

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

Behavioral Health Crisis Response Grant Program

Request for Proposals (RFP)

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

Issue Date: May 20, 2020

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

**Provider Proposals Due to
Local Behavioral Health Authority
(LBHA)/Core Service Agency (CSA)/
Local Addiction Authority (LAA):** Friday June 19, 2020 by 5:00 p.m.

LBHA/CSA/LAA Deadline to BHA: Friday July 10, 2020 by 5:00 p.m.

BHA Point of Contact: Darren McGregor
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I. Introduction

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

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

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

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

II. Background

Mission

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

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

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

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

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

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

Membership

The initial representatives on this workgroup include the following:

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

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

III. Definitions

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

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

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

- **Mobile Crisis:**

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

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

- **Crisis Stabilization:**

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

- **Residential Crisis Services/MH:**

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

- **Walk-in Center:**

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

IV. General Requirements:

A. Application Process:

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

Step 1:

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

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

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

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

Step 2:

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

a. Option 1:

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

OR

b. Option 2:

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

B. Overview:

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

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

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

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

C. Partnerships:

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

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

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

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

D. Objectives:

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

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

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

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

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

E. Scope of Service:

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

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

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

F. Priority Populations:

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

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

The goal is to reach individuals experiencing a behavioral health crisis who are at high risk of instability in the community, especially those who are in danger of harm to self or others and at risk of immediate referral to a hospital emergency room. The intent is to provide services in a more appropriate, less restrictive setting that provides immediate, safe, community-based, peer-driven services and direct linkages to ongoing care. Such services will be a better way to make meaningful and lasting treatment and support connections that will lead to improved treatment outcomes. For children/youth and their respective families, crisis response may be required due to threats of either self-harm or harm to others, inability to attend school, and/ or home/placement disruptions.

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

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

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

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

H. Staff Requirements:

Residential Crisis Beds:

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

<http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.63.04>.

Crisis Walk-in Center:

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

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

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

0.5 FTE Physician/Medical Director

4.5 FTE Nurse Practitioners

4.5 FTE Nurses

2.5 FTE Social Workers/Counselors

4 FTE Peers

3 FTE Security

4 FTE Reception

Mobile Crisis Services:

Mobile Crisis Services are to include:

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

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

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

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

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

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

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

Goals and outcomes should include:

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

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

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

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

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

Monthly Program Summary Reports:

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

Client-Level Data:

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

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

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

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

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

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

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

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

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

IV. RFP Specifications

A. Applicant Eligibility:

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

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

B. Proposal Timeframe, Submission, Contact and Term:

1. Timeline

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

2. Proposal Submission and Location

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

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

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

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

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

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

C. Award of Contract

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

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

D. Contract Requirements:

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

E. Fiscal Feasibility:

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

F. Proposal Format:

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

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

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

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

- Problem statement
 1. Severity of the problem (supported by data)
 2. Previous interventions to address the problem
 3. Local, Regional, State, and/or Federal partnerships formed to address the problem
 - Target population
 1. Children and/or
 2. Families and/or
 3. Transitional Age Youth and/or
 4. Adults and/or
 5. Older Adults
 - Type of Crisis
 1. Mental Health and/or
 2. Risk of Suicide and/or
 3. Substance Related Disorder
 - Intervention or service
 1. Mobile Crisis
 2. Walk-in Crisis Center
 3. Crisis Stabilization Center
 4. Residential Crisis Beds
2. Submit a clear and concise narrative of what the program will deliver including a detailed description of how the proposed service will be integrated and coordinated with any existing or other newly funded crisis service within the service area. **Maximum 5 points**
 3. Submit a clear and concise timeline for the implementation of services. **Maximum 5 points**
 4. Description of provider expertise and organizational capacity to provide mobile crisis services, crisis walk-in or crisis stabilization services:
 - Experience working with individuals who are Medicaid eligible and/or are uninsured.
 - Prior or current experience in providing behavioral health related walk-in crisis services or Mobile Crisis Services.
 - Prior or current experience in operating behavioral health related crisis beds.
 1. Provide a copy of current certification/license for mental health crisis beds.
 - Prior experience working with youth and families.
 - Plan to ensure compliance with federal and state confidentiality requirements, including HIPAA and 42 CFR, part 2.
 - Knowledge of American Society of Addiction Medicine (ASAM) Criteria. **Maximum 15 points.**
 5. Description of the level of support, detailed 24/7 staffing ratio, projected number of individuals to be served, the eligible functions that will be funded, and a description of the expected outcomes. **Maximum 15 points**
 6. Identification of performance and outcome indicators to be used to evaluate the program's effectiveness, including a description of the expected schedule for measuring performance and outcomes. **Maximum 15 points**

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

H. Grant Awards and Data Collection Requirements

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

I. Closing/Submission Date and Location

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

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

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

Attachment A

PRE-AWARD RISK ASSESSMENT TEMPLATE AND GUIDANCE
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Sub-recipient:	
Monitoring Period:	
Award Number:	
Federal Number:	
CFDA Number:	
Program:	
Review Date:	
Award Period:	
Date of Last Review:	
Award Amount:	

