DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marc Elrich
County Executive

Raymond L. Crowel, Psy.D.
Director

Testimony before the Montgomery County Council
Garrett F. Mannchen, Co-Chair, Montgomery County Mental Health Advisory Committee
July 7, 2020

Council President Katz and members of the Council, thank you for this opportunity to provide testimony in support of the Special Appropriation to the Fiscal Year 2021 Operating Budget to add $592,202 to expand the County's Mobile Crisis Services by hiring six additional Social Workers. My name is Garrett Mannchen and I am here today on behalf of our County's Mental Health Advisory Committee as one of the committee's two co-chairs and co-chair of the Mobile Crisis Subcommittee.

The Mental Health Advisory Committee was established by statute at Chapter 24, Article IV of the County Code. It is made up of mental health providers, consumers, parents of children and adults with mental illnesses, representatives from the County's Department of Health and Human Services, a member of the legal community (me), among others including several ex officio members. We are tasked with monitoring the adequacy of the County's mental health services, identifying needs within that system, and advising the County Executive and Council on budgetary and policy matters concerning the County's mental health system. As part of those responsibilities, the Committee has established a Crisis Response subcommittee, which has been reviewing the County's Crisis Services system for the past year.

The Mental Health Advisory Committee supports this special appropriation. Adding six additional social workers to the County's Mobile Crisis team is appropriate and necessary to enable Crisis Services to serve the entire County and respond to more calls. The resolution also provides for an "enhanced mobile crisis response plan" that will be completed in the next eight weeks. Accordingly, I am also here today to advise the Council based on the work the Crisis Response subcommittee has done over the past year.

The Committee Supports the Special Appropriation

We emphatically support adding six new social workers to the County's Mobile Crisis Team. That team is operated by the County's Crisis Center and currently consists of one team of two licensed therapists and responds to calls from 911, requests from police officers, or direct requests from members of the community. That team is one component of a larger mental health crisis-response system within Montgomery County, which includes a crisis hotline, a walk-in clinic, Assertive Community Treatment teams, crisis beds, and a Crisis Intervention Team operated by the County Police Department. The system also includes several components that operate separately from the Crisis Center, including a separate hotline operated by Everymind, which also offers text-messaging

services during certain hours each day, as well as police officers, fire and rescue, and the County's emergency rooms.

The Crisis Center staff have decades of valuable experience in responding to mental health crises, as well as providing Critical Incident Stress Debriefings following a variety of disasters and other critical incidents. Despite being the most appropriate intervention in most mental health crises, the Mobile Crisis team currently has just one team at any given time to serve our entire County of more than one million residents living within more than 500 square miles. That team is stretched very thin and is forced to turn down many calls.

Hiring six additional therapists to expand the capacity of the Mobile Crisis Team is a good first step in ensuring that residents who are experiencing a mental health crisis receive the most appropriate level of care.

In addition to the new positions, the Council should ensure the Mobile Crisis Teams have the equipment necessary to effectively do their jobs. For example, under the current model in which the team consists of two therapists (rather than a therapist and officer or EMT), the Crisis Center will need funding to purchase additional equipment, such as radio equipment that will allow team members to communicate with police if they need backup, additional vehicles, computers with VPN access, and additional equipment necessary to help the team operate safely and effectively.

Other Considerations

I also understand that the Council and County Executive will be producing a report within eight weeks after adopting this Resolution. That report will include "best practices and models for other jurisdictions, coordination with other diversion programs, changes that may be required for 911 and non-emergency call-taking and dispatch, metrics to monitor and measure progress, and crisis bed and treatment capacity." To help you prepare that report, my Committee wishes to offer the following advice.

As I noted in my previous testimony before the Council, there are several barriers to ensuring the County's Mobile Crisis Team can intervene effectively and efficiently. Adding six new therapists squarely addresses one of those barriers: capacity. Your report should also include budgetary and policy changes that will address the other barriers. Specifically, it should include the following changes.

- Decrease MCT downtime—After being dispatched to a home, MCT therapists are required to wait for two patrol officers to arrive on the scene before meeting with the client. However, because these calls are often considered a low priority for police, it frequently takes at least 30 minutes for the necessary units to arrive. During that time, the county's MCT must wait in the car with nothing to do, wasting time and resources, delaying needed mental health care to those who need it, and reducing the number of people MCT is able to help. One solution to this problem would be simply to give MCT therapists the discretion necessary to decide whether to wait for backup.

- Increased data collection—The County currently does not do a good job of tracking data around crisis services. In the past year, Crisis Services has begun collecting additional data to help us better understand, for example, the amount of time MCT must wait for police officers to arrive before responding to a call, the number of calls that were cancelled, and why they were cancelled. The County needs to improve the amount of and quality of the data it collects around crisis services.
- Follow-up after the crisis has ended—Crisis services is only as effective as its ability to connect clients with long-term mental health services. At a minimum, this should include following up with individuals after the crisis has ended and helping them get linked with appropriate mental health services, be it an outpatient mental health clinic, residential program, detox, or inpatient treatment facility. Crisis Services should also have the capacity to help individuals access related resources to address homelessness, food insecurity, substance use disorders, and domestic violence.
- Ensure coordination of care—Any solution must ensure there is effective communication between Crisis Services and the other components of the mental health crisis response system. Our crisis response system is currently siloed among several government and private agencies, each of which have their own staffs, computer systems, and policies. Such a system risks inefficiencies. Moreover, there is some risk that the system will become more fractured over time. For example, you should be aware of two Requests for Proposals soliciting grant proposals related to crisis services in the County. The first RFP is from the Maryland Department of Health's Behavioral Health Administration and is offering funding "to create services that provide access or linkages to treatment through mobile crisis services, crisis walk-in services, crisis stabilization, or residential crisis beds to those in need of immediate, in-person crisis intervention and stabilization." Montgomery County's Local Behavioral Health Authority will submit up to three providers' proposals for that grant by Friday July 10, 2020. The second RFP is the Regional Partnership Catalyst Grant Program, which also seeks to expand crisis intervention, stabilization, and treatment referral programs as part of Maryland's Total Cost of Care model. Proposals for that grant are due to be submitted this month. Any solution will need to ensure that all of the components are able to communicate with one another to provide appropriate care and to ensure no residents slip through the cracks.

We commend the Council for taking these steps toward improving the County's crisis response system. While there is a great deal of work to be done to ensure everyone in this County receives appropriate interventions when they experience a mental health crisis and to ensure mental healthcare is available to everyone who needs it, rest assured that improving the County's mental health system will ultimately save the County money by reducing the financial burden on hospitals, law enforcement, fire and rescue, and prisons. And, more importantly, these improvements will save lives. Thank you.

ATTACHMENT A

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marc Elrich
County Executive

Raymond L. Crowel, Psy.D.
Director

Testimony re Special Appropriation DHHS $592,202 for Mobile Crisis Response
Hearing Date: July 7, 2020 at 1:30pm
From: Ziva Azhdam, Commissioner, Montgomery County Mental Health Advisory Committee
Position: Support

Based on my experience, I believe it is imperative to have more social workers available for Mobile Crisis Response rather than relying on the police. With their extensive training and understanding of serious mental illness, social workers are much more likely to know how to talk to families and individuals in crises to avoid escalating the situation and help resolve the crisis without causing trauma or injury.

I have needed the services of the Montgomery County Mobile Crisis Team on several occasions when relatives were having a psychiatric crisis and needed hospitalization. Each time the Mobile Crisis Team told me that they could not help because of a lack of manpower and I should call the police.

My experience with the police officers, even those with Crisis Intervention Training, has often been traumatic.

After a long wait the police finally arrived but would not enter the house until a second police car arrived. That sometimes took an hour. Meanwhile, things were escalating and the individual having the psychiatric crisis was deteriorating. When the police did enter, their demeanor and the way they interacted with family and individuals in crisis spoke volumes about their lack of knowledge about mental illness.

One time my relative was agitated and could not immediately relax enough in order to be handcuffed before being taken to the hospital for an emergency evaluation. Instead of taking time to talk to my relative and calm him down, they got into a fight with him. I was terrified that they were going to kill him. Afterward I felt traumatized and was shaking for a long time after they took my relative to the hospital.

Other times, the police were very disrespectful to the family. On one occasion when I tried to explain the situation to the police officer, I was told to be quiet and that if I talked, they would handcuff me and take me to the police station. On another occasion, I was told in so many words that I must be a bad parent because I cannot control my adult child's behavior. The police officer said they were tired of coming to my home. A social worker would understand how

difficult it is for families to get treatment for an individual who does not comprehend that he is ill and needs treatment, and how hard families try.

On another occasion, the police officer could have easily petitioned my relative for an emergency evaluation. However, he refused to do so. I had to go to the commissioner's office at midnight. The judge agreed that the emergency petition criteria were met and granted the petition. Some of the police officers are not familiar with the statute that allows them to take into consideration information from others in making their decisions on emergency petitions.

All police officers, not just those who volunteer, should be required to take the 40-hour Crisis Intervention Training, since all encounter individuals with mental illnesses in their regular duties. However, 40 hours does not even closely compare to the training and experience of a licensed social worker.

If we want to reduce trauma and criminalization of those with serious mental illness and prevent tragedies, it would be best in most psychiatric crisis situations, to send **the mobile crisis team without a police officer.** This is in accordance with the National Guidelines for Behavioral Health Crisis Care of the Substance Abuse and Mental Health Services Administration (SAMHSA), which recommends MCT "Respond without law enforcement accompaniment unless special circumstances warrant inclusion, in order to support true justice system diversion."

I am writing this testimony because no family should be traumatized by a police officer like my family has experienced. Families and those with serious mental illness need to the considerate help, knowledge, and experience that a social worker can provide. Therefore, please pass the Special appropriation for Mobile Crisis Response.

ATTACHMENT B

Maryland
DEPARTMENT OF HEALTH

To: **Maryland Association of County Health Officers**
Maryland Association of Behavioral Health Authorities
Behavioral Health Providers

From: **Aliya Jones, M.D., MBA**

Date: **May 20, 2020**

RE: **Request for Proposals (RFP) for Crisis Response Grant Program (HB 1092)**

The Maryland Department of Health (MDH) - Behavioral Health Administration (BHA) is pleased to announce an opportunity for Local Health Departments (LHDs), Local Behavioral Health Authorities, (LBHAs), Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), and community providers statewide to apply for funding to develop and/or expand behavioral health crisis services.

Per House Bill 1092/Senate Bill 703 (2019) funding has been identified to create services that provide access or linkages to treatment through mobile crisis services, crisis walk-in services, crisis stabilization, or residential crisis beds to those in need of immediate, in-person crisis intervention and stabilization.

The attached Request for Proposals outlines in detail the application guidelines. Proposals will be rated by a team of reviewers in a competitive process. Strict adherence to the RFP guidelines is expected for a successful proposal. The BHA's mission to provide treatment services and supports that promote recovery, resiliency, health and wellness for individuals who have, or are at risk for, emotional, substance-related, addictive, and/or psychiatric disorders should also be referenced. The proposal should demonstrate how the applicant will implement the BHA mission via the proposed plan.

Providers are to submit proposals directly to their respective LBHAs/CSAs/LAAs by **Friday, June 19, 2020 by 5:00 PM.** Contacts for the LBHAs/CSAs/LAAs in each jurisdiction will accompany the RFP.

LBHAs/CSAs/LAAs are to submit selected proposals (limit 3) and request for grant funds to BHA by email to Proposals.CrisisPrograms@maryland.gov by **Friday, July 10, 2020 by 5:00 PM**

Any questions regarding this solicitation should be submitted electronically by email to Proposals.CrisisPrograms@maryland.gov by **Monday, June 1, 2020 by 5:00 PM**.

Upon selection by the BHA, you will be notified and provided with a date, time, and location of a grantee and stakeholder implementation meeting.

