OPIOID OPERATIONAL COMMAND CENTER
ORF Targeted Abatement Grant Program
Local Abatement Plan

IMPORTANT NOTE: Please review the instructions provided in the Call for Proposals document prior to completing this form.
The application package should be submitted via Smartsheet Form to the link below.
https://app.smartsheet.com/b/form/7abd36feaa304e9dad2e776c198e857f

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Total Allocated Funds: FY23 Targeted Abatement Grant $443,476.14
FY24 Targeted Abatement Grant $159,815.81
Primary State Finance and Procurement Article 7-331/Chapter 270 Legislative Provision Local Abatement Plan will fulfill (click here to review these legislative bills):

Please select the ORF provision which most accurately represents the primary focus/focus of the local abatement plan (you may identify more than one).

(i) Improving access to medications proven to prevent or reverse an overdose;
(ii) Supporting peer support specialists and screening, brief intervention, and referral to treatment services for hospitals, correctional facilities, and other high–risk populations; (VIT)
(iii) Increasing access to medications that support recovery from substance use disorders;
(iv) Expanding the Heroin Coordinator Program, including for administrative expenses;
(v) Expanding access to crisis beds and residential treatment services for adults and minors;
(vi) Expanding and establishing safe stations, mobile crisis response systems, and crisis stabilization centers;
(vii) Supporting the behavioral health crisis hotline;
(viii) Organizing primary and secondary school education campaigns to prevent opioid use, including for administrative expenses;
(ix) Enforcing the laws regarding opioid prescriptions and sales, including for administrative expenses;
(x) Research regarding and training for substance use treatment and overdose prevention, including for administrative expenses; and
(xi) **Supporting and expanding other evidence–based interventions for overdose prevention**

and substance use treatment

I. PLAN SUMMARY *The plan summary must provide a clear summary of the projects to be funded and the activities that will be conducted in service of the Local Abatement Plan, and clearly tie to the provisions of the legislation identified above.*

The "St. Mary's County Hub: Advancing Equity and Wellness" (Hub) project seeks to implement crisis management, behavioral health, and primary care services to increase access to health care, support primary and secondary prevention, address social wellness, and reduce health costs associated with emergency department visits and hospitalization for residents of the Lexington Park (20653), Great Mills (20634), and Park Hall (20667) ZIP codes in St. Mary's County. These ZIP codes were selected because of the disparities in access to behavioral health care and primary care and the social risk factors that these communities face. The Hub, its services, will implement the primary care and behavioral health services to increase access, support primary and secondary prevention, address social wellness, and reduce health costs associated with emergency department visits and hospitalization. It builds on the momentum of local partnerships - government agencies, nonprofits, practitioners, and citizen stakeholders.

St. Mary's County Health Department understands the necessity for and importance of national accreditation on the perception of the effectiveness of the services offered at the Health Hub. Accreditation is a sign of quality and commitment to excellence, which can boost our reputation and credibility with our clients, community partners and stakeholders. The St. Mary's County Health Hub has begun its pursuit to be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Consultants from Renaye Jauss Healthcare Advisors, LLC are guiding us to success. There are several benefits to CARF accreditation such as it aligns with our commitment to providing the highest level of care to our community, helps us stay competitive in the healthcare market and opens doors to new opportunities and partnerships.

With that being said, we are in need of a Clinical Program Manager. The Behavioral Health Hub Clinical Program Manager is responsible for the daily operations and oversight of the clinical programs and services provided in the facility. Scope of duties include development, implementation, and monitoring of policies, procedures, quality and performance measures, training, and supervision of the Clinical Staff. This person works in collaboration with the Hub Program Manager and the Harm Reduction Program Manager.

A. TREAT OPIOID USE DISORDER (OUD)

6. Provide treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

Local Overdose Fatality Review Teams (LOFRT) conduct confidential fatal and non-fatal overdose case reviews as a part of the Maryland Department of Health Overdose Fatality Review (OFR) Program as defined in Health General § 5-903 (Health General Article, Title 5, Subtitle 9, Annotated Code of Maryland (OFR Law)). The OFR Program is modeled after the Maryland State Child Fatality Review and Fetal and Infant Mortality review programs and provides a framework for analyzing deaths, understanding causes, and identifying strategies to prevent future similar deaths statewide. LOFRTs are composed of multi-disciplinary members including representation from organizations such as local health departments, school systems, law enforcement agencies, emergency medical services, and crisis services. LOFRTs follow a public health approach starting with the individual and then examining interpersonal, organizational, community and public policies surrounding overdose fatalities. Our LOFRT meets a minimum of quarterly for 60 minutes to discuss a number of cases specific to their jurisdiction.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

In addition to this, we provide general support for the St. Mary's County overdose response initiatives such as but not limited to the Substance Exposed Newborn (SEN) Taskforce Team. We do this by collaborating with Department of Human Services's Substance Exposed Newborn's Caseworker and Associate and the Maternal, Child and Elder Health (MCEH) Division to assess and develop a plan of safe care for newborns safety and well-being affected by addressing the substance use needs of the newborn and family.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

The purpose of **State Care Coordination** services is to expand access to a comprehensive array of community-based behavioral health services for Maryland residents in varying stages of recovery. It is designed to improve recovery outcomes for individuals identified as at high risk for relapse.

