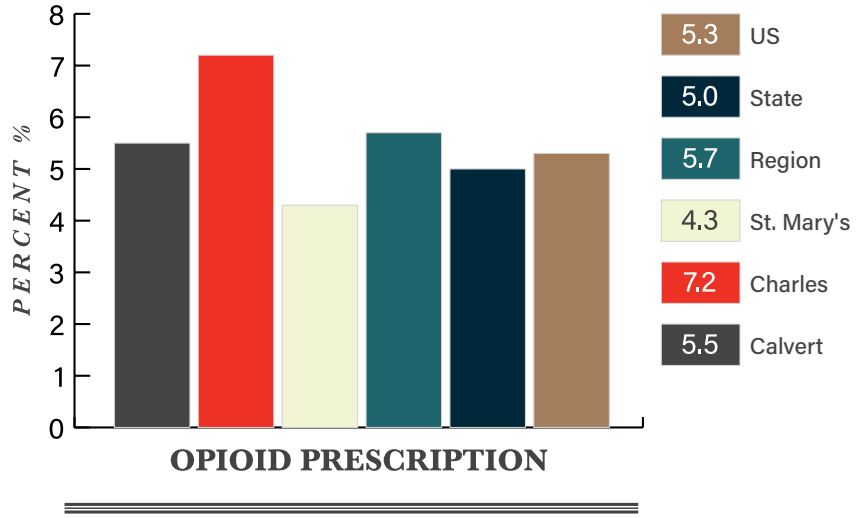


Chart 5

Mentally Unhealthy Days

As defined by the World Health Organization, health is not only measured by the absence of disease or infirmity but also by one's complete physical, mental, and social well-being. As such the number of days per month the average adult aged 18 and older reports feeling mentally unhealthy or of poor mental health is often used as one of the indicators to assess the health of a community. Based on the 2019 Maryland BRFSS survey in which respondents are asked, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?", Calvert County had the highest percentage of individuals who had at least one day their mental health was not good followed by Charles County (36.7%), and St. Mary's County (34.1%). The average rate for the region (36.2%) was lower than the state rate (39.5%). This could provide insights on wellness trends and health disparities and help identify opportunities for a public health approach that complements clinical behavioral health care.

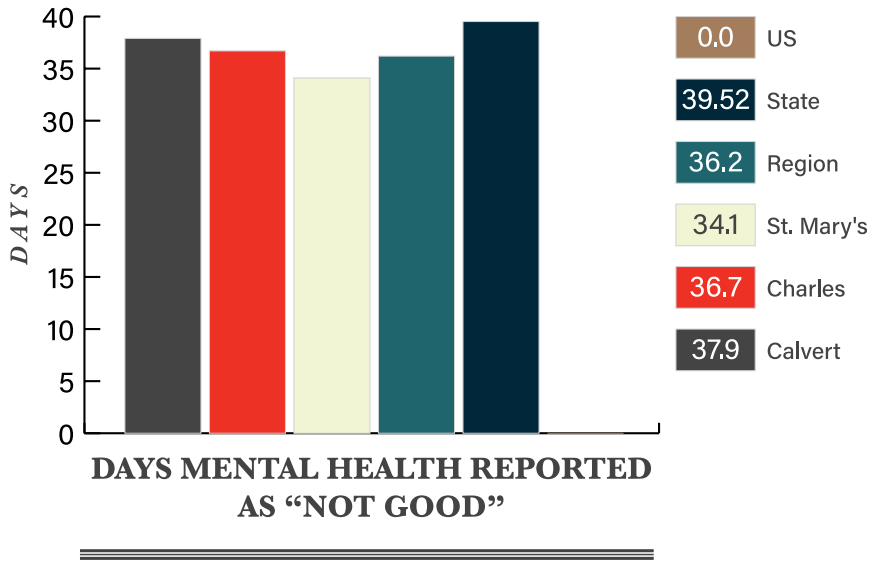


Chart 6

REGIONAL ASSETS AND BARRIERS

Concerns surrounding service and resources are consistent throughout each county. Stakeholders expressed the need for increased availability of services which may be directly correlated with the need for more providers, another concern within the community. As it stands, Fifty-five percent (55%) of stakeholders within the Tri-County (St. Mary's, Charles, and Calvert) area have expressed the need for 24/7 access to crisis focused care, given the number of behavioral health related ED visits. When evaluating the open-ended questionnaire responses, many key stakeholders mentioned alternatives to the ED such as the implementation of mobile crisis services.

Additional barriers to crisis services, outside of the hospitals' realm, include patients' uninsured/under-insured status and a lack of accessible transportation. Forty-eight percent (48%) of the stakeholders deemed transportation as an overall barrier, although as previously mentioned, it was also noted as an asset within St. Mary's County.

Lastly, there was an overall emphasis on training, either listed as a barrier or priority across counties. Based on stakeholder feedback, training needs and requirements include community education on behavioral health services in the community, and law enforcement training.

Telehealth was deemed the best asset overall across each county. Although access to services has been low, due to the COVID-19 pandemic, the rise of telehealth availability in the region has increased. In both Calvert County and St. Mary's County accessibility to both substance use and mental health programs was reported as an asset. In St. Mary's County and Charles County, they both listed Emergency Medical Services as an asset within the community.

Key stakeholders and users of regional behavioral health services completed a questionnaire that asked the following:

- knowledge of behavioral health services within their county;
- likeliness of promoting current services; and
- overall feelings of safety while accessing the services.

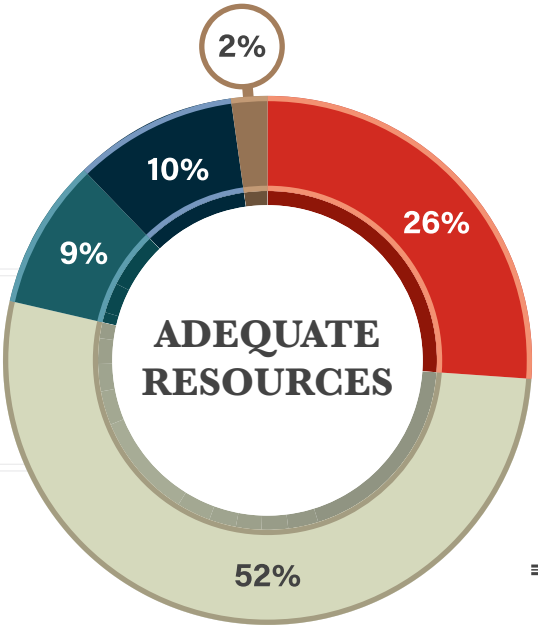
The aggregate data of the overall responses are illustrated on the following page in charts 7, 8, and 9 with knowledge of adequate resources falling under the 50th percentile.

There's nowhere to take people for crisis services after hours. They go to the ED... 'not optimal' is an understatement.

– Key Stakeholder

KEY STAKEHOLDER RESPONSES

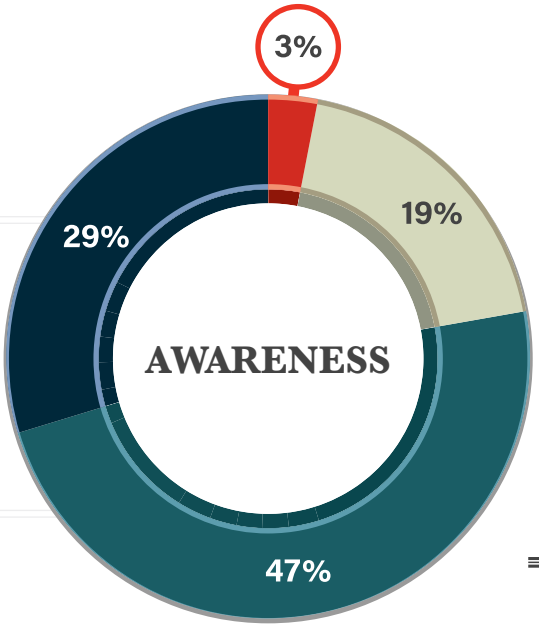
There are adequate resources to address behavioral health conditions in my county (1-5)



1/58	Strongly agree
6/58	Agree
5/58	Neither agree nor disagree
30/58	Disagree
15/58	Strongly disagree

Chart 7

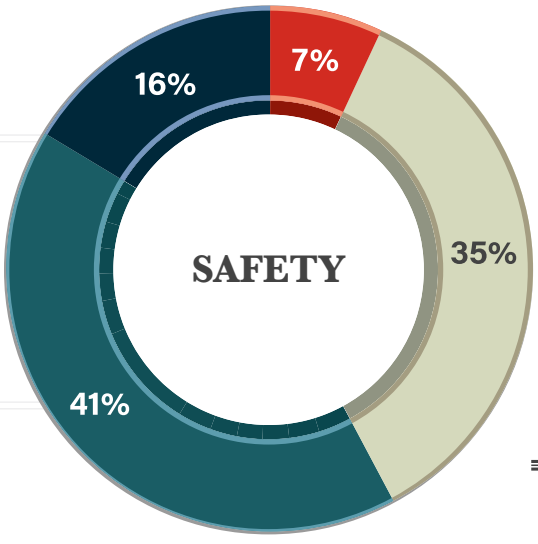
On a scale of 1-5, how aware are you of community resources (i.e. behavioral health crisis care, behavioral health outpatient services, financial assistance, etc.) (1-5)



0/58	Extremely aware
17/58	Very aware
27/58	Somewhat aware
11/58	Not so aware
2/58	Not aware at all

Chart 8

How safe do you feel (physically, emotionally, culturally, etc.) accessing current behavioral health crisis services? (1-5)



5/58	Extremely safe
9/58	Very safe
24/58	Somewhat safe
20/58	Not so safe
4/58	Not safe at all

Chart 9

Summary of Findings

After analyzing the primary and secondary data, it is clear that behavioral health and behavioral health crisis services are a priority in the Southern Maryland region. All three counties have made strides in addressing the issues in a variety of ways but there are still opportunities for improvement. Given the relatively rural nature of the region, the Health Professional Shortage Area (HPSA) and Medically Underserved Areas/Population (MUA/MUP) designations, the region is faced with scarce resources to appropriately address the prevalent clinical and behavioral health morbidities in the communities.

Key priorities and concerns regarding behavioral health crisis services that emerged from the analysis of the primary and secondary data sources included the need for the following:

- Behavioral health crisis centers with walk-in/stabilization capacity
- Outpatient Emergency Department diversion resources
- Mobile crisis services
- Residential crisis services
- Cross jurisdiction collaboration
- Accessibility of services
- Transportation

SWOT Analysis

The SWOT analysis framework (Table 1 below) is used in this assessment as a strategic planning technique to identify strengths, weaknesses, opportunities, and threats to assess the feasibility of implementing a crisis center in the service area. Using the SWOT framework allows for an evaluation of the key internal (within a region's control) and external factors (outside of the region's control) that contribute to the current status of behavioral health crisis services in the region. Based on the results of the SWOT analysis, recommendations on the type and scope of crisis services needed are made.

STRENGTHS

As the need for behavioral health crisis services becomes more evident in the region, each jurisdiction reports a commitment to collaborative efforts to ensure these services become a reality for the Southern Maryland region. Hospitals, LHDs, and community provider agencies all identify historical siloing of behavioral health crisis services and lack of intercounty collaboration as a great challenge; however, they all report readiness to move into a more collaborative and integrated approach to behavioral health crisis service delivery. Each jurisdiction has a level of crisis services that can be expanded and/or developed to fill the current gaps in care.

SWOT SUMMARY	HELPFUL		HARMFUL	
INTERNAL	(S) STRENGTHS		(W) WEAKNESSES	
	Agency/Partner commitments Best Practice Models and the Maryland Landscape	Existing Resources Substance Use Treatment Expansion	Delivery of Crisis Services: Providers, Transportation, Technology, and Regional Coordination	Local Challenges
EXTERNAL	(O) OPPORTUNITIES		(T) THREATS	
	State Funding Opportunities Funding diversification Telehealth Expansion Data collection, analysis, and data sharing capabilities	Chesapeake Regional Information Systems for our Patients (CRISP) Cultural and linguistic competency expansion A Population Health approach to Crisis Services	Social Determinants of Health (SDoH) ▪ Travel time to work ▪ Rural Populations ▪ Poverty ▪ Social Associations Funding and Sustainability	Socio-Cultural Factors ▪ Limited English Proficiency ▪ Veteran Population ▪ Change in Total Population Technology

Table 1

Agency/Partner Commitments

Recent community health assessments for the Southern Maryland region indicated that the most important health issues affecting quality of life are behavioral health conditions (substance use and mental health). Furthermore, 31% of the respondents listed substance use services, inpatient and outpatient, as a needed priority within their county. Each county has a measure of planning in place to develop a model of crisis services, providing a foundation for crisis service integration across the region.

> *"We are committed to partnering to get crisis care services".*
>
> *- Hospital Leadership Informant*

Each county within the region has a network of community partners who convene to assess and identify community health needs, identify priorities, and collectively leverage resources for a strategic approach at addressing the gaps and priorities. Some examples of these partnerships include

- Calvert: Community Health Improvement Roundtable;
- St. Mary's: Healthy St. Mary's Partnership; and
- Charles: Partnerships for a healthier Charles County.

An essential partnership for the advancement of a robust behavioral health crisis response system is the collaboration between community providers, in particular, providers of higher acuity care, and local law enforcement. All three counties have planned or implemented Crisis Intervention Team (CIT) Law Enforcement training, making this vital service well positioned to partner with community providers to deliver effective and compassionate crisis intervention care.

Best Practice Models and the Maryland Landscape

Regional and county-wide crisis care programs are manifesting across Maryland. To date, regulations for walk-in crisis services and extended crisis visits have not been established in Maryland; however, crisis care models utilize the established Community Based Behavioral Health Programs and Services regulations denoted in Code of Maryland Annotated Regulations (COMAR) 10.63. COMAR 10.21.20 and 10.21.26 also outline regulatory requirements for outpatient and Residential Crisis Services (RCS). Additionally, to provide RCS, a recommendation under this assessment, an agency must acquire an accreditation-based license. Accreditation agencies offer standards of practice for a wide variety of behavioral health programs that can be applied to Walk-In and Mobile Crisis services. Furthermore, additional best practice models have been developed for crisis care services through National Suicide Prevention Lifeline (NSPL), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Action Alliance for Suicide Prevention's Crisis Now initiative. Additional evidence-based models of care include Recovery Innovations, Inc. Living Room model, and Connections Health Solutions. A thorough review of these nationally recognized best practice models of crisis care can be applied to the development of crisis services in Southern Maryland to further achieve a standardized approach to crisis care and regulatory compliance.

Telehealth

Additional strengths include the expansion of access to care provided by new telehealth options during the COVID-19 pandemic. From the stakeholder questionnaire, 56% of stakeholders listed telehealth as a current asset within their community. Telehealth has enhanced access to care and treatment compliance for individuals with behavioral health conditions.

Existing Resources

Under the auspices of the Maryland Public Behavioral Health System (PBHS), Local Behavioral Health Authorities (LBHAs) operate within each of the counties and serve as the local point of contact in assisting individuals with access to behavioral health services. LBHAs aim to improve behavioral health systems ensuring services are provided in an accessible, culturally appropriate, and safe manner to provide better outcomes for county residents and to provide services in a more appropriate, less restrictive setting that promotes immediate, safe, and effective interventions. Goals of the LBHA include connecting individuals with services, community education and training, developing partnerships and contracts with public and private agencies, quality assurance, and monitoring of service utility and claims.

Each county offers a variety of crisis intervention efforts. Most are specific to a population (i.e., substance use, domestic violence) rather than generalized crisis care needs. A summary of crisis-oriented services is outlined on page 33 per the information provided to Renaye James Healthcare Advisors by key regional stakeholders as it relates to existing crisis services.

A summary of current crisis-oriented services is outlined below.

Charles

- Partnerships for a Healthier Charles County, established in 1994, is composed of over 30 non-profit and county agencies that collaborate on addressing the county's most pressing health needs.
- Opioid overdose prevention
- FY 2019-2021 *Behavioral Health Action Plan* outlines strategic goals including:
    1. Mobile Integrated Healthcare partnership (a $400,000 state grant funded for 3 years)
    2. Community education and outreach, and
    3. Increase county capacity to treat opioid use disorder.

