Regional Partnership Catalyst Grant Program
Funding Stream II: Behavioral Health Crisis Grant Application

Section I: Scope of Work

1. Summary of Proposal

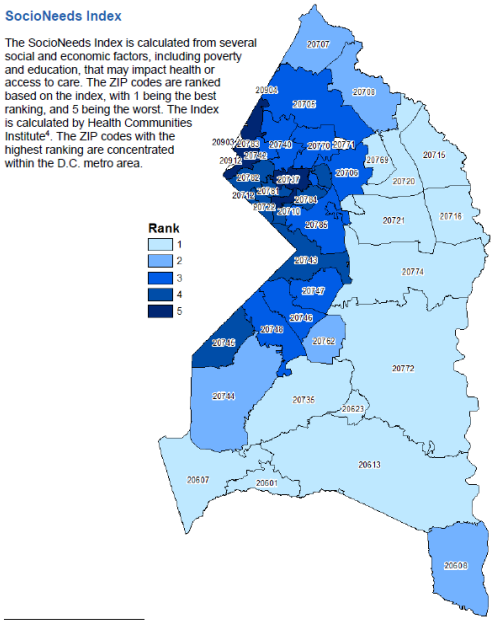
Hospital/Applicant:	Totally Linking Care in Maryland, LLC (TLC-MD)
Hospital Members:	Adventist HealthCare Fort Washington Medical Center MedStar Southern Maryland Hospital Center (MSMHC) University of Maryland Capital Region Health: • University of Maryland Prince George's Hospital Center • University of Maryland Laurel Medical Center
Health System Affiliations:	Adventist HealthCare MedStar Health University of Maryland Medical System
Funding Track:	Behavioral Health
Total Budget Request:	
Target Patient Population	
All residents of Prince George's County who are at risk for having a behavioral health (mental health and/or substance use disorder) condition.	
Proposed Activities	
Crisis Call Center Air Traffic Control Technological Enhancement: The existing Prince George's County Response System will be enhanced with the addition of purchased software to meet the Crisis Now call center standard and improve data collection. Mobile Crisis Team (MCT) Expansion: The team capacity is currently inadequate and two additional teams will be added. Crisis Receiving and Stabilization Center: A center where individuals can be assessed on demand, stabilized, observed and care coordinated by behavioral health professionals. Wraparound Care Coordination Services: For high-risk, high-need individuals who have either been discharged from inpatient psychiatry or have been seen in the emergency department (ED), They will be enrolled in a 24/7 technology-enabled care coordination emergency department diversion program. Transportation Supports: A transportation feature will be added to the MCT as well as taxi/ride-share services to connect people to the appropriate services including the crisis center.	
Measurement and Outcomes	
By 12/31/25, the main goals are to reduce ED board times for behavioral health patients by 10% and to decrease unnecessary ED and inpatient psychiatric visits. Other outcome measures will be finalized during the planning phase. Additional process measures to track the development, utilization, and patient satisfaction of the service components will also be assessed.	
Scalability and Sustainability	
Decreasing unnecessary ED and inpatient psychiatric visits will result in cost-savings that will demonstrate the value of sustaining the program.	
Governance Structure	
The Health Department (HD), LHIC and the hospitals will work with TLC-MD to establish the governance structure. TLC-MD will receive all grant funds and procure all contracts, including those needed by the Health Department, such as for service vendors and consultant services. Each member hospital and TLC-MD will assign a designee to form the program workgroup that will also include the HD. The workgroup will provide input and feedback to the grant-funded Health Department Program Director and Evaluator and will start their work with a strategic planning period. The Program Director will oversee the programmatic development and management. The Program Director will report to and obtain feedback monthly from the LHIC on grant activities.	

Participating Partners and Financial Support
Totally Linking Care in Maryland (TLC-MD) on behalf of the Partners in this grant will serve as the fiscal agent and have corporate oversight of the grant funds. Health Department staff will support the Program Director in carrying out grant duties, and funds currently allocated to the Prince George's County Crisis System will be included in the overall build out of the enhanced system. The LHIC will provide feedback and input regarding the operations. Each participating hospital will provide financial support based on the percentage of the GBR contribution. In kind support for grant oversight from the hospitals and the Health Department will include the workgroup designee, supportive Health Department staff and complimentary existing and future Health Department grants.
Implementation Plan
Crisis Call Center Air Traffic Control Technological Enhancement: We plan to investigate and procure the necessary technology. Mobile Crisis Team Expansion: We will write and issue an RFP for additional MCT services. Crisis Receiving and Stabilization Services: We will write and issue an RFP for the development and management of a center. This will not open until the second year of the grant and the first year will be a planning year. Wraparound Care Coordination Services: Will be awarded Q1 2021 Transportation Support: We will include this in the MCT RFP and secure taxi or medical ride-share services.

2. Target Population

In the National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation, SAMHSA estimates nearly 200 crisis episodes monthly in a population of 100,000 (SAMHSA, 2020). Using this ratio, it can be estimated that in Prince George's County (population of approximately 912,756) approximately 21,907 individuals will require crisis services annually. The federal data has indicated that almost 57% of those who need treatment do not receive mental health services and up to 90% of adults with both mental health and behavioral health (co-occurring) disorders do not receive treatment (SAMHSA, 2019).

