



DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

January 19, 2022

The Honorable Bill Ferguson
President of the Senate
H-107 State House
100 State Circle
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
H-101 State House
100 State Circle
Annapolis, MD 21401-1991

RE: HB 332/Chapter 172 (2020) – Annual Report on Facilities Requesting to be an Emergency Facility (MSAR #12743)

Dear President Ferguson and Speaker Jones:

In keeping with the requirements of HB 332/Chapter 172 (2020), the Maryland Department of Health (MDH) respectfully submits this report on facilities requesting to be an emergency facility that can appropriately receive and provide crisis care to individuals who have been emergency petitioned..

If you have any questions about this report, please contact Heather Shek, Director, Office of Governmental Affairs, at heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: Aliya Jones, Deputy Secretary, Behavioral Health Administration
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services, MSAR # 12743 (5 copies)

I. Background

Chapter 172 of the 2020 Acts of Maryland ([HB 332](#)) Mental Health – Confidentiality of Medical Records and Emergency Facilities List requires the Maryland Department of Health (MDH) to publish a list of emergency facilities that can appropriately receive and provide crisis care to individuals who have been emergency petitioned.

MDH is required to annually publish an Emergency Facility List (EFL). Originally the EFL consisted of emergency facilities as defined in [Md. Code Ann., Health–Gen. § 10-620](#): “includes a licensed general hospital that has an emergency room, unless MDH, after consultation with the health officer, exempts the hospital.” HG § 10-620 also allowed MDH to designate facilities that were not hospitals with emergency care as emergency facilities, but none were designated. Only a few community hospitals have not been designated as an emergency facility that can accept individuals who have been emergency petitioned.

In 2018, the Maryland Behavioral Health Advisory Council submitted the Maryland Behavioral Health Advisory Council November 2017 Strategic Plan: 24/7 Crisis Walk-in and Mobile Crisis Team Services report ([MBHAC Plan](#)) to the Maryland General Assembly. The report provided evidence to support crisis services as an essential component of any comprehensive system of behavioral health care.

In 2020, based upon the MBHAC Plan, HB332 Mental Health – Confidentiality of Medical Records and Emergency Facilities List specified that comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health centers (OHMC) may be included on the EFL. Under HB 332 MDH, in consultation with stakeholders, is required to “develop a model program structure that ensures that a program wishing to serve as an emergency facility: (1) Is adequately staffed to provide 24-hour emergency petition services; (2) Provides the necessary services required for an emergency petition; (3) Has written procedures in place that provide for involuntary admissions, through an emergency petition, including to a licensed hospital, as necessary; (4) Provides additional support to respect the due process rights of patients received through the emergency petition process; and (5) Complies with additional procedures as otherwise determined by the Department.”

Under HB332, on or before September 30th each year, MDH is required to report the number of facilities that have requested to be an emergency facility; the number of facilities that have attempted to meet the model facility standards; the progress of facilities that have attempted to meet the model facility standard; the development of collaborative models between state, local, and private entities; and whether MDH in consultation with stakeholders, has determined that any changes to the model facility standards are necessary. A facility may not be added to the EFL until the model program standard is developed.

As further described below MDH’s Behavioral Health Administration (BHA) worked with numerous stakeholders to develop the model program structure.

II. Model Program Structure Summary

The main components of what a facility needs to have in order to become a designated psychiatric emergency facility that accepts emergency petitioned individuals include:

- comprehensive services and adequate staffing;
- 24/7 hours of operation;
- assessment timelines;
- medical evaluation;
- withdrawal management capabilities for all substances along with initiation of medication for the treatment of opioid use disorder (MOUD); and
- a secure locked facility.

A designated facility's staffing needs to be higher when providing care for those with a danger to self and others who are not accepting treatment voluntarily. Unlike with emergency departments (ED) in hospitals, free-standing crisis facilities do not have outside staff who can immediately respond and come to assist in a psychiatric or medical emergency. Such emergencies may include suicidal behavior where a one-to-one observation is immediately needed or an episode of aggression that requires restraint or seclusion and unscheduled/immediate medication given intramuscularly over objection.