The BHA thanks you for your interest and looks forward to assisting providers in furthering the development of a much-needed crisis response system. If you have any questions, please email

Cc: Stephanie Slowly, Marian Bland, Darren McGregor, Steve Reeder, HB Workgroup

Maryland Department of Health (MDH)
Behavioral Health Administration (BHA)

Behavioral Health Crisis Response Grant Program

Request for Proposals (RFP)

Mobile Crisis Services, Crisis Walk-in Services, Crisis Stabilization Services, or Residential Crisis Beds

Issue Date:	**May 20, 2020**
Requesting Agency:	Maryland Department of Health Behavioral Health Administration 55 Wade Avenue, Dix Building Catonsville, MD 21228
Provider Proposals Due to Local Behavioral Health Authority (LBHA)/Core Service Agency (CSA)/ Local Addiction Authority (LAA):	**Friday June 19, 2020 by 5:00 p.m.**
LBHA/CSA/LAA Deadline to BHA:	**Friday July 10, 2020 by 5:00 p.m.**
BHA Point of Contact:	Darren McGregor Behavioral Health Administration Email: darren.mcgregor@maryland.gov

I. Introduction

House Bill 1092, Chapter 209 of the Acts of 2018/ Senate Bill 703, Chapter 210 of the Acts of 2018 directs The Maryland Department of Health's (MDH), Behavioral Health Administration (BHA) to convene a workgroup to develop the Behavioral Health Crisis Response Grant Program. This program will recommend awards to jurisdictions who are able to demonstrate crisis services need and address those needs through evidence-based services in support of the ongoing statewide efforts to provide services to individuals in crisis. This grant is designed to increase access to evidence-based treatment, reduce unmet treatment needs, and reduce deaths through the provision of treatment, and recovery support services. Funding will be used to implement new initiatives as well as to support the continuation of crisis services. Individuals will also be offered the opportunity to connect with ongoing behavioral health treatment, peer and recovery support services, case management assistance and transportation as a warm handoff to additional care, as needed. The grant period for crisis programs is July 1, 2020 through June 30, 2021.

Dedicated funding for Fiscal Year 2021 has been identified to create services that provide access or linkages to treatment through mobile crisis services, crisis walk-in centers, crisis stabilization centers, and residential crisis beds to those in need of immediate in-person crisis intervention and stabilization. Crisis intervention and stabilization includes but is not limited to behavioral health screening and monitoring; clinical evaluation and assessment; and other brief clinical interventions to stabilize the individual for referral to continuing care. As needed, individuals will be linked to community services and resources for ongoing treatment and support.

If there are insufficient funds to award grants to all applicants that have submitted proposals meeting eligibility criteria as set forth in Section IV (A) of this RFP, funds will be awarded based on a priority ranking of proposals in accordance with the evaluation criteria identified in Section IV (G). The number of awards will be based on the technical merits of the proposals submitted and the amount of funding requested in relation to the funding available for this project.

This funding opportunity is the product of a strategic plan conducted by the Crisis Subcommittee of the Behavioral Health Advisory Council. The subcommittee researched best practices on the delivery of crisis interventions with particular focus on mobile crisis services and voluntary walk-in centers. All services will be implemented through a partnership between BHA, local jurisdictions, and community providers experienced in delivering behavioral health-related disorder services.

II. Background

Mission

In FY19, the Behavioral Health Crisis Response Grant Program workgroup was formed to work with BHA and other identified stakeholders to develop a proposal, and subsequently grant funding to certain jurisdictions for the purpose of establishing identified crisis services. The workgroup will also furnish a report that describes the recipients, details the program(s) proposed, identifies the amount of the award, and provides utilization and other outcome data to the Governor and General Assembly.

The increase in the number of individuals in crisis has caused a significant increase in the use of emergency departments (EDs) which are not always the most effective interventions for this kind of event. Increase in demand for services places stress on hospitals, law enforcement, schools, and families. The Grant Program will provide support and funding to select jurisdictions to divert individuals from emergency departments and detention centers to other community-based services, where they can receive care and get connected to treatment and support services.

The Maryland Department of Health's (MDH) Behavioral Health Administration (BHA) is committed to ensuring that individuals in crisis have access to immediate and appropriate care. This includes supporting local jurisdictions with the establishment of walk-in crisis services, crisis stabilization centers, residential crisis beds, and mobile crisis services. Those jurisdictions that demonstrate need as well as capacity to integrate mental health and substance use services, and can apply evidence-based treatment practices while addressing the needs of children, adults, and older adults are considered eligible and appropriate.

The workgroup has reviewed and discussed the current landscape delivering crisis services in Maryland, as well as system infrastructure needs, and the barriers that affect the delivery of these services. The workgroup established: (1) application procedures, (2) a statewide system of outcome measurement, (3) guidelines that require programs to bill third-party insurers and the Maryland Medical Assistance Program, and (4) any other procedures or criteria necessary to carry out the program.

The workgroup of the Behavioral Health Crisis Response Grant Program shall recommend awards through a competitive grant process to local behavioral health authorities to establish and/or expand behavioral health crisis response programs and services.

The workgroup shall submit an annual report to the Governor and General Assembly beginning on December 1, 2020, that includes: (1) the number of grants distributed, (2) funds distributed by county, (3) information about grant recipients and programs and services provided, and (4) data from the statewide system of outcome measurements created by the Department.

Membership

The initial representatives on this workgroup include the following:

- Deputy Secretary for Behavioral Health
- BHA staff
- Medicaid Behavioral Health Division
- Office of Health Care Financing
- Governor's Office of Crime Control & Prevention
- Center for HIV/STI Integration and Capacity
- Opioid Operational Command Center
- Mental Health Association of Maryland
- The Institute for Innovation and Implementation
- Maryland Coalition of Families
- Substance Use Community advocate(s)
- University of Maryland representatives

Darren McGregor, in his role as Director of the BHA Office of Crisis and Criminal Justice Services, will provide the staff support required to facilitate planning activities.

III. Definitions

Behavioral Health Crisis Response Programs and Services under HB1092/SB703 are:

Crisis response services are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Mobile, telephonic and

agency-based crisis response services will ideally be available 24/7 with a three-hour response time. Individuals who may benefit from crisis response services include all ages across the lifespan including youth who have demonstrated a change in behavior, have experienced an identified trauma and those individuals who may be at imminent risk of having a psychiatric or substance use-related crisis. Direct crisis services assist with deescalating the severity of a person's level of distress and/or need for urgent care associated with a mental health or substance use disorder and seek to stabilize the individual for referral to continuing care.

- **Mobile Crisis:**

Mobile Crisis Teams consists of a two-person team and provides face-to-face services delivered in a community setting where the individual lives, works and/or socializes. The two-person team consists of a licensed behavioral health clinician and a case manager or a peer/family support provider who receives supervision and training in crisis response.

Mobile crisis services provide 24/7 availability of face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, whether at home or wherever the crisis may be occurring, to begin the process of assessment and definitive treatment outside of a hospital or health care facility. The mobile crisis team works to de-escalate the person's behavioral health crisis, engages the person in other therapeutic interventions, and assists with continuity of care by providing support that continues past the crisis period.

- **Crisis Stabilization:**

Crisis stabilization is described as a 23-hour crisis observation service that directly provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with de-escalating the severity of their crisis and/or need for urgent care. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care (SAMHSA, 2014) with the goal of avoiding unnecessary hospitalizations for individuals whose crisis might be resolved within a short time and observation. The brief observation period of crisis stabilization has shown to be associated with tangible benefits for both the service users and providers.

- **Residential Crisis Services/MH:**

Residential Crisis Services/MH (RCS) are short-term, intensive mental health and support services for children, adolescents, and adults in a community-based, non-hospital, residential setting rendered by a provider approved under Maryland Law (COMAR 10.63.04). Services are provided to prevent a psychiatric inpatient admission, to provide an alternative to psychiatric inpatient admission or to shorten the length of inpatient stay. RCS may also be provided in a treatment foster care model. A provider serving children may be approved and reimbursed at the treatment foster care and prevention model. Programs that provide residential crisis services for substance related disorders will be directed to follow COMAR 10.63.04.

- **Walk-in Center:**

24/7 walk-in services are defined as a direct service that assists with the de-escalation of a person's clinical behavioral health crisis and, if applicable, his or her possible diversion from emergency department admission, police/incarceration, or out of home treatment intervention by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability delivered in a timely manner and leading to stabilization. Anyone experiencing a behavioral health and/or substance-related crisis is eligible for acceptance regardless of age, insurance status, ethnic, cultural or linguistic (such as use of language interpreting or certified ASL interpreter) preference. The service setting, whether freestanding or attached to a hospital, will serve, as needed, as an entry point to long-term, ongoing service delivery and care. The primary functions of walk-in crisis services are: screening and assessment, crisis stabilization (including medication), brief treatment, and linkage to social services and other behavioral health services. A walk-in crisis service can function as the central point from which to organize the jurisdiction's array of crisis services and deploy services such as MCT as needed.

IV. General Requirements:

A. Application Process:

BHA is soliciting proposals from community-based organizations, nonprofit organizations, hospitals and local health departments who are interested in implementing mobile crisis services, walk-in crisis centers, residential crisis services, or crisis stabilization services to establish and/or enhance the behavioral health crisis services array in local jurisdictions throughout Maryland. All questions from potential applicants concerning this RFP must be directed to the LBHA/CSA/LAA by **Monday, June 1, 2020 at 5 p.m**. Each LBHA/CSA/LAA will submit all questions received to BHA for response no later than **Wednesday, June 3, 2020 at 5 p.m.** to proposals.crisisprograms@maryland.gov.

Step 1:

Interested entities shall submit applications to their Local Behavioral Health Authority (LBHA), Core Service Agency (CSA) or Local Addiction Authority (LAA). LBHA/CSA/LAAs are responsible for developing and managing the behavioral health system at the local level. In that role and in compliance with House Bill 1092/ Senate Bill 703 LBHA/CSA/LAAs are the entities designated to receive funds through a competitive process to establish and expand behavioral health crisis response services in their local jurisdiction.

To further BHA's goal of integration of mental health and substance use services and in accordance with BHA's requirement for each jurisdiction to submit an integrated Behavioral Health Plan to guide service delivery at the local level, for jurisdictions without a designated LBHA, the respective CSA and LAA must work together to select applications for consideration under this funding opportunity.

BHA recognizes that some LBHA/CSA/LAAs also provide direct service and may be interested and eligible to apply for this funding opportunity. If a LBHA/CSA/LAA is applying for funding as a direct service provider, the LBHA/CSA/LAA in that jurisdiction must have a process to ensure there is no

conflict of interest in reviewing and ranking proposals received. Specifically, any jurisdiction that intends to apply as a service provider for this funding opportunity must follow their conflict of interest procedures approved by BHA as part of their jurisdiction's integration plan and by **Monday, June 1, 2020**, notify BHA in writing of their intent to apply as a direct service provider and their commitment to follow the agreed upon conflict of interest plan.

Step 2:

All applications for funding will be reviewed and ranked by the LBHA/CSA/LAA according to their local procurement policies and protocols to ensure proposals are aligned with local needs and priorities. In the event of a conflict of interest, as identified above, the entity designated in the jurisdiction's BHA approved conflict of interest procedures will be the entity responsible for selecting the applicant(s) to be submitted to BHA for further consideration. Each LBHA/LAA/CSA may choses from one of the two options for proposal submission as specified below.

a. Option 1:

The LBHA/CSA/LAA may select one or more proposals for further consideration. Proposals shall not be submitted to BHA unless the LBHA/CSA/LAA has first scored and ranked each proposal received and determined that each proposal or proposals submitted meets local criteria for competitive selection. A maximum of three proposals may be submitted per jurisdiction. All applications submitted by the LBHA/CSA/LAA to BHA for consideration must meet the minimum eligibility criteria described below to be considered for funding.

OR

b. Option 2:

The LBHA/CSA/LAA may develop one composite proposal comprising elements of more than one competitively solicited proposal. Each proposal received must be objectively reviewed in accordance with identified selection criteria. Participating providers to be selected must be advised of the selected components of their proposal to be incorporated by the LBHA/CSA/LAA into the composite, and must agree to those components in partnership with other selected entities. As part of its submission to BHA, the LBHA/CSA/LAA must demonstrate that the process undertaken to develop the composite proposal was fair and equitable and consistent with local procurement policies and protocols. The application submitted to BHA must meet the minimum eligibility criteria described below to be considered for funding.

B. Overview:

The LBHA/CSA/LAA, Local Emergency Medical Services (EMS), Mobile Crisis Teams (MCTs), neighboring hospital emergency departments (EDs), law enforcement, community outreach workers and other provider and community organizations will design a system for individuals in crisis to access immediate treatment of mental health and substance disorder related crises. Additionally, they will develop appropriate triage and protocols for EMS to transport to a crisis

center and/or through mobile crisis services as an alternative to the ED will require a detailed medical screening protocol.

Crisis services will be equipped to handle multiple crises at one time, such as co-occurring crises and housing needs and provide a welcoming and respectful environment for both individuals who are transported and those who walk in. Crisis services are expected to be available seven days a week, between 18 and 24 hours a day and have the capacity to serve an identified number of individuals at one time.

Admission will be voluntary, and any person brought to a center or receiving mobile crisis or residential crisis services may leave at any time (unless deemed in need of an emergency petition/evaluation). The applicant should describe the triage, intake/assessment process, handling of services regardless of an individual's ability to pay, treatment planning, service provision, discharge planning, the discharge process, recovery support and warm handoff.

