



MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Behavioral Health Administration

Barbara J. Bazron, Ph.D.


Deputy Secretary/Executive Director

55 Wade Ave., Dix Bldg., SGHC

Catonsville, MD 21228

MEMORANDUM

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

From: Barbara J. Bazron, Ph.D. 
Deputy Secretary, Behavioral Health

Date: April 1, 2019

RE: Request for Proposals (RFP) to Establish Behavioral Health Crisis
Services (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, dedicated funding for Fiscal Year 2020 of \$3,000,000 has been identified to create services that provide access or linkages to treatment through mobile crisis teams, crisis walk-in services 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. Additionally, the term "behavioral health" should be defined in each applicant's proposal to ensure consistency in language. 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, and the proposal should demonstrate how the applicant will implement the BHA mission via the proposed plan.

All proposals must be submitted electronically to the LBHA, CSA, or LAA or by e-mail to mabha@mhma.net and received no later than **Monday, April 22, 2019 by 5:00 PM**. The following website provides the contacts for the LBHA, CSA or LAA in each jurisdiction. <https://marylandbehavioralhealth.org> The LBHA, CSA or LAA should submit approved proposals to BHA no later than **Friday, May 17, 2019 by 5:00 PM** to crisiscenter.rfp@maryland.gov

Upon selection by 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 robust crisis response system. If you have any questions, please email crisiscenter.rfp@maryland.gov

cc: Marian Bland
Darren McGregor
Lisa Morrel
Fran Phillips
HB Workgroup

Maryland Department of Health (MDH)
Behavioral Health Administration (BHA)
Behavioral Health Crisis Response Grant Program
Request for Proposals (RFP)

Mobile Crisis Team, Crisis Walk-in Center or Residential Crisis Services

Issue Date: **Monday, April 1, 2019**

Requesting Agency: Maryland Department of Health
Behavioral Health Administration
55 Wade Avenue, Dix Building
Catonsville, MD 21228

**Provider Proposals Due Date to
Local Behavioral Health Authority
(LBHA)/Core Service Agency (CSA)/
Local Addiction Authority
(LAA):** **Monday, April 22, 2019**

LBHA/CSA/LAA Deadline to BHA: Friday, May 17, 2019

BHA Point of Contact: Lisa Morrel or Darren McGregor
Behavioral Health Administration
Email: lisa.morrel@maryland.gov
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, 2019 through June 30, 2021.

Dedicated funding for Fiscal Year 2020 of \$3,000,000 has been identified to create services that provide access or linkages to treatment through mobile crisis teams, crisis walk-in services or 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 service

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 response 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

The Behavioral Health Crisis Response Grant Program workgroup is being 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 or residential crisis beds, and the implementation of mobile crisis teams. In order to support the continued expansion of crisis services, the Maryland Department of Health (MDH) has convened a workgroup to develop a crisis response grant program to allocate funding to eligible jurisdictions. 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 has established: (1) application procedures, and is working to establish (2) a statewide system of outcome measurements, (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 measurement 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
- University 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:

Mobile crisis teams, walk-in crisis services, and crisis residential beds that: (i) serve local behavioral health needs for children, adolescents, transition-age youth, adults, and/or older adults; (ii) meet national standards; (iii) integrate the delivery of mental health and/or substance use treatment; and (iv) connect individuals to appropriate community-based care in a timely manner upon discharge.

Crisis Response System:

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 seeks to stabilize the individual for referral to continuing care.