The capability to handle such emergencies while maintaining the care for others requires a minimum of four (4) staff per shift for eight (8) beds or less, who are all on-site and trained for medical or psychiatric emergencies, including training for seclusion or restraint, although these should be interventions of last resort. De-escalation training of all staff shall also be required. The four (4) staff shall include at least one (1) nurse. If a psychiatrist is not on-site, they must be available for immediate consultation, including telehealth interaction with clients, and they also must be able to respond on-site within two hours as clinically needed. If more than eight (8) beds are occupied then the minimum is five (5) staff per shift.

Hours of operation are 24/7 as per HB 332. Relative to voluntary patients, the acuity level is often higher for emergency petitioned individuals since they have been assessed as a danger to self or others, and since they are not voluntarily accepting treatment. As individuals who are emergency petitioned are less likely to be both stabilized and to have their disposition resolved in less than 16 hours, it is insufficient for designated facilities to only be open during the day and evening shifts, so they need to be open 24/7.

An examination by nursing staff shall occur within one hour of arrival. Per HG §10-624, within six hours after an emergency evaluatee is brought to an emergency facility, a physician shall examine the emergency evaluatee. The examination shall include screening for suicide risk and violence risk, with comprehensive assessment and planning when indicated. Then the physician shall determine whether the emergency evaluatee meets the requirements for involuntary admission. If in an ED setting, an

emergency physician onsite can perform this initial admission evaluation. If it is an ED physician, then there should be an examination by a psychiatrist within 24 hours, which can be via telehealth.

A nurse shall perform, at a minimum, a daily assessment of all individuals. Vital signs should be obtained at least once per shift. There shall be a daily assessment by a psychiatrist, permissible to be delivered by telehealth, with the requirement of an in-person evaluation by the third day of admission.

Services should be well linked with existing community behavioral health service providers. Individuals are to be linked to follow-up and outpatient support services upon discharge. For those in need of hospitalization, there should be written agreements with nearby community hospitals for admission to their psychiatric units, or for a medical admission if indicated.

For the complete Model Program Structure see Appendix B: Model Program Structure of Designated Psychiatric Emergency Facilities.

III. Reporting Requirements

A. Number of facilities that have requested to be an emergency facility.

From January 1, 2021, through September 1, 2021, one hospital that has an emergency department has shown a strong interest in becoming an emergency facility: Luminis Health Doctors Community Medical Center (LHDCMC), located in Lanham, Maryland in Prince George's County. LHDCMC is a medical and surgical hospital that is upgrading its emergency department's behavioral health services. Two non-hospital facilities, Grassroots Crisis Intervention, Inc. (Howard County) and the University of Maryland Upper Chesapeake Health System-Klein Crisis Center (Harford County) have indicated their possible interest, but cite barriers to becoming an emergency facility including: adequate funding, credentialing, changes in COMAR needed regarding emergency petition laws, requirements regarding medical assessments (such as laboratory testing) and capital costs (i.e. remodeling of space to allow for a seclusion room). Grassroots currently is open 24/7 for those experiencing a substance use crisis. The Klein Center previously was open 24/7, serving those experiencing either a mental health or substance use crisis, but decreased their hours of service due to financial reasons and low patient volume. Both programs would consider participating in a pilot if it addresses the barriers they have identified.

B. Number of facilities that have attempted to meet the model program structure standards.

LHDCMC is the only facility that has attempted to make progress towards meeting the standards.

C. Progress of facilities that have attempted to meet the model facility standard.

Luminis Health Doctors Community Medical Center (LHDCMC) was not able to meet their initial projected August 1, 2021 implementation date, with January 1, 2022 now as the projected date. LHDCMC has made significant progress towards meeting the standard but has been unable to recruit the necessary staff. LHDCMC will continue to market the open positions and will also recruit through reaching out to personal and professional networks.