C. Partnerships:

Successful crisis service systems require robust partnerships with the LBHA/CSA/LAA, Local Emergency Medical Services (EMS), Mobile Crisis Teams (MCTs), neighboring hospital emergency departments (EDs), law enforcement, community outreach workers and other provider and community organizations.

Law enforcement partnerships are strongly encouraged though not required. With respect to crisis responses to children, partnerships with schools, pediatricians, juvenile justice and social service partners is recommended. Crisis services can be important resources for law enforcement and school systems and can serve as alternative destinations for Emergency Petitions (EP) and service infrastructure for diversion/deflection programs.

Alternative EP destinations can save both law enforcement and hospital resources while also improving quality outcomes by utilizing center resources to connect individuals to less restrictive, long-term, sustainable care. Similarly, diversion/deflection programs allow law enforcement to connect individuals to services in lieu of prosecution for offenses with underlying behavioral health causes. Such programs have been shown to save criminal justice resources, reduce recidivism, and improve program participant outcomes.

Currently, there are several other initiatives funding crisis services in Maryland. These include mental health crisis beds funded through the ASO, as well as SOR and HSCRC grants and contracts. Applicants should indicate how the proposed services will be integrated and coordinated with any such services within the service area. In addition, applications should describe the partnerships and provide letters of support and/or MOUs with proposed project partners.

D. Objectives:

Crisis services shall be responsive to local needs and integrated into the behavioral health crisis care system. It will divert people in crisis, as safe and appropriate, away from emergency

departments and provide stronger links to community-based behavioral health care for individuals who have not been engaged by the behavioral health system. It will create a non-traditional access point for individuals with behavioral health related disorders who engage in high-risk behaviors who are experiencing a crisis and/or at risk of overdose or suicide.

Crisis services will be located as determined by the LBHA, CSA or LAA.

Crisis services shall create a hopeful, respectful environment that provides supports and services that:

- Seek to reduce harm for the individual, family, and community
- Is responsive to trauma and care is trauma informed
- Is culturally aware and competent
- Is a voluntary engagement
- Provides easy access with low barriers to care
- Is person-centered
- Is family-centered
- Supports peer and family specialists
- Focuses on recovery oriented care
- Is compliant with all federal and State regulations for behavioral health to include, but not limited to, HIPAA, 42CFR, ADA

E. Scope of Service:

The vision for this project is to develop or expand mobile crisis services, a Crisis Walk-in Center, Crisis Stabilization Center or Crisis Residential Beds that responds to local/regional needs. Services should also be grounded in a public health framework, recovery-oriented, and integrated into the acute behavioral health crisis care system. The following objectives for the project may include:

- Maximizing the use of the behavioral health system by serving as a critical access point for individuals seeking crisis services, including medication-assisted treatment
- Offering a viable alternative to costly hospital services by effectively diverting individuals not in need of emergency care into the community and by serving as an alternative destination for law enforcement EPs
- Offering services to support police-led diversion/deflection programs for vulnerable individuals experiencing crisis
- Offering basic non-emergency medical care, such as wound care, monitoring of vital signs, and initiating medication assisted treatment (MAT) for substance use disorders; MAT may be provided in coordination with hospitals and clinics
- Offering crisis bed services for stabilization, and expand access to treatment and recovery availability with the addition of MAT
- Promoting recovery and resiliency by staffing crisis services primarily with peers and offering real-time connection to ongoing treatment and recovery support services

- Promoting health equity by offering a readily accessible, low-barrier service for individuals who are seeking behavioral health crisis services
- Reducing harm and ensure the safety of people in a behavioral health crisis, their families, and communities by educating everyone on depression, suicide, and overdose
- Building a secure data infrastructure that links crisis services with the behavioral health system and broader health care systems

F. Priority Populations:

Special consideration will be given to proposals providing crisis services to the priority populations that include:

- Individuals or families who self-report to be in crisis or their child in crisis
- Individuals who are at risk of suicide
- Individuals presenting with co-occurring issues
- Individuals who meet medical criteria for safe transport to the program, as determined by approved protocols
- Individuals who walk in or voluntarily agree to be transported to crisis services by the identified partners and are medically screened

The goal is to reach 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. The intent is to provide services in a more appropriate, less restrictive setting that provides immediate, safe, community-based, peer-driven services and direct linkages to ongoing care. Such services will be a better way to make meaningful and lasting treatment and support connections that will lead to improved treatment outcomes. For children/youth and their respective families, crisis response may be required due to threats of either self-harm or harm to others, inability to attend school, and/ or home/placement disruptions.

G. Physical space requirements for Residential Crisis Beds and Walk-in Centers:

The physical space should be configured to support the service delivery model. The applicant should at a minimum describe the following: access for walk-ins and drop-offs by EMS, police or others; configuration that allows for direct line observation of clients; configuration and comfort for short stay vs. long stay clients, and for gender separation; arrangements for personal hygiene and personal belongings; and storage for first aid, medication and other medical supplies.

Finally, it is expected that the services, co-located with other organizations operating in the community, will adhere to “good neighbor” standards. The applicant should describe the

following: what dialogue they have had with the community regarding the services and how they have addressed identified concerns, how community concerns will be addressed once the facility is operational; how they will make efforts to hire from the community; and how they will provide for ongoing dialogue with the community.

H. Staff Requirements:

Residential Crisis Beds:

Crisis services will support awake staff for all hours the center is open, seven days per week/365 days per year with a mix of individuals with lived experience, Certified Peer Recovery Specialists, medical, clinical and other support staff. **The applicant should describe the staffing patterns, staffing schedules and hours of operation of the center** including on-call coordination of services when the center is closed. A nurse practitioner (NP) and a licensed professional nurse (LPN) shall be available onsite during each shift to conduct the initial low-intensity medical assessment and monitoring, provide emergency medical services, and initiate buprenorphine for opioid use disorder or other non-controlled medications, as appropriate. Nurse practitioners, while independently licensed practitioners in Maryland, shall have access to physician consultation services, if needed. One full-time social work staff for two shifts each day will work with individuals to connect them to ongoing care and provide case management services. Certified Peer Recovery Specialists shall be available onsite for each shift. Other staff, such as security staff, shall be available as appropriate. Applicants proposing to operate residential crisis beds must comply with current State guidelines noted in COMAR 10.63.04 http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.63.04.

Crisis Walk-in Center:

24/7 walk-in services are defined as a direct service that assists with the de-escalation of a person's clinical behavioral health crisis. The primary functions of walk-in crisis services are: screening and assessment, crisis stabilization (including medication), brief treatment, and linkage to social services and other behavioral health services. A walk-in crisis service can function as the central point from which to organize the jurisdiction's array of crisis services and deploy services such as MCT, as needed. Additionally, if applicable, services should assist in his or her possible diversion from emergency department admission, police/incarceration, or out of home placement by providing 24/7 access to a safe environment. Assessment, diagnosis, and treatment capability should be available and delivered in a timely manner and lead to stabilization. Anyone experiencing a behavioral health crisis is eligible for acceptance regardless of age, insurance status, ethnic, cultural or linguistic (such as use of language interpreting or certified ASL interpreter) preference. The service setting, whether freestanding or attached to a hospital, will serve as an entry point to long-term, ongoing service delivery and care.

Individuals/families typically call or walk into the Crisis Center. The Crisis Center also provides outreach to persons in behavioral health distress who may be unable or unwilling to come to the Crisis Center or to access other emergency mental health care. At times, clients are brought to the Crisis Center by law enforcement or other first responders. In situations in which a person may be unsafe but not have access to transportation, such as a victim of domestic violence, the Crisis Center has a contract with a taxi company that can be utilized to bring the person to the Crisis Center.

The Crisis Walk-in Center will be staffed 24 hours per day, 7 days per week, 365 days per year with a mix of individuals with lived experience, certified Peer Recovery Specialists, medical, clinical and other support staff.

0.5 FTE Physician/Medical Director
4.5 FTE Nurse Practitioners
4.5 FTE Nurses
2.5 FTE Social Workers/Counselors
4 FTE Peers
3 FTE Security
4 FTE Reception

Mobile Crisis Services:

Mobile Crisis Services are to include:

- Screening
- Assessment
- Crisis Stabilization
- Counseling
- Linkage to urgent care or on-going services at behavioral health outpatient centers and other appropriate services
- Accompanying the individual in crisis to hospital emergency room and assisting in appropriate disposition when clinically indicated
- Promote centralized 24/7 crisis hotline to connect callers with appropriate behavioral health resources

Mobile Crisis Services are to be provided in a setting where the crisis is occurring (i.e., private homes, boarding homes, work settings, police stations, human service agencies). Mobile Crisis services are to be provided by two-member teams, credentialed, privileged staff, and must be available to staff a minimum of three, eight hour shifts per day, seven days a week, including holidays, and provide additional services on an on-call basis.

The provider of the Mobile Crisis Services must develop agreements with the designated behavioral health emergency facility for the jurisdiction in which services are to be provided, and with Residential Crisis Services programs, inpatient psychiatric settings, and local emergency systems.

A licensed psychiatrist or nurse practitioner will work with the Mobile Crisis Team. The licensed psychiatrist or nurse practitioner shall provide clinical services and perform the following duties:

- Develop a schedule as needed for medication evaluation, medication management, direct urgent care treatment and consultation with the Mobile Crisis Team until individuals can be transitioned to outpatient treatment
- Establish urgent care treatment
- Develop follow-up urgent care treatment plans that integrate the psychiatrist or nurse practitioner and Mobile Crisis Team
- Individuals utilizing mobile crisis services care are connected or coordinated with existing crisis response services
- Providers of mobile crisis services will work with their LBHA/CSA/LAA and other key partners, including the local community hospital, to implement a 24/7 integrated, regional behavioral health crisis model

Additionally, responses for children and families should align with these best practice principles as outlined by the Mobile Response and Stabilization Services (MRSS). For information on MRSS please follow this link from The Institute at the University of Maryland: https://theinstitute.umaryland.edu/media/ssw/institute/md-center-documents/MRSS-Best-Practices.pdf

- The crisis should be defined by the parent/caregiver and/or youth themselves.
- The mobile response is in-person and delivered in home or community-settings and available within 60 minutes of contact, with telephonic support until the in-person response arrives.
- The stabilization service must include both the youth's ability to manage daily activities and establish clear connections for the youth and family, as needed, to community support, not just clinical interventions. The stabilization service can be provided for up to eight weeks.

Goals and outcomes should include:

- Support and maintain youth in their current living situation and community environment, reducing the need for out-of-home placements and placement changes
- Promote and support safe behavior in homes, school, and community
- Reduce admission to Emergency Departments, inpatient psychiatric units, detention centers and residential treatment centers due to a behavioral health crisis
- Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services
- Connect to longer stabilization services as appropriate
- Utilize evidence based tools that assess the crisis, detail the needs of the individual, and develop a plan for safety
- Training, supervision and mentoring should be clear, consistent and in line with systems of care or wraparound services

- Mobile response teams should connect to both informal and formal community supports and connections should be made to higher intensity of services, if needed

I. Funding Availability: Funding will be made available to support the first year of operations. The budget narrative should provide for Years 1, 2, and 3 as well as a plan for sustainability. Funding for subsequent years will be contingent upon performance, outcomes, utilization, available funding, etc.

J. Outcomes and Program Reporting (deliverables): The Behavioral Health Administration is dedicated to enhancing outcomes reporting system-wide in order to evaluate the quality of public behavioral health services in their jurisdiction. Outcomes should be collected to demonstrate the reach, benefits and impact of the intervention and support provided. Overall, individuals enrolled in services are expected to improve over time, and programs should be able to demonstrate expected outcomes.

The data collection and reporting requirements for this program are designed to capture a Minimum Data Set to be used to monitor program performance and outcomes and will include two core components, including: Monthly program summary reports and the submission of client-level data on designated clients.

Monthly Program Summary Reports:
The selected applicants will be required to submit program and financial reports during the entirety of the approved contract term. Monthly program summary data will be submitted to the LBHA/CSA/LAA, using a standardized reporting form, and will include: the number and type of crisis service encounters, number and source of referrals, type of clients served (e.g., mental health, substance use disorder or co-occurring), counts by other demographic and service information, and service outcomes. BHA will work with the LBHA/CSA/LAA and the selected applicants to further define required data elements, data collection tools and reporting specifications.