Calvert

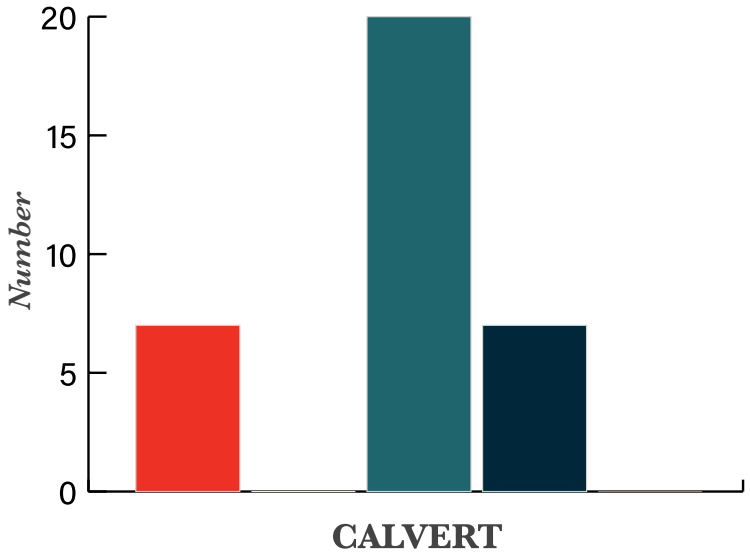
- Calvert County Health Department Crisis Intervention Center provides a 24/7 Crisis Hotline for family and sexual violence.
- Calvert Crisis Response: 24/7 call center and mobile crisis teams.
- Overdose Response Program
- 4 onsite OMHCs with limited walk-in capacity
- Community Partnerships for Residential Rehabilitation beds and Residential Crisis beds (limited to adults, opening soon for mental health)

St. Mary's

- Opioid Crisis Response Plan/Program outlining strategies to address the opioid epidemic by reducing inappropriate opioid prescribing and dispensing.
- Harm Reduction Program in Lexington Park
- Crisis hotline for domestic violence and sexual assault intervention and resources.
- Utilizes Maryland 2-1-1 for crisis hotline.

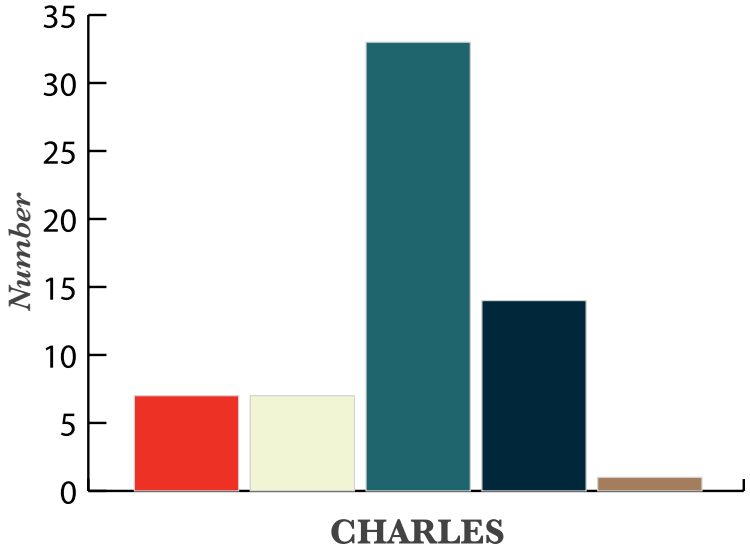
Substance Use Treatment Expansion

As a result of the national crisis faced from substance use and mental health challenges, a State of Emergency was issued for the state of Maryland in 2017, serving as an impetus to focus efforts and resources to combat the crisis. There are existing resources within the Southern Maryland region currently being used to meet the community health needs. Although limited when compared to other jurisdictions, these resources offer opportunities for treatment and linkages to care that support improved treatment outcomes. Buprenorphine practitioners make up the greatest number of providers in the region with most of the providers located in Charles County (33), followed by Calvert County (20), and St. Mary's (5). The following charts represent the number of facilities and the number of Buprenorphine practitioners available in each county (Map - SAMHSA Behavioral Health Treatment Services Locator 2021).



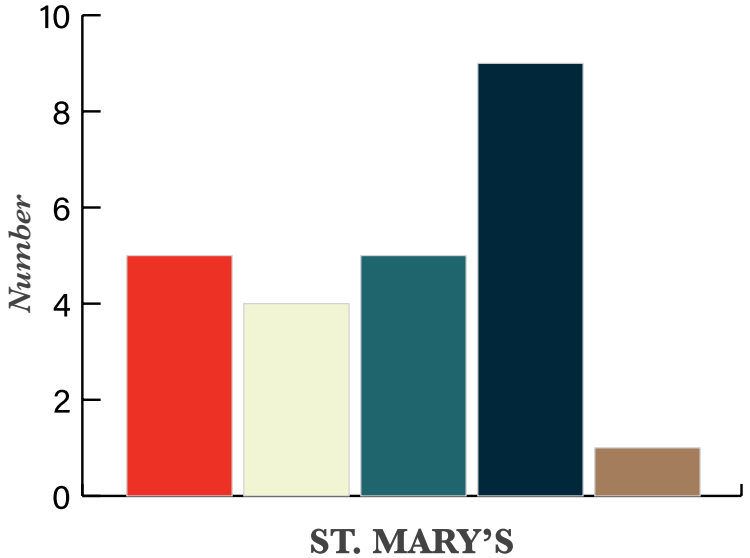
0.0	Health Care Centers
7.0	Substance Use (SU) and Mental Health (MH) Facilities
20.0	Buprenorphine Practitioners
0.0	Mental Health Facilities
7.0	Substance Use Facilities

Chart 10



1.0	Health Care Centers
14.0	Substance Use (SU) and Mental Health (MH) Facilities
33.0	Buprenorphine Practitioners
7.0	Mental Health Facilities
7.0	Substance Use Facilities

Chart 11



1.0	Health Care Centers
9.0	Substance Use (SU) and Mental Health (MH) Facilities
6.0	Buprenorphine Practitioners
4.0	Mental Health Facilities
5.0	Substance Use Facilities

Chart 12

WEAKNESSES

Over the last few decades, the landscape of behavioral healthcare has evolved. There is a critical need to implement a crisis care system that aligns with evidence–based best practices and seeks to provide safe, appropriate, and cost-effective crisis care for the Southern Maryland region to address the surge in behavioral health needs across the region, dearth of behavioral health providers, and high utilization of costly emergency services to treat behavioral health needs.

"There are very limited beds available and that, along with robust outpatient services, should be the primary focus of any collaborative effort in the region."

– Dr. Richard Ferraro
Medical Director of Charles Regional Hospital

Delivery of Crisis Services: Providers, Transportation, Technology, and Regional Coordination

In St. Mary's County, there are 114.5 mental health care providers per 100,000 population, the lowest in the region. In Charles County, there are 156 and in Calvert County, 183.7 mental health care providers per 100,000 population. These Mental Health Care Provider Rates are lower when compared to the state rate (258.4) and United States rate (202.80).

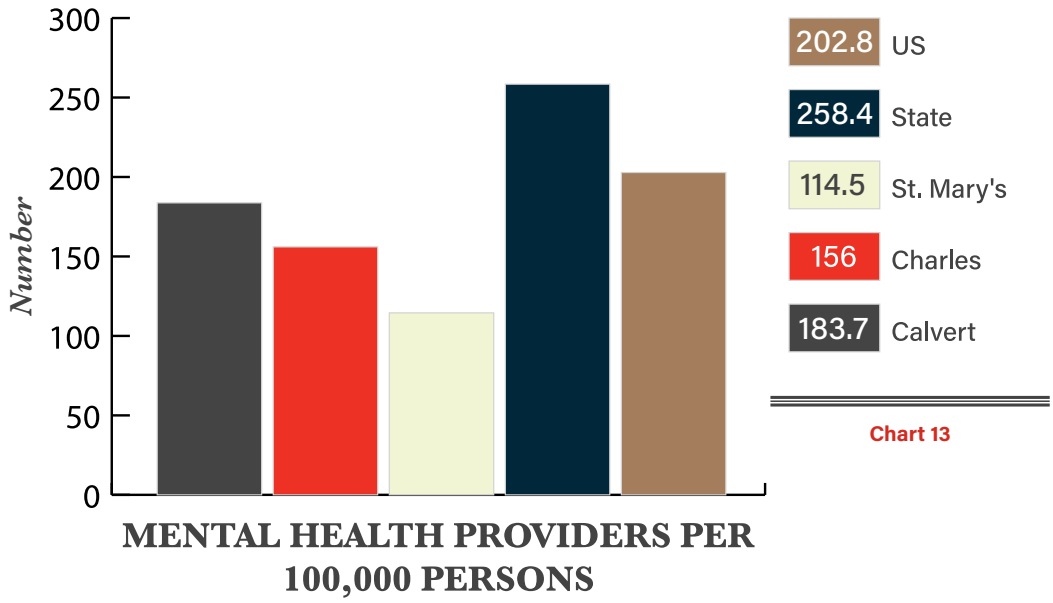


Chart 13

For the St. Mary's, Calvert, and Charles County regions, mental health provider to population ratios average 1:603 while preventable hospital stays average 51 per 1,000 Medicare participants. This data, in conjunction with primary care and dental provider paucity, qualifies the tri-county area as a Health Professional Shortage Area (HPSA) presenting a significant access barrier for crisis care services.

Each county offers an array of behavioral health programming; however, all rely on external resources for 24/7 access to crisis care services. Other than law enforcement and local hospital emergency departments, there are no on-site crisis services that are available 24/7 on a walk-in capacity and no current opportunities for local crisis hotline assistance for the general population.

To further impact access to behavioral healthcare providers, transportation is limited in the tri-county region. According to the survey analysis, about 54% of respondents listed lack of transportation as a barrier within their county. Although public transportation routes for medical assistance, senior, and public use are available, there lacks interconnectedness within the southern Maryland region. Furthermore, transportation using the State's medical assistance program is limited within jurisdictions.

Rapidly expanding over the last year, telehealth options have provided a much needed expanded access to behavioral healthcare providers. However, state regulatory restrictions limit the ability for providers and agencies in one county to serve individuals in other jurisdictions. Furthermore, many individuals do not have access to the technology, as noted by 10% of the respondents, particularly in remote areas, necessary to interact with behavioral healthcare services via telehealth.

> *We don't have access to Health Department appointments in other Counties.*
>
> *– Katherine Erly,*
> *Emergency Psychiatric Services Supervisor,*
> *Calvert Health Medical Center.*

A final challenge in the delivery of crisis care services evolves from the siloed approach to care. Each county has a variety of behavioral health services, some offering crisis care, however, there is a lack of integration of effort. The tri-county area service providers collaborate for treatment options and care delivery standards, yet, there is limited cooperation across jurisdictions. This is partially due to siloed funding streams and subsequent service location restrictions. SAMHSA's National Guidelines for Crisis Care (2020) recommends a regional approach of coordinated efforts, proposing regional healthcare and emergency service entities operating in tandem to address behavioral health crisis needs in the region.

We have difficulty placing children and adolescents due to lack of inpatient beds.

– Lori Werrell,
Regional Director, Population and Community Health, Medstar St Mary's Hospital/Medstar Southern Maryland Hospital Center.

Local Challenges

Special Populations

When analyzing specialty population needs, the highest priority for key stakeholders included child and adolescent behavioral health providers and geropsychiatric specialists. The types of services needed include outpatient counseling, medication management, residential, and inpatient treatment services. One stakeholder noted that the hospital emergency departments are utilized as the default for children and adolescents in crisis in the absence of a crisis center and ongoing, accessible community-based care for that population. In addition, key stakeholders noted the limited access to crisis center and community -based care for the aging population who often have co-occurring medical conditions and can be more complex to assess and treat psychiatrically.

Provider Staffing

One county reported the challenge with retaining behavioral health professional staff in the region was due to travel and commute times and the struggle to stay competitive in wages. Additional local challenges include lack of access to reliable transportation and lack of service availability after usual business hours.

Law Enforcement Resources and Emergency Department (ED) Services

Additional barriers to behavioral crisis care for the tri-county region include inappropriate use of law enforcement resources and ED services used to access crisis behavioral healthcare leading to higher healthcare costs, prolonged wait times, and poor patient outcomes. In St. Mary's County, the rate of ED visits related to behavioral health conditions in 2017 was 6,173 per 100,000, a higher rate than neighboring counties and the state average of 4. In Calvert County, the rate of ED visits for behavioral health conditions in 2020 was about 38.6% of 1209 patients, with 52% of that group being transferred elsewhere as an inpatient. Additionally, 32.7% (of the total number of ED visits were Emergency Petitions (EPs) alone, while St. Mary's County had 52% of their 559 ED visits result in EPs in their county. While St. Mary's County saw a significantly lower amount of ED visits, the ratio surmounts the numbers of patients seen in Calvert County. Lastly, with regards to the 30-day readmission rate, in Charles County, 983% of Medicare fee-for-service beneficiaries are readmitted to a hospital within 30 days of an initial hospitalization discharge. This was followed by 639% for St. Mary's County and 529% in Calvert County. These were significantly different for the state rate (19.9%) and United States (18.1%).

As mentioned above, the flow of handoffs and patient follow-up was noted to be a consistent concern from the stakeholders, that may result in the striking ED data above. From the survey data, 32% of the stakeholders believe that training for law enforcement should be seen as a priority, in order to subset the current overuse of ED services. The following comments extracted from the survey were made regarding law enforcement and the use of the ED:

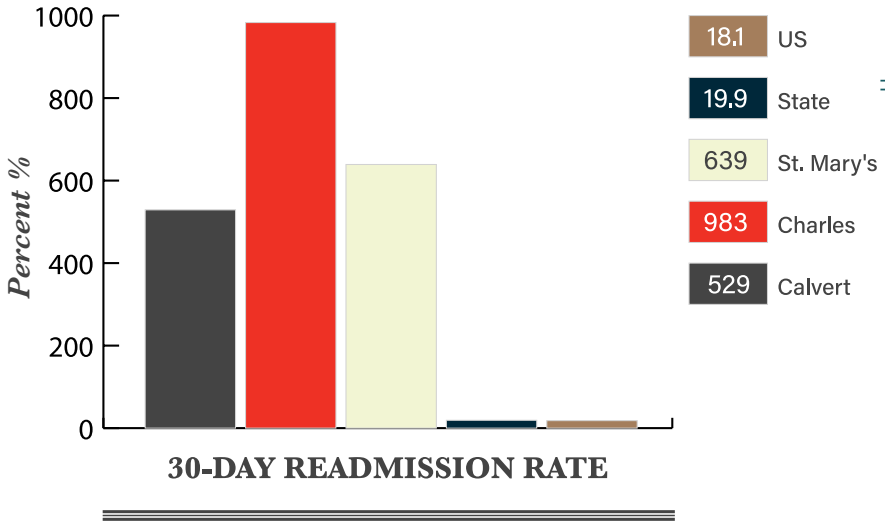


Chart 14

"Better community support and monitoring those who need medication. The court system and the jail should not be the primary resource."
– Key Informant, 2021

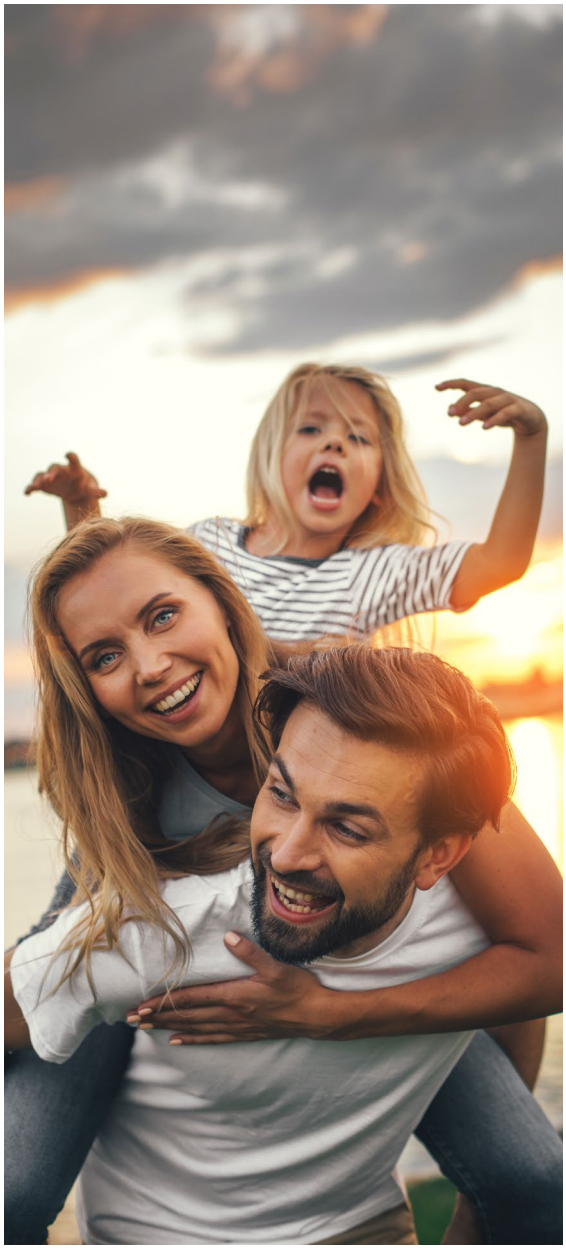
Mobile crisis response teams that are fully funded, respond to certain 911 calls, and don't include law enforcement."
– Key Informant, 2021

[We need] Somewhere other than the ER to take people in crisis.
– Key Informant, 2021

[We need] more funding for Crisis Intervention Training so we can continue towards our goal of training 100% of our officers in Crisis Intervention Training
– Key Informant, 2021

OPPORTUNITIES

With the overwhelming need for immediate access to behavioral health crisis care, the increased funding opportunities, enhanced community awareness and engagement, and the existing efforts that each county has demonstrated to address these needs, Southern Maryland is well positioned to optimize current resources and partnerships to create a collaborative and integrated behavioral health crisis system for the region.