State Care Coordinators complete an initial face-to-face intake/interview; with a telephone intake/interview only when travel distance is over 20 miles or 30 minutes from the participant's location or if safety protocols or restrictions limit in-person contact. A minimum of at least twice (2x) monthly encounters/contact is made with participants in person to review individualized recovery plan goals and objectives, and for participant check in. IRP's should be reviewed in person whenever possible; participant check-in may be via telephone or face-to-face. Collaboratively established with the participant

an individualized recovery plan (IRP) at intake that details their recovery plan while engaged in State Care Coordination and Maryland Recovery Network (MDRN) services. The IRP should be monitored and updated in an Electronic Medical Record/Electronic Health Record (EMR/EHR OR functional paper process during monthly service/contact. Verify and confirm an individual's participation in treatment at contact each month if the individual is seeking MDRN services. Documented community outreach is conducted at a minimum of (1x) one time monthly to ensure community awareness of the SCC program.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any cooccurring SUD/MH conditions or to persons who have experienced an opioid overdose.

The Local Jurisdiction shall provide or contract for the provision of the following **Peer Support Services** to enhance the behavioral health recovery for individuals served through **Behavioral Health Crisis Walk-in Services.**

1. Ensure that the delivery of services is facilitated exclusively by individuals who identify as having lived experience in behavioral health recovery.
2. Provide opportunities for Peer Recovery Specialist (PRS)/Certified Peer Recovery Specialist (CPRS) to meet with individuals in settings that are comfortable to the individual seeking support;
3. Ensure that all Peer Support Services are offered and conducted on a voluntary basis and are guided by a recovery plan which is created and maintained by the individual receiving the support;
4. Establish a relationship with a Registered Peer Supervisor (RPS), as evidenced by an RPS certificate, who will provide supervision hours to staff and/or volunteers seeking or maintaining their Certified Peer Recovery Specialist credential;
5. Through the support of PRS/CPRS's ensure that individuals receiving services are connected to local and community-based services that will help prevent future crisis events and offer stable treatment and recovery support;
6. Support services shall include, but are not limited to:
    a) One-on-one peer contacts;
    b) Peer support groups;
    c) Activities that reduce isolation;
    d) Activities that develop self-advocacy skills;
    e) Exploration of multiple pathways of recovery;
    f) Resume building and interview prep;
    g) Recovery Plan development;
    h) Accessing entitlements and other social services;
    i) Recovery advocacy work;
    j) Vocational/Educational activities;
    k) Connection to treatment-based support;
    l) Community outreach;

m) Resource connection activities;
n) Follow-up connections to ensure warm handoff to support and treatment services, as appropriate.

The **Medical Director** is responsible for the psychiatric health and wellness of clients seeking care at the Health Hub and School Based Health Centers (SBHC). The Medical Director is the primary psychiatrist providing direct clinical services to clients at the School Based Health Centers and provides oversight of other clinicians at the SBHC and Health Hub. This position ensures the care provided to participants meets the current standards of psychiatric care and is based on scientific evidence in accordance with current psychiatric practices and guidelines, applicable laws, and facility policies and procedures. The Medical Director ensures care is provided according to the treatment plan developed by the interdisciplinary team. The Medical Director provides direct services for the center's clients, supervises staff members, and provides clinical and administrative oversight for all medical/psychiatric services provided at the center.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

The **Nurse-Family Partnership (**NFP) is an evidence-based home visiting program designed to address the complex needs of first-time pregnant and parenting women and their families, including those affected by opioid use disorder (OUD) and co-occurring substance use disorder (SUD) and mental health (MH) conditions. The St. Mary's County Health Department (SMCHD) seeks funding to expand the existing NFP program to support first-time mothers, particularly in communities experiencing high rates of Severe Maternal Morbidity (SMM). With over 40 years of rigorous research, NFP has consistently demonstrated its effectiveness in improving pregnancy outcomes, enhancing child health, and promoting long-term family self-sufficiency.

Through personalized prenatal and postnatal home visits, NFP's specially trained nurses provide comprehensive support to women throughout pregnancy and the child's first two years of life. This support includes evidence-based treatment and linkages to recovery services, such as medication-assisted treatment (MAT), counseling, and prevention services for pregnant women. These services are tailored to address OUD and co-occurring SUD/MH conditions, ensuring access to education and support for families affected by the special needs of Substance-exposed newborns (SEN).

The evidence-based model of NFP is rooted in developing therapeutic relationships early in pregnancy, fostering trust and engagement that lead to positive health behaviors and outcomes. Nurses offer a nonjudgmental environment and use motivational interviewing techniques to guide clients through the change process at their own pace and according to their individual goals. NFP nurses are trained to support women facing the challenges of addiction, ensuring access to comprehensive treatment and

recovery services, including MAT.

