STATE OF MARYLAND
Community Health Resources Commission
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Coordinated Community Supports Partnerships

Grants to Service Providers

August 2023 Call for Proposals

August 18, 2023

Coordinated Community Supports Partnerships Call for Proposals

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I. BACKGROUND

America's youth are experiencing a behavioral health crisis. In a recent report, the Centers for Disease Control and Prevention (CDC) stated that young people in the United States are "collectively distressed." The CDC's most recent Youth Risk Behavior Survey (YRBS) found that 42% of high school students experience persistent feelings of sadness or hopelessness so severe, they did not engage in their usual activities for at least two consecutive weeks. Every racial and ethnic group surveyed reports experiencing these feelings at a higher rate than they had reported in the past. The YRBS results indicate a significant increase in the percentage of respondents who reported seriously considering suicide, making a suicide plan, or attempting to commit suicide, particularly for Black, female, and LGBTQ+ students.

The YRBS also reveals disturbing disparities related to race, gender, and sexual orientation. For instance, 57% of female students report persistent feelings of sadness or hopelessness and 69% of LGBTQ+ students report such feelings. Meanwhile, more Black, Hispanic, and White students are seriously considering suicide than other groups. More than half of LGBTQ+ respondents reported the same. Black, female, and LGBTQ+ students reported a higher rate of attempted suicide as well.

While statistics show consistently increasing student mental health struggles over the last 10 years, the COVID-19 pandemic exacerbated the problem. According to the U.S. Surgeon General, 25% of youth are experiencing depression-like symptoms and 20% have been experiencing anxiety-like symptoms since the pandemic began. Hospital emergency departments have admitted and treated 51% more young girls suspected to have attempted suicide compared to pre-pandemic rates. These negative trends have been especially evident among American Indian, Alaska Native, Black, Latino, Asian, Native Hawaiian, Pacific Islander, and LGBTQ+ youth.

Mental health challenges do not exist in a vacuum. Often mental wellness is a consequence of a person's school and home environments. For example, groups who report higher rates of sadness, hopelessness, and/or suicide attempts, such as LGBTQ+ students and Black students, were more likely to report experiencing unstable housing within the past year. Demographic groups who report fewer negative mental health experiences, such as male, White, and heterosexual students, tended to report higher rates of school connectedness than disparately impacted groups.

In 2021, the U.S. Surgeon General released an advisory report outlining actions that can be taken to reverse the rising tide of poor mental health among students. The report recommended empowering youth to ask for help, support others, and care for themselves. According to the report, schools can contribute to this mission by creating positive, safe, and affirming environments for their students; expanding social and emotional learning programs; recognizing changes in mental and physical health; providing a continuum of supports for mental health needs; promoting enrollment in and retainment of health coverage that includes

behavioral health services; expanding the mental health workforce; and protecting and prioritizing students with higher needs and risks.

Schools are an ideal place to deliver a Multi-Tiered System of Supports (MTSS) and services that promote mental health and prevent and address mental health challenges in youth. Delivering supports and services in schools meets students where they are. Schools are well-positioned to promote well-being and mental health for all students by fostering positive school climate, providing mental health literacy for staff and students, and developing social emotional skills. Prevention and early intervention can address behavioral health conditions before they develop or worsen. For students with identified behavioral health needs, offering services in schools increases the likelihood of engagement and completion of care, in part by overcoming transportation and other logistical barriers. Students whose behavioral health needs are supported are more likely to attend, engage, and perform well in school.

The Maryland Consortium on Coordinated Community Supports is a new entity responsible for developing a statewide framework to expand access to comprehensive behavioral health and wraparound services for Maryland students. The Consortium was created by the Maryland General Assembly as part of the Blueprint for Maryland's Future, Chapter 36 of 2021. It is comprised of 25 experts in the fields of behavioral health and education, and is chaired by former Delegate David D. Rudolph. A complete list of the Consortium's members can be found in Appendix B.

The Maryland Community Health Resources Commission (CHRC) serves as the Consortium's fiscal agent and is responsible for providing staff support for the Consortium. The CHRC was created by the Maryland General Assembly in 2005 to expand access to health care services in underserved communities across Maryland. The CHRC is an independent commission operating within the Maryland Department of Health (MDH), whose 11 members are appointed by the Governor. Since its inception, the CHRC has awarded 695 grants totaling $126 million, supporting programs in every jurisdiction of the state. These programs have collectively served more than 525,000 Marylanders, and grants awarded by the CHRC have enabled grantees to leverage $42 million in additional federal and private/non-profit resources.

The Consortium and its Subcommittees have been meeting regularly since the summer of 2022. All meetings are open to the public and all materials are posted on the Consortium's webpage, https://health.maryland.gov/mchrc/Pages/Maryland-Consortium-on-Consolidated-Community-Supports.aspx. The Consortium's four Subcommittees include: Framework, Design & RFP; Data Collection/Analysis & Program Evaluation; Outreach & Community Engagement; and Best Practices.

The Consortium engaged in three public outreach campaigns to receive feedback on the model and inform communities about upcoming grant opportunities. First, the Consortium held a public comment period from October 26 – November 16, 2022. Twelve questions were posed to the public addressing key issues for the design of the RFP, permissible uses of grant funding, and measures of program effectiveness. Eighty-one individuals provided detailed responses. A

summary of public comments received can be found in the Consortium's FY 2022 annual report. Consortium Subcommittees reviewed the public comments as they prepared recommendations for the development of this Call for Proposals (RFP). A second outreach period was held beginning in March 2023. Over 70 meetings have been held to date as part of this second outreach effort. These included meetings with statewide membership organizations, briefings with potential applicants, and interdisciplinary meetings with individual jurisdictions. A third public outreach effort solicited written responses to three key questions for the first Call for Proposals (RFP) and was held July 12-21, 2023. Forty-two responses were received.

As provided by statute, the National Center for School Mental Health (NCSMH) is providing technical assistance to the Consortium and CHRC. The NCSMH is housed in the Division of Child and Adolescent Psychiatry at the University of Maryland School of Medicine. It was established in 1995 by the U.S. Department of Health and Human Services, Health Resources and Services Administration to provide training and technical assistance to states/territories, districts, and schools to advance school mental health. The NCSMH engages in research, policy, training and technical assistance, and practice and has long partnered with the Maryland State Department of Education, the Maryland Behavioral Health Administration, and local communities to promote mental health and well-being for youth and families throughout Maryland.

GOALS OF THIS RFP

This RFP seeks to expand access to high-quality behavioral health and wraparound services for students and families across the state of Maryland. Accordingly, this RFP will support direct grants to providers of behavioral health and related services and supports to students and their families. These may include both existing providers of school-based services, as well as providers not currently operating in schools. Grants funds may be used to establish new programs or to expand existing programs.

The Commission is making available up to $120 million in funding through this RFP. This RFP supports the Consortium's statutory responsibilities by beginning to build future Community Supports Partnerships through grants to service providers.

This RFP will not fund grants to Partnership Hub organizations. The Consortium is continuing to refine parameters for future grants to Hubs, in order to ensure that future Hubs are built on, and do not duplicate, existing structures for behavioral health care coordination. The Consortium anticipates selecting and funding Hubs through another RFP in the coming months.

Based on their statutory responsibilities, the Consortium and CHRC are committed to demonstrating measurable results. The Consortium has identified four measurable, overall goals for the program:

1. Expand access to high-quality behavioral health and related services for students and families
2. Improve student wellbeing and readiness to learn
3. Foster positive classroom environments

4. Promote sustainability through revenues from Medicaid, commercial insurance, hospital community benefits, and other sources

Accountability metrics associated with each of these goals can be found on page 17. Grantees will be required to report data consistent with these goals.

Community providers must actively coordinate and partner with school districts and schools to support students and families. Schools and school districts could receive staff training and support, but will not be eligible to receive direct grant funding. Instead, community providers will partner with schools to support students and families. This will allow schools to focus on other Blueprint requirements, give students and families access to continuums of care, minimize disruptions to the behavioral health workforce, and build on successful models of school-community cooperation. All grant-funded services provided by community providers must align with priorities identified by local school districts. More information on the role of schools can be found on page 14.

Coordination will be essential for the delivery of these services. First, all services must be coordinated with and aligned with the priorities of the Local Education Agency. District and school staff must have clear avenues for communication with community providers. A letter of support from the local Superintendent or the Superintendent's designee is mandatory for all applications under this RFP (see sample in Appendix E).

Services also should be coordinated with public health and child-serving agencies, including Local Behavioral Health Authorities (LBHAs), Local Management Boards (LMBs), Local Health Departments, Local Departments of Social Services, Local Care Teams, etc. Applicants are encouraged to submit letters of support from LBHAs and/or other child-serving agencies or local government entities.

In the future, grants will be administered through Community Support Partnerships consisting of both service providers and Hub organizations. Accordingly, service providers awarded through this RFP will be expected to collaborate with Hub organizations after Hubs are selected. Organizations awarded service provider grants under this RFP may be eligible to become Hubs in the future if adequate safeguards are in place to ensure accountability. For example, the Hub function and service provider (Spoke) function should exist in different units within the organization with no shared staff. The unit responsible for the Hub should not be subordinate to or under the authority of the unit responsible for service provision.

At full implementation, this program should serve all students in each local school system regardless of income, insurance status, or zip code (see page 15). While the program will be statewide, equity will be considered in the allocation of grant funds. Services must be delivered with cultural and linguistic competence. The program will require statewide standards while also permitting local flexibility. All grantees will be required to report outcomes data (see page 17).

KEY DATES TO REMEMBER

The following are the key dates and deadlines for this RFP:	
August 18, 2023	Release of the Call for Proposals
August 29 at 10:00 a.m.	Frequently Asked Questions call for potential applicants **Zoom link**: https://us06web.zoom.us/j/89297836818?pwd=RUFrRUZzaDJVR1ViWWM5dGdLMTZjZz09 **Dial-in #: 301-715-8592** **Meeting ID:** 892 9783 6818 **/ Passcode:** 604823
October 11 at 12:00 NOON	**Deadline for receipt of applications**
Early December 2023	Award decisions, grant period begins

II. GRANTS TO SERVICE PROVIDERS

This RFP will provide direct funding for service providers statewide. Service provider applicants may request funding for more than one jurisdiction; however, a separate application must be submitted for each jurisdiction to be served.

The grant period for service providers under this RFP will be approximately 18 months. At the end of this grant period, grantees may apply for continuation funds. While grantees will be required to bill Medicaid to the maximum extent (see page 16), grantees will not be required to demonstrate sustainability at the end of the grant period. Grantees meeting performance goals and in good standing with their LEA may be eligible for continuing operating grants at the end of 18 months and/or through a future local Partnership Hub. Hubs will be encouraged but not required to include grantees from this RFP in future Partnership grants.

Under this RFP, grants to service providers must expand access to high quality behavioral health and/or wraparound services. A definition of wraparound services that will be supported by this RFP can be found on page 11. Grant funds may be requested for new or existing programs. An established program can receive grant funding if the funding represents an expansion of services or an increase in the number of individuals served. Funds from this grant may not supplant current funding for services and supports.

Applicants are required to demonstrate that their programs respond to documented local needs and priorities. Grantees should use Needs Assessments and other data to justify their programming (see page 12). In addition, all applicants must provide a letter of support signed by their local Superintendent or the Superintendent's designee that demonstrates genuine collaboration and alignment with their Local Education Agency (LEA). LEAs are encouraged to communicate clear priorities for their school districts and work with providers on proposals that will address unmet needs. Collaboration can be demonstrated by identifying specific meeting

dates, points of contact, commitments about when and where services will be provided, and details about the respective roles and responsibilities of the school(s) and service provider. LEAs should determine to which providers they will offer letters of support based on LEA determinations of system strengths and the needs, the ability of providers to augment existing supports and services, and other considerations at the discretion of the LEA. LEAs are asked to attest that grant funding would not supplant existing funding for student behavioral health. A sample letter is provided in Appendix E. Service provider applicants also should demonstrate collaboration with their LBHA, LMB, and/or other local child-serving agencies.