State Funding Opportunities

In response to increasing behavioral health crisis needs across the Southern Maryland region, funding opportunities have expanded over the last few years; this creates an option for sustainability of a crisis program. In addition to expansion of behavioral health Current Procedural Terminology (CPT) coding, many agencies and jurisdictions can apply for grants through federal and state funds. The State Opioid Response (SOR) II grant was awarded and utilized by Southern Maryland jurisdictions to address substance use education, treatment, and recovery. Currently, House Bill 108/Senate Bill 286 is positioned to fund the establishment or expansion of behavioral health crisis services in Maryland including mobile crisis teams, walk-in clinics, residential crisis beds, and other crisis services. Additional funding opportunities exist through partnerships with the Maryland Health Services Cost Review Commision (HSCRC), the Maryland Community Health Resources Commission (CHRC), and the Chesapeake Regional Information Systems for our Patients (CRISP).

Funding Diversification

As behavioral health crisis services have grown nationally, grant funders, public entities, and commercial payers have recognized the importance of providing individuals and families a safe, comfortable, effective, and efficient way to receive behavioral health crisis care while avoiding costly hospital visits and law enforcement engagement. As such, many commercial insurance payers are beginning to negotiate fee rates for crisis Walk-In and Residential Crisis services. The cost savings provides the evidence for initiating discussions around expanding coverage for participants. Furthermore, with increasing work around the standardization of crisis services as is outlined in SAMHSA's National Guidelines for Crisis Care (2020), determining consistent reimbursement rates can be realized. The Centers for Medicare & Medicaid Services (CMS) has purported its commitment to funding outpatient behavioral health services including crisis stabilization care. At present, the opportunity for funding crisis care programs is highly dependent on cost savings models. Comparing ED visit rates with mobile crisis team response rates and outcomes will easily show the efficacy of funding mobile crisis care versus hospital services. Enforcing parity laws, which requires insurers to cover reasonable care expenses, is one way to achieve coverage by demonstrating to the payer, a low-cost alternative (Call Center, Mobile Crisis, Walk-In, and Residential Crisis Services) to ED and hospital visits, ambulance, and inpatient costs.

Crisis Call Centers and Mobile Crisis Teams may be initially funded through grants and local funding streams with cross county integration of service delivery. Since most grant funding is restricted by jurisdiction, a best practice regional approach to crisis care service delivery may pose a challenge. Currently, Maryland Behavioral Health Administration (BHA) is releasing a Behavioral Health Crisis Response grant which may help cover expenses of Crisis Call Center hubs and additional crisis care services. Additionally, Call Center and Mobile Crisis services include assessment, intervention, and disposition, if provided by qualified health care providers, it can influence the case for commercial, private, and public rate structures.

Walk-In and Residential Crisis Services currently have rate structures that can be applied and expanded to more adequately cover services provided. For example, agencies that achieve accreditation-based licenses in Maryland to operate a Community Behavioral Health Center, can utilize the established fee schedule for Walk-In and Residential Crisis Services. This case can then be applied to commercial insurance payers and funders who are eager to secure cost savings in overall healthcare costs to participants.

Telehealth Expansion

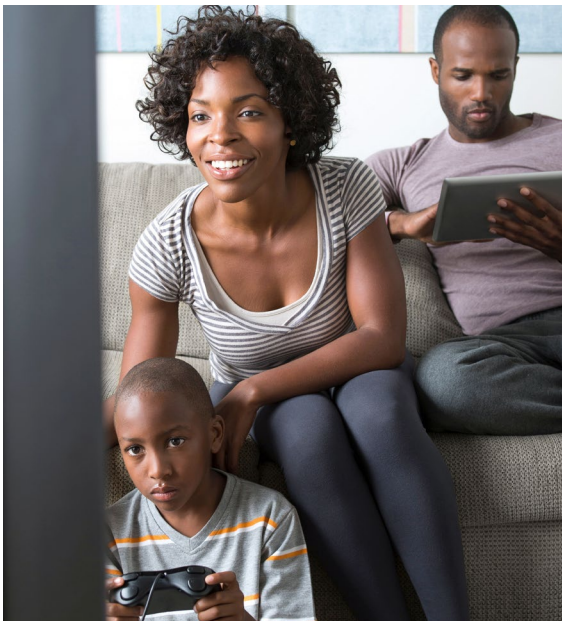
Over the past couple of years, advancements in information and health technologies have enhanced remote bidirectional services between health care consumers, providers, and caregivers. These are especially beneficial in the field of behavioral health services where there are often provider shortages or inadequate access to care. SAMHSA defines telehealth as the use of the "internet and communications technologies (ICTs), such as videoconferencing, chat, and text messaging, to provide health information and treatments in real time." (SAMHSA, 2021). The communication and servicing can take place synchronously as well to include channels such as secure email, webinars, or "videotaping a client encounter and forwarding the video to a professional who is offsite, for analysis at a later time" (SAMHSA, 2021).

Telehealth capabilities increase access to care in areas with limited mental health resources (i.e., lack of transportation, MUAs, HPSAs) through connections with specialists at different locations near or far from the patient. It is also an opportunity for an integrated primary care approach, and it augments mobile health applications or remote patient monitoring initiatives (Rural Health Information Hub, 2019).

Data Collection, Analysis, and Data Sharing Capabilities

Data obtained from stakeholder surveys, focus groups, and key informant interviews with representation from all counties in the region show that there are significant opportunities to improve on the data collection and data sharing infrastructures. These include improvements within agencies in each county and across counties effectuating clinical referrals and/or community clinical linkages. For example, information sharing across behavioral health agencies and the criminal justice systems is germane to lowering the number of individuals with a behavioral health diagnosis who end up in jail. A lack of a systematic cross-system coordination of care and the technology to aggregate data from a variety of systems for a comprehensive view of the patients at each point of care and/or service was an identified recurrent theme. Very often, misconceptions about the Health Insurance Portability and Accountability Act (HIPAA) and state confidentiality laws may cause barriers to data sharing. In such cases, an understanding of the importance of information sharing and an establishment of Business Associate Agreements or other data sharing agreements would be helpful (Reuland, 2018).

To augment the feasibility of data analysis and sharing, stakeholders need to be capable of doing so. Other challenges identified are the lack of readiness of the key stakeholders to share information and the lack of compatibility and interoperability of their systems; the later may require a significant capital investment. Connectivity to the state Health Information Exchange (HIE) as well as other information systems to augment transitions of care and a comprehensive view of the patient's history, care team, and current treatment plans is also critical.



Chesapeake Regional Information Systems for our Patients (CRISP)

Chesapeake Regional Information Systems for our Patients (CRISP), a non-profit organization that facilitates the electronic transfer of clinical information between disparate health information systems. As the State HIE, it works with a multitude of health systems, surveillance systems, and organizations and provided information on several local initiatives that can optimize interoperability among health systems in Southern Maryland. Of particular importance are the capabilities for Electronic Health Records (EHRs) to share patient information and data across health systems. CRISP is engaging in several projects designed to improve and optimize health information exchange for the purpose of achieving excellence in patient care delivery. A most recent project involves partnerships with local crisis systems to access patient health data related to hospital and emergency department encounters. This health information exchange between acute care services and crisis services allows for individualized, informed care delivery. CRISP is also exploring options to include ambulatory agencies with siloed EHRs to allow for integration of health information exchange. Additional CRISP initiatives include allowing access to CRISP data for mid-level and non-prescribing providers (including nurse practitioners and licensed behavioral health counselors), grant funding to support Social Determinants of Health (SDoH) screening and care planning, and working with Maryland BHA to expand real time information sharing among acute and ambulatory behavioral health services.

Regarding selection of an EHR for new organizations or agencies considering a new EHR platform, interoperability and data/health information sharing capabilities should be prioritized. EHRs that allow for data segmentation and tracking, and health information exchange can be costly for community agencies and may require grant funding or partnerships with larger healthcare systems.

With a mission to support the Maryland and regional healthcare community to securely share health information in order to "facilitate care, reduce costs, and improve health outcomes," CRISP is positioned to partner with community behavioral health crisis services to optimize interoperability and data integration to support the highest quality of healthcare delivery.

Cultural and Linguistic Competency Expansion

The provision of successful crisis care services require services to be delivered in a manner that is accessible and culturally relevant to all members of a community. The capacity of the crisis services and staff to render care to diverse populations and meet unique needs of each individual is a best practice standard for any behavioral health service. For the Southern Maryland region, particular attention to rural communities, health disparities, intellectual and developmental abilities, and co-occurring conditions is imperative to the "no wrong door" approach to crisis care (SAMHSA, 2020, p.22).

According to the 2016 US Census Bureau's American Community Survey 1 year estimate, "In 2000, African Americans made up 26% of the total Charles County population; by 2016, they comprise 46.4% of the total county population. As of 2016, minorities comprise roughly 58.3% of the Charles County population. The Hispanic community has also seen increases over the past few years; they now comprise 5.5% of the total county population. This is the one of the highest percentages among the 24 Maryland jurisdictions. Charles County also has one of the largest American Indian/Native American populations in the state of Maryland at 0.8% of the total county population." The 2018 Charles County CHNA reports that approximately 7.3% of Charles County residents speak a language other than English in the home. According to the same CHNA, Charles County residents reported the need for services aimed at supporting the needs of minority populations.

The population of St. Mary's County as reported in the 2016 Maryland Vital Statistics Report was 112,667 people (Maryland Department of Health, 2017). Of that population: 75.8% identify as non-Hispanic White, 15.4% as non-Hispanic Black, 5.2% as Hispanic, 3.2% as Asian or Pacific Islander and 0.4% as American Indian. Additionally, about 11.7% of the county's population have a disability (State average is 10.7%) (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates). The 2020 St. Mary's County CHNA indicated a need for "increased availability of translation and interpretation services and culturally appropriate service providers to meet the health needs of the changing population".

According to the most recent 2020 Calvert County CHNA, "the racial makeup of Calvert County is somewhat homogenous, with 80.3% of the population identifying as White... The proportion of Black/African American community members is the second largest of all races in Calvert County at 12.8% and is the only other race that makes up more than 10% of the population." Hispanic or Latino identified individuals account for 4.6% of the population (Calvert County Family Network, 2020). Calvert County CHNA data also revealed individuals living below the poverty line with increased health disparities disproportionately affected racial and ethnic minority groups.

A Population Health Approach to Crisis Services

The COVID-19 pandemic reiterated the assertion that the provision of clinical services to individuals is not a sole viable approach to meeting the behavioral health needs of a population. This is especially true in HPSA and MUAs designated regions where resources are most scarce. A population-based approach can be viewed as implementing nonclinical interventions at the system, environmental, policy, and program levels to improve mental health outcomes and SDoH among a defined population in the same geographic region and of similar sociodemographic characteristics (Purtle et al., 2020). The American Psychological Association (APA) released guidance (Box 1) for a population-based approach to addressing emerging behavioral health concerns that can be correlated with the pandemic (Evans et al., 2020). This guidance highlights the importance of complementing existing clinical approaches with population-based approaches that simultaneously improve outcomes for those accessing health care delivery systems, reduce unnecessary healthcare costs, and care coordination efforts. This is because the prevention, early detection, and treatment of behavioral health conditions can lead to improved physical and community health. According to the Center for Medicaid and Medicare Services (CMS), 50% of Medicaid enrollees have a mental health diagnosis. This aligns with emergency department (ED) claims data trends in the region. In Calvert County, for example, ED claims showed that Medicaid enrollees were the second highest category of population segment with behavioral health diagnosis in 2020. In context of the APA's guidelines, a population health approach to crisis behavioral healthcare requires early intervention and specialized, holistic care, a cornerstone of effective crisis care models as outlined in this report.

A population health approach essentially means those who access crisis behavioral healthcare receive the right care (specialized behavioral health team response), at the right time (available access 24/7/365), in the right environment (home, community, or on-site).

Box 1. Principles Guiding Population Health Framework for Behavioral Health at the American Psychological Association

- Use data and the best available science to inform policies, programs, and resources.
- Prevent when possible and otherwise intervene at the earliest moment.
- Strategize, analyze, and intervene at the community/population level (in addition to the individual).
- Reach broad and diverse audiences through partnerships and alliances.
- Utilize a developmental approach (e.g., change over time, age-appropriate interventions).
- Consider the "whole person" and the structural/systemic factors impacting individual behavior.
- Be culturally sensitive while also thinking transculturally.
- Recognize that inherent in every community is the wisdom to solve its own problems.
- Champion equity by addressing systemic issues (e.g., social determinants of health, access to treatment).

THREATS

Threats are inclusive of any external conditions that could adversely impact behavioral health crisis service delivery. For the Southern Maryland region, several factors exist that could pose a threat to success. Such factors include local social determinants of health, funding and sustainability, and serving the needs of special populations.