A key focus of the program is the identification of conditions that may benefit from early and swift intervention. To demonstrate the effectiveness of this expansion, we will implement a weighted vulnerability tool to identify high-priority risk factors among referred clients. Enrollment will be based on program capacity, with special consideration given to clients identifying with opioid use disorder (OUD).

Pregnant women with a history of or active opioid use are considered particularly vulnerable, and NFP nurses provide specialized support to address their unique needs. This includes timely referrals to appropriate medical and social services, and in-person support to manage the specific needs of a substance exposed newborn. NFP aims to expand services to support the continuum of care for the infant-mother dyad, ensuring long-term medical monitoring and support for families affected by neonatal abstinence syndrome (NAS). Additionally, data-driven metrics will be utilized to meet the performance measures required by the grantor.

In addition, NFP provides enhanced child and family supports, including trauma-informed discussion for adverse childhood experiences and expanded family support and linkage to childcare services for parents with OUD and co-occurring conditions. Home-based wrap-around services, such as parenting skills training and referral to specific support services, are also integrated into the program to foster stability and resilience.

The expansion of the Nurse-Family Partnership program within St. Mary's County will enable SMCHD to comprehensively address the needs of first-time mothers facing significant health and social challenges, particularly those impacted by OUD and NAS. Through a holistic, evidence-based approach, NFP nurses will continue to make a meaningful difference in the lives of mothers and their children, fostering healthier pregnancies, improving child health outcomes, and enhancing family self-sufficiency

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H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

The **Public Health Clinical Laboratory Scientist (CLS)** provides immediate, on-site laboratory support to individual clients seeking treatment at the Health Hub Crisis Walk In and Harm Reduction Programs. The CLS collaborates closely with medical staff, offering diagnostic testing services that are essential for evaluating and managing clients experiencing opioid-related health issues. The CLS coordinates with the HARM Reduction team members to ensure that test outcomes directly inform care strategies, enhancing the effectiveness of crisis intervention efforts for the client.

II. PLAN PROBLEM STATEMENT *The problem statement section describes why the plan is needed and identifies the most significant issues, problems, trends, or opportunities that will be addressed by the*

Local Abatement Plan.

St. Mary's County continues to experience an increased number of fatalities and non-fatal overdoses over the past few years. In FY20, St. Mary's County had 34 opioid-related fatal overdoses and in FY21 there was a total of 39. Additionally, St. Mary's County is experiencing a greater number of substance-exposed newborns who are transported to higher intensity hospitals due to severity of

symptoms. In 2018, there were 38 babies born at MedStar St. Mary's Hospital who were exposed to substances in utero and in 2019, there were a total of 39. The opioid epidemic continues to be a significant issue and we are continuously evaluating our programming to best suit the needs of our community.

Stigma of substance use disorders shames individuals into silence and prevents them from seeking help, damages hope for recovery, and ends lives. People who use drugs are labeled and defined by their struggles due to the lack of education, awareness, and understanding of our community. During stakeholder meetings, this issue continues to be a primary topic discussed in hopes of finding a solution to better serve our community. This suggests a need for a strategic initiative to address these issues.

The target population for this project is St. Mary's County community members who use substances and/or are affected by the opioid epidemic. This essentially makes the whole of St. Mary's County community the target population. With this focus, our efforts surrounding the opioid crisis will also look to address any gaps within equity. The Local Abatement Plan gives us the opportunity to expand our Health Hub located in Lexington Park with the ultimate goal of providing walk-in evaluations of mental health and addiction, crisis counseling, primary care services, and many community services that address the social wellness (mediation services, day reporting program, employment services, expungement clinics, financial support services, harm reduction program, health insurance enrollment, literacy council services, medical respite services, youth mentoring, etc). Our ultimate goal is to provide these services around the clock.

III. PLAN GOALS AND OBJECTIVES *Program Goals and Objectives should define the central aim and principal goals of the Local Abatement Plan that will be addressed by the project activities, and clearly tie to the provisions of the legislation identified.*

Goal 1 - Conduct meetings with established community partners to coordinate, complement, and integrate the St. Mary's County Strategic Plan for Overdose Response

Objective 1 -Conduct four LBHAC meetings which include St. Mary's Overdose Prevention Team (OPT) updates.

Objective 2 - Conduct four St. Mary's Overdose Fatality Review (OFR) meetings.

Goal 2 - Increase the number of individuals trained on how to administer Naloxone. Reduce overdose deaths in St. Mary's County by providing Naloxone to people who use substances

Objective 1 - Peer Recovery Specialists at the St. Mary's County Health Department will continue to provide training and information on Naloxone use to individuals in need within the community

Objective 2 - The St. Mary's County Health Department will achieve a total saturation of 5,000 Naloxone kits distributed.