This model anticipates that schools will be the entry point and primary location for supports and services. All services do not need to be provided in the school building, but must be strategically coordinated via ongoing and regular communication and collaboration with the district and schools to augment their existing Multi-Tiered System of Supports. If applicable, applicants are encouraged to include in their proposals plans for transportation of students and/or family members to services and may request grant funding to this end.

This RFP will support interventions at each of the three tiers of the Multi-Tiered System of Supports (MTSS): Tier 1 (universal promotion/prevention), Tier 2 (early intervention), and Tier 3 (treatment). Providers are not required to offer supports and services at each tier.

Mental health promotion services and supports (Tier 1) are mental health-related activities that are designed to meet the needs of all students regardless of whether they are at risk for mental health problems. Tier 1 activities include promotion of positive social, emotional, and behavioral skills and well-being. These activities also include efforts to improve school climate and promote positive behavior. These activities can be implemented school- wide, at the grade level, and/or at the classroom level and can be provided by school-employed and community-employed, school-based professionals. Examples include school-wide mental health education lessons, school climate improvement efforts, and classroom-based social emotional learning for all students.

Early intervention services and supports (Tier 2) address the mental health concerns of students who are experiencing mild distress, functional impairment, or are at risk for a given problem or concern. These students can be identified through needs assessments, screening, referral, or another school teaming processes. When mental health needs are identified early and culturally responsive, anti-racist, and equitable (CARE) supports are put in place, positive youth development is promoted, and the chronicity and severity of mental health concerns can be eliminated or reduced. Sometimes these are referred to as “selective” mental health “prevention” or “secondary prevention” services. Examples include small group interventions for students identified with similar needs, transition support groups for newcomers, brief individualized interventions (e.g., motivational interviewing, problem solving), mentoring, and/or low intensity classroom-based supports such as a daily report card, daily teacher check-in, and/or home/school note system.

Treatment services and supports (Tier 3) to address mental health concerns are provided for students who are already experiencing significant distress and functional impairment. Sometimes these are referred to as "indicated" mental health "intervention," "tertiary" or intensive services, and are individualized to specific student needs. Examples include individual, group, or family therapy for students who have identified – and often diagnosed – social, emotional and/or behavioral needs.

Grant funds should be used to expand access to services including any of the following:

- School-wide preventative and mental health literacy programming
- Individual, group, and family therapy
- Navigation and case management services
- Substance Use Disorder services
- Telehealth services
- Behavioral health education, support, and navigation for families
- Wraparound supports (see page 11)
- Support groups
- Psychiatric care and medication
- Other

Grant funding must be supplemental to and may not supplant existing funds for school behavioral health. When possible, Medicaid reimbursement should be sought, and grant funding should support activities that are not Medicaid reimbursable. Examples include but are not limited to:

- School-wide programming (Tier 1)
- Prevention and mental health promotion activities
- Support groups and other programming for targeted groups of students and families
- Start-up/expansion costs
- Screenings for behavioral health and related issues
- Services and supports for uninsured students and families
- Co-pay support to expand access to services for children and families with commercial insurance and/or implement an income based sliding scale fee schedule
- Implementation of Evidence-Based Programs
- Administrative costs such as attending school meetings
- Case management, navigation, and other services provided by community health workers and peers
- Family education and support
- Peer support
- Transportation to services
- Translation/interpretation costs
- Staff training
- Innovative technology

Behavioral health services are most effective when delivered in a culturally and linguistically competent manner. As a matter of policy, all CHRC grantees are asked to demonstrate cultural and linguistic competency, and describe the extent to which the racial and ethnic diversity of their workforce reflects the individuals to be served. Applicants are required to consider cultural relevance in selecting Evidence-Based Programs and strategies. These factors will be evaluated as part of the application review process.

EVIDENCE-BASED PROGRAMS

Service provider applicants must list the Evidence-Based Programs (EBPs) they will implement, but will have flexibility to select the EBPs that are best suited for their programs and local populations. Applicants must demonstrate that selected EBPs and/or other strategies meet documented local needs (see page 12).

This RFP includes two menus of EBPs: 15 Priority EBPs and 32 Recommended EBPs. More information on these EBPs is included in Appendix G.

- **Priority EBP Menu**. Applicants who indicate they will implement one or more of these 15 Priority EBPs and participate in statewide training and technical assistance coordinated by the National Center for School Mental Health will receive additional consideration during the application review process (5 points out of 100). Applicants selecting one or more of these EBPs must indicate how the selected EBP(s) will address documented local priorities. Training costs (other than staff time) for these EBPs should not be included in an applicant's grant budget, but applicants should indicate the number of staff who will participate in trainings.

1. Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)
2. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)
3. Safety Planning Intervention (Stanley and Brown)
4. Counseling on Access to Lethal Means (CALM)
5. Adolescent Community Reinforcement Approach (ACRA)
6. The Student Check-Up (Motivational Interviewing)
7. Therapeutic Mentoring
8. SBIRT – Screening, Brief Intervention, and Referral to Treatment
9. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back
10. Botvin Life Skills
11. Youth Aware of Mental Health (YAM)
12. Circle of Security
13. Strengthening Families Program
14. Family Check Up
15. Chicago Parenting Program

In addition, a learning collaborative on Measurement-Based Care will be coordinated by the National Center. Applicants who commit to participate in this learning collaborative also will receive added consideration during the application review process (5 points out of 100). For more information on Measurement-Based Care, see this report by Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2021/03/MBC_Report_Final.pdf

- **Recommended EBP Menu, and Other EBPs and Strategies**. Applicants may choose to implement EBPs other than the 15 Priority EBPs. As above, applicants selecting one or more of these EBPs must indicate how the selected EBP(s) will address documented local priorities. Below is a menu of 32 other EBPs that are recommended but would not receive centralized implementation support.

1. Attachment Based Family Therapy (ABFT)
2. Acceptance and Commitment Therapy (ACT)
3. Brief Intervention for School Clinicians (BRISC)
4. Check and Connect
5. Check In Check Out
6. Dialectical Behavior Therapy (DBT) for Schools
7. Interpersonal Psychotherapy for Adolescents (IPT-A)
8. IPT-A - Ultra-Short Crisis Intervention (IPT-A- SCI)
9. Support for Students Exposed to Trauma (SSET)
10. Trauma-Focused CBT (TF-CBT)
11. Executive Functioning interventions (see Brain Futures report)
12. Incredible Years
13. MindUP
14. Positive Action
15. Second Step
16. Signs of Suicide
17. Source of Strength
18. Teen Mental Health First Aid (T-MHFA)
19. Tools of the Mind
20. Conscious Discipline
21. Classroom Check Up
22. Adolescent Depression Awareness Program (ADAP)
23. Restorative Practices
24. Classroom WISE
25. Youth Mental Health First Aid (Y-MHFA)
26. Facilitating Attuned Interactions (FAN)
27. Teacher WISE
28. Be Strong Families Parent Cafes
29. Family Bereavement Program
30. Parent CRAFT- Community Reinforcement and Family Training
31. Strengthening Family Coping Resources (SFCR)
32. PEP - Educating Parents, Enriching Families

Alternatively, applicants may identify EBPs and strategies not included on either menu, but must demonstrate that these are: (1) supported by evidence of impact on target social, emotional, behavioral, and/or academic outcomes (based on research evidence, as recognized in national registries and the scientific literature, and/or supported by practice-based evidence of success in local or similar schools or communities); (2) equitable and fit the unique strengths, needs, and cultural/linguistic considerations of students and families in the target community; (3) responsive to documented local priorities; (4) have adequate resource capacity for implementation (e.g., staffing capacity; training requirements, qualifications, and staff time; ongoing coaching); and (5) monitored for fidelity.

For EBPs not included on the Priority menu, applicants are responsible to coordinate any training and implementation support, and should include these costs (if any) in their budget.

Appendix G contains additional information about Evidence-Based Programs including descriptions, links, focus areas, recommended ages, MTSS Tiers, training requirements, etc.

School-employed staff may participate in training in selected Evidence-Based Programs. Interested LEAs should fill out the form found at the following URL: https://bit.ly/EBPs_SchoolApp. Schools and school districts should not apply for training through the RFP process, but should use the link provided.

WRAPAROUND SUPPORTS

Consistent with the Consortium's legislative mandate, this RFP will support funding for wraparound supports. Under this RFP, wraparound supports are defined as holistic supports that address a student's behavioral health needs but are not considered traditional behavioral health services. Wraparound supports funded under this RFP must meet four criteria:

1. Limited to students with identified behavioral health challenges, or at significant risk, and their families;
2. When appropriate, should be connected to traditional behavioral health services;
3. Ineligible for reimbursement through Medicaid, the Developmental Disabilities Administration (DDA), or other State support (e.g., not Targeted Case Management (TCM), TCM+, or High-Fidelity Wraparound models); and
4. Must involve schools in planning and/or implementation.

Examples of wraparound supports include:

1. Transportation to behavioral health services;
2. Peer support;
3. Parenting classes;
4. Afterschool activities that implement evidence-based behavioral health programming;
5. Evidence-based mentoring programs;
6. Developing and monitoring care plans for students with identified behavioral health needs; and
7. Navigation to ***link*** students and families to essential supports such as:
   - Somatic health services and health insurance
   - Academic and vocational supports
   - Extra-curricular activities that do not implement behavioral health EBPs
   - Services that address non-medical Social Determinants of Health (SDOH) needs.

Consortium-funded wraparound supports should promote cross agency coordination. Aspects of the 2Gen approach, a model being implemented by the Maryland Department of Human Services that seeks to address the entire family through aligned and coordinated supports, could be incorporated in the provision of these services.

The Consortium's definition of wraparound for this RFP differs from the definition of wraparound in other programs:

- Community Schools: When compared with the Community Schools' definition of wraparound, the Consortium's approach is more focused on behavioral health, and is only available to targeted students and families. This RFP will not support direct funding for activities such as extended learning, field trips, tutoring, somatic health services, vision, dental, etc. that are within the Community Schools' definition of wraparound. Instead, this RFP will support programs that *link* students and families to a broad array of supports.

- High Fidelity Wraparound/Targeted Case Management: When compared to these approaches to wraparound, the Consortium's approach is less intensive and available to more students and families. This RFP will not support direct funding for models that are reimbursable through Medicaid and the 1915(i) program. Instead, programs funded by this RFP and the Partnership model should help to educate and connect families to resources for higher intensity wraparound supports.

Responding to Local Priorities and Unmet Needs – Data for Applicants

Applicants are required to demonstrate that their programs respond to documented local needs and priorities. In addition to letters of support from local Superintendents or their designees, applicants should use Needs Assessments and other data to justify their programming.

As part of this RFP, the CHRC and the Consortium are providing potential applicants with recommended documents, databases, and measures to support the preparation of grant proposals. Applicants should contact LEAs (see Appendix H) and consult the following documents to demonstrate alignment with LEA priorities:

- LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/Blueprint-plans.aspx
- Local Community Health Needs Assessments: contact local health departments and health systems
- Local Behavioral Health Authority Needs Assessments: contact Local Behavioral Health Authority
- Local Management Board Needs Assessments: contact Local Management Board
- SHAPE system analyses by LEAs: if applicable, contact local school district. More information can be found at: https://theshapesystem.com/
- Community schools' needs assessments: if applicable, contact local Community Schools

Applicants also can use data sets to identify unmet needs. These data sets are recommended, not required. Applicants may use other sources to describe needs in their communities.