We hereby plan to target all residents of Prince George's County who are at risk for having or have a behavioral health (mental health and/or substance use disorder) condition. The entirety of the Prince George's County zip codes include the following: 20601,20607,20608, 20613,20623, 20705, 20706, 20707, 20708, 20710, 20712, 20715, 20716, 20720, 20721, 20722, 20735, 20737, 20740, 20742, 20743, 20744, 20745, 20746, 20747, 20748, 20762, 20769, 20770, 20771, 20772, 20774, 20781, 20782, 20783, 20784, 20785, 20903, 20904, and 20912. Prince George's County has several municipalities and they are listed as follows: Adelphi, Avondale, Berwyn Heights, Camp Springs, Chillum, Cheverly, Colmar Manor, Fairmount Heights, Forest Heights, Forestville, Glenarden, Hillcrest Heights, Kettering, Landover/Landover Hills, Lanham Seabrook, Largo, Marlow Heights, Mitchellville, Morningside, New Carrollton, Riverside Park, Seat Pleasant, Springdale, and University Park.



Prince George's County, Maryland is the second most populous county in the state of Maryland, as a close second

to Montgomery County with a population of 1.051 million (U.S. Census Bureau, 2020). It is a diverse county with approximately one in five of its residents being foreign born (CHNA, 2019) and is predominantly Black, with Blacks comprising over 60 percent of the population (CHNA, 2019). Although it is known to be the most affluent African American community in the United States, there are areas of continued socioeconomic need as demonstrated by the SocioNeeds Index map above (CHNA, 2019). Socioeconomic factors such as lack of affordable housing are significant stressors that negatively impact the behavioral health of individuals. It has been well-established that access to healthcare including behavioral health care in Prince George's County is limited, which is another barrier to access to quality healthcare (CHNA, 2019). The number of behavioral health providers has steadily increased, but there are still significantly lower ratios of behavioral health providers to residents at 146 per 100,000 residents as compared to the state average of 258 per 100,000 residents (PGCHD, 2019). Furthermore, a smaller percentage of Prince George's County residents have health insurance than the Maryland average (CHNA, 2019) which can limit access to care, emphasizing the need for easily accessible services to better manage behavioral health conditions.

The behavioral healthcare infrastructure is in its development stages in Prince George's County, with some grants partially serving to fill in the gaps for care. Without a holistic continuum of care, patients in behavioral health crisis usually end up in the Emergency Department (ED) for care as the last resort when there are gaps within the somatic and/or behavioral healthcare system. As seen in the table to the left, alcohol-related disorders were the most common cause of behavioral health emergency room visits in 2017 closely followed by mood disorders. In 2017, there were 3,027 admissions of residents for substance-related disorders and the drug-related age adjusted-death rate nearly doubled between 2012 and 2017 (CHNA, 2019). Prince George's County has the fourth highest number of overdoses by place of occurrence in the state of Maryland and the largest gross increase of overdose deaths in the state of Maryland, which is nearly double that same period in 2019 (State of Maryland OOCC, 2020). According to the Prince George's County Drug Overdose Fatality Review Team 2019 Annual Report, it was found that almost 42 percent of the decedents reviewed had a documented history of an emergency room visit prior to their death (PGCHD, 2020). To prevent fatal overdoses, appropriately engaging all ED patients in drug and/or alcohol interventions and not simply those who use opioids is a potentially life-saving intervention for many.

Emergency Department Visits* for Behavioral Health Conditions, Prince George's County, 2017

Behavioral Health Condition	Frequency	Percent
Alcohol-related disorders	1,887	22.4%
Mood disorders	1,671	19.9%
Anxiety disorders	1,340	15.9%
Substance-related disorders	1,140	13.5%
Schizophrenia and other psychotic disorders	905	10.8%
Suicide and intentional self-inflicted injury	551	6.5%
Delirium dementia and amnestic and other cognitive disorders	296	3.5%
Attention-deficit conduct and disruptive behavior disorders	198	2.4%
Adjustment disorders	164	2.0%
Miscellaneous mental health disorders	126	1.5%
Impulse control disorders	43	1.0%
Total	**8,420**	**100%**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and percent.
Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Mental health and substance use disorder conditions are often co-morbid. According to the 2018 State Unintentional Drug Overdose Reporting System Capitol Region report encompassing both Montgomery County and Prince George's County, approximately one quarter of the overdose decedents were in mental health treatment at the time of their death and 37 percent had a mental health diagnosis (SUDORS, 2020). A behavioral health crisis model must address these co-occurring conditions to be successful in Prince George's County.

Emergency petitions are a source of emergency department psychiatric evaluations for individuals when someone is a danger to themselves or others, and are creating a strain on the limited behavioral health inpatient resources. Prince George's County granted 794 emergency petitions in CY 2019 alone through the court system, whereas Montgomery County granted 376. With a similar

population volume, Prince George's County has over double the volume of EPs and significantly lower inpatient acute behavioral healthcare capacity compared to Montgomery County. These numbers just begin to demonstrate the sheer volume of individuals in distress and seeking care in emergency rooms. In 2019, UMPGHC served 2356 patients with a behavioral health disposition in the ED. This high volume has overcrowded the ED and challenged the ability to provide high quality care, as the ED may not be the most appropriate environment for their treatment. There have been up to 17 psychiatric patients at one time in the ED, the size of a medium-sized psychiatric unit. Prince George's Police Department has repeatedly facilitated a County-wide diversion of emergency petitions from the UMPGHC ED because the psychiatric boarding was overwhelming the hospital's capacity to manage the somatic and behavioral health needs of patients in the emergency department.