Goal 3 - Increase the number of engagements made with participants who are pregnant/postpartum and using substances

Objective 1 - Peer Recovery Specialists will engage and link 5 pregnant or postpartum

clients who use substances to community treatment/support services.

Objective 2 - Peer Recovery Specialists will refer 100% of pregnant or postpartum participants who uses substances to substance use treatment and/or care coordination

Goal 4 - Increase St. Mary's County's awareness and education surrounding SUD by continuing a Go Purple Initiative

Objective 1 - Increase the number of projects and events related to promoting substance use prevention within our community

Objective 2 - Continue to implement a coalition for the Go Purple Initiative that consists of key community partners to develop a well-rounded program

Objective 3 - Number of people reached through social media informationals

Objective 4 - Number of engagements (reactions, comments, shares, clicks) through social media informationals

Goal 5 - Decrease stigma related to substance use and mental health in St. Mary's County

Objective 1 - Further expand our stigma-reducing campaign that addresses stigmatizing language

Objective 2 - Increase the number of St. Mary's County residents that understand what stigma is and how it can affect individuals with substance use disorders, mental health disorders, or co-occurring disorders

Goal 6 - Increase the number of prevention and intervention recommendations to prevent future overdoses in St. Mary's County

Objective 1 - Coordinate quarterly Local Overdose Fatality Review Team (LOFRT) Meetings

Objective 2 - Develop and submit 3 recommendations in the CRISP OFR Recommendation Tracker annually

Objective 3 - Implement 1 recommendation annually

Objective 4 - Develop an assessment and evaluation process of the implemented recommendation to ensure the recommendations are meeting the needs of the community

Goal 7 - Expand access to a comprehensive array of community-based behavioral health services for Maryland residents in varying stages of recovery.

Objective 1- Complete an initial face-to-face intake/interview; with a telephone intake/interview only when travel distance is over 20 miles or 30 minutes from the participant's location

Objective 2 - Monthly encounters/contact is made with participants in person to review individualized recovery plan goals and objectives, and for participant check in.

Objective 3 - Collaboratively establish with the participant an individualized recovery plan (IRP) at intake that details their recovery plan while engaged in State Care Coordination and Maryland Recovery Network (MDRN) services.

Objective 4 - Verify and confirm an individual's participation in treatment at contact each month if the individual is seeking MDRN services.

Objective 5 - Documented community outreach is conducted at a minimum of (1x) one time monthly to ensure community awareness of the SCC program.

Goal 8 - Provide Peer Support Services to individuals served through Crisis Walk-in Services

Objective 1-Deliverable/Milestones/Unit Measure: 180 unduplicated individuals served

Objective 2 -Track the total Number of:

a. 1 on 1 Peer Contacts (in person, virtual, or telephonic peer support sessions, of least 15 minutes in duration),

b. Peer Support Groups (groups facilitated by peers that facilitate conversation focused on a specific behavioral health topic. These groups must include 3 or more individuals).

c. Individuals who Obtained Recovery Support Services in the Following Categories:

Housing, Funded Benefits, Resource Assistance, Employment, Enrolled in a Formal Education Program, Vital Documents, Accompanied to Court, Accompanied to a Medical Appointment, Enrolled in a Treatment Program.

Goal 9 - Enhance understanding of opioid use disorder (OUD) and substance use disorder (SUD), along with co-occurring mental health challenges, while strengthening the application of trauma-informed care strategies.

Objective 1 - -Attend a minimum of 2 training opportunities related to SUD/OUD or trauma-informed care.

Objective 2 - Implement learned strategies into home visits and client interactions.

Objective 3 - Support Home Visitors in navigating difficult conversations, and challenging circumstances in their home visits.

Goal 10 - Expand screening, intervention, and referral to services for NFP-eligible pregnant women with SUD/OUD and co-occurring mental health challenges

Objective 1 - Reinforce referral partnerships with treatment providers and ensure streamlined Communication.

Objective 2 - Perform screenings to identify OUD/SUD and co-occurring MH challenges on scheduled timeline and as needed.

Goal 11 - Establish a data tracking and evaluation system to measure program effectiveness.

Objective 1 - Develop standardized data entry procedures for tracking client progress.

Objective 2 - Train staff on data collection and performance metrics

Objective 3 --Conduct quarterly reviews to assess program outcomes and identify areas for improvement.

Objective 4 - Establish a client feedback and engagement platform to assess perceived program effectiveness.

Goal 12 - Strengthen program promotion and community outreach to increase awareness and client participation.

Objective 1 - Develop targeted outreach through local organizations and social media.

Objective 2 - Host informational sessions at community centers, hospitals, and clinics.

Objective 3 - Distribute multilingual promotional materials to reach diverse populations.

Objective 4 – Hold Community Advisory Board meetings to strengthen engagement with community partners.

Goal 13 - Provide a variety of laboratory tests, assays, analytical procedure validations and quality assurance and quality control studies fields including hematology, molecular biology and virology at 4 separately located level II biosafety laboratories managed by the St Mary's County Health Department.