Examples of jurisdiction-level measures that could be used to identify priorities include: prevalence of Adverse Childhood Experiences (ACEs), substance misuse, depression and suicidality; number of justice-involved students; behavioral health provider shortages; gaps in school mental health services; number of disciplinary incidents/violence; behavioral health utilization rates for Medicaid-covered youth; and percentage of uninsured children. Examples of measures at the school level that could be used to target interventions to areas of greatest need include: socioeconomic need (free and reduced lunches), chronic absenteeism, graduation rates, number of Limited English proficient students, and student homelessness counts.

The following databases are recommended for jurisdiction-level data:

- HRSA Mental Health Professional Shortage Areas (HPSAs): https://data.hrsa.gov/tools/shortage-area/hpsa-find
- Youth Risk Behavior Surveillance System (YRBS): https://health.maryland.gov/phpa/ccdpc/Reports/Pages/State-Level-Data%2c-2021-2022.aspx
- Department of Juvenile Services Data Resource Guide: https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2022.pdf
- MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools, 2021 – 2022: https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20212022Student/2022_Student_Suspension_Expulsion.pdf
- U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program: https://www.census.gov/data-tools/demo/sahie/#/
- Maryland Medicaid claims for emergency department utilization for youth behavioral health: available on CHRC website HERE and HERE

The following databases are recommended for school-level data:

- School Report Card: https://reportcard.msde.maryland.gov/
- LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/Blueprint-plans.aspx
- Community schools' needs assessments: if applicable, contact local Community Schools

A description of each data set, suggested measures from each, and tips for utilizing these data sets are included in the Application Data Toolkit in Appendix D. Applicants should select key measures that correlate to their programs and should ***not*** include every suggested measure. Applicants may use other verifiable data sources and should describe these in their proposals.

Permissible Uses of Grant Funding

Examples of permissible uses of grant funding for service providers under this RFP include but are not limited to:

- Staff salaries
- IT hardware and software, including software/platform for Measurement-Based Care
- Supplies
- Marketing materials
- Training and professional development, including training materials and staff time (training and training materials for Priority EBPs will be supported by the National Center and should not be included in applicant budgets)
- Transportation expenses
- Subcontractors
- Indirect costs
- Incentives for program participants
- Translation/interpretation services

SCHOOLS AND GEOGRAPHIC AREAS

Schools and school districts will not be eligible to receive direct grant funding but will be actively involved in local Partnerships. As stated on page 11, school staff also may receive training in selected EBPs, and should request this training by filling out the form found at the following URL: https://bit.ly/EBPs_SchoolApp.

To ensure alignment with school district priorities, all applicants under this RFP are required to submit a letter of support from their local Superintendent or the Superintendent's designee (see sample in Appendix E). Appendix H contains contact information for key personnel in each LEA who will be coordinating the LEA's letter of support process. The CHRC will consult with LEAs before awards are made.

After grants are awarded, all grantees will be required to have a Memorandum of Understanding (MOU) with the LEA before services can be initiated. If the provider and LEA have a pre-existing MOU, this may be acceptable. While grantees will report directly to the CHRC, on-going collaboration between grantee and their respective LEAs is required. The CHRC will continue to consult with LEAs as grants are implemented to address any concerns.

Applicants must submit a separate proposal for each jurisdiction in which they propose to provide services. This is due to the unique nature and needs of each school system.

Proposals must list the schools where proposed services will be provided. If services will not be provided in a school building, applications should list the schools attended by students who will receive grant-funded services and describe how those services will be connected to the school.

Grant funds will support services for students in public schools, including public charter schools. Grants funds may support services for children in nonpublic special education schools (MANSEF), if the applicant demonstrates needs that cannot be met through existing funding sources.

The Consortium recognizes the importance of early childhood interventions. Services for students in pre-kindergarten programs that are located in public schools or are partners in the Blueprint's pre-kindergarten expansion program are eligible for funding. This RFP will not support services for students in private/parochial schools or homeschooled children.

Community Schools are schools that receive Concentration of Poverty grants under the Blueprint and provide an array of "wraparound" supports to students and families. Services funded through this RFP could be provided in Community Schools, as well as schools that are not Community Schools. Applicants should describe how requested funds would be supplemental to and clearly differentiated from Concentration of Poverty grant funding and any other existing sources of funding. By definition, Community Schools serve families with higher socio-economic needs—insofar as this RFP prioritizes areas with greater need, applicants are

encouraged to consider offering programs in Community Schools. A list of Community Schools can be found in each school district's Blueprint Implementation Plan. Applicants are encouraged to consult Community Schools' Needs Assessments. Applicants are advised that the definition of wraparound supports included in this RFP on page 11 differs from the definition of wraparound used by Community Schools.

The Coordinated Community Supports Partnership program seeks to expand access to behavioral health services for all Maryland public school students, across all income levels, regardless of insurance status. While services should be provided statewide to all children in the public school system, the CHRC will consider equity in the distribution of grant funds.

Workforce Issues

Behavioral health workforce constraints should be considered when developing proposals. Applicants could include as part of their proposals innovative strategies to address challenges in the behavioral health workforce, such as: use of supervised interns and other staff consistent with legal requirements, family and peer support programs, innovative use of technology, expanding Tier 1 and Tier 2 services, paid staff training and career ladders, and building the behavioral health workforce pipeline. While proposals may include components that address workforce challenges, an applicant's program as a whole must directly result in expanded behavioral health and/or wraparound services for students and families during the grant period.

Examples of innovative technology may include: virtual reality technology, biofeedback, remote patient monitoring, uses of Artificial Intelligence to monitor client well-being, computerized medical scribes for documentation, computerized assessment, and psychoeducational apps to complement treatment or aid in care coordination.

All applicants (and eventual grantees) must comply with behavioral health licensing requirements under Title 7.5, Subtitle 4, of the Health-General Article of the Maryland Annotated Code. When programmatic licensure is required under Maryland law, the applicant must provide proof of licensure with its application. In addition, all applicants (and eventual grantees) must ensure that, where applicable, individual health care practitioners are appropriately licensed, certified, or otherwise credentialed under federal and State law, including, but not limited to, the Health Occupations Article of the Maryland Annotated Code.

Medicaid Billing

Services supported through the Coordinated Community Supports Partnerships program should be provided to all students regardless of insurance status.

- If a child is enrolled in Medicaid, Medicaid should be billed, if applicable to the service.
- If a child is uninsured, grant funds should support the service.

- If a child has private insurance, the provider should bill the private insurer if possible and applicable to the service. Consortium grant funds could be used to pay copays, particularly for low-income families. If the provider is not able to bill a particular insurer, grant funds may be used for these services. An income-based sliding scale fee schedule could be considered.

Grants funds should support expanded access to behavioral health and wraparound services. If a service can be billed to Medicaid, grant dollars should be used to promote access and pay for non-billable activities (see page 8).

Applicants who do not currently bill Medicaid are welcome to apply under this RFP. Applicants should indicate whether they are willing to explore Medicaid billing in the future. Technical assistance may be provided during the grant period to support expanded Medicaid billing by grantees.

Grant funds may be used for services that could be reimbursable by Medicaid, DDA, or commercial insurance if barriers currently are preventing such reimbursement (e.g., wait lists, provider or patient eligibility issues, same-day exclusions, time limits, etc.). In such instances, grant funding may support the provision of these services until such time as Medicaid billing or other mechanisms are put into place. Grantees will be required to report periodically on efforts to initiate financing of services through other funding mechanisms.

All grantees that bill Medicaid will be required to enter into a cooperative agreement with their LBHA.

This RFP also will support activities that are not reimbursable by Medicaid, such as prevention activities, screenings, navigation, training, etc. (see page 8).

Budget Template and Budget Narrative

Applicants must submit a budget spreadsheet and budget narrative. See appendices I and J. Please break out funding for the two school years, 2023-2024 and 2024-2025.

As stated above, applicants must ensure funds are supplemental to and do not supplant existing funding for student behavioral health. Applicants also are encouraged to leverage other funding opportunities and clearly differentiate between funding requested through this RFP and other sources. A list of other potential sources of funding for student behavioral health can be found in Appendix F. Applicants should bill Medicaid and commercial insurance as appropriate (See page 16).

Evaluation and Monitoring

As a condition of receiving grant funds, grantees must agree to participate in an ongoing CHRC evaluation of the grant program. Grantees will be required to submit regular project progress

and fiscal/expenditure reports as well as deliverables produced under the grant as a condition of payment of CHRC grant funds.

Applicants must demonstrate the capacity to collect and report data required by the CHRC and Consortium. Grantees will be required to provide regular reporting on a number of key measures. These will include some standardized measures, as well as measures customized to the grantee's particular program. CHRC staff may work with each grantee to develop data reporting requirements for the grantee's program. Examples of standardized measures may include:

Goal	Indicators to be reported by grantees
1. Expand access to high-quality behavioral health and related services for students and families	Number of students and families served, number of schools, number of services, wait time for services, improvements in quality and array of services (SHAPE system)
2. Improve student wellbeing and readiness to learn	Number and percentage of students demonstrating improvement in social, emotional, behavioral, or academic functioning using a validated assessment tool; number and percentage of students demonstrating reduction in substance use **
3. Foster positive classroom environments	Increased use of positive classroom strategies; SHAPE system measures of improvements in school climate
4. Expand revenues from Medicaid and other funding sources for school behavioral health	Medicaid revenues, commercial insurance, other grant funding, other revenues

** Grantees will choose assessment tools that align with the conditions of individual students, such as:

- Pediatric Symptoms Checklist (PSC-17): depression, anxiety, ADHD, and acting out behavior for children under 16
- Patient Health Questionnaire (PHQ-9) or General Anxiety Disorder (GAD-7)*:* depression and anxiety for older adolescents
- CAGE-AID: Substance Use Disorder
- SNAP-IV: ADHD

For more information on validated assessment tools, see the Meadows Mental Health Policy Institute's report found here:
https://mmhpi.org/wp-content/uploads/2021/03/MBC_Report_Final.pdf

Applicants may request grant funding to support data reporting requirements, such as salary costs for a data analyst, purchase of software systems, etc. Applicants are advised that the Consortium may consider a statewide data system in the future, which may be provided to grantees in future years. Applicants should consider any data-sharing agreements that would

need to be reached with any partners for implementation and reporting on this grant, and should discuss these considerations in their grant proposals. Grantees must ensure the protection of patient/client information. The CHRC will not accept Protected Health Information (PHI) or Personally Identifiable Information (PII).

Grantees will be required to participate in ongoing grant monitoring and technical assistance provided by the CHRC, Consortium, and National Center for School Mental Health. The project team may be asked to attend virtual or in-person meetings, participate in site visits, and give reports on progress and accomplishments to the CHRC, Consortium, and other grantees.

Selection Criteria/Rubric

	Criteria	Score
1.	Responds to documented local priority; demonstrates unmet needs of the target population/community/geographic area; promotes health equity	20
2.	Organizational capacity: history of working with students and schools, cultural and linguistic competency, financial capacity including ability to bill Medicaid if applicable	15
3.	Program design and prospects for success: use of EBPs and/or other strategies, description of other return on investment, starting date for services, holistic approach, staffing plan (Note: applicants that commit to use and receive training in at least one Priority EBP and/or participate in a Measurement Base Care learning collaborative will receive 5 points more than applicants utilizing alternative EBPs and strategies.)	20
4.	Coordination/Integration: integration and alignment with existing programs, ability to be a "team player"	15
5.	Engagement with schools, families, and communities in the planning and execution of programming	15
6.	Ability to demonstrate measurable outcomes	15
	TOTAL	**100**

Other considerations:
1. Equity
2. Geographic balance
3. Prioritization by LEA
4. Ensuring programming for all ages pre-K-12

How to Apply

Frequently Asked Questions Call: A Frequently Asked Questions call for potential applicants will be held on **August 29 at 10:00 AM**. Zoom information can be found on page 6. The call will be recorded and posted on the CHRC website. A written list of Frequently Asked Questions will be posted on the CHRC website. Participation in this call is not required for applicants.