Client-Level Data:
The selected applicants will also be required to submit monthly individual client-level data on all clients who receive a face to face crisis response or a crisis stabilization service. The data will be submitted in a file format specified by the BHA and include the following data elements:

- Name of Provider
- Client First and Last Name
- Presenting Disorder: (Mental Health, SUD, Co-Occurring)
- Date of Birth
- Gender
- Race
- Client County of Residence
- Current Living Situation: (Living Independently, Private Residence, Homeless, Group Residential Placement, Other: (Specify)
- Custody Arrangement (Under 18 years): Birth Parents, Adoptive Parents, DHS Custody,

DJS Custody, Other: (Specify)
- Arrests in Past 90 Days: (Yes, No)
- Current Employment: (Yes, No)
- Type of Insurance: (Medicaid, Medicare, Uninsured, Private Insurance, Other)
- Referral Source: (Self/Family, Friends, Community Agency, School, Child Welfare, Juvenile Justice, Hospital Emergency Department, EMS, Law Enforcement, Other)
- Date/Time of Initial Crisis Call Leading to Response
- Date/Time of Initial Face to Face Mobile Response
- Date/Time of Admission to Crisis Stabilization Service
- Date/Time of Crisis Episode Resolution or Discharge from Crisis Stabilization Service
- Disposition at Resolution of Crisis Episode (No additional services needed, Individual or family declined services, warm hand off to community MH or SUD service provider, Crisis Stabilization Services, Inpatient Hospitalization, Incarceration, Other)
- If warm hand off to community provider, specify type of provider (MAT, SUD OP, SUD IOP, PRP, MH OP, Other: (Specify)

These client-level data elements will be used by BHA to create a set of operational and performance measures that will be used to evaluate the effectiveness of these crisis response initiatives and to inform program planning and continuous quality improvement efforts. Key performance metrics for measuring the success of the crisis response program include:

- Number of individuals who are linked to, and receive a community mental health or SUD service within seven days of the resolution of a mobile crisis episode or discharge from a stabilization bed.
- Number of crisis service recipients, diagnosed with OUD, who are linked to, and receive MAT Services.
- Number of mental health and SUD related hospital admissions.
- Number of mental health and SUD related emergency department visits.
- Number of child/youth users who are placed in an out of home residential or inpatient facility as a result of CRS or CSS services.
- Number of individuals who use the Crisis Walk-in Center or Crisis Stabilization Center two or more times within a 12-month period.
- Number of CRS or CSS users who are hospitalized for MH or SUD related issue as a result of the crisis response.

K. Quality Monitoring: The LBHA, CSA, or LAA will engage in monitoring activities to evaluate the quality of various aspects of service delivery. Some of these activities include:

a) Site visits to evaluate and document various administrative and programmatic requirements, b) Review of data reports to evaluate programmatic outcomes, c) Review of financial reports to evaluate financial outcomes, d) Review of general administrative compliance documents, e) Review of incident reports and follow-up actions. The selected applicant will be required to participate in all monitoring and evaluation activities.

All types of crisis services programs will maintain and train all staff in Problem Escalation Procedures. Following any incidents staff will conduct a review of the incident using Root Cause Analysis, etc.

If, during monitoring activities, it is discovered that the selected applicant is not fulfilling the obligations stated in the contract resulting from this RFP, a Corrective Action Plan may be required, with additional follow-up monitoring to ensure requirements are being met, or the contract may be terminated.

IV. RFP Specifications

A. Applicant Eligibility:

Applications must be submitted through the LBHA, CSA, or LAA, as detailed in Section IV. General Requirements Letter A. Application Process. Applications from provider organization submitted to LBHA/CSA/LAAs must meet all criteria outlined below to be considered eligible for consideration through this RFP process:

- Certification as a Medicaid provider, with the ability to access reimbursement through Optum Maryland for behavioral health care services **and/or** Maryland's Managed Care Organizations for somatic health care services.
- Accreditation and licensing as required to provide services.
- Partnership between organizations where one bills for behavioral health care and the other bills for somatic health care is allowed if there is a formal relationship established, preferably for a year or more prior to submitting a proposal in response to this RFP.
- Ability to provide buprenorphine induction and other medications for substance use disorders, as needed.
- Experience providing behavioral and/or somatic health care services for at least the last five years.
- In Good Standing with the State of Maryland or explanation as to why this does not apply to your organization. Certification can be obtained through the Department of Assessment and Taxation website.

B. Proposal Timeframe, Submission, Contact and Term:

1. Timeline

Issue Date:	**Wednesday, May 20, 2020**
Proposal Due to LBHA/CSA/LAA:	**Friday, June 19, 2020 by 5:00 PM**
LBHA/CSA/LAA submission to BHA:	**Friday, July 10, 2020 by 5:00 PM**

2. Proposal Submission and Location

Providers are to submit their proposals electronically to their respective behavioral health authorities (LBHA, CSA, or LAA) by **5:00 p.m. on Friday, June 19, 2020** for their review and recommendation. A contact list for the LBHA, CSA or LAA in each jurisdiction is attached to the RFP. As some email systems prohibit sending or receiving large files, applicants may need to split files into multiple emails. Proposals submitted after the closing date will not be considered. It is recommended that a separate email be sent with no attachments to request confirmation that the proposal was received.

LBHA, CSA, or LAA submissions must be sent electronically to BHA by email by **Friday, July 10, 2020 by 5:00 p.m.** by attaching one or more PDF files. Because some email systems prohibit sending or receiving large files, applicants may need to split files into multiple emails. Proposals submitted after the closing date will not be considered. It is recommended that a separate email be sent with no attachments to request confirmation that the proposal was received. All submitted proposals become the property of MDH-BHA.

3. For all matters concerning this RFP, the LBHA, CSA, or LAA should contact Darren McGregor as outlined in Section IV. General Requirements, Letter A. Application Process:

Darren McGregor
Behavioral Health Administration
Office of Crisis and Criminal Justice Services
Email: darren.mcgregor@maryland.gov
Phone: 410-402-8467

All provider questions must be directed to the LBHA/CSA/LAA as outlined in Section IV. General Requirements, Letter A. Application Process of this RFP.

4. Anticipated Initial Service Term: One year with annual options to renew pending available funding, meeting performance measures, and achieving expected outcomes.

C. Award of Contract

The submission of a proposal does not, in any way, guarantee an award. BHA will award funds to the LBHA/CSA/LAA, who may subcontract with sub-vendors. MDH-BHA is not responsible for any costs incurred related to the preparation of a proposal in response to this RFP.

MDH-BHA will select the most qualified and responsive applicants through this RFP process. MDH-BHA will enter into a contract with selected LBHA/CSA/LAA following the notification of award. Any awarded LBHA/CSA/LAA is required to pass all terms and conditions in the executed contract with BHA to any sub-vendor. Any selected applicant must comply with all terms and conditions applicable to the contract executed by MDH-BHA.

D. Contract Requirements:

1. The Mobile Crisis Services, Crisis Walk-in Center, Crisis Stabilization Center or Residential Crisis Beds, must be open and operational within the timeframe proposed and agreed to by the applicant and BHA.
2. Maintain sufficient liability insurance appropriate for the level of service.
3. In order for the awardee to receive funds for subsequent years, the awardee must:
    - Demonstrate good performance and outcomes, and sufficient utilization
    - Collect and report data as required
    - Have in place incident escalation procedures for employees to follow
    - Perform root cause analysis and cause and effect analysis of any incidents
    - Perform background checks on all employees
    - Comply with all federal and state laws regarding providing behavioral health services, including but not limited to HIPPA, 42CFR, ADA,
    - Maintain data security

4. In the event that the contract is terminated, the awardee must work with the LBHA/CSA/LAA and BHA to develop and execute a transition plan.

E. Fiscal Feasibility:

An approved risk assessment must be completed by the LBHA, CSA, or LAA and submitted to BHA for review along with a request for grant funding. The applicant must meet the minimum requirements per the risk assessment tool.

F. Proposal Format:

Proposals are not to exceed ten (10), **single-spaced pages** using twelve (12) point Times New Roman font. **Proposals exceeding the 10-page limit will not be considered**. Two or more LBHA/CSA/LAAs can join together and submit a single, integrated proposal for multiple jurisdictions. **Responses must be ordered and answered to match the evaluation criterion outlined in Section G.** The program budget and performance measures may be submitted as a separate attachment and will not count towards the 10-page limit. Please provide detailed information to address all the elements in the evaluation criteria.

All proprietary material should be clearly identified as such by the submitter.

G. Evaluation Criteria: **Proposals must be structured to align with each criterion.** It is recommended that subheadings be included in the proposal. The provider application will be evaluated based on the response to the following criteria:

1. A detailed description of the problem in the jurisdiction (document the extent of the need [i.e., current prevalence rates or incidence data] for the population(s) of individuals in crisis), gaps in services, and a well defended intervention. ***Maximum 20 points***

- Problem statement
    1. Severity of the problem (supported by data)
    2. Previous interventions to address the problem
    3. Local, Regional, State, and/or Federal partnerships formed to address the problem
- Target population
    1. Children and/or
    2. Families and/or
    3. Transitional Age Youth and/or
    4. Adults and/or
    5. Older Adults
- Type of Crisis
    1. Mental Health and/or
    2. Risk of Suicide and/or
    3. Substance Related Disorder
- Intervention or service
    1. Mobile Crisis
    2. Walk-in Crisis Center
    3. Crisis Stabilization Center
    4. Residential Crisis Beds

2. Submit a clear and concise narrative of what the program will deliver including a detailed description of how the proposed service will be integrated and coordinated with any existing or other newly funded crisis service within the service area. ***Maximum 5 points***
3. Submit a clear and concise timeline for the implementation of services. ***Maximum 5 points***
4. Description of provider expertise and organizational capacity to provide mobile crisis services, crisis walk-in or crisis stabilization services:
    - Experience working with individuals who are Medicaid eligible and/or are uninsured.
    - Prior or current experience in providing behavioral health related walk-in crisis services or Mobile Crisis Services.
    - Prior or current experience in operating behavioral health related crisis beds.
        1. Provide a copy of current certification/license for mental health crisis beds.
    - Prior experience working with youth and families.
    - Plan to ensure compliance with federal and state confidentiality requirements, including HIPAA and 42 CFR, part 2.
    - Knowledge of American Society of Addiction Medicine (ASAM) Criteria. ***Maximum 15 points***.
5. Description of the level of support, detailed 24/7 staffing ratio, projected number of individuals to be served, the eligible functions that will be funded, and a description of the expected outcomes. ***Maximum 15 points***
6. Identification of performance and outcome indicators to be used to evaluate the program's effectiveness, including a description of the expected schedule for measuring performance and outcomes. ***Maximum 15 points***

7. Provide a plan for sustainability of services beyond the end of the grant award period, to include a transition plan to support the project once grant funding has been exhausted. ***Maximum 10 points***
8. A budget narrative and spreadsheet that describes the funding needed to support the proposed number of individuals to be served, services to be provided and number of beds to be operated including a line item budget for years 1 and 2. Budget is aligned with the proposed activities. ***Maximum 10 points***
9. Description of the administrative process including sub-grantee monitoring of contract deliverables, contracting for Mobile Crisis Services or a Crisis Walk-in Center or Residential Crisis Services, and evaluation plan designed to measure outcomes. Note: if awarded, a copy of the sub-grantee contract and MOU agreements must be submitted to LBHA/CSA/LAA within 60 days of the award. ***Maximum 5 points***

H. Grant Awards and Data Collection Requirements

BHA will issue all awards for Mobile Crisis Services, Crisis Walk-in Center, Crisis Stabilization Center, and Residential Crisis Services to the LBHAs, CSAs, and LAAs.

I. Closing/Submission Date and Location

Providers are to submit proposals directly to their respective LBHAs/CSAs/LAAs by **Friday, June 19, 2020 by 5:00 p.m.** Contacts for the LBHAs/CSAs/LAAs in each jurisdiction will accompany the RFP.

LBHAs/CSAs/LAAs are to submit proposals and request for grant funds to BHA by email by **Friday, July 10 by 5:00 PM** to Proposals.CrisisPrograms@maryland.gov

RFP/Postponement/Cancellation: MDH-BHA reserves the right to postpone or cancel this RFP, in whole or in part.

Attachment A

PRE-AWARD RISK ASSESSMENT TEMPLATE AND GUIDANCE

Sub-recipient:	
Monitoring Period:	
Award Number:	
Federal Number:	
CFDA Number:	
Program:	
Review Date:	
Award Period:	
Date of Last Review:	
Award Amount:	

Pre-Award Risk Assessment	Yes	No	N/A
1) Sub-recipient's Prior Experience			
Does the sub-recipient have previous MDH (Federal and/or State) grant experience?			
Has the sub-recipient previously been listed on the Federal Exclusions Database?			
2) Sub-Recipient's Background			
Is the sub-recipient financially stable?			
Will the grant funds be deposited into a separate bank account?			
Does the sub-recipient have written procurement and accounting procedures in place?			
Does the sub-recipient have an inventory/equipment system in place?			
Does the subrecipient have accounting systems that can separately track all drawdowns and grant			
Does the subrecipient have a records retention policy?			
Can the sub-recipient effectively implement statutory, regulatory and other requirements imposed on them for this award?			
Does the sub-recipient have a system in place to ensure that the grant objectives are being met?			
Does the sub-recipient know what data they will need to measure their progress in meeting performance measures?			
Does the sub-recipient have a risk assessment process in place to identify and mitigate potential risks?			