Residential Crisis Services (RCS):

RCS are short-term, intensive behavioral health (mental health, substance use, and co-occurring) and support services for children, adolescents, and adults in a community-based, non-hospital, residential setting rendered by a provider. Maryland Law (COMAR 10.63.04) clearly states standards for mental health treatment for settings with residential crisis beds. Services are provided to prevent an inpatient admission, to provide an alternative to inpatient admission or to shorten the length of inpatient stay. RCS may also be provided in a treatment foster care model. A provider serving adults shall be approved at the alternative mode for Residential Crisis Services. 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 Services:

24/7 walk-in services are defined as direct services that assist with the de-escalation of a person's behavioral health crisis. As appropriate, 24/7 access to a safe environment with assessment, diagnosis, and treatment capability may provide possible diversion from emergency department admission, police/incarceration, or out of home treatment intervention. Anyone experiencing a behavioral health and/or substance-related crisis is eligible for acceptance regardless of age,

insurance status, ethnic, cultural or linguistic preference including the use of a language interpretation or support from a certified ASL interpreter. 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 a central point from which to organize the jurisdiction's array of crisis services and deploy services such as Mobile Crisis Teams (MCT) as needed.

Mobile Crisis Team:

A Mobile Crisis Team consists of a 2-person team that provides face-to-face services delivered in community setting where the individual lives, works and/or socializes. If a two-person team responds, the second person may be a case manager or a peer/family support provider, provided he/she has supervision and training as currently required for all mobile team members. Mobile Crisis Services are provided by established mobile crisis teams.

MCT is defined as community-based mobile crisis services that 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. A multi-disciplinary team, including peer support workers, 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.

Co-Occurring Capable:

Treatment programs that are Co-Occurring Capable (COC) are those that "address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (The ASAM Criteria 2013, p. 416.).

IV. General Requirements:

A. Application Process: BHA is soliciting proposals from Local Behavioral Health Authorities (LBHAs), Core Service Agencies (CSAs), Health Departments, Local Addiction Authorities (LAAs) and notn-profit providers who are interested in implementing a mobile crisis team, a walk-in crisis services, or residential crisis beds, that establishes and/or enhances the behavioral health crisis services array.

There is a two-step process where local organizations submit applications to their Local Authority. The LBHA/CSA/LAA will identify interested providers through their local procurement process. All provider proposals must be reviewed and approved by the LBHA/CSA/LAA who will then submit approved proposals to BHA. Providers selected must meet the eligibility criteria described below and receive a score greater than 70 to be considered for funding. The Local Authority may submit one proposal demonstrating how crisis services are coordinated within the jurisdiction. If the local authority is seeking to be a grant recipient, all proposals, including non-profit providers from that jurisdiction, must be submitted to BHA for review and evaluation.

B. Overview: In accordance with this solicitation, 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 providers and community organizations will develop a proposal which designs a system for individuals in crisis to access immediate treatment of mental health and substance disorder related crises. Additionally, they will develop appropriate triage process and any protocol required for EMS to transport to the Center and Mobile Crisis Team as an alternative to the ED. A detailed medical screening protocol is required to support this process.

Crisis services will be co-occurring capable, provide a welcoming, hopeful, and respectful environment for both individuals who are transported and those who walk in. This service is expected to be open seven days a week, between 18 and 24 hours a day and will have the capacity to serve an identified number of individuals at one time. The proposal should include a response to these criteria.

Admission will be voluntary, and any person brought to the facility or receives mobile 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 providers and community organizations. Applications should detail these partnerships and provide letters of support and/or MOUs with proposed project partners.

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

D. Expected Environment:

Crisis services shall be responsive to local needs and integrated into the behavioral health crisis care system. The goal is to 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 shall create a hopeful, respectful environment that provides supports and services that:

- Seeks to reduce harm for the individual, family, and community
- Is responsive to trauma and care is trauma informed
- Is culturally aware and linguistically competent (Limited English Proficiency, Deaf and Hard of Hearing)
- 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 Services: The scope for this project is to develop a coordinated, comprehensive crisis response system that includes a Mobile Crisis response, Crisis Walk-in services, or Crisis Residential Beds that responds to local/regional needs. Services should also be grounded in a public health framework, recovery-oriented, sustainable, and integrated into the acute behavioral health crisis care system. The following objectives for the project may be included in the scope of services:

- The implementation/expansion of new mobile crisis services that support the continuum of care
- 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 law enforcement-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 for substance use disorders. medication assisted treatment 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 medication-assisted treatment.