Many of those who are evaluated in the ED also require inpatient psychiatric care. Schizophrenia is the 10th leading cause of inpatient admissions in the county, excluding residents who visit hospitals in the District of Columbia (CHNA, 2019). If an individual needs inpatient psychiatric care, there are currently 60 inpatient beds between MSMHC and UMPGHC. By comparison, Montgomery County has 159 beds. Regional decreases in inpatient psychiatric beds have led to additional ED boarding. With additional resources to appropriately divert patients from the ED, there is an opportunity to reduce unnecessary ED utilization through this grant funding.

Both hospitals with inpatient psychiatric units had to essentially cut in half their capacity to minimize the risk of COVID-19 during the recent surge of COVID-19 cases. This led to increased emergency room boarding at UMPGHC and an even greater decrease in available emergency evaluation space. The impact of COVID-19 on Prince George's County has demonstrated that health disparities of racial and ethnic minorities transcend wealth. These inequities leading to health disparities are related to a myriad of factors including the impacts of race and racism on health, but also disparate local health funding. "Prince George's invests far less of its own money in health and human services than its neighbors, putting $38.94 per capita toward those services in 2018, compared with $224.25 in Montgomery County…" (Washington Post, April 26, 2020).

However, the narrative on this issue has already started to shift. The County Executive recently announced that she is shifting capital funding from the Police Department budget to develop a $20 million behavioral health center and a key council member has expressed strong support for adding funds to the Health Department budget immediately. In the era of COVID-19 and its fiscal impact, adding HSCRC grant funds to these local efforts would help create a much-needed foundation to advance health equity.

Finally, one common source of emergency room psychiatric patients and inpatient admissions are those who are brought in by law enforcement. Individuals with behavioral health conditions are also largely found in correctional settings. The Prince George's County Department of Corrections (DOC) leadership estimates that approximately 31 percent of inmates are on prescribed psychotropic medications, more than 60 percent have a diagnosable mental health disorder, and more than 80 percent report significant substance use history. Individuals with severe mental illness are sixteen times more likely to be involved in a fatal police shooting than those who are not (Carroll, 2015). Unfortunately, this also happens in Prince George's County, including the highly publicized police involved shooting of an individual with a mental illness late last year (Warfield, 2019).

3. Proposed Activities

The Prince George's County Crisis Response System has a foundation of the majority of the core components of the Crisis Now system, which is consistent with SAMHSA best practices for crisis care (NAASP, 2016; SAMHSA, 2020). The major missing element is the "sub-acute" crisis stabilization program which is our greatest opportunity. This HSCRC funding request would further build upon the current system. According to SAMHSA, "Short-term, inadequate crisis care is short-sighted. Imagine establishing emergency services in a town by purchasing a 40-year-old fire engine and turning the town's old service shop into the fire station – it will work until there is a crisis. True no-wrong-door crisis care is needed and anything short of full implementation will fall short of meeting the needs of the community" (SAMHSA, 2020). Although this expansive program comes at a cost, it has been designed to develop a sustainable system that can adequately begin to address the health inequities and disparities that have led to inadequate access to behavioral health services for the residents of Prince George's County.

A multi-sector project workgroup will be collaboratively formed as described in the Participating Partners and Decision-Making Process section. The majority of these funds are programmatic enhancement or expansion to existing services that are already available within Prince George's County at the current time. It has been well-established that these are the future direction and/or capacity needed to expand, and the project team can bring these items into service relatively quickly. Even so, the Project Team will embark on strategic planning early in the work to ensure that the services are indeed meeting the needs of the community. This process will be aided by an independent expert consultant that will be funded by this work.

Community feedback will be obtained throughout the process and before completion of the plan. There will be a competitive RFP process for this work to engage community partners. LHIC members include a local Historically Black College/University that also has a Licensed Professional Counselor training program and a Certified Peer Recovery Specialist training program. This can be highlighted as a potential recruitment source to meet vendors' staffing needs. To promote these new programs and programmatic enhancements, we plan to engage a myriad of partners including the hospitals, local government public safety partners, the local department of social services, and the LHIC -- and to use government-sponsored social media campaigns.

<u>Proposed Activity 1: Crisis Call Center Air Traffic Control Technological Enhancement</u>

The state-wide Maryland Crisis Hotline (211 option 1) is answered by a regional call center provider, the Community Crisis Services. All crisis specialists are ASIST (Applied Suicide Intervention Skills Training) trained and have nearly 60 hours of learning before answering their first calls. Community Crisis Services has answered the Maryland Crisis Hotline since its inception in 1989 and, when appropriate, calls are then directed to Prince George's Crisis Response Service, which triages the call and dispatches a team if it is clinically appropriate and a team is available.