PRE-AWARD RISK ASSESSMENT TEMPLATE AND GUIDANCE

Count the number of No & N/A responses and circle corresponding "Low," "Med," or "High" risk assessment.

0-3 No/NA	Sub-recipient is low risk for receiving grant funds.	Low		
4-7 No/NA	Sub-recipient is medium risk for receiving grant funds.		Med	
8-12 No/NA	Sub-recipient is high risk for receiving grant funds.			High

Risk Level	OIG Recommended Monitoring Procedures
High	Conduct background checks to verify proper payment of withholding taxes, credit standing, and other problem indicators; conduct internet searches and other reference checks to identify and review negative information prior to granting an award; review open OIG and inspection reports; determine if there are any ongoing OIG or other criminal investigations prior to award distribution; maintain separate bank accounts for each grant; include information on fraud awareness in grantee award packages; closely monitor grant funds to ensure funds are accounted for and appropriately spent; conduct site visits early in the process to ensure grantees maintain accurate accounting records and adequate support for their expenditures.
Medium	Determine if there are any ongoing OIG or other criminal investigations prior to award distribution; maintain separate bank accounts for each grant; include information on fraud awareness in grantee award packages; monitor grant funds more to ensure funds are accounted for and appropriately spent; conduct site visits early in the process to ensure grantees maintain accurate accounting records and adequate support for their expenditures.
Low	Conduct site visits early in the process to ensure grantees maintain accurate accounting records and adequate support for their expenditures.

Note: If a sub-recipient is rated high risk, consider imposing special requirements on the sub- recipient.

Attachment B: MABHA Contact List

22 South Market Street, Suite 8, Frederick MD 21701
301.682.9754 Fax 301.682.6019
mabha@mhma.net
www.marylandbehavioralhealth.org

Allegany County

Local Behavioral Health Authority
Allegany Co. Health Department
P.O. Box 1745
Cumberland, MD 21501
301-759-5070 Fax: 301-777-5621
achd.bhso@maryland.gov
Director: Becki Clark

Anne Arundel County

Local Behavioral Health Authority
Anne Arundel Co. Mental Health Agency
PO Box 6675, 1 Truman Parkway, 101,
Annapolis, MD 21401
410-222-7858 Fax: 410-222-7881
mhaaac@aol.com
Director: Adrienne Mickler

Anne Arundel County Health Department Behavioral Health
3 Harry S. Truman Parkway HD24
Annapolis, MD 21401
410-222-7164 Fax: 410-222-7348
hdonei00@aacounty.org
Director: Sandra O'Neill

Baltimore City

Local Behavioral Health Authority
Behavioral Health System Baltimore
100 South Charles Street, Tower 2, Floor 8 Baltimore, MD 21201
410-637-1900 Fax: 410-637-1911
www.bhsbaltimore.org
crista.taylor@bhsbaltimore.org
Director: Crista Taylor

Baltimore County

Local Behavioral Health Authority
Baltimore County Department of Health,
Bureau of Behavioral Health
6401 York Road, Third Floor
Baltimore, MD 21212
410-887-3828 Fax: 410-887-3786
shouse@baltimorecountymd.gov
Director: Stephanie House

Calvert County

Local Behavioral Health Authority
Calvert County Health Department
P.O. Box 980
Prince Frederick, MD 20678
410-535-5400 x311 Fax: 410-414-8092
Andrea.mcdonald-fingland@maryland.gov
Director: Andrea McDonald-Fingland

Caroline County

Core Service Agency
Mid-Shore Behavioral Health, Inc.
28578 Mary's Court, Suite 1
Easton, Maryland 21601
410-770-4801 Fax: 410-770-4809
kdilley@midshorebehavioralhealth.org
Director: Katie Dilley

Local Addictions Authority
Caroline County Behavioral Health Program
403 South 7th Street
Denton, Maryland 21629
410-479-1882 Fax: 410-479-4918
Terri.Ross@maryland.gov
Director: Terri Ross

Carroll County

Local Behavioral Health Authority
Carroll County Local Behavioral Health Authority
290 South Center Street
Westminster, MD 21157
410-876-4823 Fax: 410-876-4832
sue.doyle@maryland.gov
Director: Sue Doyle

Cecil County

Core Service Agency
Cecil County Core Service Agency
401 Bow Street
Elkton, MD 21921
410-996-5112 Fax: 410-996-5134
shelly.gulledge@maryland.gov
Director: Shelly Sawyer

Local Addictions Authority
Cecil County Health Department
401 Bow Street
Elkton, MD 21921
410-996-5106 ext. 299 Fax: 410-996-5707
ken.collins@maryland.gov
Director: Kenneth Collins

Charles County

Local Behavioral Health Authority
Charles County Local Behavioral Health Authority
P.O. Box 1050, 4545 Crain Highway
White Plains, MD 20695
301-609-5757 Fax: 301-609-5749
karynm.black@maryland.gov
MDH.CharlesCountyCSA@Maryland.gov
Director: Karyn Black

Dorchester County

Core Service Agency
Mid-Shore Behavioral Health, Inc.
28578 Mary's Court, Suite 1
Easton, Maryland 21601
410-770-4801 Fax: 410-770-4809
kdilley@midshorebehavioralhealth.org
Director: Katie Dilley

Local Addictions Authority
Dorchester County Addictions Program
524 Race Street, 1st floor
Cambridge, MD 21613
410-228-7714 ext. 106 Fax: 410-228-8049
donald.hall@maryland.gov
Director: Donald Hall

Frederick County

Local Behavioral Health Authority
Frederick County Health Department, Behavioral Health Services
350 Montevue Lane
Frederick, MD 21702
301-600-1755 Fax: 301-600-3237
awalker@frederickcountymd.gov
sdrennan@frederickcountymd.gov
Director: Andrea Walker
Deputy Director: Sarah Drennan

Garrett County

Local Behavioral Health Authority
Garrett County Behavioral Health Authority
1025 Memorial Drive
Oakland, MD 21550
301-334-7440 Fax: 301-334-7441
fred.polce@maryland.gov
Director: Fred Polce

Harford County

Core Service Agency
Office on Mental Health of Harford County 2231 Conowingo Road, Ste. A
Bel Air, MD 21015
410-803-8726 Fax: 410-803-8732
jkraus@harfordmentalhealth.org
Director: Jessica Kraus

Local Addictions Authority
Harford County Health Department
120 S. Hays St.
Bel Air, MD 21014
410-877-2338 Fax: 410-638-4954
Shawn.martin@maryland.gov
Program Manager: Shawn Martin

Howard County

Local Behavioral Health Authority
Howard County Health Department
8930 Stanford Road
Columbia, MD 21046
410-313-7316 Fax: 410-313-6212
rrbonaccorsy@howardcountymd.gov
Director: Roe Rodgers-Bonaccorsy

Kent County

Core Service Agency
Mid-Shore Behavioral Health, Inc.
28578 Mary's Court, Suite 1
Easton, Maryland 21601
410-770-4801 Fax: 410-770-4809
kdilley@midshorebehavioralhealth.org
Director: Katie Dilley

Local Addictions Authority
Kent County Health Department
300 Scheeler Road
Chestertown, MD 21620
410-778-5864 Fax: 410-778-7002
brenna.fox@maryland.gov
Director: Brenna Fox

Montgomery County

Local Behavioral Health Authority
Department of Health & Human Services
401 Hungerford Drive, 1st floor
Rockville, MD 20850
240-777-1414 Fax: 240-777-1145
teresa.bennett@montgoverycountymd.gov
Teresa Bennett, Acting Director, LBHA
240-777-3360 Fax: 240-777-1145
Rebecca.garcia@montgomerycountymd.gov
Rebecca Garcia, Operations Manager, LBHA

Prince George's County

Local Behavioral Health Authority
Prince George's County Health Department
Dyer Regional Health Center
9314 Piscataway Road
Clinton, MD 20735
301-856-9500 Fax: 301-856-9558
lcwaddler@co.pg.md.us
Manager: L. Christina Waddler
ssmith2@co.pg.md.us
Assistant Manager: Sherese Smith

Queen Anne's County

Core Service Agency
Mid-Shore Behavioral Health, Inc.
28578 Mary's Court, Suite 1
Easton, Maryland 21601
410-770-4801 Fax: 410-770-4809
kdilley@midshorebehavioralhealth.org
Director: Katie Dilley

Local Addictions Authority
Queen Anne's County Health Department
206 North Commerce Street
Centreville, MD 21617
410-758-1306 x4534 Fax: 410-758-2133
maggie.thomas@maryland.gov
Director: Maggie Thomas

Somerset County

Local Behavioral Health Authority
8929 Sign Post Road, Ste 2
Westover, MD 21871
443-523-1700 Fax: 410-651-3189
shannon.frey@maryland.gov
Director: Shannon Frey

St. Mary's County

Local Behavioral Health Authority
St. Mary's County Health Department
21580 Peabody Street PO Box 316
Leonardtown, MD 20650
301-475-4330 Fax: 301-363-0312
Smch.LBHA@maryland.gov
tammym.loewe@maryland.gov
Director: Tammy Loewe

Talbot County

Core Service Agency
Mid-Shore Behavioral Health, Inc.
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ATTACHMENT C

Regional Partnership Catalyst Grant Program

January 30, 2020

Health Services Cost Review Commission
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Funding Announcement

The Health Services Cost Review Commission (HSCRC) is seeking proposals for the new Regional Partnership Catalyst Grant Program. This funding program is intended to support hospitals' continuing work with community resources on building the foundation needed to sustainably support the population health goals of the Total Cost of Care (TCOC) Model. Under the Regional Partnership Catalyst Grant Program, hospitals and their partners will collaborate to implement or expand investments in the two announced statewide population health priority areas – diabetes prevention & management and behavioral health crisis services. The Regional Partnership Catalyst Program is a temporary funding mechanism intended to encourage eligible hospitals to work together with community partners on building important foundations to improve population health. Funding will be issued for the following five year period:

- Year 1: CY2021 (January 1, 2021 – December 31, 2021)
- Year 2: CY2022 (January 1, 2022 – December 31, 2022)
- Year 3: CY2023 (January 1, 2023 – December 31, 2023)
- Year 4: CY2024 (January 1, 2024 – December 31, 2024)
- Year 5: CY2025 (January 1, 2025 – December 31, 2025)
- Grant funding will end on December 31, 2025.

Proposal Requirements and Timeline

Proposals must be single-spaced, single sided, Calibri style and 11 point font size and submitted using the requirements described herein by the date below to hscrc.rfp-implement@maryland.gov in order to be considered. **Separate proposals must be submitted for each funding stream.** A review committee appointed by the HSCRC will review the applications and make decisions about awards.

- Funding Announcement: January 31, 2020
- Proposal Deadline: June 19, 2020, 11:59 pm EST
- Proposal Disposition Notifications – September 2020
- Commission Draft Award Recommendations – October 2020
- Commission Final Award Recommendations – November 2020
- Rate Orders Issued – January 2021

Background

The Maryland All-Payer Model, which launched in 2014, established global budgets for Maryland hospitals to reduce Medicare hospital expenditures and improve quality of care. Global budgets provide hospitals with a fixed amount of revenue for the upcoming year. A global budget encourages hospitals to eliminate unnecessary hospitalizations, among other benefits. Under the All-Payer Model, Maryland achieved significant savings for Medicare and improved quality. However, the Maryland All-Payer Model historically focused primarily on the hospital setting, constraining the State's ability to sustain its rate of Medicare savings and quality improvements.

In 2019, the Centers for Medicare & Medicaid Services (CMS) and the State of Maryland initiated the Maryland Total Cost of Care (TCOC) Model, which seeks to broaden transformation of Maryland's healthcare system by setting a per capita savings target on Medicare total cost of care in the State. The TCOC Model builds on the success of Maryland's All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care, and by committing the State to a sustainable growth rate in per capita total cost of care spending for Medicare beneficiaries.

The TCOC Model holds Maryland fully at risk for the total cost of care for Medicare beneficiaries and sets Maryland on course to save Medicare over $1 billion by the end of 2023 by adopting new and innovative policies aimed at improving care, improving population health, and moderating the growth in hospital costs. The goal of the TCOC Model is to transform Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities by increasing collaboration among health systems, payers, community hospitals, ambulatory physician practices, long-term care, and other providers, as well as patients and families, public health, and community-based organizations.