D. Development of collaborative models between state, local, and private entities.

The MDH BHA, working with community stakeholders, is designing and implementing an innovative, comprehensive, integrated behavioral health crisis system, the Maryland Crisis System Model, to serve children, youth, adults, and senior adults while operating with a regional and local approach. Based on best practices, the Maryland Crisis System Model includes an immediate, recovery-oriented solution to support individuals in crisis; avoid unnecessary emergency department visits and hospitalizations; and avoid unnecessary incarceration. In January 2021, the Maryland Crisis System Workgroup (MCSW) was launched to serve as the statewide convening structure to develop the crisis system. The purpose of the workgroup is to provide an opportunity to collaborate statewide; explore national, state, and local models; and work with numerous partners. Under this structure, there are five working subcommittees including:

- Best Practices/Standardization,
- Data Dashboard,
- Financial Stability/Sustainability,
- 988 Integration, and
- Children, Adolescent, Young Adult

Through the MCSW and its Best Practices/Standardization subcommittee, members have worked to develop and review the model set forth in HB332. The final version of the model program structure will be distributed to MCSW members, comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, outpatient mental health centers, local jurisdictions, and those emergency departments that are not a designated emergency facility. Through this process, facilities, comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health centers interested in working with BHA will be invited to develop collaborative models and refine the model program structure.

E. Whether MDH, in consultation with stakeholders, has determined that any changes to the model facility standards are necessary.

Diverse stakeholders, including hospital and behavioral health providers, people with lived experiences, advocacy organizations, and numerous state partners, were involved in the development of the model program structure. These stakeholders will continue to be involved as the model develops and changes are made. At this time, as the

implementation of the model facility standards is ongoing, no changes are recommended.

See Appendix C for the list of stakeholders involved in the development of the model program structure.

Appendix A: Emergency Facility List

The Emergency Facility List for 2021 is shown below and can also be found at this website: <https://health.maryland.gov/bha/Pages/State-psychiatric-facilities.aspx>



**Behavioral Health Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2020**

| Allegany County | |
|---|--|
| Western Maryland Regional Medical Center 12500 Willowbrook Rd. Cumberland, MD 21502 (240) 964-8585 | |
| Anne Arundel County | |
| Anne Arundel Medical Center 2001 Medical Parkway Annapolis, MD 21401 (443) 481-1000 | UMD Baltimore Washington Medical Center 301 Hospital Drive Glen Burnie, MD 21061 (410) 787-4306 |
| Baltimore City | |
| Bon Secours Baltimore Health System 2000 W. Baltimore Street Baltimore, MD 21223 (410) 362-3000 | Johns Hopkins Hospital & Health System 600 N. Wolfe Street Baltimore, MD 21287 (410) 955-5964 |
| Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD 21224 (410) 550-0100 | UMD Medical Center Midtown Campus 827 Linden Avenue Baltimore, MD 21201 (410) 225-8100 |
| Sinai Hospital of Baltimore (<i>Lifebridge Health</i>) 2401 W. Belvedere Avenue Baltimore, MD 21215 (410) 601-5461 | MedStar Union Memorial Hospital 201 E. University Parkway Baltimore, MD 21218 (410) 554-2000 |
| University of Maryland Medical Center 22 S. Greene Street Baltimore, MD 21201 (410) 328-1219 | |

Baltimore County

MedStar Franklin Square Medical Center
9000 Franklin Square Drive
Baltimore, MD 21237
(443) 777-7068

Northwest Hospital
5401 Old Court Road
Randallstown, MD 21133
(410) 521-5950

St. Joseph Medical Center
7601 Osler Drive
Towson, MD 21204
(410) 337-1226

Calvert County

Calvert Memorial Hospital
100 Hospital Rd.
Prince Frederick, MD 20678
(410) 535-8344

Caroline County

UMD Shore Medical Center at Easton
219 S. Washington Street
Easton, MD 21601
(410) 822-1000

UMD Shore Medical Center at Chestertown
100 Brown Street
Chestertown, MD 21620
(410) 778-3300

UMD Shore Medical Center at Dorchester
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

Carroll County

Carroll Hospital Center
200 Memorial Avenue
Westminster, MD 21157
(410) 848-3000

Cecil County

Union Hospital
106 Bow Street
Elkton, MD 21921
(410) 398-4000

Charles County

UMD Charles Regional Medical Center
5 Garrett Avenue
La Plata, MD 20646
(301) 609-4160

Dorchester County

UMD Medical Center at Dorchester
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

Frederick County

Regional Health System
400 W. Seventh Street
Frederick, MD 21701
(240) 566-3300

Garrett County

Garrett Regional Medical Center
251 N. Fourth Street
Oakland, MD 21550
(301) 533-4000