According to SAMHSA and the Crisis Now model, the best practices for a crisis call center include air (Care) traffic control-features added to a call center. TLC-MD proposes to support the Crisis Call

Center Air Traffic Control Technological Enhancement to the call center with an advanced reporting dashboard. Features include the ability to track and connect individuals with community resources by allowing community partners to indicate appointment and/or bed availability and facilitate digital referrals. The system has the potential to coordinate with the first responder systems as well as electronic health records, emergency medical services, schedules and bed registries.

Proposed Activity 2: Mobile Crisis Team Expansion

Using SAMHSA's Crisis System Calculator, Prince George's County would require approximately six mobile crisis teams to meet the estimated behavioral health crisis need – currently, there are only one to two mobile crisis teams serving the entirety of Prince George's County of nearly one million residents. The longer it takes for a team to respond, the greater risk to safety of the individual and the less inclined the individual is to further use or promote the service. An element that SAMHSA promotes as a best practice for the essential qualities that must be "baked into" comprehensive crisis systems includes law enforcement and emergency medical services collaboration. The current crisis system is partially funded by the Prince George's Police Department. The crisis response system responds promptly to police calls when requested to lend their expertise. Having the expertise of a crisis-trained behavioral health professional working with police officers offers the opportunity to prevent any unnecessary emergency department visits or arrests.

The number of teams and geography play a key role in mobile crisis service availability and utilization. The distance from Laurel, Maryland to Aquasco, Maryland is 49 miles, with a minimum travel time of one hour without traffic. Therefore, if a team is responding to a crisis in Laurel and their next call is in Aquasco, it would take a minimum of one hour for the team to respond to the crisis in Aquasco. In order to reduce response time, designating teams for various geographic regions would make this service stronger and we would plan to do this with this funding. Furthermore, mobile crisis team expansion would enable the MCTs to also respond to SUD-related emergencies as well as mental health emergencies. The team historically did not respond to SUD calls and with this grant, the expanded scope of the MCT service would require additional team training and specialization in SUD. For teams composed of two behavioral health professionals, in alignment with best practices, we will request that peers be incorporated into the MCT staffing model for the teams funded by this grant.

Proposed Activity 3: Crisis Receiving and Stabilization Services

According to SAMHSA, a "high proportion of people in crisis who are evaluated for hospitalization can be safely cared for in a community-based crisis facility and the outcomes for these individuals are at least as good as hospital-based care, while the cost of crisis care is substantially less than the costs of inpatient care and accompanying medical clearance charges" (SAMHSA, 2020). Expansion of the mobile crisis call center and mobile crisis team capacity is an important component of a holistic crisis system but is inadequate without the creation of a crisis receiving and stabilization center according to the Crisis Now model and SAMHSA best practices. To safely prevent unnecessary emergency room visits and hospitalizations for a large population of people such as those in Prince George's County, there must be a location to which to divert individuals. Otherwise, there will be additional identification of those with behavioral health needs without an alternative destination that is not the hospital or jail. Mobile crisis team expansion alone could increase emergency room utilization and hospitalization due to additional identification of individuals in a behavioral health crisis.

We are proposing to establish a crisis receiving facility that can accept individuals in crisis 24/7/365 days in a year on a walk-in self-referred basis and by the support of law enforcement and/or the emergency medical services as capable by law. The center will accept anyone who is medically stable regardless of age, diagnosis, or insurance status for mental health or substance use disorder presentations. The center would triage and evaluate individuals for safety, initiate treatment, and coordinate the appropriate resources necessary for the ongoing care of the individual. The standard of

care with respect to staffing for such as facility is having some psychiatric staffing, behavioral health clinicians, nurses, peers, security, and other support staff. Telehealth may be utilized to improve cost-efficiency. There would need to be adequate space and trained staff to deescalate individuals who are experiencing acute psychiatric conditions and provide stabilizing behavioral health services. Furthermore, if an individual needed an extended observation period to ensure stability and/or support during a state of intoxication or withdrawal from a substance, an observation space would be available.

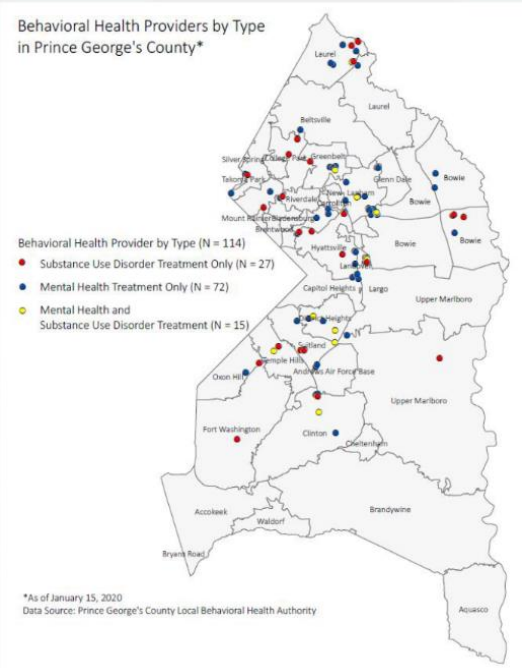
This type of service would fill the gap for individuals who also are in transitional periods in their care such as post hospital discharge, or briefly awaiting a residential placement, and would safely provide treatment until they establish care with their regular or a newly identified provider. The emergency room physicians at UMPGHC and MSMHC have initiated a buprenorphine induction program as an extension of their Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs from the emergency room and this could be a strong transitional location for those who are in need of rapid access to opioid treatment services as well.