While changes to hospital payment mechanisms consistent with the All-Payer Model are well under way, the new TCOC model requires continued work and investments to integrate and support the efforts of additional parts of the healthcare systems including independent ambulatory physicians, community providers, public health, and others to improve care delivery for patients. In its November 2019 public meeting, the Commission approved the creation of temporary Regional Partnership Catalyst Grants to support hospitals' engagement with community resources to build the foundation needed to sustainably support the population health goals of the TCOC Model.

Maryland hospitals that have global budgets established under the rate-setting authority of the HSCRC and meet the additional requirements identified in this announcement are eligible to apply for the Regional Partnership Catalyst Grants. *Awards will only be available to the most promising and competitive hospital applicants.* The aggregate amount available for Regional Partnership Catalyst Grant Program is up to 0.25 percent of statewide hospital revenue. The maximum amount a hospital may receive from multiple successful proposals may not exceed 0.75 percent of the hospital's FY 2020 approved net patient revenue plus markup.

Regional Partnership Catalyst Grants

The Regional Partnership Catalyst Grants will be narrowly focused to support activities that align with goals of the TCOC Model and the Memorandum of Understanding that Maryland established with CMS for a Statewide Integrated Health Improvement Strategy (SIHIS). The Regional Partnership Catalyst Grant Program will include allocations of funds called "funding streams" that are designed to encourage focus on the key state priorities. This funding announcement is for the following two funding streams that will have funds issued in January 2021 through hospital rate orders:

- **Funding Stream I: "Diabetes Prevention & Management Programs**" – This funding stream awards grants to Regional Partnerships in order to support the implementation of the Centers for Disease Control (CDC) approved diabetes prevention and American Diabetes Association (ADA) recommended diabetes management programs and related interventions that will strengthen the diabetes prevention and management programs.

- **Funding Stream II: "Behavioral Health Crisis Programs"** – This funding stream would award grants to Regional Partnerships to support the implementation and expansion of behavioral health crisis management models that improve access to crisis intervention, stabilization, and treatment referral programs.

The Regional Partnership Catalyst Grant Program may also include a third funding stream that will award grants to Regional Partnerships to support one additional population health priority area that Maryland may define. A separate funding announcement would be issued for the third priority area.

The intent of the Regional Partnership Catalyst Grant Program is to achieve the following:

- Partnerships and strategies that result in long term improvement in the population health metrics that are part of the new TCOC Model
- Increased number of prevention and management services for persons with potential for or living with diabetes
- Reduced use of hospital emergency departments and improved approaches for managing acute behavioral health issues
- Integration and coordination of physical and behavioral health services for improved quality of care
- Engagement and integration of community resources into the transforming healthcare system

Hospitals interested in applying will be required to submit proposals describing how they will use the Regional Partnership Catalyst Grant Program funds to work in collaboration with Local Health Improvement Coalitions, Local Health Departments, community-based organizations,

local behavioral health authorities, social service organizations, physician groups, etc. to build the foundation that will support improvement in population health in the long run. Successful hospital proposals will articulate detailed plans for implementing or expanding support systems in the aforementioned population health priority areas.

Funding Stream I: Diabetes Prevention & Management

The diabetes funding stream will competitively award grants to Regional Partnerships that choose to implement and support the Centers for Disease Control and Prevention (CDC) recommended National Diabetes Prevention Program (National DPP). Maryland needs significantly more diabetes prevention and management resources in order to provide the service to all Marylanders in need. Given the State's shortage of resources, Regional Partnership Catalyst awards are intended to help hospitals work with community resources to build a more adequate National DPP provider capacity within Maryland that becomes available for the entire health system to utilize.

As an additional component of the diabetes funding stream, funds will also be competitively awarded to develop, promote, and track development of Diabetes Self-Management Training (DSMT). Regional Partnerships may submit plans to implement National DPP, DSMT, or both programs in the same proposal. Proposals should specify how hospitals in collaboration with community partners intend to increase the number of diabetes prevention and management resources and should include planning, startup, implementation, and operational costs.

Proposals may also include funding requests for additional diabetes related "wrap around services" -- programs that supplement National DPP and/or DSMT services and bolster the likelihood of a positive impact on diabetes burden in the Regional Partnership's geographic service area. Regional Partnerships can opt to implement Medical Nutritional Therapy (MNT) as an optional wrap around service to supplement National DPP and/or DSMT. Regional Partnerships may also propose other additional wrap around services. Proposals must detail how the wrap around services will align with and/or enhance National DPP and/or DSMT.

Funding Stream II: Behavioral Health Crisis

The behavioral health crisis services funding stream will competitively award grants to Regional Partnerships that choose to develop and expand comprehensive crisis management services that enable Marylanders to receive care in settings other than traditional hospital emergency departments. Proposals should include one or more of the following elements from the "Crisis Now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention:

- Crisis Call Center & "Air Traffic Control" Services
- Community-Based Mobile Crisis Teams
- Short-term, "sub-acute" residential crisis stabilization programs

Proposals may also include funding requests for additional behavioral health crisis wrap around services that are intended to bolster the likelihood of a positive impact in the Regional Partnership's geographic service area. Proposals must detail how the wrap around services will align with and/or enhance the Crisis Now action plan elements.

Measuring Impact

Regional Partnerships that are awarded funds will be responsible for achieving HSCRC defined scale targets as a condition of grant continued funding. If scale targets are not achieved, the HSCRC may discontinue funding for the Regional Partnership. Appendices A-C represent *a preliminary list* of the scale targets and metrics that will be required for reporting. The final scale targets, metrics, and reporting requirements will be issued following the award process for each Regional Partnership. At that point, Regional Partnerships may opt to decline funding if they do not agree with newly added scale targets. Scale targets are pre-determined targets that Regional Partnerships will need to achieve during the grant period in order to receive continued funding. The targets will be set from data, such as claims, so that progress can be independently verifiable and objectively measured between Regional Partnerships. Regional Partnerships will *not* be accountable for a specific total cost of care savings goal during the grant period, but will instead be held accountable to achieve scale targets. For Regional Partnerships that opt to include wrap around services in their proposals, the Regional Partnership will still be accountable to achieve all established funding stream scale targets for core grant services (National DPP, DSMT, and Crisis Now behavioral health crisis services). Additionally, Regional Partnerships will also need to achieve the HSCRC defined scale targets set for wrap around services.

Eligibility Criteria

Maryland hospitals that have global budgets established under the rate-setting authority of the HSCRC are eligible to apply for the Regional Partnership Catalyst Grants. Proposals for a competitive Regional Partnership Catalyst grants may be submitted by:

- Multiple hospitals as lead applicants
- An individual hospital participant from a Regional Partnership as a lead applicant applying on behalf of a Regional Partnership

A hospital may participate in multiple Regional Partnership Catalyst Program proposals. There is no limit to the number of Regional Partnership Catalyst Grant Program proposals that any one hospital may join. Where a hospital is participating in multiple Regional Partnerships however, each proposal will need to demonstrate how the hospital plans and resources are distinct from one another. The maximum total dollars that may be awarded to an individual hospital is 0.75 percent of its FY 2020 approved net patient revenue plus markup whether the hospital participates in one or multiple Regional Partnership Catalyst Program proposals.

To be eligible for consideration, all proposals must include details about collaborating organizations that will be part of the Regional Partnership Catalyst Program. Details about arrangements for resource sharing, financial payments, and/or in-kind support must be disclosed in the proposals. Specifically, the proposal should clearly detail how resources, funds, or in kind support will flow to all partners. Proposals that include broad and meaningful partnerships and diverse approaches to engaging communities in implementing National DPP, DSMT, Crisis Now, and/or wrap around activities will receive higher points when scored than proposals that do not have strong collaboration models.

Competitive Regional Partnership Catalyst Grant Program awards are intended as an add-on to approved hospital rates. If awarded, enhanced reporting will be expected. Activities will be monitored and measured to demonstrate how funds have been used and to show the impact that the related programs and interventions have on diabetes and behavioral health metrics as well.

Proposal Requirements

Proposals must be submitted before the deadline. Proposals that are late, incomplete, or in a format that does not adhere to requirements specified will not be considered. Proposals must be formatted as follows:

- Section I: "Scope of Work" – this section of the proposal should describe in detail the proposed activities for the Regional Partnership.
- Section II: "Financial Projections" – the section of the proposal should describe in detail the proposed budget

Section I: Scope of Work

The scope of work section must include the seven sections listed below.

- Sections 1-7 of the proposal must be submitted as a PDF of Microsoft Word or similar formats and may not exceed 25 pages.
- Section 8 (Implementation Work Plan) must be submitted as a PDF of Microsoft Excel or a common project management software, such as Microsoft Project.

1. Summary of Proposal (3 Pages)

Regional Partnerships are required to summarize their proposal using the standard template in Appendix D for the required summary format table. Complete one summary table for each proposal submitted (e.g., one table for diabetes and one table for behavioral health crisis services).

2. Target Population

This section must define the geographic scope of the model via a comprehensive list of the ZIP codes and hospitals included, as well as counties and incorporated cities. Additionally, data and a corresponding narrative should be used to describe the health needs that the proposed activities will address within the proposed geographic area.

3. Proposed Activities

This section must include a description of the proposed model(s) to be implemented or expanded. The description should include information on the target patient population(s), the services and/or interventions the patients will receive, and the role of each participating partner in the program or intervention. This section should also describe the planning, foundation building (e.g., technology, workforce, delivery model, etc.), and outreach strategies that will be included in the proposed activities. The discussion of the proposed model should be very specific and describe the planning, implementation, and monitoring of all elements of the proposed model.

4. Measurement and Outcomes

HSCRC will work with CRISP to develop reporting tools that measure Regional Partnership progress towards scale targets. These tools will be made available to Regional Partnerships as they are developed. This section of proposals should describe additional tools the Regional Partnership will use to coordinate and measure its progress towards scale targets. This section also should describe the expected results and include baseline data and measures. Appendices A-C are a guide for types of measures that the HSCRC will use to gauge the success of the investment. In addition to high level goals that the applicants are pursuing, program-specific measures should be proposed by applicants. Applicants should provide the evidence basis for their approach.

5. Scalability and Sustainability

This section should detail how the intervention/program is sustainable after the grant period expires and funding is discontinued. Plans for funding an expansion of the program/intervention if it proves successful should also be described. The partners should demonstrate a commitment to sharing resources and addressing alignment of payment models on an ongoing basis.

6. Participating Partners and Decision-Making Process

This section should include a list of the participating entities and the roles they will play in the Regional Partnership's plan using the template in Appendix E. Additionally, this section should also include a description of a shared decision making process that incorporates the perspectives of all partners. If a formalized governance structure will be used, it should be described in this section. This section should describe the roles and responsibilities for

partnering organizations and the proposed funding for each.

7. Implementation Work Plan (no page limit to this non-narrative section, must be submitted as a PDF of Microsoft Excel or a common project management software, such as Microsoft Project)

This section should clearly describe how different initiatives will move from a planning to implementation phase, including when the intervention(s) will begin.

Section II: Financial Projections

1. Budget

Proposals must include a complete and comprehensive line item projected budget using the format in Appendix F to specify expected expenses and how funds, resources, and/or in-kind support will be distributed and flow to collaborating hospitals, providers, community-based organizations (CBOs) or other collaborating organizations. If more than one hospital applies as a lead applicant, the proposal and budget must clarify if:

- Each of the lead hospitals will receive an increase in rates to generate the funds to be shared in accordance with a proposal; or
- One of the collaborating hospitals will receive an increase in rates to be shared with the other collaborating hospitals.

Awarded funds will be issued to hospitals through rate orders, beginning in January 2021, with all funding expiring December 31, 2025. The proposed budget is expected to demonstrate the applicant's ability to execute the described scope of work to the extent practicable, within the grant period. For each year awards are made, it is expected that funds will be expended within twelve months of fund issuance. Budget projections should be based on no rollover of funds. Rollover of funds from one grant year to another grant year will not be allowed and unused funds, as determined through HSCRC staff audits, will be retracted through rates by HSCRC. Funds can only be used for planning, capital expenditures, implementation, service delivery and operating expenses related to the population health priority areas. The HSCRC reserves the right to terminate an award at any time for what it considers to be material lack of performance, (i.e. failure to achieve scale targets), or for its determination that a participating hospital is not meeting the letter or intent of an application as approved. If the HSCRC determines that a hospital has used award funds in a manner inconsistent with the approved proposal, the Commission may require repayment of those funds inappropriately used.

Examples of ineligible expenses are described in Appendix G.

2. Budget and Expenditures Narrative (no more than 3 pages)

Proposals must include a brief narrative justifying the expenses included in the line item budget. This section of the proposal should also include the percentage of the total investment of the program covered by the award and the source of any other funding that may apply to

support the proposed activities. Investments included in the budget should have the potential to impact the population health priority areas within the communities that each regional partnership serves. Additionally, investments included in the budget are expected to be data driven and able to be evaluated using measurable outcomes.