Harford County

UM Upper Chesapeake Medical Center
500 Upper Chesapeake Drive
Bel Air, MD 21014
(443) 643-2064

UM Harford Memorial Hospital
501 S. Union Avenue
Havre de Grace, MD 21078
(443) 843-5000

Howard County

Howard County General Hospital
(Johns Hopkins Health System)
5755 Cedar Lane
Columbia, MD 21044
(410) 740-7777

Kent County

UMD Shore Medical Center at Chestertown
100 Brown Street
Chestertown, MD 21620
(410) 778-3300

Montgomery County

Holy Cross Health
1500 Forest Glen Road
Silver Spring, MD 20910
(301) 557-6500

MedStar Montgomery Medical Center
18101 Prince Philip Drive
Olney, MD 20832
(301) 774-8900

Shady Grove Medical Center
(Adventist Health Care)
9901 Medical Center Drive
Rockville, MD 20850
(240) 826-6000

Suburban Hospital Health Care System
8600 Old Georgetown Road
Bethesda, MD 20814
(301) 896-3880

White Oak Medical Center
(Adventist HealthCare)
11890 Healing Way
Silver Spring, MD 20904
(240) 637-4000

Prince George's County

UM Laurel Medical Center
7300 Van Dusen Road
Laurel, MD 20707
(301) 725-4300

Prince George's Hospital Center
3001 Hospital Drive
Cheverly, MD 20785
(301) 618-2000

MedStar Southern Maryland Hospital Center
7503 Surratts Road
Clinton, MD 20735
(301) 877-4500

Queen Anne's County

UMD Shore Medical Center at Easton
219 S. Washington Street
Easton, MD 21601
(410) 822-1000

UMD Shore Medical Center at Chestertown
100 Brown Street
Chestertown, MD 21620
(410) 778-3300

St. Mary's County

MedStar St. Mary's Hospital
25500 Point Lookout Road
Leonardtown, MD 20650
(301) 475-8981

Somerset County

Peninsula Regional Medical Center
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

Talbot County

UMD Shore Medical Center at Easton
219 S. Washington Street
Easton, MD 21601
(410) 822-1000

Washington County

Meritus Medical Center
11116 Medical Campus Road
Hagerstown, MD 21742
(301) 790-8300

Wicomico County

Peninsula Regional Medical Center
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

Worcester County

Peninsula Regional Medical Center
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

Appendix B: Model Program Structure of Designated Psychiatric Emergency Facilities

Introduction

Chapter 172 of the 2020 Acts of Maryland (House Bill (HB) 332) - Mental Health – Confidentiality of Medical Records and Emergency Facilities List requires that the Maryland Department of Health publish a list of emergency facilities that can appropriately receive and provide crisis care to individuals who have been emergency petitioned. This Designated Psychiatric Emergency Facilities list, published by the Behavioral Health Administration (BHA), historically has included those community hospital emergency departments (ED) that have the appropriate level of behavioral health services, therefore most Maryland hospital EDs are on the list. HB 332 allows comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers and outpatient mental health centers (OHMC) to also be considered for inclusion on this list. These facilities must meet the staffing and other criteria required, including these listed in HB 332: (1) Is adequately staffed to provide 24-hour emergency petition services; (2) Provides the necessary services required for an emergency petition; (3) Has written procedures in place that provide for involuntary admissions, through an emergency petition, including to a licensed hospital, as necessary; (4) Provides additional support to respect the due process rights of patients received through the emergency petition process; (5) Complies with additional procedures as otherwise determined by the Department.

In consultation with stakeholders, a model program structure should be created for the additional types of facilities now eligible to be a Designated Psychiatric Emergency Facility, which could also apply to EDs that are not currently designated facilities. Annually on September 30, a report is to be submitted to the General Assembly listing the facilities seeking to become an emergency facility and whether they have met the program criteria, and if revisions to the criteria have been made.