Proposed Activity 5: Wrap-Around Care Coordination Program

Intensive case management and care coordination are keys to preventing individuals from overusing high-cost hospital-based resources. One way that MSMHC worked to improve their inpatient psychiatry readmission rate was to engage a behavioral health focused technology company to provide 24/7 technology-enabled virtual and in-person case management through their Care Coordination Program. In the last year, the vendor's work has led to nearly a 69 percent reduction in the readmission rate at the six Maryland hospitals that use this 32-day intervention program. MSMHC provides this intervention for a limited cohort determined to be at the highest risk of returning to the inpatient psychiatry unit within 30 days. The program includes risk stratification, screening, and assessment leading to predictive analytics that direct the case manager in how to work most effectively with those at highest risk of seeking acute care services. The services provided to the patient include implementation of a hospital discharge plan; coordination with providers and community medical and social resources; education and coaching; and monitoring of progress and medication adherence. Through this funding opportunity, TLC-MD plans to expand this program within the MSMHC inpatient psychiatry discharges and add this service to the UMPGHC inpatient psychiatry discharge plans. Individuals with behavioral health presentations who have been determined to be high-risk and/or high-need in the emergency departments of the hospitals that do not have inpatient psychiatric units will also have an opportunity to use the service.

MSMHC uses this intervention for a cohort of about 30 individuals who discharge from their inpatient psychiatry unit per month. It is specific to the individuals served. Although this intervention is not a standard part of the Crisis Now model, the impressive outcomes will decrease emergency department utilization because the emergency department is the primary hospital entry point to an inpatient psychiatry unit. This service will complement services provided for the highest need individuals and integrate into in the crisis network as the other services can be used to facilitate the work of this care coordination program. This service will also directly impact the ED behavioral health repeat utilization metric as well since the majority of inpatient psychiatric admissions are from the ED.

Proposed Activity 6: Transportation



The expansion of behavioral health crisis services in Prince George's County will only be effective if residents can access the services. Given the county has urban, suburban and rural environments, some areas have limited access to behavioral health services, known as "treatment deserts" as seen on the map. Outpatient mental health centers are clustered along the beltway and center of the county leaving many geographic areas without any behavioral health services at all. This grant could support connecting these residents to care by providing transportation services to ensure that people are physically connected to care when necessary.

The crisis team currently does not provide a transportation service for those in crisis, but through this grant funding, this would be an added feature of the MCT services in addition to the taxi and/or medical ride-share capabilities to be provided as well from hospital and/or crisis center-based supports. This service would better connect individuals to the components of the crisis system and/or treatment centers. For example, although there are relatively few residential substance use disorder treatment beds in the county, this funding could transport people to treatment facilities across the state to an available bed. Through enhanced means of access to the current and proposed services, including the new receiving/stabilization center, county residents in a behavioral health crisis will have one less barrier to receiving the care that they critically need with the added transportation services from this grant funding.

4. Measurements and Outcomes

Applicant Evaluation and Performance Measurement Plan. The leadership team will engage in a robust evaluation plan to monitor the ongoing processes and progress toward meeting the program goals and objectives. The Evaluation and Performance Measurement Plan (EPMP) describes the project's comprehensive approach to generating data, and continuously using high quality data to inform, fine-tune, and improve programming and project evaluation. The EPMP provides a monitoring and evaluation system that includes continuous quality improvement activities and tracks the project's delivery of quantitative results and qualitative findings to measure progress toward the project outputs and outcomes. Rapid cycle quality improvement relies upon the collecting of data throughout the program, rather than solely at static intervals. Each project activity will be assessed multiple times for opportunities for improvement. Metric development is an integral part of our data development and quality improvement process. Each activity will be continually assessed for efficiency, effectiveness, and relevance in relationship to the objectives. In cases where the outputs or preliminary outcomes are not aligned with the proposed intent of the program, the activity will be reassessed and revised to attain intended outcomes.

Strategic inputs for this program include key partners, integration of the Crisis Now model, existing behavioral health competencies and services that exist in Prince Georges County and its formal collaboration with the Prince George's County Health Department and the LHIC. Primary evaluation questions are based on public health programmatic triple AIM goals and guide our evaluation approach:

1. How was the existing Prince George's Crisis system for behavioral health services expanded based on the Crisis Now Model by the end of the period of performance?
2. How has the patient's experience with accessing timely and appropriate behavioral health crisis services changed in Prince George's County?
3. What proposed outcomes/quality improvements resulted from integration of the Crisis Now Model and enhancing existing behavioral health crisis services in Prince George's County?
4. How has the Crisis Now Model integration in Prince George's County improved behavioral health cost of care?