Evaluation Process

An evaluation committee formed by the HSCRC will review and score the grant proposals for both core and wrap around services. Additionally, the HSCRC will engage key subject matter experts with diabetes prevention/management and behavioral health crisis management expertise to assist in the review and evaluation of grant applications. The HSCRC will make awards based on applications received and will determine how funds are dispersed. This means that:

- Determinations by the evaluation committee are not subject to appeal;
- The evaluation committee may suggest alterations to the scope or amount of a proposal during the process; and
- The evaluation committee may require an applicant to alter a proposal or proposals to come into compliance with the award limitation described above.

After the evaluation committee process is complete, HSCRC staff will present a recommendation on award funding to HSCRC Commissioners who will approve final funding determinations. Commissioners may adjust the funding recommendations, at their discretion.

Evaluation Criteria

Applications will be reviewed and funding awarded based on the following criteria:

1. **Alignment with TCOC Model goals and population health priorities –** The potential for the proposed activities to achieve the scale targets in Appendices A-C.

2. **Widespread Engagement & Collaboration** – The extent to which community organizations with the ability to influence health in the priority areas have been engaged meaningfully through financial arrangements, resource sharing, and/or in-kind support.

3. **Evidence-Based Approaches** - Whether the proposed activities are well-conceived, evidence-based, and appropriately propose how to implement the investments in an efficient and effective manner to address the population health priority areas.

4. **Outreach and Engagement Approaches –** The degree to which effective healthcare consumer engagement strategies have been incorporated into the proposal with targets and measures. Approaches that will integrate input and feedback from diverse consumers, patients, clients, families, and caregivers into the outreach and education approach.

Outreach and engagement activities that directly engage consumers, patients, clients, families, and caregivers and lead to their improved understanding of disease prevention/health promotion, health conditions, access to resources and services, treatment options, medicines, devices, and other treatments , self-care, disease management, and personal responsibility for healthcare costs.

5. **Innovation** - The extent to which the proposed activities innovatively use health information technology (telehealth, electronic health records, health information exchange, etc.), community resources (community health workers, promotoras, peer recovery specialists, and other "helpers" and facilitators) to improve care and engage patients. The extent to which the proposed activities supports alignment and the use of information across partners in the regional partnership with the goal of improving the delivery of care in a manner that achieves the scale targets outlined in Appendix A-C.

6. **Sustainability Plan** - The extent to which the Regional Partnership has identified criteria to determine the effectiveness of proposed activities, long term costs, and alternative funding strategies in order to be successful beyond the five-year grant period.

7. **Implementation Plan** - Level of detail and feasibility of implementation plans including governance model to enable partners to work together effectively.

8. **Budget** - The reasonableness and adequacy of the proposed budget. A clear description of how awarded funds will be disbursed to organizations included in the proposal consistent with existing law.

Resources Available to All Hospitals

In an effort to support hospitals during the process of establishing their plans for Regional Partnerships, HSCRC will assemble resources and provide answers to frequently asked questions on the HSCRC website at: https://hscrc.maryland.gov/Pages/regional-partnerships.aspx. Additionally, during the RFP planning period, Regional Partnerships may opt to receive one-on-one technical assistance from HSCRC staff on RFP questions and proposal planning (on a limited basis for each proposal). To arrange technical assistance calls, contact:

Erin Schurmann
Center for Payment Reform & Provider Alignment
Maryland Health Services Cost Review Commission
Phone: 410.764.2577
Email: erin.schurmann@maryland.gov

Additional questions about the Regional Partnership Catalyst Grant Program may be submitted via email to hscrc.rfp-implement@maryland.gov.

Appendix A – Scale Targets Diabetes Prevention Program

General Philosophy: Developing access to the National Diabetes Prevention Program Lifestyle Change Program (National DPP) is an evidence-based intervention that will help the State achieve savings under its outcomes-based credit and by improving population health. The scale targets to support this program's development will focus on ensuring that new National DPP programs are being established and scaled to meet the needs of Maryland's population living with prediabetes. Therefore, the scale targets are not only focused on development of new services, but also recruitment of patients, retention and success of program participants. This multi-faceted approach will ensure that successful and sustainable programs are established through Regional Partnerships (RPs). The targets are intended to incentivize an all-payer approach, though will only be measured Medicare and Medicaid claims due to data limitations. Some targets repeat in two years to incent improvement and gradation of different focuses as RPs develop; for example, there is an enrollment target in both years three and four to continue focus and incent improvement in key metrics. Of note, targets are dependent upon one another and to meet future targets RPs should consult the estimated progression of referral, enrollment and completion outlined in Table 1 below. To facilitate reporting, HSCRC will work with CRISP over CY2020 to develop a reliable referral system and tracking mechanism for Regional Partnerships. The scale targets have been developed in consultation with National DPP experts, the State Medicaid program and existing National DPP programs within Maryland.

Regional Partnership funding intended to support wrap-around National DPP services will also be held to these scale targets since they are intended to optimize and support National DPP development. The scale targets are based on a relatively small prevalence rate of adults living with prediabetes (10.5 percent of adults) and therefore money accepted for direct National DPP services and wrap around services for optimizing National DPP should still have a measurable impact on National DPP claims.

Table 1. Expected Statewide National DPP Progression[1]

Regional Partnership Funding Year	Year 1	Year 2	Year 3	Year 4	Year 5
% of Population with Prediabetes in RP Service Area Referred to a National DPP	0%	10%	20%	30%	40%
Enrollment Rate of Referred Population	0%	5%	10%	20%	30%
% of Population with Prediabetes in RP Service Area Enrolled in National DPP	0%	0.5%	2%	6%	12%
Completion Rate (per Scale Target) of Referred Population	0%	10%	20%	35%	55%
% of Population with Prediabetes in RP Service Area Completing a National DPP	0%	0.1%	0.4%	2.1%	6.6%

Overall Methodology:

1. RP Submits Participating Hospitals for Funding Stream Interventions
2. HSCRC Establishes Baseline Population in the RP Zip codes
   a. National DPP Services – The prediabetes population as established by multiplying the statewide prediabetes prevalence average from the BRFSS adult estimate by the cumulative adult (ages 18+) population across an RP's selected zip codes. [2]
3. HSCRC Applies Evidence-based target to Baseline population (See Table Below)
4. HSCRC Establishes a target percentage for each Year of funding
5. HSCRC will report ongoing performance on all measures for RP tracking, targets will not change year over year

[1] https://ama-roi-calculator.appspot.com/
[2] https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/BRFSS_BRIEF_2016-10_Prediabetes.pdf

RP Year	*Target*[3]	*Logic*	*Numerator*	*Num. Data Source*	*Denominator*	*Den. Data Source*	*Evidence-Based Target*
National DPP and Wrap Around National DPP Services Scale Targets Years 1-5							
1	At least 1 Preliminary, Pending or Full CDC-Recognized Program in service area with a LOS indicating Qualification in a Payment Program (MDPP or Medicaid)	In order to meet the following targets, RPs will need to ensure their National DPP partners are established or programs are in the CDC recognition process in year one.	N/A	N/A	N/A	N/A	Evidence-base indicates that establishment of services is possible within one year of operation.[4]
2	REFERRALS through CRISP	Determine if patients are being offered program and ensure outreach is growing and there is a strategic efficiency to moving beneficiaries into the program	Total participants referred through CRISP to a participating National DPP provider across all payers within the RP jurisdiction	CRISP	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[5] **AND** U.S. Census Bureau Adult population by zip[6]	10%[7]
3							20%[8]

[3] CPT codes for measurement are indicated in parenthesis, when applicable.
[4] Rehm CD, Marquez ME, Spurrell-Huss E, Hollingsworth N, Parsons AS. Lessons from Launching the Diabetes Prevention Program in a Large Integrated Health Care Delivery System: A Case Study. *Popul Health Manag*. 2017;20(4):262–270. doi:10.1089/pop.2016.0109. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5564042/
[5] 10.5 percent as of 2014 Survey. https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/BRFSS_BRIEF_2016-10_Prediabetes.pdf
[6] https://data.imap.maryland.gov/datasets/eb706b48117b43d482c63d02017fc3ff_1
[7] https://ama-roi-calculator.appspot.com/
[8] Nhim K, Khan T, Gruss SM, et al. Primary Care Providers' Prediabetes Screening, Testing, and Referral Behaviors. *Am J Prev Med*. 2018;55(2):e39–e47. doi:10.1016/j.amepre.2018.04.017 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6241213/

3	ENROLLMENT *Medicare*: Submit claim for first session (G9873), OR Submit claim for Bridge Payment (G9890) *Medicaid*: G9873, E1639, or 0488T	To measure if enrollment is increasing in both Medicare and Medicaid programs, at least one claim for a National DPP service should be viewable in State data.	Medicare claims for a first session or bridge payment **AND** Medicaid claims for a first session (in-person or virtual) or milestone 1 (virtual)[9]	Medicare CCLF Medicaid Claims	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[4] **AND** U.S. Census Bureau Adult population by zip[5]	2%[6]
4							6%[6]
4	RETENTION *Medicare:* Submit claims indicating 9 core sessions attended (G9875) *Medicaid:* Sessions 5-9 retention (G9875) and Milestone 3 (G9875)	A successful National DPP program will keep beneficiaries as long as possible within a year of enrollment to ensure they have the best outcomes and benefit of the program.	Medicare and Medicaid claims indicating 9 core sessions or milestone 3	Medicare CCLF Medicaid Claims	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[4] **AND** U.S. Census Bureau Adult population by zip[5]	2.1%[6]
5							12.4%[6]

[9] Note: The Medicaid reimbursement structure contains two payment tracks for DPP services. The 'Session and Performance-Based Payments' track accommodates both in-person and virtual DPP providers and closely mirrors the MDPP (Medicare) payment schedule. The 'Milestone-Based Payments' track was built to accommodate virtual providers and aggregates payments into lump sums for certain timepoints/length of participation in the program. For more information, please contact Maryland's Medicaid administrators.

5	OUTCOMES *Medicare:* Submit codes indicating 5% or 9% bodyweight loss achieved or maintained (G9878, G9879, G9880, G9881) *Medicaid:* Bill any form of 5% or 9% bodyweight loss Reimbursement (G9878, G9879, G9880, G9881)	National DPP is an outcomes-based payment and sustainable RP programs will need to ensure they can show beneficiaries lose weight in their program for maximal reimbursement and return.	Medicare and Medicaid claims indicating 5% or 9% bodyweight loss.	Medicare CCLF Medicaid Claims	Adult population with prediabetes in RP service zip codes	BRFSS Prevalence[4] **AND** U.S. Census Bureau Adult population by zip[5]	1.8%[10]

[10] Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, et al. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study [published correction appears in Lancet. 2009 Dec 19;374(9707):2054]. *Lancet*. 2009;374(9702):1677–1686. doi:10.1016/S0140-6736(09)61457-4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022/

Appendix B – Scale Targets Diabetes Management

General Philosophy: Impacting diabetes management care across the state will help improve population health, care outcomes and total costs of care. Diabetes education services or Diabetes Self-Management Training (DSMT) is a Medicare reimbursed intervention that can be offered in both the community and health care settings, making it ideal for the Regional Partnership structure. The scale targets for DSMT funding will initially focus on showing development and growth of DSMT to increase Marylanders' access to the services. Next, the targets will focus the RPs on retaining beneficiaries and bringing participants to benefit completion to maximize the behavior effect on those who access the program. The targets are intended to incentivize an all-payer approach, though will only be measured Medicare claims due to data limitations. Some targets repeat in two years to incent improvement and gradation of different focuses as RPs develop. Finally, diabetes outcomes will be measured from the aggregate Prevention Quality Indicator 93 (PQI93) measure for diabetic admissions developed by AHRQ.[11] While the effect of DSMT alone may be minimal on each RP's participating hospital's rate of PQI93, HSCRC staff believe that duplication with the Potentially Avoidable Utilization (PAU) reimbursement incentive policy and the all-payer application facilitates amplified hospital focus. Staff have aligned the expected reduction with the State's Diabetes Action Plan's targeted hospitalization reductions.

For wrap around DSMT services requesting RP funding, the creation of scale targets based on a common outcome presents operational and equity issues. To effectively evaluate the impact equally across RPs, HSCRC staff will again utilize the common PQI93 measure. The measure will also benefit from added hospital focus in the PAU program and will mirror that of DSMT services mentioned above.