Cover Sheet: The cover sheet should be filled out electronically using the Smart Sheet at this URL: https://app.smartsheet.com/b/form/118606f8811140b189656eb5d58bfb79. The deadline for electronic submission of the cover sheet is **12:00 NOON on October 10, 2023.**

Full Application – Electronic Submission: The complete grant application should be emailed to: **jen.clatterbuck@maryland.gov**. The deadline for electronic submission of the full application is **12:00 NOON on October 11, 2023**.

In the subject line of the email, please state your organization's name, jurisdiction (county), and "Community Supports Partnerships Application." Please submit the Executive Summary and Project Proposal as an Adobe Acrobat PDF (see below).

Full Application – Hard Copy Submission: In addition to the electronic grant application submission, two (2) hard copies of the full application with the items listed below must be sent via USPS mail, express delivery service, or hand delivery. Applications must be postmarked by **October 11, 2023**. If sent by an express delivery service, the package must indicate that the package was picked up for delivery by the close of business on **October 10, 2023,** to be considered a complete grant application package.

The original hard copy of the full grant application must include a signed original of each of the following:

- Transmittal Letter;
- Print-out of Cover Sheet (optional);
- Executive Summary and Full Project Proposal (no signature required);
- Contractual Obligations, Assurances, and Certifications;
- Form W-9;
- Copy of behavioral health license (if applicable);
- Letter of support from Superintendent or designee; and
- Other letters of support (optional).

The original grant application with all items listed above, and all appendices or attachments, must be bound together and labeled "Original." Do not use three ring binders.

As noted above, the two (2) hard copies of the full grant application should be sent to the address below:

Jen Clatterbuck, CHRC Administrator
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Full Application requirements: Full grant applications must include the following items:

(1) Transmittal Letter: This letter from the applicant organization's chief executive officer should specify the title of the proposal, the applicant organization, and the project director and state that the applicant organization understands that submission of a proposal constitutes acceptance of the terms of the grants program.

(2) Grant Application Cover Sheet: Cover sheets are required and will be submitted electronically through the Smart Sheet accessible at this URL: https://app.smartsheet.com/b/form/118606f8811140b189656eb5d58bfb79. Applicants may print a copy to include with their application package. The Cover Sheet will contain the following fields:

- Organization name
- Federal Tax ID Number (EIN)
- Street Address
- Which jurisdiction?
- Which schools will be served?
- Total Budget request
- New program or expansion of existing program?
- Date when services could begin
- Total number of unduplicated individuals/families to be served at each tier of MTSS: Tier 1 (universal/prevention), Tier 2 (brief/small group), and Tier 3 (individual).
- What is the program's overall focus? What kinds of services will be provided?
- Which EBPs will be used? For Priority EBPs, indicate the number of staff members requesting EBP training.
- Does the organization bill Medicaid currently? Does the organization intend to bill Medicaid in the future?
- Behavioral Health license type and number, if applicable
- Attestation that grant funds will be supplemental to and will not supplant existing funding for school behavioral health
- Name and contact information for official authorized to execute contract on behalf of the applicant organization
- Name and contact information for project director
- Name and contact information for fiscal contact
- Additional contact information
- Electronic signature

(3) Executive Summary: A 300-500-word overview summarizing the key points of the proposal. Please see page 22 for more information on this requirement.

(4) Contractual Obligations, Assurances, and Certifications: The agreement should be completed and signed by either the chief executive officer or the individual responsible for conducting the affairs of the applicant organization and authorized to execute contracts on behalf of the applicant organization.

(5) Project Proposal: See proposal requirements below for detailed instructions.

(6) Form W-9

(7) Copy of Behavioral Health License if applicable (facility or individual)

(8) Required: Letter of support from the local Superintendent or their designee (see sample in Appendix E)

(9) Optional: Other letters of support

SERVICE PROVIDER PROJECT PROPOSAL REQUIREMENTS

Project proposals should be clear and concise, single spaced, in 11 or 12 point font. Proposals should be approximately 10-12 pages, excluding table of contents, executive summary, and appendices. Brevity is encouraged. All pages of the proposal must be numbered.

The project proposal should be structured using these topic headings:

- Table of contents (not included in page limit)
- Executive Summary (300-500 words, not included in page limit)
- Background and Justification
- Organizational Capacity
- Financial Capacity
- Project Plan
- Coordination/Integration
- Ability to demonstrate measurable outcomes
- Project Budget and Budget Justification
- **Mandatory Appendices**
    - Letter of support describing close collaboration with Local Education Agency and/or MOU with LEA (see sample letter in Appendix E)
    - Resumés of key staff
    - If indicated in application, sliding scale fee schedule
- **Optional Appendices**
    - Additional letters of support from Local Behavioral Health Authority, Local Management Board, Local Health Department, County Executive, County Council, implementation partners, and/or community organizations
    - Letters of support from principals of schools where services will be offered
    - Service maps and inventories of services

Detailed instructions follow.

Executive Summary

- What jurisdiction(s) will be served? Which schools within the jurisdiction(s)? How many schools are currently served by the program, prior to the grant?
- How many total unduplicated youth, families, and others will receive grant-funded services above the current baseline? What is the current baseline? How many of these unduplicated individuals will receive services at each of the three MTSS Tiers: Tier 1 (universal/prevention), Tier 2 (brief/small group), and Tier 3 (individual)? See page 7.
- Briefly describe the priorities and unmet needs in this community that the program proposes to address.
- What is the program's overall focus? What key services will be provided (see page 8)? What key Evidence-Based Programs will be implemented (see pages 9-10)?
- Briefly describe how the program will integrate with existing services in the school and community.
- Funding amount requested, and brief description of other sources of funding (Medicaid, local grants, in-kind, etc.).
- Date when will services be initiated.

Background and Justification

- Briefly describe the population(s) to be served (i.e., demographics, insurance coverage, income levels, etc.).
- Provide evidence that the proposed program responds to a documented local priority (see page 12). Applicants may use community health needs assessments, LBHA or LMB Needs Assessments, Community Schools Needs Assessments, information from LEAs, and/or other sources to describe the unmet needs and priorities. Use quantitative and/or qualitative data.
- Briefly use data to demonstrate need. Recommended data sets are included in Appendix D. Select a few data points that best highlight the need for the program; do not include every measure.
- List the schools that will receive services and explain the reasoning for selecting these schools.
- Will certain sub-groups of students/families within those schools be prioritized? Why? How?
- How will the proposed services address health equity?

Organizational Capacity

- Briefly describe the organization's mission, structure, and governance.
- Describe the organization's history of supporting youth and adolescent behavioral health. Describe the organization's history of working in schools. Describe the organization's history of working with the target community.
- Describe the organization's staff. Include information about staff training and cultural and linguistic competency. Describe the extent to which the staff reflects the community served. Provide an organizational assessment of racial and ethnic minority representation and cultural competency among the organization's staff and/or the

organizational approach to achieve racial and ethnic diversity proportional to the community served.
- Describe the qualifications and licensure of key staff. Provide resumés of up to five key staff in the appendix.

Financial Capacity
- Briefly describe the organization's history of financial management.
- Does the organization currently bill Medicaid? If so, include Medicaid provider number. Describe existing capacity to bill Medicaid and any barriers to Medicaid billing. Which services will be eligible for Medicaid reimbursement? Which services are not billable?
- If applicable, will a sliding scale fee schedule be supported? If so, include sliding scale fee schedule in the appendix.
- If applicable, will private insurance be billed? If so, will grant funds be used to pay co-pays to private insurers according to an income-based sliding scale fee schedule?
- What other sources of funding will support the organization's existing and new school-based services (e.g., local support, other grants, hospital community benefit, etc.)? See Appendix F for a list of other grant-making organizations. How will Coordinated Community Supports Partnerships grant funding be blended with funding from other sources? Describe any in-kind support that will be provided. Will matching funds be provided?

Program design and prospects for success
- Which services will be provided? What date will services begin?
- How many total unduplicated youth, families, and others will receive grant-supported services above the current baseline? What is the current baseline? How many of these unduplicated individuals will receive services at each of the three tiers of MTSS (see pages 7-8). Briefly describe your methodology for developing these estimates.
- Where will service be provided? If services will not be provided in the school building, describe means to facilitate access to services (e.g., transportation, etc.).
- What times during the day will services be provided? Will services be provided over the summer?
- What evidence-based strategies will be used (see menus of Priority and Recommended evidence-based programs on pages 9-10 and in Appendix G)? What other strategies will be used, and how are they justified (see page 10)?
- Describe the extent to which programming will be: holistic, trauma-informed, youth-guided, and culturally responsive.
- How will the program address challenges in hiring and retaining behavioral health staff?
- How will referrals be made to the program? How will services be "marketed" to families and school staff?
- The appendix must include a letter of support from the Superintendent or the Superintendent's designee. Include a name and contact information for the LEA. Describe physical space available in schools for programming and clarify times during the school day when services could be provided. If applicable, letters of support from

Superintendents and principals should commit to making confidential spaces available for services. A sample letter is included in Appendix E.

Coordination/Integration

- Describe collaboration with the Local Education Agency (LEA) in developing the proposal, including specific meeting dates. How will school staff be involved in the program? How will student information be shared with school staff?
- Optional: Include in the appendix any letters of support from the Local Behavioral Health Authority, Local Management Board, and other youth-serving agencies.
- How will the proposed program integrate with existing behavioral health services and supports for the target population and the identified schools? Applicants are encouraged to consult the Local Education Agency Blueprint Implementation Plans submitted to the Blueprint Accountability and Implementation Board. How will the proposed program avoid duplication?
- Describe all partners who will be involved in the program, including referral partners and others. Describe the processes and organizational structures that will be put into place to ensure that the partnership(s) are effective. Include letters of commitment in the appendix. How will information be shared between partner organizations?
- Will the program address the holistic needs of children and families, including medical needs and non-medical Social Determinants of Health? Describe any referral relationships.
- Will Community Schools be served? (See lists of Community Schools found in Local Education Agency Blueprint Implementation Plans, question 144.) If so, how will the program integrate with services provided by Community Schools? If applicable, how does the program respond to Needs Assessments developed by Community Schools? How will the program supplement and not supplant services provided by Community Schools and funded by concentration of poverty grants (see pages 14-15)?
- Discuss the organization's willingness to participate in training, technical assistance, and grant monitoring provided or coordinated by the National Center for School Mental Health, the Consortium, and CHRC, including training in Evidence-Based Programs.
- Discuss any reservations about working with a local Partnership Hub organization in the future (see page 5).

Engagement with families and communities

- Describe the extent to which youth and families were consulted in program design.
- How were communities involved in program design? What priorities have been identified by the community, and how will the program respond to these?
- How will feedback from families and communities be collected and incorporated into future programming?
- How will parents and families be involved in treatment plans, if applicable?
- Please include in the appendix any letters of support from key community agencies and organizations (e.g., community-based organizations, Departments of Social Services, etc.)

Ability to demonstrate measurable outcomes

- Describe the organization's capacity for data management and outcomes reporting. What data systems will be used? Note: Grant funding may be requested for data systems.
- Comment on the organization's ability to collect and report standardized data measures on page 17. Discuss any measures that will *not* be collected. Optional: What additional, customized process and outcome measures could be collected to demonstrate the impact of this program?
- Which validated assessment tools will be used to demonstrate impact? (See pages 17-18)
- Describe how the organization currently conducts self-assessment as part of continuous quality improvement efforts, and if applicable, describe the support needed to build the organization's evaluation capacity. For programs with existing evaluation expertise and/or infrastructure, include a description of how the success of the program will be measured, timeline(s) for measurement, who will conduct the evaluation, if/how disproportionality is addressed, and the dissemination of results. Provide quantifiable goals/targets, above the current baseline, for each measure.
- How will student and family satisfaction/engagement be measured? Please include a copy of any satisfaction/engagement survey in the appendix.
- Does the organization utilize an EMR system?
- How will the program ensure that the count of individuals/families served is unduplicated?