Specific intended program outputs and outcomes are listed in the Program Output and Outcome Measures chart below:

Performance indicators	Data sources	Frequency of collection/report	How findings will be used for QI
What types of resources were used for planning and implementing the proposed program?			
# of staff dedicated to program activities, by role and affiliation	Work plan, Org Chart, Budgets	Bi-annual	Ensure sufficient staff are dedicated to program
# of individuals dedicated to the program advisory committee	Advisory Committee Enrollment and Acceptance Forms	Bi-annual	Ensure sufficient volunteers are dedicated to program
What activities were implemented to meet the proposed integration of the CrisisNow Model?			
Formal fiduciary partnerships with program vendors	Fully-Executed Contracts, MOUs and Agreements	Annual	Ensure contractual partnership and clearly delineated scope of work
Integration of required crisis call software and implementation	Software Licenses, Training Records	One-time review	Ensure appropriate technology and software
Integration of a Trauma Informed Model throughout all aspects of the enhanced Prince George's County crisis response system	TLC, Collaborative Partners, and Vendors Program Protocols	Pre and Post (year 1 and year 4)	Ensure integration of a trauma-informed approach to care
What deliverables were met as a result of the program activities implemented?			
Improve patient experience in timely accessing the right type of behavioral health crisis care	Crisis Referral Data, ~~Crisis Bed Data~~, ED Hospital Data	Year 2 -5	Exemplify the impact of the enhanced crisis model
Enhance 211 service and Crisis Call Line- "Air Traffic Control" central hub	Procedures and Protocols,	Year 1 - 4	Ensure 211 crisis call expansion services
Expansion of Mobile Crisis Team and services in Prince George's County	MOUs and LOS, Partnership Records	Year 1 - 4	Ensure expansion of Mobile Crisis Services

Use of proposed readmission prevention program as an integral feature of the Readmission Reduction Program	Utilization Records	Year 1 - 4	Ensure the use of readmission prevention services in PGCO
Increase by 10% behavioral health patients diverted from ED admission, per 100,000 residents	Hospital ED Records, EMR Data	Bi-annual	Assess program efficacy and success
Reduce by 10 percent of behavioral health patients per 100,000 residents readmitted into Prince George's County Hospitals	Hospital EMR Data	Bi-annual	Assess program efficacy and success
Reduce by 10% repeat ED admissions of behavioral health patients per 100,000 residents	Casemix, CRISP Data, ED Hospital Data,	Annual	Assess program efficacy and success, key HSCRC and TLC proposed outcome
Reduce ED Boarding Time of behavioral health patients per 100,000 residents by 10%	Casemix Integration with CRISP, ED Hospital Data,	Annual	Assess program efficacy and success, key HSCRC and TLC proposed outcome
Improve cost of care for behavioral health by 10% per 100,000 residents	CRISP Utilization Data, HSCRC Selected Data Matrix	Annual	Assess program efficacy and success, key HSCRC and TLC proposed outcome

Strategies, activities, and outcomes will be monitored and evaluated through a participatory process and outcome monitoring. The evaluation team includes a Program Director, Evaluator, Expert Consultant, representatives from collaborating partners and the TLC member partners involved in this project. The evaluation team will collaborate to identify relevant questions, finalize the evaluation design, select final measures and data collection methods, and conduct data collection and analysis. Once data are analyzed, the evaluation team will reach consensus about findings, conclusions, recommendations, and dissemination of results. To address quality improvement, the work group will prepare an action plan to improve program performance, using Plan, Do, Study, Act methodology or other quality improvement processes.

Performance monitoring and evaluation activities: The evaluation lead will conduct various types of evaluation activities to generate necessary information and data from project start to finish.

Formative research activities. Formative research including focus groups, surveys, key informant interviews, and structured interviews will be conducted with hospital partners, key stakeholders, and advisory committee members to obtain input on the development of a Crisis Now model in Prince George's County.

Process monitoring and evaluation activities. Process monitoring and evaluation of project activities as described in the work plan will be conducted on an ongoing basis. The evaluation lead will utilize evaluation questions and indicators to develop or modify checklists and other tools as necessary to monitor and evaluate processes, such as the development of data abstraction forms, checklists, and data dashboards.

5. Scalability and Sustainability

It is increasingly clear that failure to have a comprehensive crisis system for behavioral health results in significant escalated health care and criminal justice costs. NASMHPD reports that healthcare costs alone associated with escalated mental health crises are double the costs found in a jurisdiction with a comprehensive crisis system. The most obvious way to bring the Prince George's County system to scale and sustain it moving forward is to document and report the number of individuals diverted from the Emergency Department (ED), as well as savings associated with reduced time spent in the ED before the individual is connected with appropriate treatment. Clear documentation of the savings and achievement of better clinical outcomes for individuals with behavioral health conditions in crisis is expected to result in support for permanently shifting more resources to a comprehensive network of crisis services in the county, using Federal, State and County government funding sources. In addition, hospital and behavioral health stakeholders can continue to advocate for changes in state laws as well as policies of the Maryland Insurance Administration to create an all-payer system among insurance companies for behavioral health crisis services, with all insurers contributing to the crisis system based on a per member per month assessment. This would also bring the state into greater compliance with national parity legislation since individuals undergoing a physical health crisis can simply call 911 to receive a rapid and appropriately staffed crisis response, but individuals in a behavioral health crisis cannot. As noted, this shift would most likely require changes in state legislation and/or a shift in policy direction by the Maryland Insurance Administration.