Objective 1 - Performs sensitive chemistry techniques such as urine drug of abuse testing for people with mental health and substance use disorders.

Objective 2 - Performs a variety of laboratory tests, assays, analytical procedures, validations and quality assurance/quality control studies in hematology, analytical chemistry, diagnostic microbiology, immunology, molecular biology and virology.

Objective 3 - Performs molecular techniques such as PCR to identify pathogens for epidemiological purposes.

Objective 4 - Operates and troubleshoots specialized laboratory instrumentation, e.g. molecular PCR analyzer and hematology analyzer.

Objective 5 - Maintains maintenance logs on laboratory instrumentation collection of chlamydia, gonorrhea, and trichomonas, urine drug of abuse, Step A, Staph, various STDs, and laboratory processing training and competency upon hire and annually.

IV. PLAN PROGRAM MEASUREMENT/PERFORMANCE INDICATORS

What you will use to measure (a) the effectiveness of the plan's support of the selected Goal/Strategy, (b) how it fills a gap in the region, and (c) how it serves its intended demographic. These measures may be quantitative (numeric) and qualitative (descriptive). These performance measures must be reported on annually, by project and ORF provision.

Activity Type	***Performance Measure(s)***
Provide Behavioral Health Services at Hub	● Number of individuals seen in MSMH ED dept for BH emergencies ● Recidivism rates associated with local detention center ● Number of individuals linked to BH care (seen by BH provider at Hub / connected to partner org) ● Change in number of ED visits from service area related to BH ● Number of residents referred for Hub BH services by Minority Outreach Coalition (MOC) ● Number of individuals that receive MAT at Hub
Provide Primary Care Services at Hub	● Number of individuals linked to primary care (seen by PCP at Hub / connected to PCP), change in ● Number of ED visits from service areas related to preventable complications, ● Number of residents referred for Hub PC services by Minority Outreach Coalition (MOC)

Social Wellness	● Number of individuals that participate in classes/events/workshops ● Number of residents referred by Minority Outreach Coalition (MOC) of individuals referred to evidence based community programs ● Number of individuals receiving health information at each PC visit ● Number of individuals taking health literacy/health education classes. ● Number of Hub patients connected with Community Health Worker ● Number of individuals connected to a Medicaid enrollment specialist ● Number of persons receiving medical respite services ● Number of readmissions within 30 days of persons without stable housing who are discharged from hospital ● Number of medical respite participants linked to primary care services at Hub ● Number of medical respite participants receiving BH care coordination via Hub ● Number of medical respite patients case managed into stable housing ● Number of individuals that participate in classes/events/workshops ● Number of residents referred by Minority Outreach Coalition (MOC)
Social Wellness - Legal Barriers	● Number of records expunged ● Number of clinics held ● Number of persons served through expungement/legal services clinics ● Number of persons with expunged records who subsequently obtained employment within 3 months ● Number of persons with expunged records who subsequently obtained housing within 3 months ● Number of mediations completed

Social Wellness - Economic Stability	● Number of individuals completing seminars, workshops, programs ● Number of individuals attending events, community updates, listening tours, citizens academy, feedback on perceived impact of participation
Social Wellness - Neighborhood/Built Environment	● Number of participants in workshops, ● Number of workshops ● Number of Hub clients/patients newly connected to Housing Authority support services ● Number of Hub clients/patients receiving assistance in working towards home ownership, ● Number of Hub clients/patients receiving assistance in managing rent, ● Number of Hub clients/patients participating in workshops who are new homeowners within 24 months of beginning assistance ● Number of homeless individuals and families who obtain stable housing through the provision of emergency shelter, supportive housing, rapid re-housing, assistance applying for housing vouchers and urgent needs assistance
Social Wellness - Education	● Number of individuals that completed workshops/coaching; feedback re: impact of training on educational progress and plans
Social Wellness - Social/Community Context	● Number of referrals made ● Number of clients that made contact with partnering organizations ● Number of referrals to mentoring program and increased resilience scores based on the child and youth resilience measure score for participants
Overdose Prevention Team (OPT)	● Number of Strategic Plans for Overdose Response updated (1 every 3 years)

Local Overdose Fatality Review Team (LOFRT)	• Coordinate Local Overdose Fatality Review Team (LOFRT) Meetings (4 annually) • Develop and submit recommendations in the CRISP OFR Recommendation Tracker (3 annually) • Implement 1 recommendation annually • Develop an assessment and evaluation process of the implemented recommendation to ensure the recommendations are meeting the needs of the community (1 annually)
State Care Coordination Supervisor	• Number of individuals served - adults (150 annually) • Number of individuals provided case management services (150 annually) • Number of screenings completed - individuals (150 annually)
Crisis Walk In Peer/Peer Supervisor	• Provide Peer Support Services to an unduplicated count of one hundred eighty (180) individuals served through Crisis Walk-in Services • Track the total number of 1 on 1 Peer Contacts • Track the total number of Peer Support Groups • Track the total number of individuals who Obtained Recovery Support Services in the Following Categories: Housing, Funded Benefits, Resource Assistance, Employment, Enrolled in a Formal Education Program, Vital Documents, Accompanied to Court, Accompanied to a Medical Appointment, Enrolled in a Treatment Program.