Social Determinants of Health (SDoH)

Transportation, Travel Time to Work and Rural Populations

Inadequate transportation was identified by participants in the online survey, focus groups, and key informant interviews as a key problem in the region in terms of accessibility of services and timeliness of care provided. There are limited public transportation systems in the region which can negatively impact the ability of vulnerable populations that are socioeconomically challenged to obtain care especially in the more rural areas

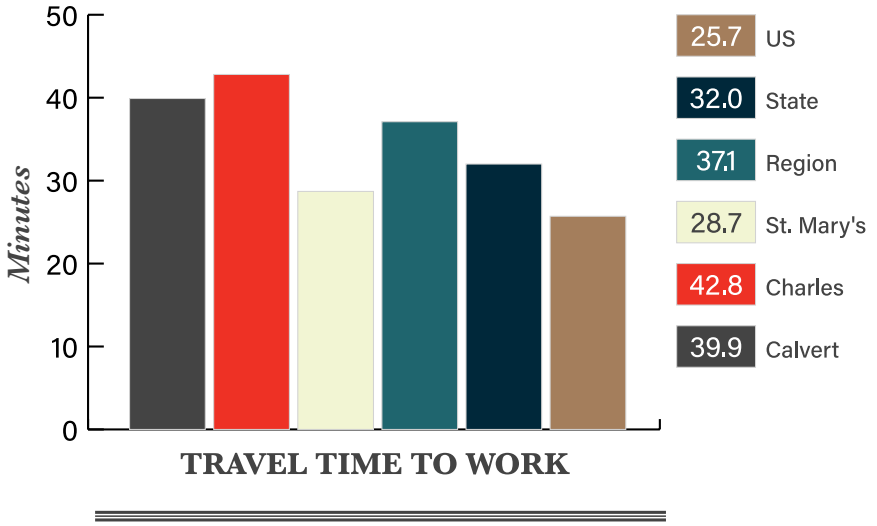


Chart 15

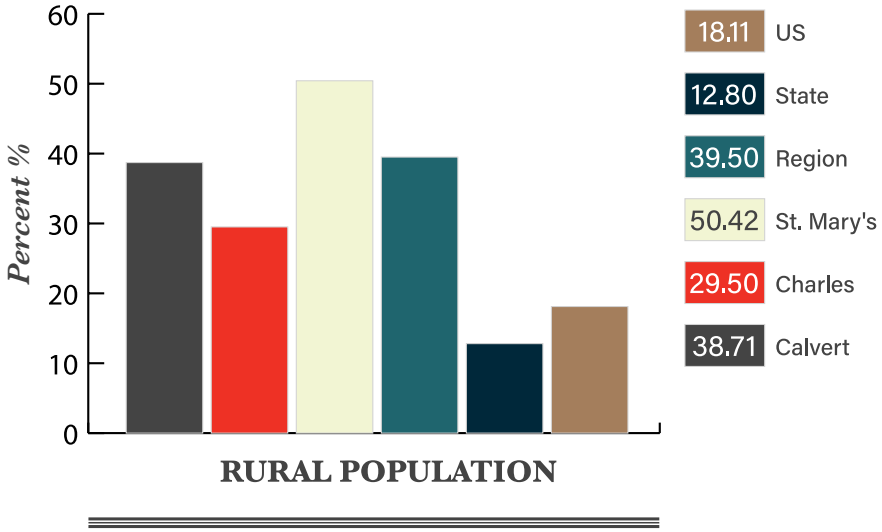


Chart 16

Based on the United States Census Bureau, American Community Survey data for the 2010-2014 period, the average travel time to work (average minutes commuting to work by any means of transport) in Charles County was highest in the region at 42.8 minutes followed by Calvert County (39.9 minutes), and St. Mary's County (28.7 minutes). The average rate for the region (37.1 minutes) was higher than the state and U.S rates of 32.0 and 25.7 minutes respectively. This indicator provides insight to lifestyle factors that could negatively impact the community health outcomes such as sedentary behaviors and amount of time spent away from one's social network and family. As asserted by Christian (2012), "individuals with longer commutes are increasingly less engaged in health-related activities." Most especially for Charles County with a higher commute time, this could be indicative of poor community health outcomes including mental health. It can be hypothesized that the long commute times are due to the relatively more rural nature of the region. Up to 50.42% of the population in St Mary's County live in rural areas, 38.71% in Calvert, and 29.5% in Charles. The average rate of individuals living in rural areas for the region (39.5%) was significantly higher than the state and U.S rates of 12.8% and 18.11%.

Poverty

Research shows that poverty can be a cause as well as an outcome of mental health which is defined by the social, economic, and physical environments in which people live (Elliott, 2016). This is because there is an increased likelihood for populations living in poverty to have limited resource access, including health insurance and physical and mental healthcare. The household poverty rate indicator which measures the percentage of households with incomes below the poverty line can be used to assess the poverty levels of a community. Based on the United States Census Bureau 2014 data, St Mary's County had the highest poverty rate in the region at 8.6% followed by Charles County and Calvert County both at 7.2%. The average rate for the region (7.7%) was lower than the state and U.S rates of 10.5% and 15.6% respectively. Overall, the median household income based on the United States Census Bureau data for the 2010-2014 period, the value at which half of the households in the region earn more and half earn less was $87,945 which was significantly higher than the state and U.S averages of $75,572 and $56,135.

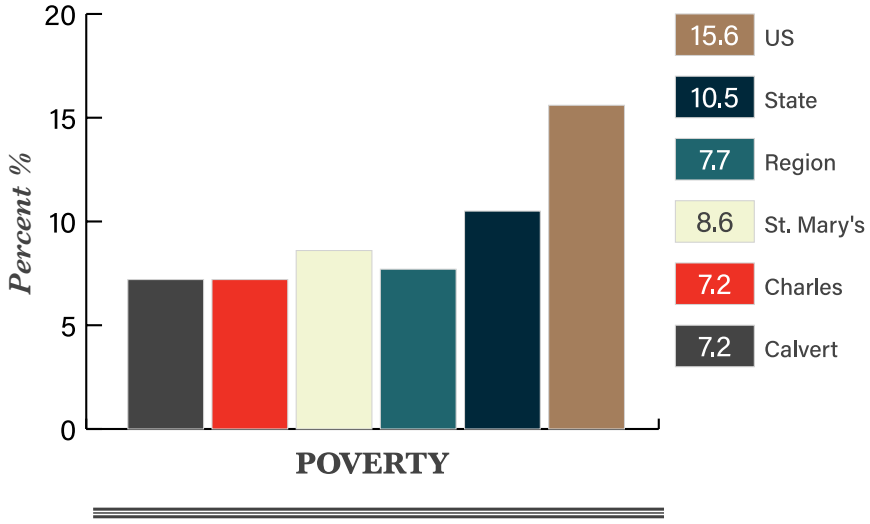


Chart 17

Social Associations

The social association rate indicator measures the number of social organizations per 10,000 population. These organizations could include religious, civic, political groups or sports organizations. Significant evidence from research shows that there is increased utilization of available mental health services resulting from increased social participation especially amongst individuals with suicidal ideation (Youn et al., 2020). This is of importance as it provides an opportunity for public policy and programs to improve mental health in the general population through promotion of social organizations memberships for improved mental health outcomes. Based on the United States Census Bureau 2013 data, St Mary's County had the highest social associations rate in the region at 7.0% followed by Calvert County (6.9%), and Charles County at 6.3%. The average rate for the region (6.7%) was lower than the state and U.S rates of 9.0% and 9.4% respectively.

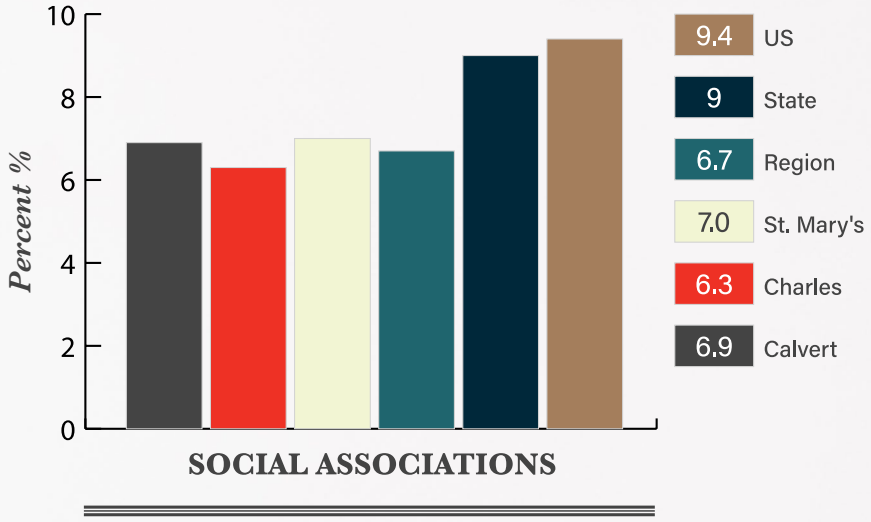


Chart 18

Socio-Cultural Factors

Population with Limited English Proficiency

In all three counties in the region, 1 in 3 children identified as Latino or Hispanic origin. This is significant as the Latino/Hispanic population is likely to face more socio-economic barriers and poorer health outcomes than non-Latino Whites. This SDoH often negatively impacts their access to resources necessary for them to stay healthy and thrive. With regards to the adult population, 1 in 22 adults are Latino/Hispanic in St. Mary's County:1 in 29 in Calvert and 1 in 20 in Charles (Salud America!, 2021; Calvert County Family Network, 2020).

An inability to speak English creates barriers to healthcare access, and language barriers have been shown to decrease the odds of mental health service use by foreign-born individuals, especially Latino immigrants (Kim et al, 2010).

This is of importance as Latino/Hispanic communities often face disparities in both access to and quality of treatment. According to Brown (2013), more than half of Hispanics ages 18-25 with serious mental illness are likely not to receive treatment for their health condition. Language barrier is one contributing factor (Brown, 2013). Based on the US Census Bureau, American Community Survey (2015-2019), the percentage of the population aged 5 years and older who speak a language other than English at home and speak English less than "very well" for the region (1.9%) was significantly lower than the state (6.96) and US (8.4%) rates; however, disparities exist within subpopulations in the region especially in St. Mary's County where the rate was 17.12% for Hispanic or Latino populations when compared to 1.30% for non-Hispanic or Latino populations. In Charles County, the rate was 16.99% within Hispanic or Latino population compared to 1.72% within non-Hispanic populations. In Calvert County, the rate was 5.82% within Hispanic or Latino populations when compared to 0.89% within the non-Hispanic or Latino population. These disparities are relevant because an inability to speak English creates barriers to healthcare access, and language barriers have been shown to decrease the odds of mental health service use by foreign-born individuals, especially Latino immigrants (Kim et al, 2010).

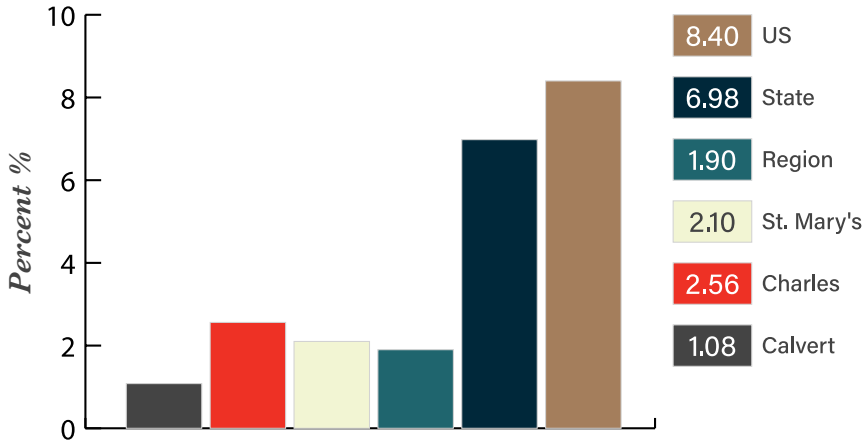


Chart 19

Veteran Population

Mental health challenges continue to be on the increase within the veteran population. An estimated 20% of the veterans who served in either Iraq or Afghanistan suffered from either major depression or post-traumatic stress disorder and 19.5% were diagnosed with a traumatic brain injury (Tanielian, et al., 2008). More so, the National Council for Mental Wellbeing reports that less than 50% of returning veterans in need receive any mental health treatment although approximately 22 veterans die by suicide every day. The emotional difficulties increase with lengths of deployments and impact other family members including children and spouses. Based on the US Census Bureau, American Community Survey data (2015-2019) period, Charles County had the highest percentage of veterans in the region at 13.53% followed by Calvert County (12.61%), and St. Mary's County (12.48). These rates along with the average rate for the region (12.9%) were significantly higher than the state and U.S rates of 7.86% and 7.29% respectively.

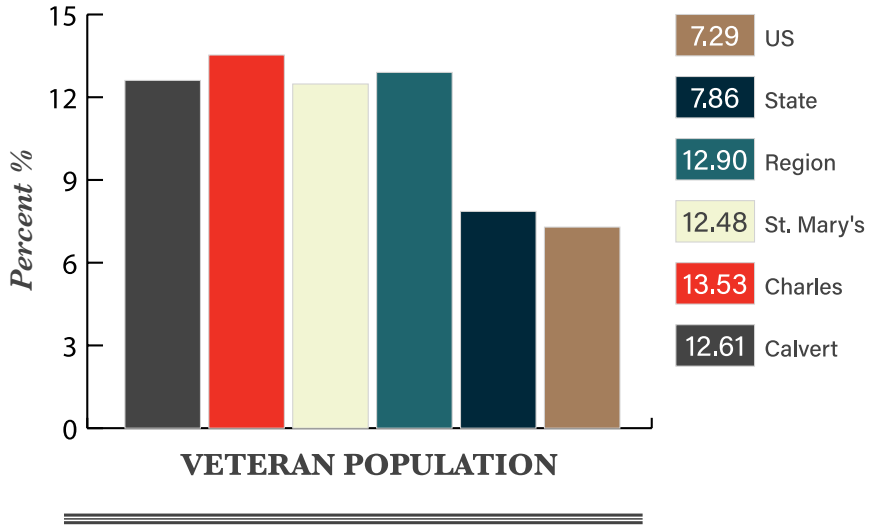


Chart 20

Change in Total Population

During the timeframe of 2000 - 2010, St. Mary's County had the highest change in total population at 21.97% followed closely by Charles County (21.57%), and Calvert County (19.02%) (Community Commons, 2021). These rates along with the average rate for the region (12.9%) were significantly higher than the state and U.S rates of 9.01% and 9.75% respectively.

The Hispanic population were the key drivers of this population increase. In St. Mary's County, there was a 131.06% change in the Hispanic population as opposed to a 19.75% non-Hispanic population change. This trend was prevalent in Charles County with a 129.94% change in Hispanic population as opposed to a 19.07% in non-Hispanic population change. Calvert County experienced a 114.71% Hispanic Population change when compared to a 17.54% non-Hispanic Population change during the same period.

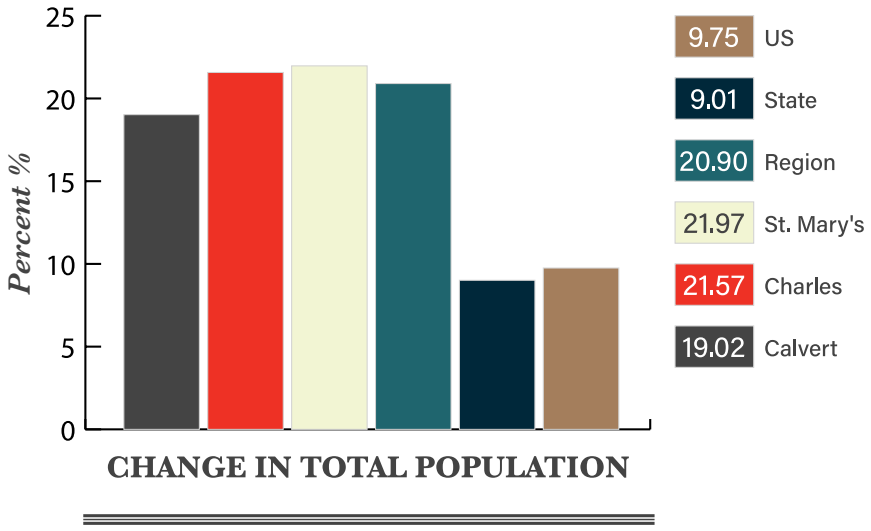


Chart 21

Funding and Sustainability

Although grant funding and additional CPT coding contribute to funding for crisis care services, there are still gaps in coverage for call center and mobile crisis care. Crisis call centers and Mobile Crisis Services currently have no reimbursable rates from public or private health insurance plans and are therefore highly reliant on grant funding for coverage of services. Many current grant funding opportunities span 1-3 years, which may afford Crisis Call Centers and Mobile Crisis Services the time needed to work toward sustainable funding resources such as reimbursable CPT coding. Additional threats exist for current crisis services that are eligible for reimbursement through public and private health insurance plans such as Walk-In services and Residential Crisis Services. These threats include lack of adequate reimbursement given the extensive care and treatment required to appropriately serve individuals utilizing Walk-In and Residential Crisis Services. For example, Walk-In services may be reimbursable for up to 1-2 hours of traditional care (i.e. counseling assessment or medication evaluation), but are not inclusive of nursing services, peer support services, and administrative costs incurred during these visits. Furthermore, if individuals require longer lengths of stay than 1-2 hours, those expenses are not captured in current CPT reimbursement rates. Collaboration will be required between service providers and payers to show the quality, value, and lower costs of crisis care services compared to ED and inpatient costs traditionally accessed for crisis care.