Appendix A.

Commissioners, Maryland Community Health Resources Commission

Edward J. Kasemeyer, CHRC Chair, Former Senator and Chair of the Maryland Senate Budget & Taxation Committee

TraShawn Thornton-Davis, MD, Assistant Service Chief, OB/GYN, DCSM, Mid-Atlantic Permanente Medical Group

Scott T. Gibson, Chief Strategy Officer, Melwood Horticultural Training Center, Inc.

Flor D. Giusti, Johns Hopkins, Bayview

Maria J. Hankerson, PhD

David Lehr, Chief Strategy Officer, Meritus Health

Karen-Ann Lichtenstein, Former President and CEO, The Coordinating Center

Roberta "Robbie" Loker

Carol Masden, LCSW-C

Sadiya Muqueeth, DrPH, MPH, Chief Health Policy Officer, Baltimore City Health Department

Destiny-Simone Ramjohn, PhD, Vice President, Community Health and Social Impact, CareFirst

Appendix B.

Members, Maryland Consortium on Coordinated Community Supports

David D. Rudolph, former Delegate and Chair, Maryland Consortium on Coordinated Community Supports

Erin McMullen, Maryland Department of Health | Chief of Staff, Office of the Secretary

Emily Bauer, Maryland Department of Human Services | Two-Generation Program Officer

Mohammed Choudhury, Maryland Department of Education | State Superintendent

Edward Kasemeyer, Maryland Community Health Resources Commission | Chair

Mary Gable, Director of Community Schools | Assistant Superintendent, Division of Student Support, Academic Enrichment, & Educational Policy, Maryland State Department of Education

Christina Bartz, Council on Advancement of School-Based Health Centers | Director of Community Based Programs, Choptank Community Health Systems

Dr. Derek Simmons, Public School Superintendents Association of Maryland | Superintendent, Caroline County Public Schools

Tammy Fraley, Maryland Association of Boards of Education | Allegany County Board of Education

Dr. Donna Christy, Maryland State Education Association | School Psychologist, Prince George's County Public Schools

Gail Martin, Maryland Chapter of the National Association of Social Workers | former Baltimore County Public Schools Team Leader, School Social Work

D'Andrea Jacobs, PhD., Maryland School Psychologists Association | School Psychologist, Baltimore County Public Schools

Dr. John Campo, MD, Maryland Hospital Association | Director of Mental Health, Johns Hopkins Children's Center, Johns Hopkins University Hospital

Sadiya Muqueeth, DrPH, MPH, member, Maryland Community Health Resources Commission | Chief Health Policy Officer, Baltimore City Health Department

Ryan Moran, representative of the Maryland Medical Assistance Program | Deputy Secretary, Health Care Financing and Medicaid Director, Maryland Department of Health

Larry Epp, Ed.D., representative of the community behavioral health community with telehealth expertise | Director of Outcomes and Innovation, Families and Communities Service Line, Sheppard Pratt Health System

Gloria Brown Burnett, local Department of Social Services | Director, Prince George's County Department of Social Services

Michael A. Trader, II, representative of local departments of health | Director of Planning, Quality, and Core Services, Worcester County Health Department

Dr. Kandice Taylor, member of the public with expertise in equity in education | School Safety Manager, Baltimore County Public Schools

The Honorable Katie Fry Hester, Maryland Senate

The Honorable Eric Ebersole, Maryland House of Delegates

The Consortium currently has four vacancies

Appendix C.

Abbreviations

ADHD: Attention Deficit Hyperactivity Disorder
ACE: Adverse Childhood Experience
Blueprint: Blueprint for Maryland's Future, also known as Kirwan bill
CDC: Centers for Disease Control and Prevention
CHRC: Maryland Community Health Resources Commission
Consortium: Maryland Consortium on Coordinated Community Supports
CSP: Community Supports Partnership
DDA: Maryland Developmental Disabilities Administration
EBP: Evidence-Based Program
EIN: Employer Identification Number
EMR: Electronic Medical Records
FY: Fiscal Year
HPSA: Health Professional Shortage Area
HRSA: Health Resource and Services Administration
Jurisdiction: a Maryland county or Baltimore City
LBHA: Local Behavioral Health Authority
LEA: Local Education Agency, or school district
LGBTQ+: lesbian, gay, bisexual, transgender, queer, or questioning persons or community
LMB: Local Management Board
MANSEF: Maryland Association of Nonpublic Special Education Facilities
MDH: Maryland Department of Health
MOU: Memorandum of Understanding
MSDE: Maryland State Department of Education
MTSS: Multi-Tiered System of Supports
NCSMH or National Center: National Center for School Mental Health
Partnerships: Community Supports Partnerships, or CSPs
PHI: Protected Health Information
PII: Personally Identifiable Information
RFP: Request for Proposals, or Call for Proposals
SAHIE: Small Area Health Insurance Estimates program
SDOH: Social Determinants of Health
SHAPE: School Health Assessment and Performance Evaluation, assessment developed by NCSMH, https://theshapesystem.com
TCM+: Targeted Case Management Plus
YRBS: Youth Risk Behavior Surveillance System

Appendix D.

Data Toolkit for Applicants

As part of the Coordinated Community Supports Partnerships Call for Proposals, the CHRC and Consortium are providing potential applicants with recommended databases and measures to support the preparation of grant proposals. These data sets can be used by applicants to identify unmet needs and develop programs and priorities. These data sets are recommended, not required. Applicants may use other data and sources to describe need in their communities.

Examples of jurisdiction-level measures that could be used to identify priorities include: prevalence of ACEs, substance misuse, depression and suicidality; number of justice-involved students; behavioral health provider shortages; gaps in school mental health services; number of disciplinary incidents/violence; behavioral health emergency department and overall utilization rates for Medicaid-covered youth; and percentage of uninsured children. Examples of measures at the school level that could be used to target interventions to areas of greatest need include: socioeconomic need (free and reduced lunches), chronic absenteeism, graduation rates, number of Limited English proficient students, and student homelessness counts.

The following databases are recommended for jurisdiction-level data:

- HRSA Mental Health Professional Shortage Areas (HPSAs): https://data.hrsa.gov/tools/shortage-area/hpsa-find
- Youth Risk Behavior Surveillance System (YRBS): https://health.maryland.gov/phpa/ccdpc/Reports/Pages/State-Level-Data%2c-2021-2022.aspx
- Department of Juvenile Services Data Resource Guide: https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2022.pdf
- MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools
  2021 – 2022:
  https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20212022Student/2022_Student_Suspension_Expulsion.pdf
- U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program: https://www.census.gov/data-tools/demo/sahie/#/
- Maryland Medicaid claims data: see CHRC website
- SHAPE system analyses by LEAs: if applicable, contact local school district
- Local Community Health Needs Assessments: optional, contact local health departments and health systems
- Local Behavioral Health Authority Needs Assessments: optional, contact Local Behavioral Health Authorities
- Local Management Board Needs Assessments: optional, contact Local Management Board

The following databases are recommended for school-level data:

Appendix D.

- School Report Card: https://reportcard.msde.maryland.gov/
- LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/Blueprint-plans.aspx
- Community schools' needs assessments: if applicable, contact local Community Schools
- List of Community Schools: https://marylandpublicschools.org/about/Documents/OFPOS/State%20Aid/FY24_State Aid_MASTER_FINAL_6-16-2023.zip

A description of each data set, suggested measures from each, and tips for utilizing these data sets are included in the Application Data Toolkit posted on the Call for Proposals website. Applicants should select measures that correlate to their programs and should ***not*** include every suggested measure. Applicants may use other verifiable data sources, and should describe these in their proposals.

Recommended online databases:

1. Health Professional Shortage Areas (HPSAs): https://data.hrsa.gov/tools/shortage-area/hpsa-find

Suggested measures:
a. Geographic HPSA for Mental Health
b. Population HPSA for Mental Health

Other tips:
- Jurisdiction-level data.
- Use the following filters:
    - Maryland
    - County
    - HPSA Discipline: Mental Health
    - HPSA Status: Designated
    - HPSA Designation Types: All Geographic, All Population
- May include HPSA score, on a scale of 0-26.

2. Youth Risk Behavior Surveillance System (YRBS): https://health.maryland.gov/phpa/ccdpc/Reports/Pages/State-Level-Data%2c-2021-2022.aspx

Suggested measures (High School):
a. Percentage of students who felt sad or hopeless almost every day for more than two weeks in a row (QN25)
b. Percentage of students who seriously considered attempting suicide (QN26)

c. Percentage of students who reported that their mental health was most of the time or always not good (QN85)
d. Percentage of students who ever took prescription pain medicine without a doctor's prescription (QN49)
e. Percentage of students who ever used heroin (QN52)
f. Percentage of students who ever used methamphetamine (QN53)
g. Percentage of students who reported that a parent or other adult in their home most of the time or always swore at them, insulted them, or put them down (QN110)
h. Percentage of students who have ever been separated from a parent or guardian because they went to jail, prison, or a detention center (QN113)
i. Percentage of students who reported that their parents or other adults in their home most of the time or always slapped, hit, kicked, punched, or beat each other up (QN114)

Suggested measures (Middle School):
a. Percentage of students who felt sad or hopeless almost every day for more than two weeks in a row (QN49)
b. Percentage of students who ever seriously thought about killing themselves (QN14)
c. Percentage of students who reported that their mental health was most of the time or always not good (QN44)
d. Percentage of students who ever took prescription pain medicine without a doctor's prescription (QN29)
e. Percentage of students who reported that a parent or other adult in their home most of the time or always swore at them, insulted them, or put them down (QN79)
f. Percentage of students who have ever been separated from a parent or guardian because they went to jail, prison, or a detention center (QN82)
g. Percentage of students who ever saw someone get physically attacked, beaten, stabbed, or shot in their neighborhood (QN11)

Other tips:
- Jurisdiction-level data.
- Use County Level Summary Tables for Middle School and/or High School.
- Compare with State Level Summary Tables and with other County Level Summary Tables.
- Some measures indicate Adverse Childhood Experiences (ACEs).
- Measures above correspond to the 2021 YRBS report. A new version may become available and questions may vary.

3. Department of Juvenile Services Data Resource Guide:
https://djs.maryland.gov/Documents/DRG/Data_Resource_Guide_FY2022.pdf

Suggested measures:
a. Number of referrals to DJS per thousand youth ("Total complaints" x 1000/total youth population)

Other tips:

- Jurisdiction level data begins on page 36.
- Compare with statewide data found on page 26 or data from other jurisdictions.
- Numerator is "Total Complaints" found at the bottom of the Complaint Source table.
- Denominator is the total youth population listed under "U.S. Census and Maryland Department of Planning Estimation Data" at the top right of the page.
- Race and ethnicity data is also available, data on types of offenses, trends.

4. MSDE report on Suspensions, Expulsions, and Health Related Exclusions Maryland Public Schools
2021 – 2022:
https://www.marylandpublicschools.org/about/Documents/DCAA/SSP/20212022Student/2022_Student_Suspension_Expulsion.pdf

Suggested measures:

a. Percentage of students suspended or expelled for the jurisdiction

Other tips:

- Jurisdiction-level data.
- Summary table on page 1.
- Compare with statewide data or data from other jurisdictions.
- Includes data tables disaggregated by race and ethnicity, grade, frequency/repeated offenses, elementary vs middle vs high school, types of offenses, etc.

5. U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) Program:
https://www.census.gov/data-tools/demo/sahie/#/

Suggested measures:

a. Percentage of uninsured individuals under the age of 18

Other tips:

- Jurisdiction-level data.
- Use the following filters:
    - Maryland
    - County
    - Age group: Under 19
    - HPSA Designation Types: All Geographic, All Population
- Filters for race subgroups are not available for the Under 19 age group or Counties.
- Compare rate with statewide benchmark or other jurisdictions.

Appendix D.