In the absence of the creation of an all-payer system for crisis services, data will be collected through "air traffic control" software documenting the number of diversions and reduced time in the ED, and then calculating the per hospital cost reduction as a result of those diversions/time in the ED. An appropriate amount of the realized savings could then be shifted toward permanent funding of the crisis system. This could be accomplished by negotiating with insurance companies to shift a portion of the savings to support the comprehensive crisis system.

Some aspects of a crisis operation, such as receiving center evaluations and treatment can potentially be billed to Maryland Medicaid, Medicare, and commercial payers. The team will explore this option. Additional crisis services could potentially be added to the Maryland Medicaid benefits package. The team will also explore this option.

Furthermore, the County Council has acknowledged that the Health Department needs additional funding: "[Councilmember Danielle] Glaros [D-District-3] said that reliance on grants, which are typically short-term and come with restrictions, hurts programming and staff recruitment and retention. She is pushing for a big increase in county funding in next year's budget, despite the anticipated loss of revenue from the prolonged shutdown. 'People can laugh if they want, but I'm going to make these big requests,' Glaros said. 'Because the need is great, and we need to prioritize it'" (Washington Post, 2020).

Multiple efforts are underway at the Federal level to add additional resources to the national crisis network, including proposed legislation to add 5% to federally funded Behavioral Health Block Grants, increases in funding for CCBHCs, additional funds for behavioral health providers to support individuals needing treatment in the time of COVID-19 and its aftermath, additional funds for suicide prevention, funds to reduce disparities related to COVID-19, etc. There has never been a better time for demonstrating the value of a robust crisis system for behavioral health and then advocating for permanent funding.

6. Participating Partners and Decision-Making Process

Totally Linking Care Maryland (TLC-MD) was formed by the hospitals in Prince Georges, Calvert and St. Mary's County as the Regional Partnership Transformation Grant Program entity for the region. In this request, the three involved systems (UMMS, MedStar, and Adventist) operating in Prince George's County will participate under the TLC-MD umbrella to submit as the lead for a comprehensive group of partners dedicated to improving the behavioral health environment for all citizens of Prince George's County specifically.

- University of Maryland Capital Region Health (UMPGHC & UMLRH)
- MedStar Southern Maryland Hospital Center (MSMHC)
- Adventist HealthCare Fort Washington Medical Center

The Program Director would be data-driven and innovative, have a strong knowledge of behavioral health systems and crisis and acute care systems. This integration into the Health Department will assist in the coordination of care at the individual and systems level. This person would build relationships with referral sources such as federally qualified health centers to meet the needs of undocumented residents and work to build not only local, but potentially regional partnerships that might allow for cost-sharing, especially as the local system is being built.

Furthermore, evaluation capacity must be built into this work as well, and an individual with behavioral health epidemiological skills and a working knowledge of the health information exchange will be important to understand the service utilization, associated costs, measure outcomes, and inform quality assurance/improvement activities. This 0.5 FTE would be an employee of the Office of Assessment and Planning within the Prince George's County Health Department.

Finally, because of the complex nature of this project, there is a need for ongoing consultative work to ensure that this program will be successful and meet its desired metrics. There is a need for someone who understands strategic planning, Maryland's behavioral health system, the strengths and weaknesses of local jurisdictional models, grant management, the political landscape, national crisis landscape, healthcare financing, and program evaluation. A strong consultant with this skillset will help to navigate the building of this system. The entire program team will constantly remain engaged in continuous quality improvement activities while working to achieve the goals within the Measurement and Outcomes section.

TLC-MD will convene a leadership structure for the proposal. Each member hospital will assign a designee to the leadership group and these three individuals will join as designees from hospital entities with the PD, evaluator, and a designee from the LHIC to form the program steering committee. The grant-funded consultant will support the work as well and will advise during the process. The programmatic aspects of the workgroup will be led by the Program Director.

The community voice will include a representative from the Prince George's Healthcare Action Coalition (PGHAC), which is the local health improvement coalition for Prince George's County. The behavioral health component of the subgroup of the PGHAC will be the Behavioral Health Advisory Group (BHAG). The Behavioral Health Advisory Group is comprised of the following partners: Department of Corrections, Local Behavioral Health Authority, Prince George's County Public Schools, commercial payers, community behavioral health agencies, local post-secondary institutions, hospital systems, American Society of Addiction Medicine, National Alliance on Mental Illness (NAMI), and others.