Technology

Effective crisis systems must integrate technology across the continuum of crisis care. Technology needs to operate reliably 24 hours per day, 7 days per week, 365 days per year: a possible challenge in rural communities. Call Center technology should allow for multiple entrance points from phone to chat and texting technologies. Every connection is responded to in real time, coordinating overflow calls with a robust back-up and triage process. This may present a challenge in communities with more scarce resources. Additional technology needs set forth by the National Guidelines for Behavioral Health Crisis Care include the incorporation of Caller Identification, GPS-enabled functionality, and links to real time registries (inpatient and crisis bed registries, outpatient appointments, etc.).

Identified Priorities

IDENTIFICATION OF PRIORITIES

The current array of behavioral health services in Southern Maryland was evaluated to determine the priorities, gaps, and needs of the region. Input was gathered via key stakeholder interviews, surveys, regional health data reviews, and community health needs assessments to determine

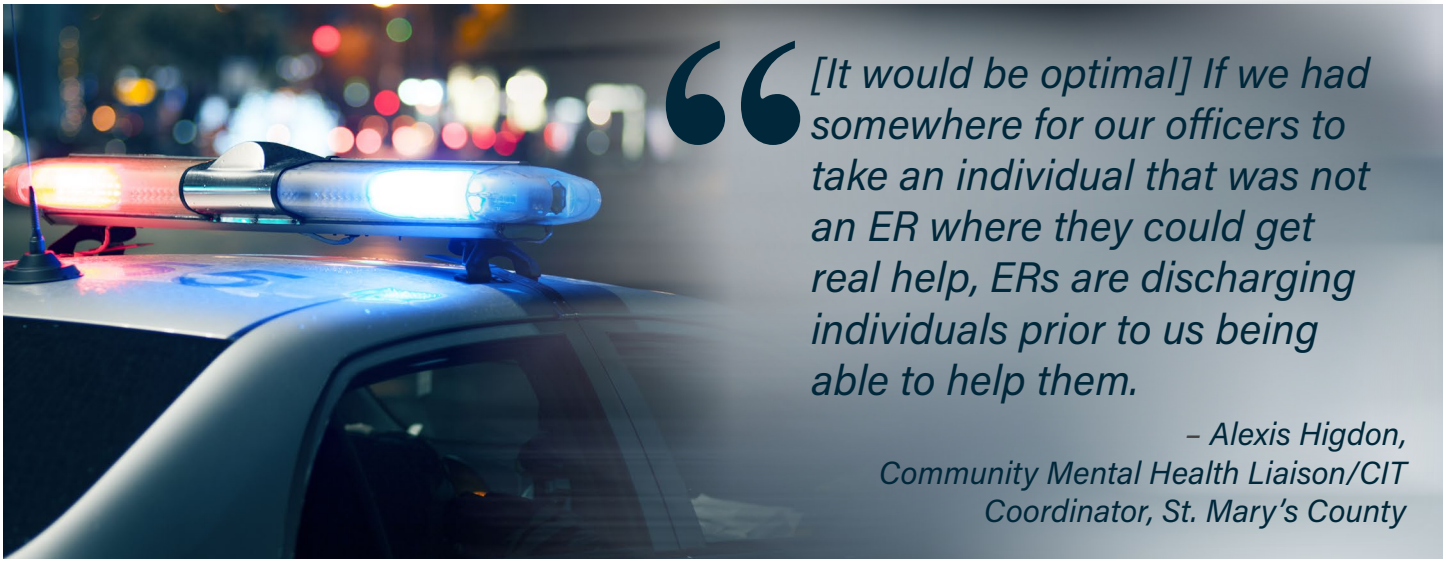
- the current regional infrastructure that supports crisis services;
- the population(s) to be served;
- the status of behavioral health crisis access; and
- the impact of behavioral health crises on the community.

Additional data was collected from local hospitals pertaining to behavioral health emergency department visits, psychiatric inpatient utilization, and patient dispositions.

Each county has, at a minimum, some level of crisis care services ranging from crisis hotlines to limited walk-in clinic capacity and community partnerships with agencies that can provide inpatient, intermediate, and outpatient levels of care. Each county reported a dearth of child and adolescent providers including licensed counselors and prescribers. Each county also reported limited resources for geriatric psychiatric services, particularly for intermediate and inpatient levels of care.

Additionally, while each county has some crisis care services, not all crisis services are available 24/7. For example, SAMHSA's (2020) National Guidelines for Behavioral Health Crisis Care recommends 24/7 crisis receiving facilities for short-term stabilization. Currently in the region, there are Walk-In centers and limited Residential Crisis beds but none that are available for immediate access 24/7. Of the Residential Rehabilitation Program (RRP) beds and Residential Crisis Services (RCS) beds, none are geared for children and adolescents or the geriatric population, and most are geared toward substance use conditions rather than an integrated (mental health and substance use) utility.

Another priority area is the integration of the tri-county crisis response system. SAMHSA recommends a regional and collaborative approach to crisis care. Each county, mostly due to funding restrictions, offers services in their respective counties. This siloed approach to crisis care inhibits individuals from freely accessing services in the closest location and is misaligned with the Crisis Now model's "no wrong door" approach to accessing crisis care. A priority need for the tri-county area entails at minimum, a collaborative approach to crisis care services, and ideally a fully integrated approach. The regional priorities are listed in the following tables.



"[It would be optimal] If we had somewhere for our officers to take an individual that was not an ER where they could get real help, ERs are discharging individuals prior to us being able to help them.

– Alexis Higdon, Community Mental Health Liaison/CIT Coordinator, St. Mary's County

Top Regional Priorities (focus group and interview responses)

Child/Adolescent Crisis Services

Geropsychiatry Crisis Services

24/7 access to Crisis Services

Residential Services- Child/Adolescent

Residential Services- Geriatric

Tri-county integrated Crisis Response System

The following table represents the top priorities of the questionnaire respondents (58 respondents)

PRIORITY	NUMBER OF RESPONDENTS	%
24/7 access	33	56.9
Crisis Services Center	31	53.5
Mobile or Community Outreach team	30	51.7

Table 2

The following table shows that these priorities were also consistent when analyzed by county.

Top Priorities by County (questionnaire responses)

COUNTY	RESPONDENTS	PRIORITIES
Charles	21	1. 24/7 Access 2. Crisis Stabilization Center 3. Crisis Services for Youth
St. Mary's	26	1. Mobile/Community Health Outreach 2. Crisis Stabilization Center 3. Crisis Hotline
Calvert	6	1. 24/7 Access 2. Mobile/ Community Health Outreach 3. Crisis Stabilization Center

Table 3

Recommendations

Based on the top priorities that were found in our analysis, we have generated the following recommendation in an effort to reduce or mitigate current barriers present within the tri-county area and to address the priorities that were identified by key stakeholders in each county.

The Essential Principles for Modern Crisis Care Systems, as outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care, was used to inform the recommendations for Southern Maryland Crisis Center Services. These principles provide the following expected outcomes of Crisis Services.

- Recovery-oriented (person-centered treatment planning).
- Peer driven (hire credentialed peers and provide support to best optimize the unique shared experience that peers have with individuals accessing crisis services)
- Trauma-Informed (create calm environments where staff understand the need for safety, transparency, peer support, choice and independence, collaboration, and empowerment for the individual in crisis).
- Zero Suicide/Safer Suicide Care (a commitment to safety and reduction in suicide, providing a caring and competent workforce, assessing and addressing suicide risk, ensuring individual have timely and collaborative access to care, use of evidence-based treatment methods, providing aftercare support, and ensuring data driven quality improvement efforts).
- Safety and security for staff and people in crisis (commitment to safety for both staff and individuals served).
- Partnerships with Law Enforcement and Emergency Medical Services (implement CIT training for law enforcement, hold regular meetings with Law Enforcement and Emergency Medical Services to continuously partner and improve services provided to individuals in crisis, shared data on outcomes).

I. CREATE A HUB-AND-SPOKE MODEL

To complement the current array of crisis services offered in each county, the model recommended includes a main Crisis Center hub providing a

- Crisis Hotline/Call Center,
- Mobile Crisis Team,
- Walk-In Clinic,
- Residential Crisis Services,
- and satellite offices or 'spokes' in other areas of each jurisdiction.

The satellite offices (spokes) are intended to provide some crisis services but not necessarily all recommended services. This hub-and-spoke model is best served through collaborative and integrated efforts to ensure consistency in practices, policies, and procedures (Bostock, L. & Britt, R., 2014). This hub-and-spoke model will also ensure achievement of best practice integration of standards of care. Consistency in standard operating procedures, governance, and oversight lends itself to higher quality outcomes. It also helps make a case for sustainable funding from public and private payers as more cohesive and uniform service structures fosters a standard of stability and reliability that is required to establish pay structures (SAMHSA, 2020).

Additionally, technological integration of this hub-and-spoke model would create seamless information sharing and access to data to drive outcomes and quality improvement measures. Information readily available to providers allows for informed decision making that contributes to enhanced quality of care outcomes.

The additional benefits of the hub-and-spoke model will help to drive a key component of crisis care services, real time coordination of aftercare and outpatient follow-up services.

Each jurisdiction should promote cross-county collaboration as much as possible, especially to access follow-up appointments for individuals served in any of the crisis center locations. Access to a multi-county database of resources and partnerships enhance the availability of community support and treatment options for the individuals served. SAMHSA's National Guidelines for Behavioral Health Crisis Care emphasizes the importance of immediate connection and follow up with aftercare services to avoid exacerbating crisis situations.

Finally, a Crisis Center hub with satellite services for each jurisdiction can help meet provider shortage needs by extending the reach beyond agency lines. Collaboration among the jurisdictions can foster a team approach to caring for individuals regionally. For example, a child and adolescent provider in Charles County can provide a telehealth assessment for a child needing evaluation in St. Mary's County and vice versa. Allowing providers to "float" care across the region further extends provider capacity and more efficiently addresses the resource scarcity.

II. OFFER COMPREHENSIVE CRISIS CENTER SERVICES (EVIDENCE INFORMED/PROMISING PRACTICES)

According to SAMHSA's National Guidelines for Behavioral Health Crisis Care (2020), behavioral health crisis services across the nation are insufficient and fail to meet evidenced based practice standards. SAMHSA further proposes that effective and high-quality crisis services bridge the gap between outpatient and inpatient behavioral health needs by offering a full continuum of care grounded in best practices of crisis care including:

- a 24/7/365 regional/statewide crisis call center that can coordinate care in real time, resolve crisis situations telephonically, and offer connections to community resources and treatment appointments to reduce the potential for crisis escalation;
- a central mobile crisis team that can dispatch to community members in crisis, avoiding inappropriate emergency department and law enforcement utilization and tied to a Crisis Intervention Team trained officer as/when needed to defuse crisis situations in the community and avoid legal dispositions; and
- a walk-in crisis stabilization program (up to 23 hour stabilization and/or residential crisis services) to provide a safe, comfortable, appropriate setting to assess and treat behavioral health crisis needs, avoiding hospital emergency departments, scarcely available inpatient beds, and law enforcement engagement. Services can provide a brief assessment and connection with community resources and appointments, up to 23 hour stays for further stabilization when the individual cannot safely discharge to the community, and up to 5-10 residential crisis days for further stabilization and connection to ongoing community treatment.

These services are necessary in order to change the current default of access to crisis care which has historically included inappropriate utilization of law enforcement; hospital emergency departments which do not provide the specialized environment, services, and specialists necessary to best serve the behavioral health population; and costly inpatient care. When default access options are utilized, it leads to an increase in unnecessary incarceration, overcrowded emergency departments, and longer lengths of stay due to the lack of availability to lower levels of care (SAMHSA, 2021).

A. Crisis Hotline/Call Center Hub

According to SAMHSA (2020) the cornerstone of an effective and integrated Crisis Service system is a regional, 24/7 crisis call center hub that provides live interaction via phone, text, or chat with individuals experiencing a behavioral health crisis. SAMHSA recommends that the call center hub meet National Suicide Prevention Lifeline (NSPL) standards for assessing and addressing suicide risk. Additionally, the call center structure delivers quality, coordinated care in real time (SAMHSA, 2020).

The Call Center Hub integrates with other local, regional, state, and national systems of crisis response to achieve efficient connection with individuals accessing crisis services (SAMHSA, 2020). For example, Southern Maryland may consider integrating with 2-1-1 Maryland and the upcoming national 9-8-8 crisis response phone numbers as well as local crisis hotlines. Additionally, integration with local law enforcement and emergency medical services is highly recommended and is adapted to the local needs and capacity of the service area. To optimize funding and provide consistency in operations and infrastructure, it is recommended that one primary agency be the designated site for the Call Center Hub and on-site services in each county with governance and oversight of local satellite locations. This will provide a seamless and consistent delivery of services in each jurisdiction. Furthermore, cross county collaboration can enhance consistency in practice standards across the region.

Call Center personnel include licensed behavioral health professionals (counselors) and peer support specialists who can assist callers with a variety of assessment and resource navigation needs. The Call Center will house or integrate with resource databases, ensuring community providers and resources listed are up to date. The function of Call Center personnel involves brief screenings, risk assessments, supportive crisis counseling, and disposition. Dispositions may encompass resource linkage and care coordination, dispatching of a Mobile Crisis Team to the caller's location, connecting a caller to emergency medical services, contacting local law enforcement to request a Crisis Intervention Team (CIT) officer response (if available) in collaboration with the Mobile Crisis Team.

The Call Center Hub serves persons of all ages residing in the jurisdiction(s) that are experiencing a behavioral health crisis. According to SAMHSA (2020) staff expertise should include trauma-informed care delivery, "suicide safer" care, recovery oriented and peer driven care delivery, and collaboration with community providers, law enforcement, and emergency medical services.

Call Center hubs operate 24 hours per day, 7 days per week, 365 days per year. Calls are answered in real time and coordinated to address overflow. Personnel should be equipped to follow NSPL standards for assessing and addressing risk and trained to efficiently connect with Mobile Crisis Teams.

According to SAMHSA, best practice elements for a crisis call center include incorporation of caller identification (Caller ID), GPS enabled technology to coordinate with mobile teams and emergency services as needed, coordination with state bed registries and local hospitals, and the ability to connect callers with scheduled outpatient appointments using a warm handoff to encourage engagement in follow up care.

B. Mobile Crisis Team

The Mobile Crisis Team provides immediate in-person response to the scene of a behavioral health crisis. The team includes licensed behavioral health professionals (counselors) and peer support specialists who can navigate their assigned region. Mobile Crisis Team response is coordinated with local law enforcement CIT officers to respond to individuals in crisis. Services provided include behavioral health assessment including integration of NSPL risk assessment and response standards, crisis counseling, resource connections, and aftercare coordination. Mobile Crisis Teams may also provide follow up visits, wellness checks, and other community-based visits. Mobile Crisis Teams are dispatched with no less than 2 personnel responding to a community crisis. This can be a tandem response with Law Enforcement CIT and/or Emergency Medical Services as needed.

In addition to trauma-informed and recovery-oriented approaches to service delivery, mobile crisis teams intervene in crisis situations and require additional training in safety protocols including de-escalation and usage of least restrictive intervention methods. Services are provided 24 hours per day, 7 days per week, 365 days per year. Referrals are received directly from the Call Center hub and coordinated with local law enforcement CIT officers as deemed necessary.

Mobile Crisis Teams can be dispatched to serve individuals of all ages and therefore staff should maintain competencies in addressing crisis situations with children, adolescents, adults, older adults, and family systems. Additional training in cultural competencies is necessary to treat a diverse population. Staff should also be equipped to follow NSPL standards for assessing and addressing risk and safety issues.

It is recommended that each Southern Maryland County will staff their own Mobile Crisis Team for efficiency in response time and optimal resource partnerships and utilization. This also allows for ease of funding sources as most will be funded through local/state/regional grants and funds that are typically awarded to specific county/jurisdictions. The individual counties can serve as partner sites dispatched by their main Call Center hub. Inter-county collaboration and interoperability will be needed to achieve best practice standards and seamless transitions of care for individuals served.