Overall Methodology:

1. RP Submits Participating Hospitals for Funding Stream Interventions
2. HSCRC Establishes Baseline Population in the participating RP Hospitals,
    a. DSMT Services – Medicare diabetic population as determined by an ICD-10 diagnosis code for diabetes within baseline year.
    b. Non-DSMT Services -- The Medicare diabetic population as determined by an ICD-10 diagnosis code for diabetes within baseline year.
3. HSCRC Applies Evidence-based target to Baseline population (See Table Below)
4. HSCRC Establishes a target percentage for each Year of funding
5. HSCRC will report ongoing performance on all measures for RP tracking, targets will not change year over year

[11] https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V60-ICD10/TechSpecs/PQI_93_Prevention_Quality_Diabetes_Composite.pdf

RP Year	*Target*[12]	*Logic*	*Numerator*	*Num. Data Source*	*Denominator*	*Den. Data Source*	*Evidence-Based Target*
DSMT Services Funding Scale Targets Year 1-5							
1	American Diabetes Association (ADA) Accreditation	The ADA provides resources and accreditation for DSMT programs so that they may receive Medicare reimbursement, without demonstrating this progress RPs will not be successful in meeting the following claims-based metrics.	Either ADA DSMT Accreditation or a Letter of Support from an existing community partner with an accreditation.	RP Self-Report, HSCRC Audit	N/A	N/A	N/A
2	Initiation of DSMT Services *Medicare*: At least one claim for DSMT (G0108 or G0109)	Initiation of DSMT must reach a critical mass so that providers reach critical efficiency	Continuously enrolled Part A and B Medicare beneficiaries **WITH** at least one claim for DSMT services (G0108 or G0109)	Medicare CCLF	Continuously enrolled Part A and B Medicare beneficiaries **WITH** At least one ICD-10 code for indicating diabetes **WITHIN** RP Hospitals' Service Area[13]	Medicare CCLF	15%[14,15,16]
3							25%[3,4,5]

[12] Parentheses indicate CPT code for measurement in Medicare claims, when applicable.

[13] "Within RP Hospitals' Service Area" refers to inpatient and outpatient claims associated with a hospital and Regional Partnership's member hospitals.

[14] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation-Program

[15] Li R, Shrestha SS, Lipman R, et al. Diabetes self-management education and training among privately insured persons with newly diagnosed diabetes--United States, 2011-2012. *MMWR Morb Mortal Wkly Rep*. 2014;63(46):1045–1049. https://pubmed.ncbi.nlm.nih.gov/25412060-diabetes-self-management-education-and-training-among-privately-insured-persons-with-newly-diagnosed-diabetes-united-states-2011-2012/

[16] Strawbridge, L. M., Lloyd, J. T., Meadow, A., Riley, G. F., & Howell, B. L. (2015). Use of Medicare's Diabetes Self-Management Training Benefit. Health education & behavior : the official publication of the Society for Public Health Education, 42(4), 530–538. doi:10.1177/1090198114566271 https://pubmed.ncbi.nlm.nih.gov/25616412-use-of-medicares-diabetes-self-management-training-benefit/

3	Retention of Participants *Medicare:* Beneficiaries who have five or more claims for DSMT (G0108 or G0109)	For DSMT programs to have maximal impact participants must stay in the program and RPs must optimize their services to do so.	Continuously enrolled Part A and B Medicare beneficiaries **WITH** at least five claims for DSMT services (G0108 or G0109)	Medicare CCLF	Continuously enrolled Part A and B Medicare beneficiaries **WITH** At least one ICD-10 code for indicating diabetes **WITHIN** RP Hospitals' Service Area[13]	Medicare CCLF	15%[3,4,5]
4							20%[3,4,5]
5	Completion Rate *Medicare:* Beneficiaries who have ten or more claims for DSMT (G0108 or G0109)	For DSMT programs are designed to produce an outcome by the end of the benefit, which is ten sessions per beneficiary per lifetime.	Continuously enrolled Part A and B Medicare beneficiaries **WITH** at least ten claims for DSMT services (G0108 or G0109)	Medicare CCLF	Continuously enrolled Part A and B Medicare beneficiaries **WITH** At least one ICD-10 code for indicating diabetes **WITHIN** RP Hospitals' Service Area[13]	Medicare CCLF	5%[3,4,5]
5	Diabetes Outcomes PQI93 Rate by hospital participating in each RP	Impacting management of diabetes should show an impact on the outcomes for diabetes patients, especially with regards to prevention quality and admissions measured by PQI93.	Inpatient or Observation visits >= 24 hrs flagged with PQI93 **WITHIN** RP Hospitals' Service Area	HSCRC Casemix Data	Maryland adults **WITHIN** RP Hospitals' Service Area[12]	5-year American Community Survey	5% reduction[8]

Wrap Around DSMT Services Scale Targets for Year 3 and 5							
3	OUTCOMES PQI93 Rate by hospital participating in each RP	Impacting management of diabetes should show an impact on the outcomes for diabetes patients, especially with regards to prevention quality and admissions measured by PQI93.	Inpatient or Observation visits >= 24 hrs flagged with PQI93 **WITHIN** RP Hospitals' Service Area	HSCRC Casemix Data	Maryland adults **WITHIN** RP Hospitals' Service Area[12]	5-year American Community Survey	2.5% reduction[17]
5	OUTCOMES PQI93 Rate by hospital participating in each RP	Impacting management of diabetes should show an impact on the outcomes for diabetes patients, especially with regards to prevention quality and admissions measured by PQI93.	Inpatient or Observation visits >= 24 hrs flagged with PQI93 **WITHIN** RP Hospitals' Service Area	HSCRC Casemix Data	Maryland adults **WITHIN** RP Hospitals' Service Area[12]	5-year American Community Survey	5% reduction[8]

[17] Maryland Diabetes Action Plan https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspx

Appendix C – Scale Targets Behavioral Health Crisis Services

General Philosophy: Crisis Services will take time to build and scale to a measurable impact within each hospital. The HSCRC has consulted experts and literature to develop reasonable targets to ensure the impact and sustainability of funding.[18,19,20] The first three years of Regional Partnership funding will be dedicated to building crisis services and establishing efficient interventions. By the fourth year of implementing crisis services, hospitals should experience a reduction in Emergency Department (ED) boarding times as hospitals more efficiently begin diverting and referring patients to newly created crisis centers. Finally, as crisis centers become more established in the community and connect to other emergency systems like police and EMS, hospitals should experience an overall reduction in the number of repeat ED cases for behavioral health. Scale targets will be implemented to mirror this progression throughout the five years of funding. Of note, there is currently no reliable way of measuring ED boarding times for psychiatric patients. The NQF measures of OP-18c has sample size issues for Maryland, which may unreliably skew performance. Over the next year, HSCRC staff will work with CRISP to develop an ADT-based measure of ED psychiatric boarding with industry input.

Overall Methodology:

1. RP Submits Participating Hospitals for Funding Stream Interventions
2. HSCRC Establishes Baseline Population in RP Hospitals' service area
    a. Crisis Services -- BH ED Utilizers as determined by CCS logic for Substance Abuse and Mental Health Flags PLUS CCW Substance Abuse ICD-10 procedure-based codes within Casemix
3. HSCRC Applies Evidence-based target to Baseline population (See Table Below)
4. HSCRC Establishes a target percentage for each Year of funding
5. HSCRC will report ongoing performance on all measures for RP tracking, targets will not change year over year

[18] Balfour, M. E., Tanner, K., Jurica, P. J., Rhoads, R., & Carson, C. A. (2016). Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs. *Community mental health journal*, *52*(1), 1–9. doi:10.1007/s10597-015-9954-5
[19] Salkever, D., Gibbons, B., & Ran, X. (2014). Do comprehensive, coordinated, recovery-oriented services alter the pattern of use of treatment services? Mental health treatment study impacts on SSDI beneficiaries' use of inpatient, emergency, and crisis services. *The journal of behavioral health services & research*, *41*(4), 434-446.
[20] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. https://theactionalliance.org/sites/default/files/crisisnow.pdf

Crisis Services Scale Targets – Years 1-5

RP Year	*Target*	*Logic*	*Numerator*	*Num. Data Source*	*Denominator*	*Den. Data Source*	*Evidence-Based Target*
Crisis Services (Including Crisis Now and other Wrap Around Support Services) Scale Targets – Years 1-5							
1 through 3	Crisis Services Planning and Development	Each RP should show development of the Crisis Now component(s) indicated in their application	1. 5-Year Development and Business Plan for RP Crisis Services 2. MOUs with Community Partners, Member Hospitals and local emergency services (if indicated partners in business plan) 3. Crisis Protocols for Services indicated in application/award letter	RP Self-Report, HSCRC Audit	N/A	N/A	N/A
4	ED Boarding Times	As hospitals integrate Crisis Services into emergency operations, the ED wait times or boarding times for behavioral health patients should reduce.	Aggregate wait time for ED BH Cases as determined by CCS + CCW Flag Logic **WITH** An inpatient admission or observation stay	Casemix Integration with CRISP ADT Feeds	Aggregate wait time for ED BH Cases as determined by CCS + CCW Flag Logic **WITHIN** RP Hospitals	Casemix Integration with CRISP ADT Feeds	**To Be Developed with CRISP – will be released with funding notice**

5	ED Behavioral Health Repeat Utilization	Crisis Services should be established within the community for preventative ED utilization and outreach in addition to integration with other emergency services like police and EMS.	All ED BH Cases as determined by CCS + CCW Flag Logic **WITH** 3 or more ED visits in the past calendar year	Casemix	Total ED BH Cases as determined by CCS + CCW Flag Logic **WITHIN** RP Hospitals	Casemix	10% Reduction[21]

[21] Salkever D, Gibbons B, Ran X. Do comprehensive, coordinated, recovery-oriented services alter the pattern of use of treatment services? Mental health treatment study impacts on SSDI beneficiaries' use of inpatient, emergency, and crisis services [published correction appears in J Behav Health Serv Res. 2014 Oct;41(4):559]. *J Behav Health Serv Res.* 2014;41(4):434–446. doi:10.1007/s11414-013-9388-1.
https://pubmed.ncbi.nlm.nih.gov/24481541-do-comprehensive-coordinated-recovery-oriented-services-alter-the-pattern-of-use-of-treatment-services-mental-health-treatment-study-impacts-on-ssdi-beneficiaries-use-of-inpatient-emergency-and-crisis-services/?from_single_result=Do+Comprehensive%2C+Coordinated%2C+Recovery-+Oriented+Services+Alter+the+Pattern+of+Use+of+Treatment+Services%3F+Mental+Health+Treatment+Study+Impacts+on+SSDI+Beneficiaries%E2%80%99+Use+of+Inpatient%2C+Emergency%2C+and+Crisis+Services

Appendix D – Proposal Summary Template

As such, the applicants should provide short summaries with the most relevant points. Reviewers will rely on the more detailed Project Narrative for a more complete understanding of the proposal.

Hospital/Applicant:	
Hospital Members:	
Health System Affiliations:	
Funding Track:	
Total Budget Request:	

Target Patient Population
Proposed Activities

Measurement and Outcomes
Scalability and Sustainability
Governance Structure

Participating Partners and Financial Support List member hospitals/community collaborators and describe any resource sharing, financial support and/or in-kind support, if applicable.
Implementation Plan
Budget & Expenditures

Appendix E – Listing of Regional Partnership Collaborators

Please complete the following table for each Regional Partnership Collaborator. Create more tables, as necessary.

Name of Collaborator (1):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Name of Collaborator (2):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Name of Collaborator (3):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Name of Collaborator (4):	
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type and Purpose of Resource Sharing arrangements, if any	
Roles and Responsibilities within the Regional Partnership:	

Appendix F - Budget Template

Hospital/Applicant:	
Regional Partnership Members:	
Funding Track:	
Total Budget Request:	

Workforce/Type of Staff	**Description**	**Amount**
IT/Technologies	**Description**	**Amount**

Wrap Around Services (that are not captured above)	**Description**	**Amount**
Other Indirect Costs	**Description**	**Amount**
Total Expenses & Investments		

Appendix G – Examples of Expense Not Covered

Examples of expenses that will not be covered under the Regional Partnership Catalyst Grant Program include:

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for diabetes and/or behavioral health activities.
- Investments to improve coding or documentation, including upgrades to systems to be compliant with regulatory changes such as ICD-10.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- CRISP participation fees other than specific projects not otherwise available to all CRISP users.
- Any expenses for physicians that do not clearly related to diabetes and/or behavioral health crisis services (i.e., expenses for acquiring existing physicians that does not result in any change in access but simply results in the existing physicians being owned by the hospital).
- Any expenses that are primarily for marketing purposes unless these are specifically related to diabetes and/or behavioral health crisis services.
- Accreditation fees.
- Financial rewards to providers (e.g., pay-for-performance incentives). Programs however may use ROI for provider gain sharing and pay-for-performance incentives that are consistent with legal requirements.
- All other expenses that do not fall under the intent of the grant program.