7. Public Behavioral Health System Service Claims data:

- ED Utilization Among Children Ages 0-17
- FY 2021 Age 0-17 MH and SUD Service Use

Suggested measures:

a. Emergency Department utilization rates per 1,000 Medicaid, under 18 (column D)
b. Utilization of mental health services per 1,000 Medicaid, under 18 (column F)
c. Utilization of substance use services per 1,000 Medicaid, under 18 (column G)

Other tips:

- Compare rates with statewide average at the bottom of the table, or other jurisdictions.

7. MSDE School Report Card: https://reportcard.msde.maryland.gov/

Suggested measures:

a. Socioeconomic need (look at "Free and Reduced Meals" under "Demographics/Student Group Populations")
b. Limited English proficient students (look at "English Learner" under "Demographics/Student Group Populations")
c. Student homelessness counts (look at "Homeless" under "Demographics/Student Group Populations")
d. Chronic absenteeism (look at "Attendance" under Demographics/Student Group Populations;" left side menu includes several different measures of chronic absenteeism)
e. Graduation rates (for High School only, look at "Report Card")

Other tips:

- School-level data.
- Compare data with benchmarks for the state or the jurisdiction.
- Demographic data sets may be the most useful for demonstrating need, though academic data can also be referenced.
- Look at data definitions.
- Report Card details include Equity Data for academic measures; can be disaggregated by race and economic disadvantage).

8. LEA Blueprint Implementation Plans: https://aib.maryland.gov/Pages/Blueprint-plans.aspx

Suggested measures:

a. List of community schools (question 144)

Other tips:

- Questions 144, 147, 151, 152, 153, 154, and 157 may be useful to applicants in developing proposals.
- Behavioral Health Service Coordinators are listed in question 149.

9. List of Community Schools:
https://marylandpublicschools.org/about/Documents/OFPOS/State%20Aid/FY24_StateAid_MASTER_FINAL_6-16-2023.zip

Tips:

- Tab 10A includes a list of all Maryland schools.
- The column labeled "Pers" refers to Personnel Grants and the column labeled "PPG" refers to Per-Pupil Grants. (An eligible school first will be given a personnel grant to hire staff and develop a Community School Implementation Plan. If the school is still eligible the following year, they are then given the per-pupil grant to provide services. Eligibility requirements for these grants will expand annually during the span of the Blueprint to qualify more schools for aid.)
- A school that is labeled "Eligible" for a Per-Pupil Grant is currently a community school.
- A school that is "Eligible" for a Personnel Grant but "Not Eligible" for a Per-Pupil Grant is likely to become a community school next year.

Appendix E.

Sample letter of support from Superintendent or Designee

[LEA LETTERHEAD]

Date

Dear Maryland Community Health Resources Commission,

XXXX Public Schools is pleased to support the application of [APPLICANT ORGANIZATION] for a service provider grant under the Community Supports Partnerships Call for Proposals (RFP) issued by the Maryland Community Health Resources Commission in June 2023.

XXXX Public Schools has been working/planning with [APPLICANT ORGANIZATION] since [DATE]. [DESCRIBE PREVIOUS INTERACTIONS.] [NAME(s) OF LEA STAFF MEMBER(S)] has reviewed [APPLICANT ORGANIZATION'S] proposal and determined that it aligns with the priorities of XXXX Public Schools.

If [APPLICANT ORGANIZATION] is funded under the RFP, XXXX Public Schools commits to:

- Permit [APPLICANT ORGANIZATION] to provide the following services: XXXX
- Permit services to be provided in the following schools OR for students from the following schools: XXXX
- Permit services to be provided during the following times: XXXX
- [IF APPLICABLE] Provide confidential spaces in schools for the provision of services
- [IF APPLICABLE] Refer students to services provided by [APPLICANT ORGANIZATION] in the following way(s): XXXX
- OTHER

OPTIONAL: [APPLICANT ORGANIZATION] commits to the following: XXXX

[APPLICANT ORGANIZATION] currently has a Memorandum of Understanding with XXXX Public Schools OR XXXX Public Schools will develop a Memorandum of Understanding by [DATE] with [APPLICANT ORGANIZATION] if [APPLICANT ORGANIZATION] is selected for funding under this RFP.

If awarded, grant funds will not supplant existing funding for student behavioral health.

XXXX Public Schools requests a favorable review of [APPLICANT ORGANIZATION'S] proposal under the Community Supports Partnerships RFP.

Sincerely,

Superintendent/Designee

Appendix F.

Other Funding Opportunities for Student Mental Health Services

Federal government grant makers:

- **U.S. Substance Abuse and Mental Health Services Administration (SAMHSA**): various grant opportunities including: Mental Health Awareness and Training Grant (MHAT)/Project AWARE; Preventing Youth Overdose: Treatment, Recovery, Education, Awareness and Training; Behavioral Health Partnership for Early Diversion of Adults and Youth; Strategic Prevention Framework – Partnerships for Success; Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program; Mental Health Awareness Training Grants; National Child Traumatic Stress Initiative; and Linking Actions for Unmet Needs in Children's Health.
  Link: https://www.samhsa.gov/grants/grants-dashboard

- **U.S. Health Resources & Services Administration (HRSA):** various grant opportunities including: Rural Communities Opioid Response Program – Child and Adolescent Behavioral Health; Developmental-Behavioral Pediatrics (DBP) Training Program; Comprehensive Systems Integration for Adolescent and Young Adult Health; and Primary Care Training and Enhancement - Residency Training in Mental and Behavioral Health (PCTE-RTMB).
  Link: https://www.hrsa.gov/grants/find-funding

- **U.S. Department of Education**: various grant opportunities, applicants must be mostly schools and school districts.
  Link: https://www2.ed.gov/fund/grants-apply.html?src=pn

Maryland state/local government grant makers:

- Behavioral Health Administration, Local Behavioral Health Agencies (LBHAs), Core Service Agencies (CSAs), and Local Addictions Authorities (LAAs)
- Community Health Resources Commission (CHRC) - other RFPs
- Governor's Office of Crime Control & Prevention for Maryland - Local Management Boards (LMBs)
- MDH Office of Minority Health and Health Disparities - Minority Outreach and Technical Assistance
- MDH School-Based Health Centers program
- Opioid Operational Command Center (OOCC)
- Rural Maryland Council

Private Foundations:

- Abell Foundation
- Annie E. Casey Foundation
- Asuherman Family Foundation (Frederick County)

Appendix F.

- Baltimore Children and Youth Fund
- Baltimore Community Foundation
- Blaustein Philanthropic Group
- Caplan Foundation for Early Childhood
- CareFirst
- Community Trust Foundation (Allegany and Garrett Counties)
- France-Merrick Foundation
- Goldseker Foundation
- Herbert Bearman Foundation
- Hoffberger Family Philanthropies
- Horizon Foundation (Howard County)
- John J. Leidy Foundation (Baltimore)
- Joseph & Harvey Meyerhoff Family Charitable Funds
- Lockhart Vaughan Foundation (Baltimore)
- M&T Charitable Foundation
- Middendorf Foundation
- PNC Foundation
- Reginald F. Lewis Foundation
- Richman Foundation
- Robert W. Deutsch Foundation
- Robert Wood Johnson Foundation
- Straus Foundation (Baltimore)
- Stulman Foundation
- United Way
- Venable Foundation
- Weinberg Foundation
- William J. and Dorothy K. O'Neill Foundation
- Women's Giving Circle (Howard County)
- Zanvyl and Isabelle Krieger Fund

Appendix G.

Menus of Evidence-Based Programs

PRIORITY MENU

The Consortium will prioritize funding for the following school mental health practices for which free statewide training and implementation support will be offered by the National Center for School Mental Health, in partnership with intervention developers/trainers:

Interventions 1-15 are intended for delivery by school mental health clinicians (may be employed by district/school or school-based community partner).

A Note on Cultural Responsiveness:
The far-right column includes publicly available information on national EBP repositories and/or the intervention website about characteristics of youth and caregivers involved in intervention studies (e.g., race/ethnicity, geography, gender) and/or resources to support cultural relevance. There is significant variability in the number of studies conducted across interventions and the extent to which data were disaggregated for specific population groups. It is important when selecting interventions for your community to consider fit with the unique strengths, needs, and cultural/linguistic considerations of students and families in your school community.

	EBP – Programs/Trainings	Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
1	Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C/UP-A)	Addresses emotional disorders, including anxiety, depression, and traumatic stress	7 and up	3 - individual	A type of cognitive/behavioral therapy (CBT)	Level I: One-day remote workshop Level II: Remote consultation on a course of treatment over a 12–16-week period ToT: One-on-one feedback based on	**UP-C/UP-A** is included in the CA Clearinghouse for Child Welfare with evidence to support use with following demographic groups: Hispanic/Latino, Non-Hispanic White, African American, Asian American, and Pacific Islander populations

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	EBP – Programs/Trainings	Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
						audio recordings of UP sessions	
2	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	Modules address anxiety, depression, disruptive behaviors, and traumatic stress	6 and up	3 - individual	Cognitive/behavioral therapy (CBT) for anxiety including post-traumatic stress, depression, and behavioral parent training for disruptive behaviors.	5-Day MATCH Direct Services Workshop 2-Day MATCH Supervision and Consultation Workshop	**MATCH-ADTC** is included in the CA Clearinghouse for Child Welfare and NIJ Crime Solutions with evidence to support use in multiple diverse populations. **Note from Developer:** MATCH-ADTC has been primarily tested and found to be effective in youths aged 5-15 in urban and suburban settings. Caregiver handouts are available in Spanish and the entire MATCH protocol has been translated into German and French. MATCH-ADTC is based on the MAP system (Managing and Adapting Practice) which is inherently responsive to diverse clinical and cultural factors.
3	Safety Planning Intervention (Stanley and Brown)	Suicide prevention	6 and up	3 - individual	Helping at-risk adolescents develop a list of coping strategies and sources of support		Information not available in national repositories searched.
4	Counseling on Access to Lethal Means (CALM)	Suicide prevention	All ages	3 - individual	Counseling on reducing access to means of self-harm	Group Workshop: ~3 hours, virtual T4T: ~10 hours over 2 days, virtual	Information not available in national repositories searched. **Note from Developer:** The trainings are focused on culturally adapting to different types of gun owners (those who are more run-of-the-mill, those who are more political and have a stronger identity as a gun owners, those who own primarily for self-defense, youth).

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EBP – Programs/Trainings		Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
							The most recent version CALM-AAP is on the American Academy of Pediatrics website and includes a section geared to working with young people (young Black boys and young men in particular) who live in neighborhoods with high homicide rates and whose access to firearms might be their own or one shared among their friends. For more information on resources to support safe suicide care for specific populations, please review: Populations | Zero Suicide (edc.org)
5	Adolescent Community Reinforcement Approach (A-CRA)	Substance Use Disorder	12 and up	3 - individual	Cognitive/behavioral treatment to reinforce substance-free lifestyles	Virtual or in-person, one-day training OR shortened one-day training (Intro to A-CRA)	**A-CRA** is included in the CA Clearinghouse for Child Welfare and NIJ Crime Solutions with evidence to support use with Black, American Indians/Alaska Native, Asian/Pacific Islander, Hispanic, White populations and in rural, suburban, and urban areas. For more information on A-CRA's research with diverse populations, please review: Cultural and Gender Relevance | Lighthouse Institute | EBTx | A-CRA | Chestnut Health Systems Cultural Responsiveness Committee Bibliography (chestnut.org)
6	The Student Check-Up	Therapy/counseling to elicit	12 and up	2/3 – individual	Semi-structured school-based motivational	Choice of half-day, full-day, or two-day group workshops	Information not available in national repositories searched.