SAMHSA's National Guidelines for Behavioral Health Crisis Care (2020) summarize that Mobile Crisis care helps individuals reach crisis relief quickly in their familiar environment while avoiding unnecessary emergency department visits, law enforcement involvement, and hospitalizations.

C. Walk-In Crisis Center (with up to 23 hour stabilization)

Walk-In Crisis Centers offer immediate access (no appointment necessary) for individuals of all ages (children, adolescents' adults, and older adults) experiencing a behavioral health crisis who are medically stable. This service line offers health screening, behavioral health assessment, counseling support and brief intervention, care coordination with community providers, and medication management services during usual business and extended hours. Some Walk-In Crisis Centers operate 24 hours per day, 7 days per week depending on population needs and capacity, while others operate during business hours with extended evening and weekend hours as local needs dictate. From the walk-in clinic, individuals can be transferred to other levels of care including the on-site Residential Crisis Services, inpatient, emergency department, or other levels of care.

Some Walk-In Crisis Centers have capacity for brief observation spaces for individuals that require medical or safety monitoring for less than 23 hours and do not require a longer stay in a Residential Crisis Services or other setting. These observation spaces may provide more comfortable seating with ongoing monitoring while services are being coordinated for ongoing care.

Staff include a multidisciplinary team including prescribers, licensed behavioral health professionals (counselors), behavioral health technicians used for observation and 1:1 support as needed, peer recovery specialists, and nursing. All staff are trained in least restrictive methods of maintaining safety, management of aggression, trauma informed care, and NSPL standards for risk assessment and intervention.

Walk-In Crisis Centers offer another layer of crisis intervention that avoids unnecessary law enforcement involvement, emergency department usage, and hospitalization. According to SAMHSA's guidelines, services should be coordinated to expedite law enforcement drop-off and access points. The Crisis Now model also purports that individuals accessing crisis services via hospital emergency departments often report increased levels of stress and worsening of symptoms due to crowds, noises, limited privacy, and exposure to the conditions of other patients. A behavioral health crisis specific Walk-In Crisis Centers seeks to provide a more conducive environment for receiving crisis services, utilizing specialized staff and person-centered, trauma informed care approaches. Additionally, the inclusion of crisis stabilization for up to 23 hours can most effectively support the needs of Walk-In Crisis clients who require a more intensive level of crisis care.

For consistency in infrastructure, governance, and funding, the Walk-In Crisis Center is operated by one agency, co-located with the Call Center hub and Mobile Crisis Team for that county. Satellite centers may be established in other parts of each county as the need determines.

D. Residential Crisis Services

Residential Crisis Services (RCS) are provided 24 hours a day, 7 days per week, 365 days per year, onsite and co-located with the Call Center hub, Mobile Crisis Team, and Walk-In Crisis Center. This will allow consistency in service delivery, infrastructure, governance, and funding. Additional satellite crisis residential beds may be established in other areas of each county as the need determines. Additionally, based on the survey and stakeholder interviews, it is recommended for RCS beds to include a mix of mental health licensed beds and substance use licensed beds to best serve the needs of the population. It is recommended that RCS be available for adolescents (ages 12+) through older adulthood, ensuring separate spaces for adolescents and adults. A partnership or memorandum of understanding with a state pediatric hospital and/or behavioral health facility is recommended for children under the age of 12 years requiring residential services.

Data suggests that a large percentage of individuals cared for in a hospital emergency department and psychiatric inpatient unit can be safely and more appropriately cared for in a RCS facility. This service is accessed via Walk-In Crisis Center after assessment is completed and a RCS bed is deemed medically necessary to de-escalate and further stabilize a behavioral health crisis. Additional access points from hospital emergency departments should follow protocols for eligibility criteria. Residents who may benefit from RCS include those who are medically stable (or can maintain medical stability with support) and who cannot safely discharge to the community and who require further stabilization of crisis and/or need immediate prescribing and monitoring. Services provided include a physical health assessment with the capacity to meet mild to moderate medical needs, behavioral health assessment including suicide and violence risk screening, access to immediate prescribing, counseling (individual and group), milieu therapy, education, care coordination, and follow-up activities. Services may also include mild to moderate medical detox support, depending on agency capacity, as presented in this American Society of Addiction Medicine (ASAM) chart found in Appendix F.

The RCS can provide no more than 16 beds to align with current Code of Maryland licensing requirements. The ratio of adolescent to adult beds and mental health to substance use beds is determined based on current inpatient and emergency department data indicating volume and need for those populations. It is recommended that services begin with voluntary individuals, then expand to involuntary individuals (for example, Emergency Petitioned individuals, court ordered treatment) or involuntary pilot program individuals (as state regulations allow). No seclusion or restraint is utilized, and the least restrictive environment is available and offered. Any hands-on intervention is utilized only to maintain an individual's safety until stabilization. These concepts are supported by RI International, a global crisis system pioneer, utilizes the Crisis Now "Living Room model" model of care which incorporates an integrated, peer driven, suicide safer, trauma-informed, and recovery-oriented model of care to provide a safe, comfortable, calming, and healing environment for individuals in their care. These elements are incorporated into all staff training as well as training in least restrictive intervention methods where any hands-on approach is only utilized in emergency situations and to maintain safety while awaiting assistance.

For the RCS, staffing is available 24 hours per day, 7 days per week, 365 days per year with a minimum amount sufficient to safely meet the needs of the population. The staff mix consists of licensed behavioral health professionals (counselors), behavioral health technicians/assistants, peer recovery specialists, nursing, and prescribers, with interventions being peer driven.

E. Ancillary Crisis Services

1. *Security*

According to SAMHSA (2020), essential principles for crisis care systems include considerations for safety and security for persons served and staff. A "no force first" approach is provided through continuous staff training and competencies with crisis intervention best practices. Additional security measures can be embedded in to the design of the physical space to include lock boxes for items that may pose a risk to safety (i.e. pocket knives, scissors, belts, etc.), limited and weighted furniture, ligature resistant fixtures, and creating a comfortable environment conducive to a relaxed state (i.e. soft paint colors and lighting). Partnerships and integrated intervention efforts with local law enforcement and emergency services is recommended as a best practice.

2. *Pharmaceutical Services*

Due to the heavy cost of onsite pharmaceuticals, it is recommended to partner with a local 24/7 pharmacy for medication needs. Several crisis centers choose to implement processes to house individual's home medications on site while maintaining a small amount of commonly used medications on site in smaller quantities.

3. *Laboratory Services*

In alignment with pharmaceutical services, laboratory services can be provided through partnership with local laboratories who can provide on-site draws and courier services for results.

4. *Linens, Food Services, Environmental Services*

Options for business agreements with linen, food, and environmental (cleaning) services are recommended to reduce cost on in-house staffing and supplies, and the need for additional inspections and licensing that would be required for services such as on-site food preparation.

III. ADDRESS RURAL COMMUNITIES

Rural communities are adversely impacted by geographic barriers and provider shortages making it more challenging to provide immediate, quality care to individuals in those regions. SAMHSA suggests several approaches to address to maximize opportunities for accessing crisis care in rural areas:

- Assess how local agencies, such as first responders, provide intervention, transportation, and emergency help to the rural region. Use this knowledge to inform the crisis service delivery in rural areas and explore possible partnerships with existing first responder agencies.
- Optimize telehealth services to reach individuals in remote areas who may have transportation barriers. Telehealth options should incorporate multiple platforms and devices to accommodate most individuals in the community.
- Provide options for community members with prior substance use and mental health conditions to become certified and employed as a Peer Recovery Specialist.
- Work with funders to establish reimbursement rates that support growth of crisis services for rural communities.
- Provide crisis response time expectations that align with geography and provide timely care.

IV. EXPAND THE POPULATION SERVED

Crisis Center services will provide immediate access to care for individuals and families experiencing a mental health and/or substance use crisis and who are in need of immediate access to behavioral health interventions. Individuals served include children, adolescents, adults, and older adults and must self consent (or parent/guardian consent if a minor) for service.

Indivduals who meet medical criteria for behavioral health crisis care include those at risk of suicide or self-harm, severe symptom exacerbation of mental health conditions, high behavioral health needs presenting risk of homelessness, substance use conditions, and co-occuring conditions. Additional safety concerns and risks may be present. Individuals in need of immediate life saving medical interventions are routed to appropriate emergency medical service providers.

Priorities identified in key stakeholder interviews, focus groups, and evident in ED utilization data reveal the need for crisis service access for children and adolescents, specifically access to Stabilization and/or Residential Crisis care outside of an ED and inpatient care. Additionally, the older adult population was identified as a target group in need of crisis services specialized to meet the unique aging needs (ex. assistive devices and equipment, communication assistance, and co-occurring medical conditions).

V. IDENTIFY KEY STAKEHOLDERS/GOVERNANCE

Many individuals enter ongoing mental health treatment through crisis services. It is critical that the local community build and maintain a strong system of crisis services (Health Management Services, 2006). A key stakeholder group is recommended to be developed to create short and long term solutions to the community's need for behavioral health crisis services including a comprehensive and coordinated system of care to both address and prevent behavioral health crises. Common themes related to the need for tri-county collaboration and inter-county communication emerged from the qualitative data collected from focus groups, individual interviews and survey. The most emerging trend and need was the collaboration between law enforcement agencies and hospitals. It is recommended that a crisis network committee be formed to increase collaboration between points of entry (law enforcement, court system, hospitals, school health centers, community providers, etc.) and crisis center services. This committee should be comprised of a representative from each county, point of entry agency, consumer(s), peer support personnel, community mental health provider (s), community medical provider (s), a community citizen or user of behavioral health services, as well as an external facilitator to guide unbiased decision making in crisis services. It is recommended that a key stakeholder committee be formed prior to beginning the implementation of a crisis center to determine best practices for enhancing inter-county and tri-county communication and collaboration. The key stakeholder committee may focus on barriers to care like how law enforcement can access services or transport across state lines and create a referral and linkage to treatment warm hand-off protocol for law enforcement and hospital personnel.

Additional Considerations

REDESIGN LOCAL BEHAVIORAL HEALTH CRISIS SERVICES

The above strategies, services, and recommendations can be implemented both at the regional level and the local jurisdictional level based on the feasibility which can be determined by several factors. The hub-and-spoke model has been used by many behavioral health programs to provide prevention and crisis management services in Maryland and across the nation. This model can connect community providers (clinical and non-clinical) around a central hub that offers a comprehensive set of behavioral health services as well as care coordination programs for an integrative approach to total patient care. While the hub usually provides a comprehensive range of behavioral services and is in a central and accessible location where often the most need is, the spokes are satellite locations with access and support from the hub. The advantage of this model for the Southern Maryland region is that the hub could be centrally located for ease of access of services from the other jurisdictions, while the spokes are located at the various LHDs complimenting or enhancing existing efforts. Another benefit is that most especially in rural jurisdictions or regions where transportation is challenging, the hub-and-spoke model can enhance access to care and improve early detection and treatment. **As such, this model can also be implemented by each LHD independently within their jurisdictions to meet the needs of their populations based on gaps and challenges identified that may be distinct from the other jurisdictions.** Appendix D provides a tabular description of variations to the hub-and-spoke model that have been implemented to improve health outcomes for populations served based on literature review of 10 hub-and-spoke models (Bostock & Britt, 2014).

Management and Leadership

LHDs are separate entities in Maryland that administer and enforce State, county and municipal health laws, regulations, and programs. In alignment with the Maryland Annotated Code, Health-General §§ 10–1201 through 10–1203, LHDs run behavioral health agencies under the auspices of the State Behavioral Health Administration (BHA). While this structure permits LHDs to appropriately serve primarily the needs of their constituents, it can be a limiting factor with the implementation of collaborative efforts that entail conceding or delegating oversight of programs to a different LHD and/or authority. In addition, based on review of some of the models in the state, the hospital systems have been key stakeholders whose commitment and leadership are critical to the success of services provided. The "Klein Family Harford Crisis Center" model in Harford County for example, included the local hospital as the one of the lead entities providing fiscal management as well as administrative oversight of the services. For such a model to be successfully implemented in the Southern region, all three local hospitals would need to work together or defer to the leadership of one or come to a consensus on how resources would be leveraged and what the priority protocols of care would be.

Multi-agency Collaboration and Information Sharing

While not insurmountable, an inadequate information sharing structure or capability to enhance multi-agency collaboration for successful implementation of behavioral health services could be a limiting factor. This is even more concerning if a regional approach is undertaken based on the primary research data gathered, the different information systems within the various jurisdictions are challenged with bidirectional data sharing, systems access, and the exchange and cooperation, within and across agencies and organizations. One of the recurring feedback received from the key informant interviews was that the three counties in the region do not have a history of strong collaboration and do not have an avenue or mechanism at the regional level for common issues to be addressed. Potential solutions to this could necessitate heavy capital investment to get key stakeholders on a compatible data sharing platform to optimize the health of individuals at each point of care and improve efficient use of efforts while reducing waste. Collaboration with stakeholders such as CRISP to identify financial support to promote interoperability of the state's HIE system as well as other data exchange platforms could also enhance viable and safe data sharing options.

Service Accessibility and Adoption

A regional approach to behavioral health services could lead to a better alignment of priorities and leveraging of resources from all stakeholders to address needs, augment capacity building, enhance advocacy efforts for policy, systems, and environmental changes for a collective impact. However, each jurisdiction knows its population the best, has knowledge of local circumstances, and can more promptly shift resources to address pressing needs to ensure its constituents receive the services needed for improved outcomes and wellness. As such a limitation with a regional approach could be that it will create a psychological distance of the services from the constituents especially if managed by a different jurisdiction of independent organization. This coupled with potentially the geographic distance for some populations irrespective of how central the services (i.e., hub) could lead to low usage of resources. This is particularly so as the topography of the Southern Maryland region is unique when compared to other regions in the state and a central location to all three counties could take an average of 1.5 -2.0 hours for some zip code locations.

To augment their existing behavioral health services successfully and independently, it is highly recommended that each LHD understand the full scale of behavioral health issues within their jurisdictions, the region, and state at large, understand the key drivers and gaps, and ensure that evidence based programs and best practices are implemented to address them. This would entail some minimal level of assurance in their capacity to do as evidenced by political support, sufficient resources, and key stakeholder collaboration.

Potential Locations

To review and assess the availability and suitability of real estate infrastructures within the region, several factors were identified based on the framework proposed by Kraft and Furlong to evaluate public policies (2015). The eight select factors constituted the criteria used and using a Likert scale from 1, as Strongly Disagree, to 4 as Strongly Agree, the factors were scored to recommend an optimal location for a crisis center. Seven Renaye James Healthcare Advisors staff members using the criteria completed the review and scoring of the identified real estate properties in the region and an average score for each factor was obtained. The sum of all the averages for the factors for each property was ranked and the three properties with the highest scores selected.

- **Effectiveness:** refers to the likelihood of successfully implementing the programs and services at the location. The layout of the building, accessibility options, bed capacity, safety exits, parking spaces, and contract terms were taken into consideration.
- **Cost:** primarily focused on the financial cost of the facility and took into consideration existing amenities and turnkey structures.
- **Technical feasibility:** pertains to the availability and reliability of technologically related assets or barriers including Wi-Fi accessibility, interoperability of systems, and connectivity.
- **Political Will:** refers to the likelihood of stakeholder consensus on the location. Primary data obtained through the online survey, key informant interviews, and focus groups was prioritized.
- **Efficiency:** entails the implementation of the services in the most productive and efficient manner to augment care transitions from hospital systems to outpatient facilities and/or other community-based services and vice versa. The nearness to a local hospital was prioritized.
- **Equity:** this pertains to the fairness of the location especially taking into consideration those in need of services. As such, priority was assigned to locations within high prevalence zip codes and underserved areas.
- **Social acceptability:** assesses the extent to which the public would be accepting of the location as a resource for behavioral health service. Particular attention was paid to zoning laws in place and for the surrounding areas.
- **Administrative feasibility:** refers to the likelihood that the services and programs can be implemented smoothly from the identified location and the ease of administration.