Eligibility for Service and Facility Schedule:

A Designated Psychiatric Emergency Facility must be secure, so that it can accept both individuals who present voluntarily with behavioral health issues and those who present involuntarily on an emergency petition. Unlike crisis facilities or urgent care centers that only serve individuals who voluntarily present for assessment and treatment, a Designated Psychiatric Emergency Facility needs to be open 24 hours a day, 7 days a week, also a requirement of HB 332. Relative to voluntary patients, the acuity level is often higher for emergency petitioned individuals since they have been assessed as a

danger to self or others, and since they are not voluntarily accepting treatment. As individuals who are emergency petitioned are less likely to be both stabilized and to have their disposition resolved in less than 16 hours, it is insufficient for designated facilities to only be open during the day and evening shifts, so they need to be open 24/7.

Receiving facilities must have a secure and locked dedicated drop-off space, so that when mobile crisis, law enforcement or medical services personnel bring an individual to the facility their turnaround time can be minimal. Although SAMHSA recommends that the facilities be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders, but when they have no open beds or the acuity is too high, for reasons of safety, a facility does need the ability to temporarily not accept new admissions. The process should include personnel calling ahead for permission to transport someone to the facility, but this should not be used as an opportunity for the facility to inappropriately screen who is brought to the facility, based on clinical or insurance status. Personnel may stop bringing individuals to the facility if admission is denied too often. The process should be similar to when EDs undergo alerts and temporarily ambulances are diverted due to overcrowding or not having any open monitored beds. There should be written agreements with other nearby crisis facilities and EDs for accepting individuals during times of diversion.

Staffing:

The number of staff in a designated facility needs to be higher than in a voluntary facility to be able to handle the greater risk for psychiatric emergencies within the facility for emergency petitioned individuals. Unlike hospital-based emergency rooms, free standing crisis facilities do not have outside staff who can immediately respond and assist in a psychiatric or medical emergency. Minimum staffing requirements for all shifts is 24 hours a day, therefore they need to be able to handle such emergencies without impacting the care of others in the facility. Such emergencies may include suicidal behavior where a one-to-one observation is immediately needed, or an episode of aggression that requires restraint or seclusion with unscheduled/immediate medication given intramuscularly over objection if it has been refused during the emergency. Both the ability for restraint and a seclusion room are required, since depending on the individual, one or the other may be preferable or more appropriate for someone, if these interventions of last resort become necessary.

The capability to handle such emergencies while maintaining the care for others requires a minimum of four staff per shift for eight beds or less, who are all on-site and trained for medical or psychiatric emergencies, including training for seclusion or restraint, although these should be interventions of last resort. De-escalation training of

all staff shall also be required. The four staff shall include at least one nurse. If a psychiatrist is not on-site, they must be available for immediate consultation, including telehealth interaction with clients, and they also must be able to respond on-site within two hours as clinically needed. Minimum staffing requirements can include one security staff trained for emergencies including seclusion and restraint, but the other staff must be clinically licensed. If more than eight beds are occupied, then the minimum is five staff per shift. There needs to be an ability to quickly increase staffing during periods of higher acuity, and the threshold for this needs to be low, especially for facilities with sixteen or more beds. Staffing during day shift or evening shifts should be higher than minimum staffing ratios because of the likelihood of a greater number of voluntary and involuntary admissions, the presence of a full time social worker for working on disposition, and the presence of medical staff. Certified Peer Specialists, with their lived experience, can be essential clinical team members who can assist with engaging clients, education, and facilitating community transitions.

Core Components of the Behavioral Health Assessment and Treatment:

An examination by nursing staff shall occur within one hour of arrival. Per Health-General Article §10-624, Annotated Code of Maryland, within six hours after an emergency evaluatee is brought to an emergency facility, a physician shall examine the emergency evaluatee. There shall be a screen for suicide risk, and a comprehensive suicide risk assessment and planning when indicated. There shall be a screen for violence risk, and a comprehensive violence risk assessment and planning when indicated. Then the physician shall determine whether the emergency evaluatee meets the requirements for involuntary admission. If in an ED setting, an emergency physician onsite can perform this initial admission evaluation. If it is an ED physician, then there should be an examination by a psychiatrist within 24 hours, which can be via telehealth.

Services shall be comprehensive and provide on-site behavioral health crisis stabilization, and withdrawal management capabilities for all substances. The initiation of medication for the treatment of opioid use disorder shall also be offered.