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	EBP – Programs/Trainings	Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
	(Motivational Interviewing)	behavior change			interview designed to help adolescents adopt academic enabling behaviors (e.g., participation in class) School-Based Motivational Interviewing (S-BMI) is a specific type of MI used in the school setting to adopt academic enabling behaviors (e.g., participation in class), decrease risky behaviors, and engage in health-promoting behaviors.		**Note from Developer:** The majority of Student Check-Up RCTs were conducted in a small urban setting with graduate students implementing the intervention with over 50% of the middle school student population identifying as Black.
7	Therapeutic Mentoring	Mentoring/ Modeling; Coping Strategies	Mentors who work directly with youth	2 - individual	Develops competencies of mentors in the areas of mental health theory, research, and practice to ensure youth have access to high quality, strengths-based, culturally responsive, and effective mentors	12, weekly 90-minute virtual sessions	Information not available in national repositories searched. For more information on Therapeutic Mentoring research, please review: Publications – The Center for Evidence-based Mentoring (cebmentoring.org)
8	SBIRT – Screening, Brief Intervention, and	Substance Use Disorder early intervention	9 and up	2 – individual	Screening, brief intervention, and referral to treatment	-SBIRT in Schools is a self-paced online 4.5 hr. training	**School-Based Brief Interventions for Substance Use Among Youth** is included in NIJ Crime Solutions with evidence to support use with Black and White students

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EBP – Programs/Trainings		Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
	Referral to Treatment				for substance use disorders	-SBIRT with Adolescents is a 5.5 hr., in person or virtual training -Kognito SBI is a self-paced, simulated 1.5 hr. training	
9	Cognitive Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back	Early intervention for students experiencing post-traumatic stress reactions	6th-12th grade (CBITS) K-5th grade (Bounce Back)	2 – small group plus individual trauma narrative	Games and activities that teach skills for healing from traumatic events, as well as cognitive/behavioral therapy to address trauma symptoms	CBITS: ~Four, 3-hour virtual trainings Bounce Back: ~Three, 3-hour virtual trainings	**CBITS** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic/Latino, and White youth in urban environments **Bounce Back** is included in the CA Clearinghouse for Child Welfare , Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic/Latino, and White youth in urban environments
10	Botvin LifeSkills	Prevention program focused on substance use, coping skills, social skills, etc. (Social-Emotional Learning)	3rd grade and up	1 - universal	Prevention programs to help adolescents develop confidence and skills to successfully handle challenging situations	Virtual, one-day workshop	**Botvin LifeSkills** is included in the CA Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, White, Hispanic/Latino, Asian, and Native American youth

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EBP – Programs/Trainings		Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
							Blueprints for Healthy Youth Development indicates that LST is generalizable to a variety of ethnic groups, and has been proven effective with White, middle-class, suburban and rural youth, as well as economically-disadvantaged urban minority (African American and Hispanic/Latino) youth. For more information on Botvin's research base, please review: Evaluation Studies - Botvin LifeSkills TrainingBotvin LifeSkills Training
11	Youth Aware of Mental Health (YAM)	Suicide Prevention, Mental Health Literacy	9th-12th grade	1 - universal	A 5-session interactive school-based program for students to learn about and discuss mental health to enhance peer support and reduce depression and suicidal behavior.	5-day instructor course, in-person	Information not available in national repositories searched. For more information on YAM's youth driven program in diverse communities, please review: Youth Aware of Mental health (y-a-m.org)
12	Circle of Security	Strengthening attachment between caregivers/educators and children, behavior problem reduction	Parents/ caregivers and educators of children ages 0-5	1/2 - group	A manualized, video-based program divided into eight chapters during which trained facilitators reflect with caregivers about how to promote secure attachment	~25-35 hours, including self-directed learning and 5 required online live sessions; suggested to use half of work schedule over 2-week period	**Circle of Security** is included in The California Evidence-based Clearinghouse for Child Welfare with evidence to support use in the following demographic groups: predominately female caregivers, African American female caregivers, children ages ~1-7, caregivers and their preschool children affected by prenatal alcohol exposure (PAE) and fetal alcohol spectrum disorder (FASD).

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EBP – Programs/Trainings		Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
							For more information on Circle of Security's approach to cultural responsiveness, please review: Is COSP Culturally Responsive – Circle of Security International
13	Strengthening Families Program	Family bonding; parenting	High-risk and general population families	Family Support and Education	The Strengthening Families Program (SFP) is an evidence-based family skills training program for high-risk and general population families. Parents and youth attend weekly SFP skills classes together, learning parenting skills and youth life and refusal skills. They have separate class training for parents and youth in the first hour, followed by a joint family practice session in the second hour.	16 hours of virtual live training + 7 hours of pre-training prep	**Strengthening Families Program** is included in The California Evidence-based Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use for male and female children with African American caregivers For more information on Strengthening Families Program's research with diverse populations, please review: Research - Strengthening Families Program
14	Family Check Up	Parenting and family management	Families with children ages 2 through 17	Family Support and Education	The Family Check-Up is a brief, strengths-based intervention effective for reducing children's problem behaviors by improving parenting and family	E-Learning course: 11-13 hours of self-paced learning and evaluation Provider training: 15-18 hours	**Family Check Up** is included in The California Evidence-based Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Caucasian, Hispanic/Latino, Asian, & Biracial families;

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EBP – Programs/Trainings		Focus/Short Description	Target Audience	Tier/ Modality	Description/Services	Training Time Commitment and Modality	Cultural Responsiveness
					management practices. An initial interview and a comprehensive assessment are used to gather information about the unique needs and strengths of the family. Providers use motivational interviewing to help parents identify areas of strength and areas of improvement.	Certification of Supervisor-Trainers: ~50-60 hours Provider Training modality: self-paced e-learning, interactive webinar training and follow-up consultation Supervisor-Trainer: individualized consultation, observation, and evaluation; review and provide feedback on video sessions	male and female children, and female caregivers.
15	Chicago Parenting Program	Positive parenting, behavior problem reduction	Ages 2-8	Family Support and Education	12-session evidence-based parenting program created for parents of young children (2-8 years old) to strengthen parenting and reduce behavior problems in young children	~3 hour, 4-day virtual training	**Chicago Parenting Program** is included in CA Evidence-Based Clearinghouse and NIJ Crime Solutions with evidence to support use with the following demographic groups: African American, Hispanic, and White families; some studies included male caregivers For more information on research with diverse populations, please review: Our Research (chicagoparentprogram.org)

Appendix G.

In addition to school mental health practices, applicants may request to participate in a learning collaborative on measurement-based care:

EBP – Learning Collaboratives	Short description	Targeted Audience for Delivery	Tier	Description/Services
Measurement-Based Care	Addresses a range of problems including anxiety, depression, and trauma	all	3 - individual	Use of frequent assessments to evaluate effectiveness of therapy and adjust as needed

Appendix G.

Recommended Menu

The Consortium will also consider funding school mental health practices not on the above list, but that are:

- supported by evidence of impact on target social, emotional, behavioral, and/or academic outcomes (based on research evidence, as recognized in national registries and the scientific literature, and/or supported by practice-based evidence of success in local or similar schools or communities)
- equitable and fit the unique strengths, needs, and cultural/linguistic considerations of students and families in your community
- have adequate resource capacity for implementation (e.g., staffing capacity; training requirements, qualifications, and staff time; ongoing coaching)
- monitored for fidelity

Applicants could receive funding to implement Recommended interventions but would need to arrange their own training and implementation support.

Examples of practices that may be funded within the Recommended Menu include, but are not limited to:

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
1	Attachment Based Family Therapy (ABFT)	Helps a parent and child build an emotionally secure relationship	Youth between 12-18 and parents	2/3	Attachment-Based Family Therapy (ABFT) is the only manualized, empirically supported family therapy model specifically designed to target family and individual processes associated with adolescent suicide and depression. ABFT emerges from interpersonal theories that suggest adolescent depression and suicide can be precipitated, exacerbated or buffered against by the quality of interpersonal relationships in families. It is a trust-based, emotion-focused psychotherapy model that aims to repair interpersonal ruptures and rebuild an emotionally

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					protective, secure-based parent–child relationship. ABFT consists of five therapeutic tasks that are addressed and completed as the course of therapy progresses.
2	Acceptance and Commitment Therapy (ACT)	Psychological flexibility	Ages 6-18	2/3	Uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility
3	Brief Intervention for School Clinicians (BRISC)	Addresses emotional and behavioral stressors	HS students	2/3	Responsive to the typical presenting problems of high-school students, as well as their approach to help-seeking and their patterns of service participation
4	Check and Connect	Student engagement and persistence in school	k-12	2/3	The "**Check**" component refers to the process where mentors systematically monitor student performance variables (e.g., absences, tardies, behavioral referrals, grades), while the "**Connect**" component refers to mentors providing personalized, timely interventions to help students solve problems, build skills, and enhance competence
5	Check In Check Out	Addresses common classroom behavior challenges	K-12	2/3	A student receiving CICO meets with adults throughout the school day to reinforce and track behavioral goals.
6	Dialectical Behavior Therapy (DBT) for Schools	Emotional Problem Solving	Grades 6-12	2/3	Helps adolescents manage difficult emotional situations, cope with stress, and make better decisions
7	Interpersonal Psychotherapy for Adolescents (IPT-A)	Depression / Suicidal ideation and behavior	Ages 12-18	2/3	outpatient treatment for teens who are suffering from mild to moderate symptoms of a depressive disorder, including major depressive disorder, dysthymia, adjustment disorder with depressed mood, and depressive disorder not otherwise specified
8	IPT-A - Ultra-Short Crisis Intervention (IPT-A- SCI)	Suicidal ideation and behavior	Adolescents	2/3	To address the critical need in crisis intervention for children and adolescents at

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					suicidal risk, based on Interpersonal Psychotherapy (IPT), the ultra-brief acute crisis intervention is comprised of five weekly sessions, followed by monthly follow-up caring email contacts to the patients and their parents, over a period of three months.
9	Support for Students Exposed to Trauma (SSET)	Trauma	Children in late elementary school through early high school (ages 10-16)	2/3	A series of ten lessons whose structured approach aims to reduce distress resulting from exposure to trauma. SSET is designed to help schools and school systems that do not have access to school-based clinicians. Designed with and for teachers and nonclinical school counselors, this program targets students in fifth grade and above. SSET uses a lesson-plan format instead of a clinical manual.
10	Trauma-Focused CBT (TF-CBT)	Trauma	Children and adolescents	2/3	structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 8-25 sessions with the child/adolescent and caregiver
11	Executive Functioning interventions (see Brain Futures report)	Executive functioning	Various age groups, interventions available for Pre-K-12	1, 2/3	See pgs. 44-66 here Universal, group, and individual interventions that target executive functioning (I.e., planning, meeting goals, following directions, etc.)
12	Incredible Years	SEL	Infant, toddler, school-age children	1	Incredible Years is a series of interlocking, evidence-based programs for parents, children, and teachers. The goal is to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence.
13	MindUP	Mindfulness; SEL; Brain Literacy	Offered in three age-related levels,	1	MindUP is a classroom program that provides a curriculum at the intersection of neuroscience, positive psychology, mindful

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
			Pre-K–2, Grades 3-5, and Grades 6-8		awareness, and SEL. The aim of MindUP is to help students focus their attention, improve self-regulation skills, build resilience to stress, and develop a positive mindset in school and in life
14	Positive Action	Positive youth development; Behavior supports	PreK-12	1	Positive Action is a 7-unit curriculum that works through the Thoughts-Actions-Feelings (TAF) Circle to emphasize actions that promote a healthy and positive TAF cycle.
15	Second Step	SEL	PreK –12 Staff	1	Second Step programs help students build social-emotional skills—like nurturing positive relationships, managing emotions, and setting goals
16	Signs of Suicide	Suicide prevention	Students in grades 6-12	1	SOS teaches students how to identify signs of depression and suicide in themselves and their peers, while providing materials that support school professionals, parents, and communities in recognizing at-risk students and taking appropriate action.
17	Source of Strength	Suicide prevention	K-12 (separate programs for elementary and secondary)	1	Sources of Strength is a radically strength-based, upstream suicide prevention program with shown effectiveness in both preventative upstream and intervention outcomes. Sources of Strength has both an elementary and secondary model. Sources Secondary trains groups of Peer Leaders supported by Adult Advisors to run ongoing public health messaging campaigns to increase wellness and decrease risk in their schools. Sources Elementary is implemented as a universal classroom based Social Emotional Learning curriculum. The model incorporates the Sources of Strength protective factor framework, more robust language on mental