The total scores ranged from 62-131. Using the aforementioned criteria as well as a site visit to select locations in each county to review accessibility and capability to house the recommended services, the following locations are listed for consideration:

LOCATION	COUNTY	SQUARE FOOTAGE	SCORE	SITE VISIT	COMMENTS
11370 Pembrooke Square, Waldorf, MD	Charles	11,000	131	Yes	8 miles from Charles County Regional Medical Center.
45007 East Run Drive, Lexington Park, MD	St. Mary's	13,500	128	Yes-full build out required	New Construction, Warm Shell Condition.
43871 Airport View Drive, Hollywood, MD	St. Mary's	20,000	108	No	20,000 Sq feet available, conference rooms and private parking.
2425 Solomons Island Road Suites G, H Huntington, MD	Calvert	3, 000	91	Yes- full build out needed	2.1 miles from Calvert Health Medical Center; located in the rear of an office complex.

Please see Appendix E for location rubric scores and maps.

Table 4

In addition to the aforementioned locations/ properties available for occupancy, an additional location in St. Mary's County, the former PNC Building in Lexington Park, has been identified as an ideal location for Behavioral Health crisis services. The property is located at

21625 Great Mills Road
Lexington Park, MD 20653.

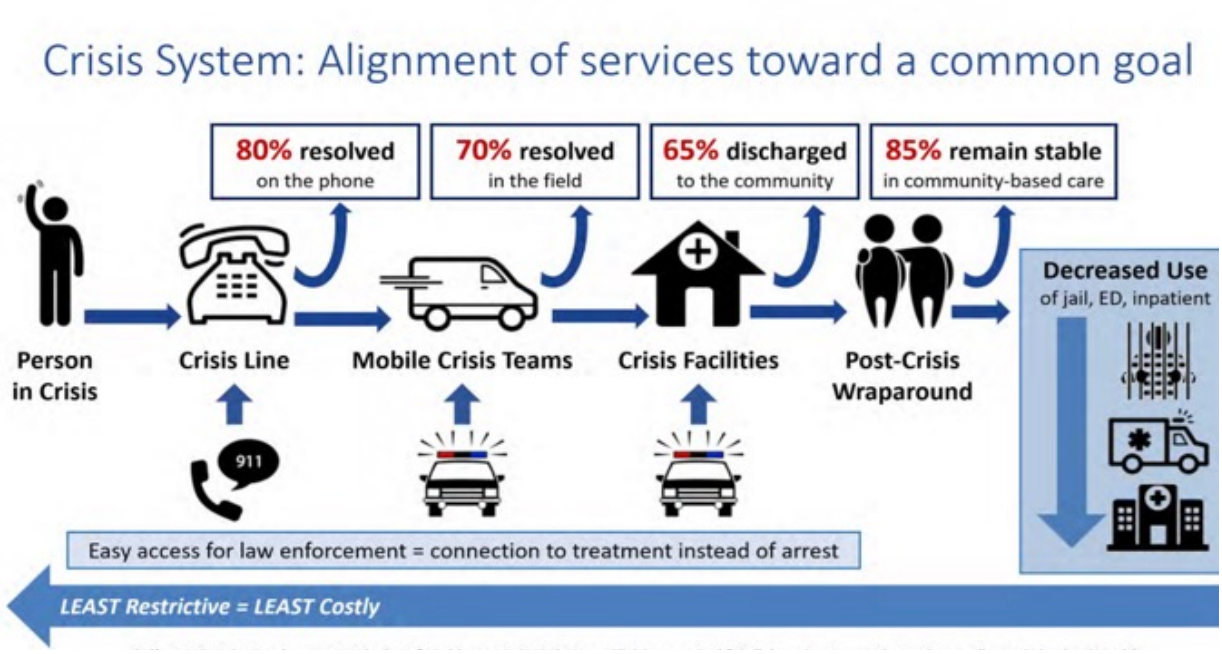
This location is in close proximity to a Satellite St. Mary's Co. Sheriff's Office, the Department of Social Services, Three Oaks Center, a homeless shelter, and the Housing Authority. The location will be designed to accommodate crisis services including stabilization, co-responders, LEAD, Day Reporting Center, and Harm Reduction. Additional primary care and COVID-19 services will be co-located in this location as well. The proximity to county partners, the ability to house comprehensive behavioral health crisis services, and the capacity to co-locate needed community and public health services, make this location an optimal choice for a crisis center.

Closing Remarks

AFTER IMPLEMENTATION OF AN EVIDENCE-BASED CRISIS CARE SYSTEM

An example of a successful crisis care model includes the essential elements outlined above. One study conducted by the National Association of State Mental Health Directors (2020) found that a robust system of crisis care implemented in Southern Arizona in fiscal year 2019 produced an 80% resolution of crisis calls without dispatching a mobile crisis team, law enforcement, or emergency medical services. Of the individuals receiving mobile crisis team services, 70% of crisis situations were resolved with that visit without the need for transfer to a hospital or other higher level of care. Of the individuals accessing walk-in crisis services, 65% per discharge to the community with aftercare other than hospitals, emergency departments, or jail. Furthermore, a staggering 85% of individuals who received crisis services remained stable in the community without subsequent emergency department or hospital utilization within 45 days of discharge from the crisis center.

The infographic illustrates the improvements attained as a result of implementing an evidence-based crisis care system.



MITIGATING CHALLENGES

This Southern Maryland environmental scan and assessment identified the many challenges facing the region regarding the provision of comprehensive behavioral health crisis centers; however, stakeholder feedback clearly illustrated that many are eager to contribute to a plan to improve access and outcomes in their local communities. A regional approach, although intriguing, may be technically, geographically, financially, and politically impractical (see section Additional Considerations). Nonetheless, the Crisis Services model recommended (using a hub-and-spoke model) has been identified as an evidence-based practice yielding improved community outcomes and reduced morbidities. This model, even at the county hub-and-spoke level, can be used to improve care, reduce ED and hospital behavioral health admissions, and reduce incarceration for those in crisis by having the region agree on and standardize the following:

- policies, procedures, and workflows;
- operational and clinical metrics;
- consistent, comprehensive training of staff and teams;
- technology and data sharing requirements;
- staffing ratios and staffing credentials;
- management of special populations (children/adolescents/geriatrics/Limited English Proficiency); and
- management of other SDoH

As recommended, one first step is convening a key stakeholder committee to serve as the first step in the development of a regional partnership and commitment to improving access to behavioral health crisis services. This committee and forum is key to identifying the timeline, the efforts and the resources available to provide these behavioral health crisis services to the region and to determine the level these critical services can be provided.

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Appendix

APPENDIX A

1. What best describes your role?
    a. Client/Consumer of Services
    b. Community Provider (Social Services, Primary Care, etc.)
    c. First Responder (EMT, Fire and Emergency Medical)
    d. Health Department
    e. Hospital/Facility Staff
    f. Justice Services (Judge, Probation, Attorney, etc.)
    g. Law Enforcement Agency (Sheriff, police, etc.)
    h. Local Behavioral Health Authority
    i. Other (please list)

2. What county do you perform your role
    a. Calvert County
    b. Charles County
    c. St. Mary's County
    d. Other

3. What is the primary population you serve in your current role?
    a. Adults
    b. Aging/Older Adults
    c. Children and/or Youth
    d. Developmental Disability Individuals
    e. Justice or Court Involved Individuals
    f. Homelessness
    g. Behavioral health (Mental health/ Substance Use) - Adults
    h. Behavioral health (Mental health/ Substance Use) - Youth
    i. Maternal/Infant Health
    j. Medical/Health - Adults
    k. Medical/Health - Pediatrics
    l. Military/Veterans
    m. Other or multiple populations please define

4. How many years have you been in your current role?
    a. Less than one year
    b. 1-3 years
    c. 4-6 years
    d. 7-9 years
    e. 10+ years.

5. What do you think are the five greatest barriers to accessing behavioral (mental health and/or substance use) health care in your county? Please select up to five.

    a. Accessibility Challenges (physical, hearing, vision)
    b. After Hours (5pm) not available
    c. Affordability of services
    d. Limited availability of service (wait list, bed availability, etc.)
    e. Lack of awareness of behavioral health services
    f. Insurance (Uninsured/Underinsured)
    g. Lack of childcare
    h. Limited English Proficiency
    i. Lack of convenient location
    j. Lack of privacy
    k. Provider shortage
    l. Safety concerns
    m. Scheduling/Cannot get appointment
    n. Stigma/Shame
    o. Lack of technology
    p. Lack of accessible transportation
    q. Other (please specify)

6. What are the top five assets in your community that allow access to Behavioral Health care? Please select up to five.

    a. Community Health Centers
    b. Emergency Medical Services
    c. Supportive Friends/Family
    d. Free clinics and free pharmacies
    e. Financial assistance
    f. Accessibility to providers - Primary Care
    g. Accessibility to providers - Psychiatrist
    h. Accessibility to providers - Psychologist, Counselor, Clinical Social Worker
    i. Accessibility to programs - (substance use treatment, mental health programs, etc.)
    j. Accessible Location
    k. Medical and Health Transportation
    l. Public Transportation
    m. School Health Services
    n. Telehealth
    o. Other (please specify)

7. Please rate your assessment of the following statement: There are adequate resources to address BH conditions in your county?

    Strongly disagree

    Disagree

    Neither agree nor disagree

    Agree

    Strongly agree

8. On a scale of 1-10, how likely are you to recommend a family/friend to your local hospital for crisis behavioral health services? 1-Not likely at all, 10= Extremely Likely

9. On a scale of 1-5, how aware are you of community resources (i.e. behavioral health crisis care, behavioral health outpatient services, financial assistance, etc.)

    1- Not aware at all

    2- Not so aware

    3- Somewhat aware

    4- Very aware

    5- Extremely aware

10. How safe do you feel (physically, emotionally, culturally, etc.) accessing current behavioral health crisis services?

    1- Not safe at all

    2- Not so safe

    3- Somewhat safe

    4- Very safe

    5- Extremely safe

11. Where do you currently refer yourself or others for behavioral health crisis care (mental health and/or substance use crisis)?

12. What key changes would you like to see your county implement to improve behavioral health crisis care access?

13. What are your top three priorities for behavioral health crisis care in your county? Please select up to three.

    a. 24/7 access
    b. Medication Assistance Treatment (MAT)
    c. Mobile/Community Outreach Treatment Team
    d. Crisis Hotline
    e. Walk-in Clinic
    f. Crisis Stabilization Center
    g. Child and Adolescent Behavioral Health Crisis Services
    h. Maternal/Infant Health Behavioral Health Crisis Services
    i. Peer Support Services
    j. Substance use Services (Outpatient, Intensive Outpatient, Partial Hospitalization)
    k. Substance use Services (Inpatient, Detoxification)
    l. Training - Community Education
    m. Training - Law Enforcement Crisis Intervention Training
    n. Other (please specify)

14. What is your preferred location for a crisis center? _____

15. Please provide any additional information you would like to add.

16. We value your time and input. If you would like to be contacted to provide additional input, please provide your name and phone number or email address.

APPENDIX B - QUERY RESULTS FOR MARYLAND BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

HEALTH RISK BEHAVIOR	CALVERT	CHARLES	ST. MARY's	REGION	STATE
Any Alcohol Consumption in last 30 days	59.1	55.7	54.4	56.2	53.6
Chronic Drinking	4.9	0	3.7	4.6	5.4
Binge Drinking in Past 30 days	16.7	14.1	19.1	16.3	14.8
Asked About Alcohol at Last Routine Checkup	93	81.4	87.8	86.2	81.5
Asked About Drinking in Person or On Form at Last Routine Checkup (How much?)	83.5	79.2	71.1	77	71
Asked if I Drank More than 5/4 Drinks	25.7	24.5	46.4	32.7	35.1
Offered Advice on Harmful or Risky Drinking at Last Routine Checkup	16.6	20.5	32.3	22.8	24.4
Advised to Reduce or Quit	0	0	0	0	7.3

APPENDIX C- HIGH SCHOOLS: YRBS 2018

HIGH SCHOOL STUDENTS	CALVERT		CHARLES		ST. MARY's		REGION		STATE	
Health Risk Behavior	Heterosexual	Gay, Lesbian, or Bisexual	Heterosexual	Gay, Lesbian, or Bisexual	Heterosexual	Gay, Lesbian, or Bisexual	Heterosexual	Gay, Lesbian, or Bisexual	Heterosexual	Gay, Lesbian, or Bisexual
QN113: Percentage of students who have ever lived with anyone who was an alcoholic or problem drinker, used illegal street drugs, took prescription drugs to get high, or was a problem gambler	23.1	34.4	22.5	30.7	24.1	36.4	23.2	33.8	22.4	35.5
QN114: Percentage of students who ever lived with anyone who was depressed, mentally ill, or suicidal	27.7	51.5	25.5	47	29.0	56.1	27.5	51.5	26.1	49.6
QN115: Percentage of students who reported someone in their household has ever gone to jail or prison	22	40.9	27.1	34.8	24.3	29.3	24.5	35	22.4	32.3
QN116: Percentage of students who reports a parent or other adult in their home regularly swears at them, insults them, or puts them	22	40.9	22.3	39.3	19.3	36.9	21.2	39	18.1	36.6

APPENDIX D: MATRIX OF HUB-AND-SPOKE MODELS

MODEL	MANAGEMENT STRUCTURE	CONTEXT AND CHARACTERISTICS
Multiple hubs	Single manager	All hubs provide same core services to provide reach across large geographical area (possibly rural)
Main hub with satellite sites	Single manager	Hub provides core service and satellites provide specialist services spokes may also be soft entry points to the core service
Hub-and-spokes (sometimes referred to as a cluster depending on the role of spokes and leadership model)	Hub manager also responsible for spokes sometimes with or without middle managers for each spoke	Formal structure, share operational policies and procedures Staff might work across spokes Consistency and fidelity to delivery model Specialist outreach model
Hub provides one stop shop facility and services	Most likely that spokes are managed separately by partnership organizations and services	Spokes provide referral routes to hub Hub provides training center Flexibility – longer opening hours Can change core components to meet changing needs
Hub provides central specialized care and spokes provide core services	Emphasis is on the network as the managing organization rather than the individual services	Care providers coordinate core activities in the spokes Use of web-based technology to disseminate expertise and/or administer treatment Benefit from remote specialists rather than having to be on site

(Bostock, & Britt, 2014)

APPENDIX D: MATRIX OF HUB-AND-SPOKE MODELS (CONT.)