- 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.

F. Target Population: The eligibility criteria for behavioral health crisis services are:

Individuals or families who self-report that they or their children are in crisis. Crisis is defined by the individual or family. The goal is to reach individuals who are at high risk of instability in the community to include immediate injury due to a behavioral health crisis. The intent is to meet individuals where they are currently, access care their clinical/support needs and provide immediate, safe, community-based, peer-driven services. Direct linkages to ongoing care should be made to ensure meaningful and lasting connections that will lead to improved treatment outcomes. For children/youth and their respective families, a crisis response may be required due to their inability to attend school 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 application for this service 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 building, 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 opened, 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. **The applicant should describe the staffing patterns, staffing schedules and hours of operation of the Center** including on-call

services designed to respond to the individual's immediate needs when the center is closed and to coordinate on-going services.

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, when 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 Services:

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 a 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.

Crisis Walk-in services will be housed in a facility that will be staffed 18 to 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 Response:

Mobile Crisis Response includes:

- Screening;
- Assessment;
- Crisis Stabilization;
- Counseling;
- Linkage to urgent care or on-going services at behavioral health outpatient centers and other appropriate services; and,
- Accompanying the individual in crisis to hospital emergency room and assisting in appropriate disposition when clinically indicated.
- Promote and staff a 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, etc.) Mobile crisis services are to be provided by two-member teams, credentialed, privileged staff, and must be available to staff three (3), eight (8) hour shifts per day, seven (7) days a week, including holidays. If a 24 hour service is not warranted, the service must describe how crisis will be addressed during the off hours (e.g. on-call hours).

The provider of the Mobile Crisis Team 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. The provider of the Mobile crisis services must participate in a Crisis Response Task Planning Group, which will be chaired by the CSA.

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 within walk-in crisis center
- 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 key partners, including the local community hospital, to implement a 24/7 integrated, regional behavioral health crisis model. Services will be coordinated and co-located with the County Health

Department, Crisis Hotline, and the Mobile Crisis Team

Additionally responses for children and families should align with these best practice principles:

- 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 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 supports, not just clinical interventions. The stabilization service can be provided for up to 8 weeks.

MRSS goals 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.
- There is a distinction between the Response Service component (up to 72 hours) and the Stabilization Service component (up to 8 weeks) but they must be connected.
- Initial Response requires an identified Crisis Assessment, Crisis Needs Assessment and Safety Planning tools to be implemented.
- 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 MRSS 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 of information to be used to monitor program performance and outcomes. All successful applicants will be required to support the following: monthly program summary reports, monthly financial reports and the client-level data on designated clients. The specific data collection protocol and instructions will be provided to all successful applicants after receipt of an award. The entity (LBHA, CSA, LAA) contracted with BHA to monitor the grant will be responsible for having the data collected and submitted to BHA.

Monthly Program Summary Reports:

The selected applicants will be required to submit program reports during the entirety of the approved contract term. Monthly program summary data will be submitted to BHA, 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 (i.e., Mental Health, Substance Use Disorder or Co-Occurring), counts by other demographic and service information, and service outcomes. The Behavioral Health Administration will work with 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 may 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 BHA 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 applicants will be required to participate in all monitoring and evaluation activities.

The Center and/or Mobile Crisis Team 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, LAA, or LHD. Non-profit agencies are eligible to apply. Applications must meet all criteria outlined below to be considered eligible to be considered through this RFP process:

- Certification as a Medicaid provider, with the ability to access reimbursement by billing Beacon Health Options 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 access reimbursement for behavioral and somatic health care services from Medicaid and private insurance companies.
- 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.
- Special consideration will be given to jurisdictions able to link multiple behavioral health crisis services; jurisdictions providing specialty services to children, youth and transition-aged youth; jurisdictions with established partnerships working to support social determinants of health; and jurisdictions demonstrating the greatest need for behavioral health crisis services.