A nurse shall perform, at a minimum, a daily assessment of all individuals. Vital signs should be obtained at least once per shift. There shall be a daily assessment of psychiatric status by a psychiatrist, permissible to be delivered by telehealth, with the requirement of an in-person evaluation by the third day of admission. If in an ED setting, an emergency physician onsite can perform the daily assessment of psychiatric status required after the admission assessment by the psychiatrist, but the assessment of psychiatric status by a psychiatrist must occur at least every 72 hours (in-person or via telehealth), or more often as clinically indicated.

Services should be well linked with existing community behavioral health service providers. Individuals are to be linked to follow-up and outpatient support services upon discharge. For those in need of hospitalization, there should be written agreements with nearby community hospitals for admission to their psychiatric units, or for a medical admission if indicated.

Medical Evaluation:

The admission psychiatric assessment and the nursing assessment in non-ED settings shall include a medical review of systems and medical history to assess whether the individual is medically stable enough to remain in the facility, or is in need of transport to an ED. Within 24 hours of admission a medical evaluation by medical staff who are either a physician, nurse practitioner, or physician's assistant must occur. For those in need of psychiatric hospitalization, a physical exam is often required before acceptance for admission. Laboratory work and other diagnostic procedures deemed necessary shall be performed as ordered for either of these evaluations, and subsequent evaluations. Non-ED settings must have the capacity to quickly secure basic laboratory screening and results that psychiatric patients in crisis would also receive in an ED, or might be required by hospitals prior to an admission. This includes, but is not limited to, complete blood count, chem-20, pregnancy testing, blood alcohol level, urinalysis, urine drug screens, and COVID-19 testing. Non-ED settings must also provide medication levels for common psychiatric medications, such as lithium and valproic acid, to check for compliance or increased levels, commonly used anticonvulsants, and levels for medications with significant risk if overdosed on, such as aspirin, acetaminophen, or tricyclic antidepressants.

Legal and Accreditation Issues:

Emergency petition and involuntary hospitalization procedures must be followed with respect for the due process rights of patients received through the emergency petition, and with certification for involuntary hospitalization. This includes the patient's right to an Involuntary Admission hearing before an administrative law judge as provided in Health-General Article §10-632.

Relevant statutes include Health General §§10-613, 10-614, 10-615, 10-616, and 10-617, Health-General Article §§10-620, 10-621, 10-622, 10-623, 10-624, and 10-625, and Health-General Article §§10-631, 10-632, and 10-633.

When involuntary hospitalization is needed, a certificate to accompany application for involuntary admission is required from two clinicians, with physicians, psychiatric nurse

practitioners, and psychologists eligible to complete the certifications. Facilities shall have timely access to two such clinicians in order to not delay the process.

Health General §10-624 has an established requirement directing law enforcement as follows: "peace officer shall take an emergency evaluatee to the nearest emergency facility if the peace officer has a [emergency] petition." A statute change may be required to allow law enforcement to bypass a closer ED to bring someone to a nearby non-ED designated psychiatric emergency facility. As jurisdictions move towards more behavioral health related 911 calls being directed to mobile crisis teams instead of law enforcement, a statute change may be required to allow for crisis teams to transport individuals who have been emergency petitioned.

Accreditation in Behavioral Health Crisis Services from an appropriate accrediting body, such as the Joint Commission or CARF, is required. If accreditation is lost or becomes provisional after being added to the Designated Psychiatric Emergency Facility list, BHA may monitor the plan of correction or potentially may have the facility removed from the list.

Facilities should track a variety of data including but not limited to number of admissions, number of emergency petitioned individuals served, and length of stay, and quality improvement metrics such as hospitalization rates, readmission rates, time from discharge until follow-up appointment, number of emergency petitioned individuals not accepted, and seclusion and restraint numbers.