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EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					health, and a prevention lens that many elementary SEL models lack.
18	Teen Mental Health First Aid (T-MHFA)	Mental health literacy	Teens in grades 10-12, or ages 15-18,	1	Teaches students how to identify, understand and respond to signs of mental health and substance use challenges among their friends and peers.
19	Tools of the Mind	Social-emotional; Self-regulatory skills Teacher professional development	PreK and K staff	1	Tools of the Mind is a research-based early childhood model combining teacher professional development with a comprehensive innovative curriculum that helps young children to develop the cognitive, social-emotional, self-regulatory, and foundational academic skills they need to succeed in school and beyond.
20	Conscious Discipline	Trauma-informed SEL	Teachers; Admin; MH Professionals; Parents	1	Conscious Discipline creates a compassionate culture and facilitates an intentional shift in adult understanding of behavior via the Conscious Discipline Brain State Model. It provides specific brain-friendly, research-backed strategies for responding to each child's individual needs with wisdom.
21	Classroom Check Up	Classroom management	Teachers	1	Contains web-based tools and training in the form of intervention modules to support both teachers and coaches. Each module incorporates elements such as videos, assessment instruments, strategy tools, and action planning tools to facilitate effective and efficient implementation of evidence-based classroom management practices
22	Adolescent Depression Awareness Program (ADAP)	Depression	Adolescents	1	Includes 3 classes focused on interactive activities, video sessions, and discussions
23	Restorative Practices	Problem solving and conflict resolution	K-12	1	A classroom and school-based strategies to proactively build healthy relationships and a sense of community to prevent and address conflict and wrongdoing

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	EBP – programs/trainings	Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
24	Classroom WISE	Mental health literacy	K-12	School Staff Training	Classroom WISE is a free self-guided online course focused on educator mental health literacy, informed by and co-developed with educators and school mental health professional across the United States
25	Youth Mental Health First Aid (Y-MHFA)	Mental health literacy	Adults who regularly interact with young people	School Staff Training	Youth Mental Health First Aid, an 8-hour course, is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.
26	Facilitating Attuned Interactions (FAN)	Provider-parent relationship	Mental health, School Nurse/Health Suite, Educators and Teacher Assistants and Administration, Special Education teams	Family Support and Engagement	FAN's aims to strengthen the provider-parent relationship, resulting in parents who are attuned to their children and ready to try new ways of relating to them.
27	Teacher WISE	Educator well-being	Teachers and school staff at all levels	School Staff Training	Helps educators assess their own well-being and personalize their learning with specific strategies that enhance their well-being
28	Be Strong Families Parent Cafes	Family relationships	Families and caregivers	Family Support and Education	Cafés are structured, small group conversations to facilitate transformation and

Appendix G.

EBP – programs/trainings		Focus/Short description	Target Audience for Delivery	Tier/Modality	Description/Services
					healing within families, build community, develop peer-to-peer relationships, and engage parents as partners in the programs that serve them.
29	Family Bereavement Program	Family Bereavement	Youth who are 8 to 18 years old who have lost a parent/caregiver and the surviving parent/caregiver	Family Support and Education	A community-based or clinical program, is designed to enhance parenting skills, teach helpful coping methods, foster constructive communication, and create and sustain healthy parent-child relationships following the recent death of a parent or caregiver through group sessions.
30	Parent CRAFT- Community Reinforcement and Family Training	Substance Use	Families of teens or young adults	Family Support and Education	Community Reinforcement and Family Training, or CRAFT, is an approach to help parents and other caregivers change their child's substance use by staying involved in a positive, ongoing way.
31	Strengthening Family Coping Resources (SFCR)	Trauma; PTSD	Families living in traumatic contexts	Family Support and Education	SFCR is a manualized, trauma-focused, skill-building intervention. It is designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder and other trauma-related disorders in children and adult caregivers. SFCR provides accepted, empirically supported trauma treatment within a family format.
32	PEP - Educating Parents, Enriching Families	Family Relationships	Families with children from 5-18	Family Support and Education	Gives families the knowledge to understand the underlying causes of their children's behavior, and the practical skills and tools they need to address problems right away

Appendix H.

Contact information for key school district (LEA) staff

Jurisdiction	Point of contact for applicants
Allegany Co.	Debbie Metheny, Director of Special Education and Student Services, debra.metheny@acpsmd.org
Anne Arundel Co.	Ryan Voegtlin, Director of Student Services, rvoegtlin@aacps.org
Baltimore City	Courtney Pate, Director, Office of Health and Specialized Student Services, cmpate@bcps.k12.md.us
Baltimore Co.	Deb Somerville, Director of Health Services, dsomerville@bcps.org
Calvert Co.	Suzanne McGowan, Supervisor of Student Services, mcgowans@calvertnet.k12.md.us
Caroline Co.	Cara Calloway, Mental Health Coordinator, calloway.cara@ccpsstaff.org
Carroll Co.	Information will be posted on the CHRC website when it is available
Cecil Co.	John Roush, Director of Student and School Safety, jroush@ccps.org and Kristen Lehr, Coordinator for Behavior and Mental Health Services, kblehr@ccps.org
Charles Co.	Dr. Mike Blanchard, Supervising School Psychologist, mblanchard@ccboe.com and Kathy Kiessling, Director of Student Services, kkiessling@ccboe.com
Dorchester Co.	Information will be posted on the CHRC website when it is available
Frederick Co.	Lynn Davis, Supervisor of Mental Health Services, Lynn.Davis@fcps.org
Garrett Co.	Information will be posted on the CHRC website when it is available
Harford Co.	Joe Harbert, Director of Health and Wellness, Joseph.Harbert@hcps.org and Christina Alton, Mental Health Specialist, Christina.Alton@hcps.org
Howard Co.	Consortium@hcpss.org
Kent Co.	Dr. Vienna Walker, Supervisor of Student Services, 410-810-3170, vwalker@kent.k12.md.us and Vandrick Hamlin, Mental Health and School Safety Coordinator, 410-778-7128, vhamlin@kent.k12.md.us
Montgomery Co.	Dr. Patricia Kapunan, School System Medical Officer, Patricia_Kapunan@mcpsmd.org
Prince George's Co.	YCFT@pgcps.org
Queen Anne's Co.	Matt Evans, Supervisor of Student Services, starke.evans@qacps.org
Somerset Co.	Tracey Cottman, Supervisor Student Services, tcottman@somerset.k12.md.us
St. Mary's Co.	Robin Schrader, Supervisor of Mental Health Services, rmschrader@smcps.org
Talbot Co.	Rob Schmidt, Mental Health Coordinator, rschmidt@tcps.k12.md.us
Washington Co.	Jeremy Jakoby, Director of Student Services, School Counseling, and School Health, JakobJer@wcps.k12.md.us and Marjorie Sharkey, Behavioral Health Services Coordinator, sharkmar@wcps.k12.md.us
Wicomico Co.	Kim Miles, Assistant Superintendent for Student & Family Services, kmiles@wcboe.org
Worcester Co.	Lauren Williams, Coordinator of School Health, Mental Health, and School Counselors, LAWilliams@worcesterk12.org

Appendix I.

Budget Spreadsheet Template

Budget Form Template - August 2023 Community Support Partnership Call for Proposals MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION			
Organization Name:	Project Name:		
Revenues			MCHRC MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Total CHRC grant request			
Line Item Budget for CHRC Grant Request	**School year 2023-2024 Budget Request (December 2023-June 2024)**	**School year 2024-2025 Budget Request (July 2024-June 2025)**	**Line Item Total Budget Request**
Personnel Salary (enter the requested information for each FTE)			
% FTE - Name, Title			0
% FTE - Name, Title			0
% FTE - Name, Title			0
Personnel Subtotal	**0**	**0**	**0**
Personnel Fringe (no more than 25% of Personnel costs)			0
Equipment / Furniture / IT			
a.			0
b.			0
Supplies			0
Travel / Mileage / Parking (staff travel costs should be on a separate line from client travel costs)			0
Staff Training / Development			0
Contractual (>$5k itemize below with details in budget justification)			
a. Professional/other services by vendor/contractor (1)			0
b. Professional/other services by vendor/contractor (2)			0
c. Professional/other services by vendor/contractor (3)			0
d. Lease or rental costs (not included under "Equipment/furniture," "Supplies," "Other Expenses," or "Indirect Costs")			0
Other Expenses (**MUST** detail below)			
a. Other			0
b. Other			0
c. Other			0
Indirect Costs: no more than 10% of direct costs (>10% - refer to Budget Form instructions and RFP)	0	0	0
Totals	**0**	**0**	**0**

This template is available on the RFP webpage, https://health.maryland.gov/mchrc/Pages/notices.aspx.

Appendix J.

Budget Narrative Template
NAME OF APPLICANT
August 2023 Coordinated Community Supports Partnerships RFP

Total CHRC Request

Provide the total amount of grant funding requested under this RFP.

Personnel Salaries

The budget spreadsheet should include a line for each position. The budget narrative should list each staff position and provide the total cost, percent FTE, name, and brief description of work to be performed in support of the project for each individual. Please identify any salary increases (i.e., 3% COLA raise in year 2).

Personnel Fringe

Provide percentage used in calculation of salary fringes and identify any increases in the rate used for budget calculations. **The Commission advises that the fringe rate be calculated at no more than 25%. If the grantee requests more than 25%, the applicant will be required to provide a compelling rationale for exceeding this amount.**

Equipment/Furniture/IT

In the narrative provide a brief description of any equipment/furniture/IT with a brief explanation for the use of the item(s) to be purchased with grant funding in support of this project.

Supplies

Identify types of supplies and estimated costs. Do not budget for supplies associated with EBPs on the Priority Menu, as these will be provided.

Travel/Mileage/Parking

Identify costs and reasons for travel and how travel funds will be spent. Travel costs for individuals receiving services should be on a different line than any travel costs for staff.

Staff Trainings/Development

Identify type of training, who will receive the training, and costs for the training. Do not budget for costs for EBP trainings from the Priority Menu in the RFP, however, you may budget for staff salaries/stipends associated with receiving these trainings.

Contractual

Individual contractual budget items that exceed $5,000 must be listed separately on the grant budget template. List services provided by a business, organization, or individual who is not a state employee such as: advertising, utilities, repairs and rentals/leases, and professional services.

Identify each individual vendor/contractor, the cost of the total contract, and how this contract relates to the overall execution of the program. Do not include expenses covered under other line items such as “Equipment/Furniture”, “Supplies”, “Other Expenses” or under “Indirect Costs”.

Other Expenses

Identify in sufficient detail any additional expenses using grant funding and provide estimates of the expenses.

Indirect Costs

Indirect costs cannot exceed 10% of the direct costs. Indirect costs are those for activities or services that benefit more than one project. Examples of indirect costs include utilities, insurance, rent, audit and legal expenses, equipment rental, and administrative staff. However, in light of recent legislation approved by the Maryland General Assembly which requires the State to honor certain rates for indirect costs on certain State-funded grants and contracts with nonprofit organizations that involve federally approved rates, the CHRC will consider permitting higher indirect cost rates (above 10%) on a case-by-case basis if the applicant can demonstrate that a higher rate has been approved by the federal government.

Please note:

1) **Items that cannot be included as direct or indirect expenses include late fees, depreciation, interest expenses, and costs for severance packages.**

2) **If there are additional line items added to the budget form template, please provide similar details and explanations of these items in the budget narrative.**