List of Behavioral Health TLC-MD Collaborators

Name of Collaborator	***Prince George's County Health Department***
Type of Organization	Local Health Department
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	TBD – based on award and final volume calculations
Type and Purpose of Resource Sharing arrangements	Coordination of other related grants such as three remaining years of annual $1M SAMHSA Systems of Care grant for Transitional Age Youth to braid funding; blending existing crisis funding with funds received from the HSCRC; seeking additional local, state and federal funds and other funding opportunities
Roles and Responsibilities within the RP	Program Director Lead Monitoring and evaluation (M&E) Lead Service promotion and referrals
Name of Collaborator	***Behavioral Health Advisory Group of the Prince George's County Health Action Coalition***
Type of Organization	Local Health Improvement Coalition. Members include American Society of Addiction Medicine, Optum Maryland, the LBHA, CASA, PGCo Department of Corrections-Division of Community Corrections, Faith-based consultant, Aetna, PGCo Public Schools, PGCo Parks & Planning, Bowie State University, U of M College Park, iMind Behavioral Health, Mary's Center, NAMI, PGCo Healthcare Alliance, PGCo Department of Social Services and others.
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	Coalition staff support
Type and Purpose of Resource Sharing arrangements	Community resource sharing/networking, promotion, community stakeholder input. Description of vast stakeholder involvement with potential reach detailed in narrative.
Roles and Responsibilities within the RP	Monthly input and feedback on program Service promotion and referrals
Name of Collaborator	***Prince George's County Office of the County Executive***
Type of Organization	Local government
Type and Purpose of Resource Sharing arrangements	Community resource sharing/networking
Roles and Responsibilities within the RP	Payer, local, state government advocacy Service promotion and referrals
Name of Collaborator	***Prince George's County Police Department***
Type of Organization	Local police department
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	Crisis system response support and existing funding to crisis response system
Type and Purpose of Resource Sharing arrangements	
Roles and Responsibilities within the RP	Promotion, support of utilization
Name of Collaborator	***Prince George's County Office of Sheriff***
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	Local sheriff
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	Subject matter expertise
Type and Purpose of Resource Sharing arrangements	
Roles and Responsibilities within the RP	Service promotion and utilization

Name of Collaborator	***Prince George's County District Court***
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	Local district court
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	Subject matter expertise
Type and Purpose of Resource Sharing arrangements	
Roles and Responsibilities within the RP	System promotion and utilization
Name of Collaborator	***Prince George's County Department of Social Services***
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	Local department of social services
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	Subject matter expertise
Type and Purpose of Resource Sharing arrangements	
Roles and Responsibilities within the RP	System promotion and referrals
Name of Collaborator	***Prince George's Healthcare Alliance***
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	Community Health Worker Organization and Administrator of Prince George's Health Assures Program
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	No direct financial support. In-kind behavioral health care coordination if eligible for services.
Type and Purpose of Resource Sharing arrangements	Community based resource information
Roles and Responsibilities within the RP	System promotion and referrals
Name of Collaborator	***Behavioral Health Services and Systems Management, LLC***
Type of Organization: (i.e. LHIC, Non-Profit, LBHA)	Behavioral health consultation services
Amount and Purpose of Direct Financial Support, if any Type and Purpose of In-Kind Support, if any	No direct financial support for this specific consultant requested. In-kind consultative services of Dr. Gayle Jordan-Randolph
Type and Purpose of Resource Sharing arrangements	
Roles and Responsibilities within the RP	System development guidance, mentorship, and networking

7. Implementation Plan – (See attached)

Section II: Financial Projections

1. Budget

Hospital/Applicant:	Totally Linking Care in Maryland
Regional Partnership Members:	Adventist Fort Washington MedStar Southern Maryland Hospital Center University of Maryland Capital Region Health
Funding Track:	Behavioral Health

2. Budget and Expenditures

TLC-MD and the Prince George's County Health Department convened a grant planning team consisting of member hospital representatives, the Prince George's County Health Department Medical Director of Mental Health Services and an expert behavioral health consultant to develop this program concept and budget.

Workforce: In order to ensure that the project is successful, and the outcome measures are met, we propose a 1.0 FTE Program Director and .5 FTE Evaluator dedicated to the program. Along with the indirect time of the TLC-MD Executive Director and the in-kind time and talent from each hospital, the health department and the LHIC we feel we will have a strong governance team in place. The addition of a subject matter expert consultant rounds out the workforce dedicated to implementing the programs outlined below

IT/Technologies: Central to the Crisis Now model is the concept of an Air Traffic Control system to help place persons in crisis appropriately. The software estimates include interface licenses for the various partners, direct patient messaging, intensive user support capabilities and a premier Tableau level-dashboard reporting system. This addition to the county call center will not only allow for better coordination of services, deployment of teams, and placement of those in crisis, but also access to databases by which to make decisions as this project matures and to also have rich data available for the evaluator.

Services: Given the large geography and population of Prince Georges County, additional Mobile Crisis teams, strategically located, are necessary to respond in the time frames determined by best practices in the Model. This budget will support the addition of at least two more teams following our current county program standards.

Wraparound services: to support residents identified as being at risk for inpatient hospitalization if not properly supported in the community, three wraparound services are proposed. All three will help stabilize persons clinically as well as help to remove any social determinant of health barriers that might be identified by the mobile crisis team, hospital emergency department or the crisis stabilization center staff. We propose three programs that can be employed alone or in concert for appropriate persons. The care coordination program is envisioned to provide 24/7 telephonic support and opportunities for in-person interactions with behavioral health care coordinators to assist when clients need reassurance or assistance for 30 days following a hospital encounter, assistance in getting appointments with community providers, medications or meeting other identified needs. Transportation is often seen as a significant barrier to care, and as such a fund will be available and criteria for use developed to aid clients in getting to the crisis center, community appointments and other needed services to maintain the individual in the community setting,

Indirect: TLC-MD as the hospital coalition for Prince George's county and the vehicle for collaboration on funding opportunities among the member hospitals requires operating funds to fulfill the obligations of the various projects it undertakes. We have a proven track record having been an awardee in the last round of transformation grants as well as the major subrecipient and partner with Prince Georges County on the PreventionLink 4-year $12 million cooperative agreement with the CDC.

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