Bibliography:

[SAMHSA National Guidelines for Behavioral Health Crisis Care.](#)

[Maryland BHAC Strategic Plan, 2018.](#)

[Behavioral Health Crisis Stabilization Centers: A New Normal.](#)

[DC Crisis Regulations.](#)

[Georgia Rules and Regulation for Crisis Stabilization Units.](#)

[Crisis Now Crisis Services Task Force.](#)

[Crisis Intervention Team Core Elements.](#)

[New York Comprehensive Psychiatric Emergency Program \(CPEP\) Regulations.](#)

[Roadmap to the Ideal Crisis System, Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry.](#)

[Comprehensive Crisis Response Center Planning Group Recommendations Submitted to the Behavioral Health Administration, State of Maryland, 2018.](#)

Appendix C: Stakeholders Involved in the Development of the Model Program Structure

Maryland Crisis System Workgroup - HB 332
Stakeholder Representation
August 24, 2021

| Organizational Representation | Stakeholders |
|--|--|
| <p>Advocacy - Behavioral Health Community</p> | <p>Moira Cyphers, Policy Director Compassion Advocacy Mcyphers@compassadvocacy.com</p> <p>Lori Doyle, Director of Policy Maryland Community Behavioral Health Lori@mdcbh.org</p> <p>Ann Geddes Maryland Coalition for Families ageddes@mdcoalition.org</p> <p>Kate Farinholt, Executive Director National Alliance on Mental Illness ed@namimd.org</p> <p>Kevin Keegan, Director Operations Catholic Charities kkeegan@cc-md.org</p> <p>Dan Martin, Senior Director Mental Health Association of Maryland dmartin@mhamd.org</p> <p>Pat Miedusiewski miedusiewski pmiedusiewski@aol.com</p> |

| Organizational Representation | Stakeholders |
|--|--|
| <p>Crisis Intervention/Community Provider/Administrator</p> | <p>Tina Marie Brown <u>Affiliated Sante Group</u> Tbrown@santegroup.org</p> <p>Jen Corbin, Crisis Intervention Specialist Anne Arundel Mental Health Agency, Inc. jcorbin@aamentalhealth.org</p> <p>James Drake <u>Affiliated Sante Group</u> jdrake@santegroup.org</p> <p>Marianna Izraelson Grassroots Crisis Services mizraelson@grassrootscrisis.org</p> <p>Deanna Krizan, Director, BCRI Dkrizan@bcresponse.org</p> <p>Karen Johnson <u>Affiliated Sante Group</u> Kjohnson2@santegroup.org</p> <p>Alison Paladino <u>Affiliated Sante Group</u> Apaladino@santegroup.org</p> <p>Andre Pelegrini, VP Finance <u>Clinical Management and Development Services</u> a.pelegrini@cmdsinc.com</p> |
| <p>Elected Official</p> | <p>Del. Karen Lewis Young, District 3A Karen.lewis@maryland.gov</p> |

| Organizational Representation | Stakeholders |
|---|--|
| <p>Hospital - Practitioner/ Administration/Finance/Oversight</p> | <p>Dr. Stephanie Knight University Maryland Dept. Psychiatry sknight@som.umaryland.edu</p> <p>Rod Kornrumpf, Vice President Anne Arundel Behavioral Health Rkornrumpf@aahs.org</p> <p>Jennifer Redding, Executive Director Behavioral Health University of Maryland Upper Chesapeake Health Jennifer.Redding@umm.edu</p> <p>Megan Renfrew, Associate Director External Affairs Megan.Renfrew1@maryland.gov</p> <p>Katherine Smith, Director Tidal Health Katherine.smith@tidalhealth.org</p> |
| <p>Law Enforcement</p> | <p>Capt. Carl Brooks, Police Operations Bureau Harford County Sheriff's Office brooksc@harfordsheriff.org</p> <p>Lt. Steve Thomas, CIT Coordinator Anne Arundel County Police p01225@aacounty.org</p> |

| Organizational Representation | Stakeholders |
|--|--|
| Local Behavioral Health Authority | <p>Adrienne Breidenstine, Vice President, Policy GBRICS, BHSB Adrienne.breidenstine@bhsbbaltimore.org</p> <p>Chauna Brocht, Director, GBRICS Project Implementation Chauna.brocht@bhsbbaltimore.org</p> <p>Katie Dilley, Executive Director Mid Shore Core Service Agency kdilley@midshorebehavioralhealth.org</p> <p>Brigitte Kealy bkealy@midshorebehavioralhealth.org</p> <p>Adrienne Mickler, Executive Director Catherine Gray, Director Operations Anne Arundel Mental Health amickler@aamentalhealth.org</p> <p>Crista Taylor, CEO/President Behavioral Health Systems Baltimore Ctaylor@bhsbbaltimore.org</p> |
| Local Health Departments | <p>Shelly Gullege (Youth and family) Cecil County Health Department Shelly.gulledge@maryland.gov</p> <p>Prince George's Health Department Dr. Bellina Shaw brshaw@co.pg.md.us</p> |
| Persons with Lived Experience | <p>Katie Rouse, Executive Director On Our Own Maryland Katier@onourownmd.org</p> |
| Private Commercial Insurance | <p>Ashley Johnson Carefirst Ashley.johnson@carefirst.com</p> <p>Oleg Tarkovsky Carefirst Oleg.tarkovsky@carefirst.com</p> <p>Michael Udwin Carefirst Michael.udwin@carefirst.com</p> |