MODEL	MANAGEMENT STRUCTURE	CONTEXT AND CHARACTERISTICS
Hub is strategic center with strategic lead	Spokes have separate managers	Spokes are managed independently Spokes from within same sector and division Hub responsible for coordination and delivery of data
Hub provides core leadership. There may be one or two hubs	Spokes are outsourced (multi agency partnership)	Informal clusters Sharing of extended services Training Program fidelity Enhancing capacity of voluntary sector
Virtual hub, for example a virtual site might be hosted in a school just to provide an administrative base and address)	Spokes are all outreach in community settings	Low cost Lack of identity or focal point
Network of services that are joined together sharing the same vision for practice and outcomes but there is no central hub	Management structure provided through network. Likely to have steering group made up of network managers.	Capacity building Community cohesion Focus often more about multi agency collaboration than running services and activities
Hub acts as emergency or crisis response center	Spokes are bi-directional to and from the hub and provided by a collaboration of services (likely to be both formal and informal arrangements)	Spokes provide direct access to emergency care Spokes provide after care and links to community support

(Bostock, & Britt, 2014)

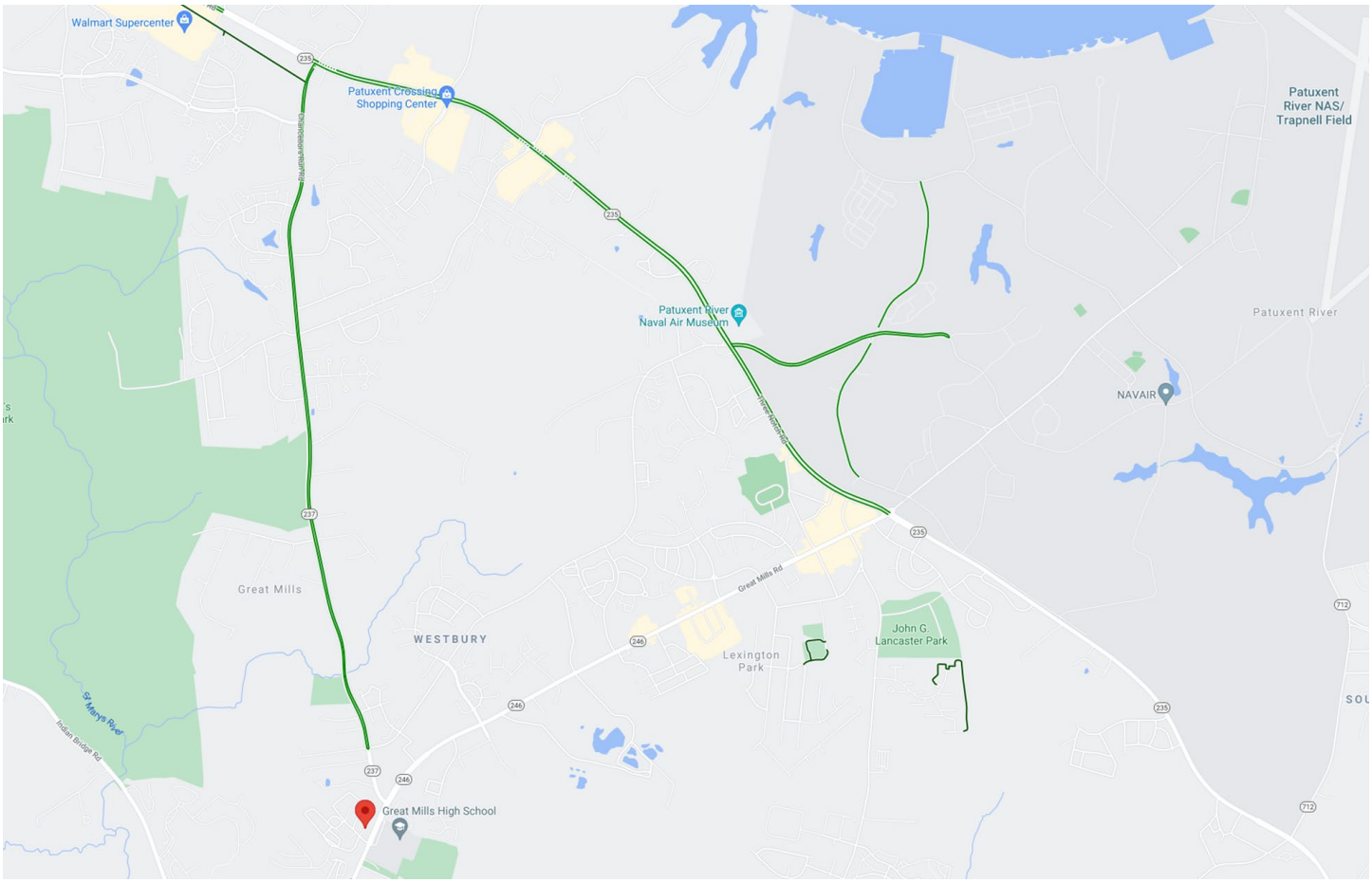
APPENDIX E

1. 11370 Pembrooke Square
   Waldorf, MD 20603
2. 45007 East Run Drive,
   Lexington Park, MD 20653
3. 2425 Solomons Island Rd,
   Huntingtown, MD 20639
4. 43871 Airport View Drive,
   Hollywood, MD 20636

Pembrooke Square Medical Center

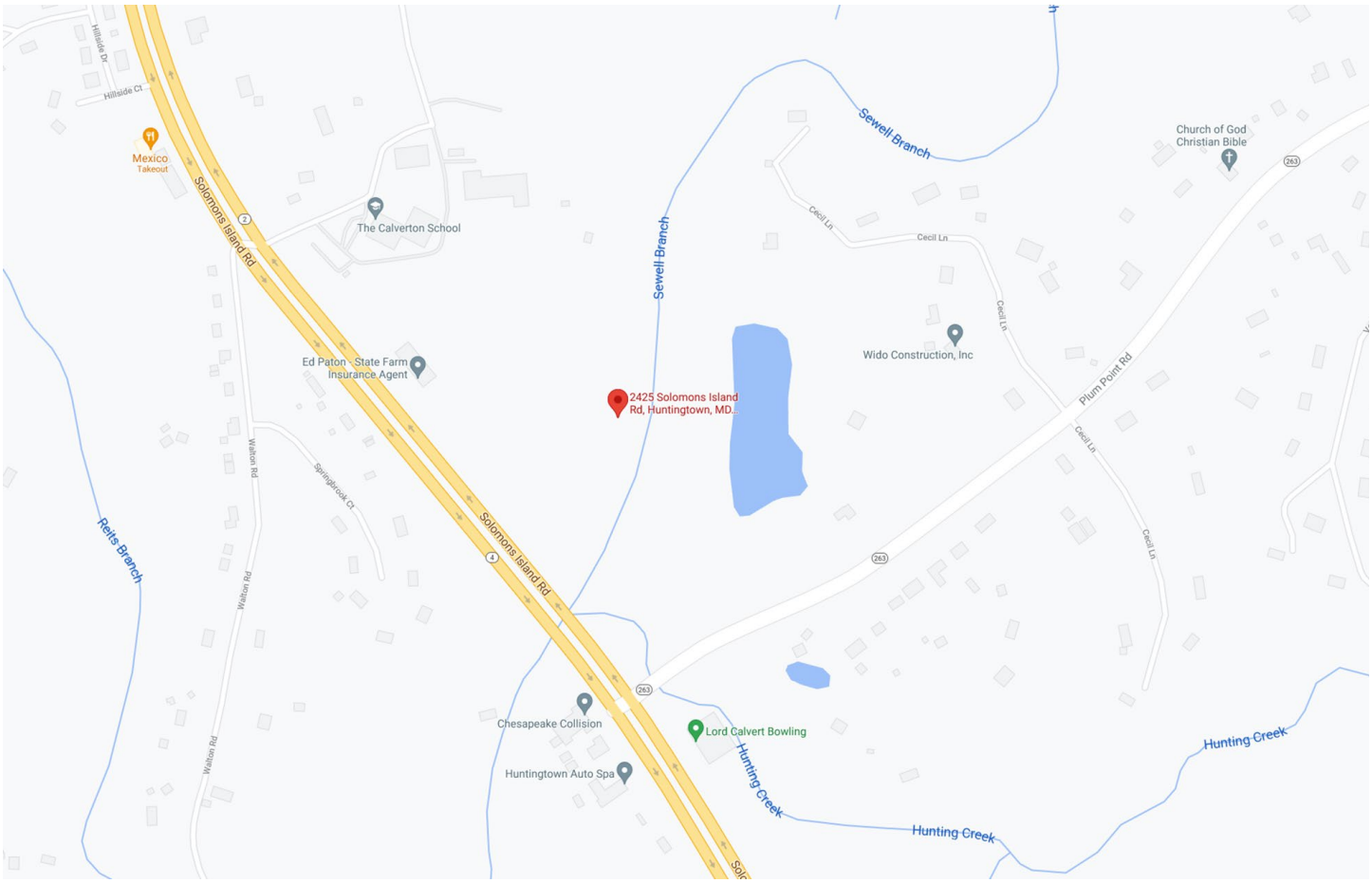
11370 Pembrooke Square
Waldorf, MD 20603

APPENDIX E (CONT.)



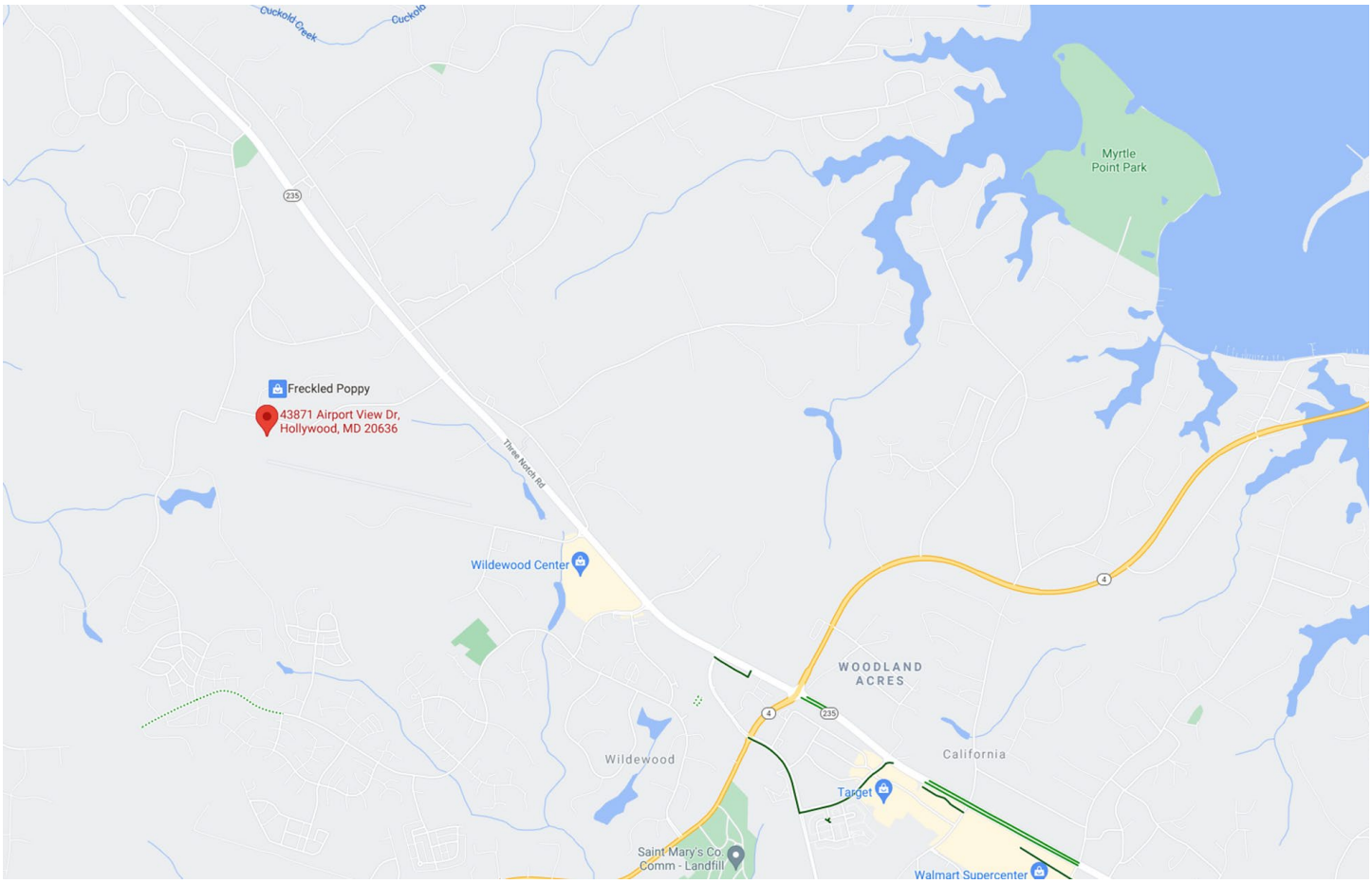
45007 East Run Drive
Lexington Park, MD 20653

APPENDIX E (CONT.)



2425 Solomons Island Rd,
Huntingtown, MD 20639

APPENDIX E (CONT.)

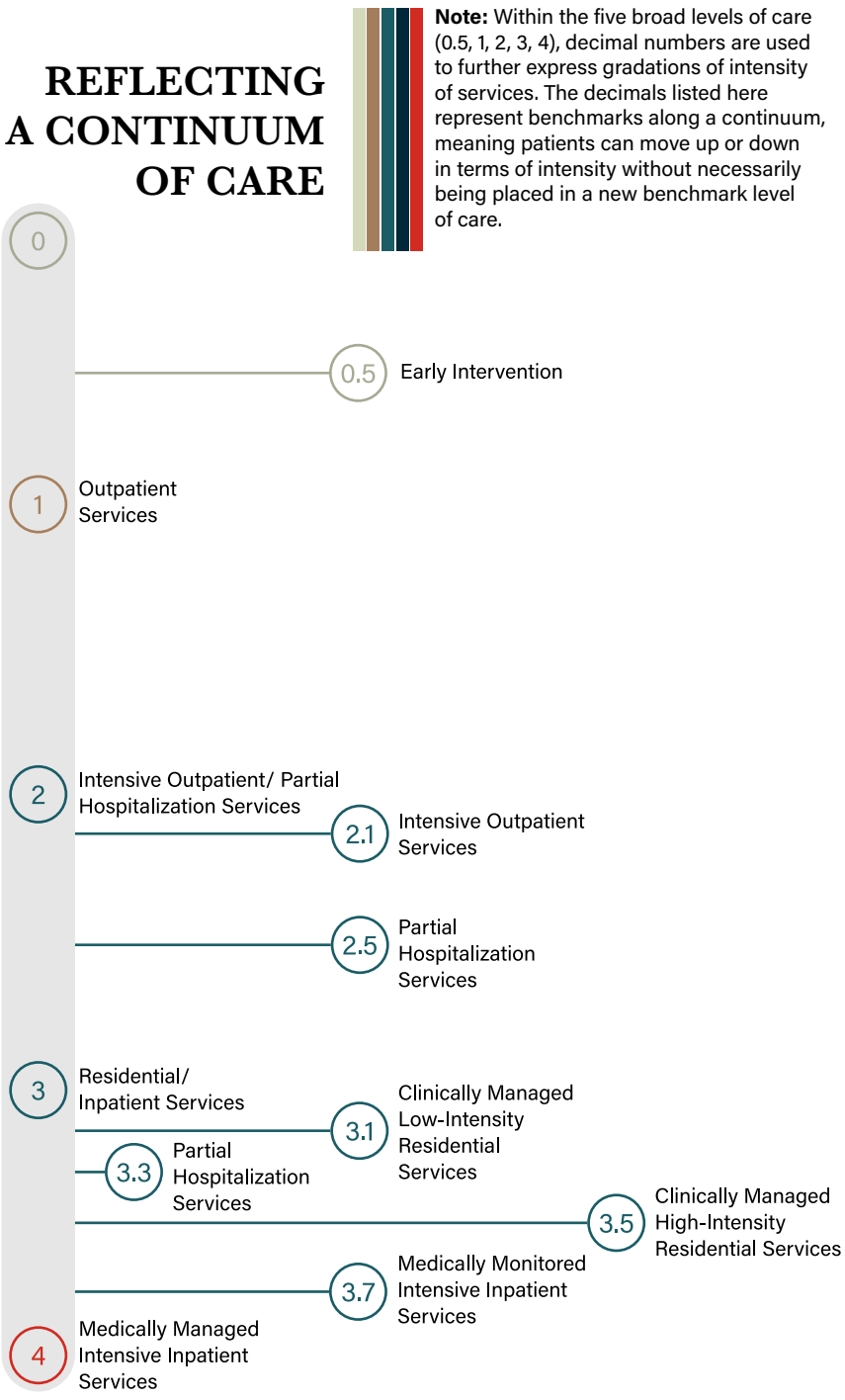


43871 Airport View Drive,
Hollywood MD 20636

APPENDIX E (CONT.)

LOCATION	EFFECTIVENESS	COST	TECHNICAL	POLITICAL WILL	EFFICIENCY	EQUITY	SOCIAL ACCEPTANCE	ADMINISTRATIVE FEASIBILITY	TOTAL SCORE
11370 Pembrooke Square, Waldorf, MD 20603	18	17	18	13	17	12	18	18	131
28170 Old Village Road, Mechanicsville, MD 20659	10	10	18	9	9	11	15	11	93
111 & 113 Chesapeake Beach Rd, Owings MD 20736	7	11	16	10	11	11	12	11	89
2425 Solomons Island Road, Suites G&H, Huntington MD 20639	9	10	16	10	10	11	14	11	91
7627 Leonardtown Rd, Hughesville MD 20637	7	8	11	7	8	8	6	7	62
45807 East Run Drive, Lexington Park, MD 20653	17	16	18	13	17	13	18	16	128
43871 Airport View Dr Hollywood MD 20636	16	14	18	11	13	13	13	10	108

APPENDIX F



Adapted from the American Society of Addiction Medicine (ASAM), this graph is used to depict levels of care treatment options for individuals accessing substance use services.

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