B. Proposal Timeframe, Submission, Contact and Term:

1. Timeline

Issue Date:	Monday, April 1, 2019
Proposal Due to LBHA/CSA/LAA:	Monday, April 22, 2019
Approved Provider Proposals due to BHA:	Friday, May 17, 2019

2. Proposal Submission and Location

All proposals must be submitted electronically to the LBHA, CSA, or LAA by e-mail to mabha@mhma.net and received no later than **Monday, April 22, 2019 by 5:00 PM**. The following website provides the contacts for the LBHA, CSA or LAA in each jurisdiction. <https://marylandbehavioralhealth.org>

If the local authority is seeking to be a grant recipient, all proposals, including non-profit providers from that jurisdiction must be submitted to BHA for review and evaluation.

Selected provider proposals must be submitted electronically to BHA by email by **Friday, May 17, 2019 by 5:00 PM** to crisiscenter.rfp@maryland.gov by attaching one or more PDF files. **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 is Lisa Morrel or Darren McGregor, whose contact information is listed below.

Lisa Morrel
Behavioral Health Administration
Office of Crisis and Criminal Justice Services
Email: lisa.morrel@maryland.gov
Phone: 410-402-8338

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

4. Anticipated Initial Service Term: One (1) year with annual options to renew pending available funding, performance, outcomes, utilization, etc.

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 applicant through this RFP process. MDH-BHA will enter into a contract with selected applicant following the notification of award. Any selected applicant must comply with all terms and conditions applicable to the contract executed by MDH-BHA.

D. Contract Requirements:

1. Mobile Crisis Team, Crisis Walk-in Services 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 Behavioral Health Administration 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 request for grant funding. The applicant must meet the minimum requirements per the risk assessment tool.

F. Proposal Format: (Please read carefully)

Proposals, not to exceed ten (10), **single-spaced pages** using twelve (12) point Times New Roman font, shall be submitted by the governing body of a jurisdiction or its designee.

Proposals exceeding the 10-page limit will not be considered. Two or more jurisdictions or their designee can join together and submit a single, integrated proposal. **Responses must be ordered and answered to match the evaluation criteria 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.

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. overdose deaths, suicides, psychiatric inpatient stays] 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 Response
 2. Voluntary Walk-in Crisis Center
 3. Crisis Stabilization Center

2. Submit a clear and concise narrative of what the program will deliver. **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 a mobile crisis team, crisis walk-in or crisis residential beds:
 - Experience working with individuals who are Medicaid eligible and/or are uninsured.
 - Prior or current experience in providing behavioral health related crisis services.
 - Jurisdictional efforts to continue developing the crisis continuum of care.
 - Jurisdictional efforts to develop a comprehensive integrated system of care.
 - 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.**
2. 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**
3. 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**
4. 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**
5. 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**
6. Description of the administrative process including sub-grantee monitoring of contract deliverables, contracting for Mobile Crisis Team, Crisis Walk-in Services or Residential Crisis Beds, 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 Team, Crisis Walk-in Center, and Residential Crisis Services to the LBHAs, CSAs, and LAAs.

I. Closing/Submission Date and Location

Providers will submit proposals to the LBHAs/CSAs/LAAs by **Monday, April 22, 2019 by 5:00 PM**. The following website provides the contacts for the LBHAs/CSAs/LAAs in each jurisdiction. <https://marylandbehavioralhealth.org>

LBHAs/CSAs/LAAs shall submit vendor selection and request for grant funds to BHA by email: by **Friday, May 17, 2019 by 5:00 PM**.

Any questions regarding this solicitation should be submitted electronically by email: crisiscenter.rfp@maryland.gov by **Monday, April 15, 2019**.

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