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

PRE-AWARD RISK ASSESSMENT TEMPLATE AND GUIDANCE

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

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

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

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

Attachment B: MABHA Contact List



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

Allegany County

Local Behavioral Health Authority

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

Anne Arundel County

Local Behavioral Health Authority

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

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

Baltimore City

Local Behavioral Health Authority

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

Baltimore County

Local Behavioral Health Authority

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

Calvert County

Local Behavioral Health Authority

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

Caroline County

Core Service Agency

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

Director: Katie Dilley

Local Addictions Authority

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

Director: Terri Ross

Carroll County

Local Behavioral Health Authority

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

Director: Sue Doyle

Cecil County

Core Service Agency

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

Director: Shelly Sawyer

Local Addictions Authority

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

Director: Kenneth Collins

Charles County

Local Behavioral Health Authority

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

Director: Karyn Black

Dorchester County

Core Service Agency

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

Director: Katie Dilley

Local Addictions Authority

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

Director: Donald Hall

Frederick County

Local Behavioral Health Authority

Frederick County Health Department,
Behavioral Health Services
350 Montevue Lane
Frederick, MD 21702
301-600-1755 Fax: 301-600-3237
awalker@frederickcountymd.gov
sdrennan@frederickcountymd.gov

Director: Andrea Walker

Deputy Director: Sarah Drennan

Garrett County**Local Behavioral Health Authority**

Garrett County Behavioral Health
Authority

1025 Memorial Drive

Oakland, MD 21550

301-334-7440 Fax: 301-334-7441

fred.polce@maryland.gov

Director: Fred Polce

Harford County**Core Service Agency**

Office on Mental Health of Harford
County 2231 Conowingo Road, Ste. A
Bel Air, MD 21015

410-803-8726 Fax: 410-803-8732

jkraus@harfordmentalhealth.org

Director: Jessica Kraus

Local Addictions Authority

Harford County Health Department
120 S. Hays St.

Bel Air, MD 21014

410-877-2338 Fax: 410-638-4954

Shawn.martin@maryland.gov

Program Manager: Shawn Martin

Howard County**Local Behavioral Health Authority**

Howard County Health Department
8930 Stanford Road

Columbia, MD 21046

410-313-7316 Fax: 410-313-6212

rrbonaccorsy@howardcountymd.gov

Director: Roe Rodgers-Bonaccorsy

Kent County**Core Service Agency**

Mid-Shore Behavioral Health, Inc.

28578 Mary's Court, Suite 1

Easton, Maryland 21601

410-770-4801 Fax: 410-770-4809

kdilley@midshorebehavioralhealth.org

Director: Katie Dilley

Local Addictions Authority

Kent County Health Department

300 Scheeler Road

Chestertown, MD 21620

410-778-5864 Fax: 410-778-7002

brenna.fox@maryland.gov

Director: Brenna Fox

Montgomery County**Local Behavioral Health Authority**

Department of Health & Human Services

401 Hungerford Drive, 1st floor

Rockville, MD 20850

240-777-1414 Fax: 240-777-1145

teresa.bennett@montgomerycountymd.gov

Teresa Bennett, Acting Director, LBHA

240-777-3360 Fax: 240-777-1145

Rebecca.garcia@montgomerycountymd.gov

**Rebecca Garcia, Operations Manager,
LBHA**

Prince George's County**Local Behavioral Health Authority**

Prince George's County Health Department

Dyer Regional Health Center

9314 Piscataway Road

Clinton, MD 20735

301-856-9500 Fax: 301-856-9558

lcwaddler@co.pg.md.us

Manager: L. Christina Waddler

ssmith2@co.pg.md.us

Assistant Manager: Sherese Smith

Queen Anne’s County

Core Service Agency

Mid-Shore Behavioral Health, Inc.
28578 Mary’s Court, Suite 1
Easton, Maryland 21601
410-770-4801 Fax: 410-770-4809
kdilley@midshorebehavioralhealth.org

Director: Katie Dilley

Local Addictions Authority

Queen Anne’s County Health
Department
206 North Commerce Street
Centreville, MD 21617
410-758-1306 x4534 Fax: 410-758-2133
maggie.thomas@maryland.gov

Director: Maggie Thomas

Somerset County

Local Behavioral Health Authority

8929 Sign Post Road, Ste 2
Westover, MD 21871
443-523-1700 Fax: 410-651-3189
shannon.frey@maryland.gov

Director: Shannon Frey

St. Mary’s County

Local Behavioral Health Authority

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

Director: Tammy Loewe

Talbot County

Core Service Agency

Mid-Shore Behavioral Health, Inc.
28578 Mary’s Court, Suite 1
Easton, Maryland 21601
410-770-4801 Fax: 410-770-4809
kdilley@midshorebehavioralhealth.org

Director: Katie Dilley

Local Addictions Authority

Talbot County Health Department
100 South Hanson Street
Easton, MD 21601
410-819-5600 Fax: 410-819-5691
sarah.cloxtan@maryland.gov

Director: Sarah Cloxtan

Washington County

Core Service Agency

Washington Co. Mental Health Authority
339 East Antietam Street Suite 5
Hagerstown, MD 21740
301-739-2490 Fax: 301-739-2250
rickr@wcmha.org

Director: Rick Rock

Local Addictions Authority

Washington County Health Department
Division of Behavioral Health Services
925 N. Burhans Blvd
Hagerstown, MD 21742
240-313-3310 Fax: 240-313-3239
victoria.sterling@maryland.gov

Director: Victoria Sterling

Wicomico County

Local Behavioral Health Authority

Wicomico Behavioral Health Authority
108 East Main Street
Salisbury, MD 21801
410-543-6981 Fax: 410-219-2876
Michelle.hardy@maryland.gov

Director: Michelle Hardy

Worcester County

Local Behavioral Health Authority

Worcester County Local Behavioral
Health Authority

6040 Public Landing PO Box 249

Snow Hill, MD 21863

410-632-3366 Fax: 410-632-0065

jessica.sexauer@maryland.gov

Director: Jessica Sexauer