Nurse-Family Partnership (NFP)	• Number of referrals with SUD/OUD history or active use • Number of newly enrolled women with disclosure of SUD/ OUD History and co-occurring MH conditions • Number of clients who received MH screening • Number of clients who received SUD/OUD screening • Number of clients who were referred to MH services • Number of referrals to substance use support services • Number of clients who were referred to MH services that initiated care • Number of clients who were referred to substance use support services that initiated care • Number of clients who have initiated MAT therapy • Number of substance exposed newborns delivered • Number of substance exposed newborns delivered who are receiving specialized care from pediatrician/ specialist • Number of substance exposed newborns with neonatal abstinence syndrome (NAS) • Number of families with a substance exposed newborn who received education and support • Number of clients with SUD/OUD/SEN/MH history who receive parent-skills training • Number of clients with SUD/OUD/SEN/MH history who receive comprehensive wraparound services including transportation, housing, job placement/ training, child care # of SUD/OUD or trauma informed training completed
Laboratory Management	• Number of urine drug of abuse tests provided (450 annually) • Number of Sexually Transmitted Infection (STI) tests provided to include HIV/ Syphilis and Hepatitis C (250 annually)

V. PLAN TIMELINE

Enter project information as necessary

Goal(s)	**Key tasks/activities**	**Person(s) responsible**	**Progress Measurement**	**Begin date**	**End date**
Specific and measurable goals that are relevant signs of the effectiveness of the project's support of the selected Goal/Strategy, filling a gap in the region, and serving intended demographic	What are the steps you will take and tasks you will accomplish to achieve the goal	Who is responsible for the key tasks/activities	How will you measure success or completion of a task/activity? Please provide list of measures that you will document to assess your own progress towards task/activity	When will the task/activity start?	When will the task/activity end and/or when will the goal be achieved?

Conduct meetings with established community partners to coordinate, complement and integrate the St. Mary's	Conduct quarterly Overdose Fatality Review Team meetings. Incorporate Overdose Prevention Team (OPT) updates into quarterly LBHAC	Opioid Prevention Supervisor, St. Mary's County Health Department Behavioral Health Division Prevention & Promotion/Opioid Response Team	Number of meetings held. Conduct four LBHAC meetings which include St. Mary's Overdose Prevention Team (OPT) updates. Conduct four St. Mary's Overdose Fatality Review (OFR) meetings. Strategic Plans for Overdose Response updated (every 3 years)	FY2024	FY2028

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APPENDIX I

Strategic Plan for Overdose Response	meetings.	Stakeholders			

Increase the number of individuals trained on how to administer Naloxone. Reduce overdose deaths in St. Mary's County by providing Naloxone to people who use substances	Overdose Response Program (ORP) will continue to give virtual and in-person Naloxone trainings. Peers will continue to follow up with non-fatal overdoses and provide Naloxone. Continue to attend community outreach events where Naloxone is available for distribution.	St. Mary's County Health Department's Opioid Response Program, St. Mary's County Health Department's Harm Reduction Team	Number of individuals training and providing Naloxone. Peer Recovery Specialists at the St. Mary's County Health Department will continue to provide training and information on Naloxone use to individuals in need within the community St. Mary's County Health Department will achieve a total saturation of 5,000 Naloxone kits distributed.	FY2024	FY2028
Increase the number of engagements made with participants who are pregnant/postpartum and using substances	Monitor data on the number of engagements made with clients who are pregnant/postpartum and using substances to ensure that the population is being reached and provided	St. Mary's County Health Department's Harm Reduction Team	Number of participants who are pregnant/postpartum. Peer Recovery Specialists will engage and link 5 pregnant or postpartum clients who use substances to community treatment/support services. Peer Recovery Specialists will refer 100% of pregnant or postpartum participants who uses substances to substance use treatment and/or care coordination	FY2024	FY2028

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APPENDIX I

	resources.				
Increase St. Mary's County's awareness and education surrounding SUD by continuing a Go Purple Initiative	Develop social media information, training, projects and/or events related to building the community's awareness and education surrounding SUD/Mental Health each month.	Opioid Response Supervisor, St. Mary's County Health Department Behavioral Health Division Prevention & Promotion/Opioid Response Team	Number of projects and events related to promoting substance use prevention within our community Number of people reached through social media informationals Number of engagements (reactions, comments, shares, clicks) through social media informationals	FY2024	FY2028
Decrease stigma related to substance use and mental health in St. Mary's County	Further develop our stigma reducing campaign that was created in FY21 to provide more information to the community in regards to what sigma is, the types, etc.	Opioid Response Supervisor, St. Mary's County Health Department Behavioral Health Division Prevention & Promotion/Opioid Response Team	Number of St. Mary's County residents that understand what stigma is and how it can affect individuals with substance use disorders, mental health disorders, or co-occurring disorders	FY2024	FY2028