| Organizational Representation | Stakeholders |
|---|--|
| <p>State of Maryland, Behavioral Health Administration</p> | <p><u>Priya Arokiaswamy</u>, Assistant Director, Evidence Based Practices Priya.arokiaswamy@maryland.gov</p> <p>Marian Bland, Director Clinical Services Marian.bland@maryland.gov</p> <p>Susan Bradley, Chief of MIS and Data Analysis Susan.bradley@maryland.gov</p> <p>Rhonda Callum, Senior Clinical Manager Rhonda.callum@maryland.gov</p> <p>Lisa Fassett, Policy and Regulations Lisa.fassett1@maryland.gov</p> <p>Mona Figueroa, Director of Evidence Based Practices Mona.figueroa@maryland.gov</p> <p>Marion Katsereles, Director Finance Marion.katsereles@maryland.gov</p> <p>Sharon Lipford, Program Administrator Crisis Systems and Emergency Management Sharon.Lipford@maryland.gov</p> <p>Darren McGregor, Director Crisis Services/Criminal Justice Office of Crisis and Criminal Justice Services Darren.McGregor@maryland.gov</p> <p>Connie Martin, Finance Manager Connie.martin2@maryland.gov</p> <p>Stephanie ODea, Director Older Adults, Deaf/Hard of Hearing Stephanie.Odea@maryland.gov</p> <p>Dr. Angel Onime, Director of Policy Angela.onimne@maryland.gov</p> <p>Barry Page, Program Manager B.page@maryland.gov</p> <p>Daryl Plevy, Deputy Director Operations Daryl.plevy@maryland.gov</p> |

| Organizational Representation | Stakeholders |
|---|--|
| State of Maryland, Behavioral Health Administration | <p>Kathy Rebbert-Franklin, Director Service Access and Practice Innovation Kathleen.rebbert-franklin@maryland.gov</p> <p>Stephanie Slowly, Acting Chief of Staff Stephanie.slowly@maryland.gov</p> <p>Ed Soffe, Coordinator 211 press 1 Edward.soffe@maryland.gov</p> <p>Susan Steinberg, Director Managed Care Susan.steinberg@maryland.gov</p> <p>Suzette Tucker, Manager Women's Services Suzette.tucker@maryland.gov</p> <p>Dr. Steve Whitefield, Medical Director Steven.whitefield@maryland.gov</p> <p>James Yoe, Director Data Systems James.yoe@maryland.gov</p> |
| Organizational Representation | Stakeholders |
| State of Maryland, Office of Health Care Financing - Medicaid Administration | <p>Andrew Guy, Health Policy Analyst Andrew.guy@maryland.gov</p> <p>Elizabeth Kasameyer, Division Chief Elizabeth.kasameyer@maryland.gov</p> <p>Sharon Neely, Health Policy Analyst Sharon.neely@maryland.gov</p> <p>Rebecca Raggio, Chief Medicaid Behavioral Health Rebecca.Raggio@maryland.gov</p> <p>Tricia Roddy, Director Tricia.rodny@maryland.gov</p> |
| State of Maryland, Office of the Attorney General | <p>Eleanor Dayhoff, Assistant Attorney General Eleanor.dayhoff@maryland.gov</p> |

| Organizational Representation | Stakeholders |
|--|---|
| State of Maryland, Opioid Operations Command Center | Marianne Gibson, Deputy Director Marianne.gibson@maryland.gov Robin Rickard, Director Robin.rickard@maryland.gov |