Increase the number of prevention and intervention recommendations to prevent future overdoses in St. Mary's County	Conduct quarterly Local Overdose Fatality Review Team meetings.	Overdose Prevention Coordinator, St. Mary's County Health Department Behavioral Health Division Prevention & Promotion/Opioid Response Team	Number of meetings held Number of recommendations made Number of recommendations implemented Number of recommendations assessed and evaluated	FY2026	FY2027
Expand access to a comprehensive array of community-based behavioral health services for Maryland residents in varying stages of recovery.	Provide care coordination services	State Care Coordination Supervisor, St. Mary's County Health Department Behavioral Health Division Care Coordination Team	Number of individuals served - adults Number of screenings completed - individuals Number of individuals provided case management services	FY2026	FY2027
Provide Peer Support Services to individuals served through Crisis Walk-in Services	Provide peer support services	Crisis Walk In Peer Recovery Specialist, Peer Recovery Specialist Supervisor, St. Mary's County Health Department Behavioral Health Division Harm Reduction Team	Number of unduplicated individuals served Number of 1 on 1 Peer Contacts (in person, virtual, or telephonic peer support sessions, of least 15 minutes in duration) Number of Peer Support Groups (groups facilitated	FY2026	FY2027

			by peers that facilitate conversation focused on a specific behavioral health topic. These groups must include 3 or more individuals). Number of individuals who Obtained Recovery Support Services in the Following Categories: Housing, Funded Benefits, Resource Assistance, Employment, Enrolled in a Formal Education Program, Vital Documents, Accompanied to Court, Accompanied to a Medical Appointment, Enrolled in a Treatment Program.		
Enhance understanding of opioid use disorder (OUD) and substance use disorder (SUD), along with co-occurring mental health	-Attend a minimum of 2 training opportunities related to SUD/OUD or trauma-informed care. -Implement learned strategies into home visits and client	Nurse-Home Visitors & CHN Supervisor	Number of SUD/OUD or trauma-informed trainings completed (quarterly) 1:1 Reflective Supervision (biweekly) Case Conferences (biweekly)	FY2026	FY2027

challenges, while strengthening the application of trauma-informed care strategies.	interactions. -Support Home Visitors in navigating difficult conversations, and challenging circumstances in their home visits.				
Expand screening, intervention, and referral to services for NFP-eligible pregnant women with SUD/OUD and co-occurring mental health challenges	-Reinforce referral partnerships with treatment providers and ensure streamlined communication. -Perform screenings to identify OUD/SUD and co-occurring MH challenges on scheduled timeline and as needed.	Nurse-Home Visitors, & CHN Supervisor	Number of screenings completed (quarterly) Number of referrals made (quarterly) Number of clients engaged in Medication-Assisted treatment (MAT) (quarterly)	FY2026	FY2027

Establish a data tracking and evaluation system to measure program effectiveness.	-Develop standardized data entry procedures for tracking client progress. -Train staff on data collection and performance metrics -Conduct quarterly reviews to assess program outcomes and identify areas for improvement. -Establish a client feedback and engagement platform to assess perceived program effectiveness.	Nurse Home Visitors, CHN Supervisor, Administrative Assistant	Accuracy and timeliness of data Entries. Number of reports generated (quarterly)	FY2026	FY2027

Strengthen program promotion and community outreach to increase awareness and client participation.	-Develop targeted outreach through local organizations and social media. -Host informational sessions at community centers, hospitals, and clinics. -Distribute multilingual promotional materials to reach diverse populations. -Hold Community Advisory Board meetings to strengthen engagement with community partners.	Nurse Home Visitors, CHN Supervisor, Administrative Assistant	Number of outreach events attended. (quarterly) Number of new enrollments (quarterly)	FY2026	FY2027
Provide a variety of laboratory tests, assays, analytical procedure validations and quality assurance and quality control	Laboratory Management	St. Mary's County Health Department Clinical Services Division, Public Health Clinical Laboratory Scientist (CLS)	• Number of urine drug of abuse tests provided (450 annually) • Number of Sexually Transmitted Infection (STI) tests provided to include HIV/ Syphilis and Hepatitis C (250 annually)	FY2026	FY2027

studies fields including hematology, molecular biology and virology at 4 separately located level II biosafety laboratories managed by the St Mary's County Health Department.					

VI. SPEND PLAN DESCRIPTION *Detailed explanation of planned expenses. Clearly define the major categories contained in the budget and provide the basis for and justify cost projections in narrative form. Please also include a brief summary of any other funding sources or grant opportunities which the subdivision may be using to support this project.*

For this project, some of the spending will occur through salary budget items to employ a Clinical Program Manager to oversee daily operations and oversight of the clinical programs and services provided in the facility.

Funding will be used to support two staff members 0.5 FTE for the Nurse Family Partnership Program (NFP) - Community Health Nurse Supervisor and Administrative Specialist. NFP also prioritizes the continued training of Nurse Home Visitors who work with pregnant women and their families regarding the most up-to-date treatment of OUD and co-occurring conditions. Training initiatives focus on best practices for care and compliance with any requirements to ensure that children born with NAS receive appropriate referrals and safe care plans.

In addition to this, funding will also be used to support (1) 1.0 FTE for 12 months including benefits for the Local Overdose Fatality Review Team program. We would like to send this staff member to the annual National Forum on Overdose Fatality Review, location varies, hosted by the Bureau of Justice Assistance's Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) in partnership with the U.S.

Centers for Disease Control and Prevention. National Forum presentations highlight the ongoing need for education, awareness, and support for OFR initiatives and the ways in which they impact and support communities.

Furthermore, funding through this grant will support (1) 0.5 FTE (full-time) State Care Coordinator Supervisor for 12 months including benefits relevant to providing State Care Coordination services. Services provided will serve (150) individuals.

Moreover, funding through this grant will support (1) 1.0 FTE (full-time) Crisis Walk In Peer Recovery Specialist and (1) 0.15 FTE (full-time) Peer Recovery Specialist Supervisor for 12 months including benefits. Furthermore, funding will support (1) 1.0 FTE (full-time) Psychiatric Medical Director Health Hub/School Based Health Centers.

Funding will support (1) 1.0 FTE (full-time) Public Health Clinical Laboratory Scientist (CLS) for 12 months including benefits. In addition to this, funding will be utilized for various tests such as urine drug of abuse and sexually transmitted infection (STI) testing to include Syphilis/HIV and Hepatitis C.

Funding will also be used to support staff training and conferences for professional development. Our team is continuously looking for training opportunities to expand our knowledge and skill set. We are interested in several training programs such as Maryland Reinforcing Overdose Prevention Through Training & Advocacy (ROPTA) Mental Health First Aid series, Reground our Response series, Overdose Lifeline series and GenerationRX series. Mental Health First Aid is a universal, evidence-based training which teaches the public how to recognize, respond and provide resources to people experiencing mental health or substance use challenges. Regrounding our Response promotes awareness, resources and evidence-based strategies for reducing overdose and substance misuse. Overdose Lifeline is an evidence-informed training series aimed at raising overdose awareness, teaching prevention strategies and educating about local and national resources. GenerationRX is an evidence-informed prevention education and awareness program designed to educate people of all ages about safe medication practices and the potential dangers of misuse.

Furthermore, we are interested in hosting a Sequential Intercept Model (SIM) Workshop in our county. SIM Workshops are designed to tap into local expertise by bringing together key stakeholders to develop a “map” that illustrates how people with mental and substance use disorders come in contact with and flow through the local criminal justice system. This map identifies opportunities and resources for diverting people to treatment and indicates gaps in services.

In addition to this, we are interested in training related to the population such as Counseling on Access to Lethal Means (CALM) training. Lethal means are objects potentially uses by individuals experiencing a suicidal crisis such as medications, alcohol, opioids and other substances. CALM training is a powerful addition to existing strategies to reduce the risk of suicide death in at-risk people while respecting their rights and autonomy. This training is for mental health clinicians, substance abuse counselors, crisis intervention services, etc. and helps keep at-risk clients safe by learning how to collaborate with them to implement not only safe storage of firearms but dangerous medications as well.

Lastly, our division offers several training sessions provided by PESI throughout the year to assure that our clinicians are trained and up to date on best practices and evidence based practices. An example of a related training offered by PESI includes a 2-day anti stigma of substance abuse training which dives into

topics such as defining addiction, the history of addiction and treatment, addiction criteria and understanding the different addictive diagnoses, neurobiology of addiction, the disease model of addiction and misconceptions and stigmas of addiction, as well as much more.

In the future, we hope to use this funding to expand our Health Hub crisis walk-in services into evening hours to provide services specifically Monday through Friday from 3 pm - 11 pm. In order to do this, additional staffing support will be needed which includes but is not limited to a Social Worker, Peer Recovery Specialist, Administrative Assistant, and Direct Care Assistant. Other needs would include IT support, security, facilities support, lab support to include trichomoniasis, chlamydia and gonorrhea testing, on-call pay for behavioral health support staff, etc.

To the best of my knowledge, I certify that all the information provided herein is true and correct.

IX. AUTHORIZED OFFICIAL SIGNATURE: _____ Date:
Printed Name:
Title:

X. ADDITIONAL SIGNATURES

The signatures below serve to convey the coordination of other local entities or government partners involved in the local abatement plan. Additional signatures should be added as necessary

Signature: _____
Printed Name:
Title:

Signature: _____
Printed Name:
Title:

Signature: _____
Printed Name:
Title:

Signature: _____

Printed Name:

Title: