Greater Baltimore Region Integrated Crisis System (G-BRICS)

Regional Partnership Catalyst Grant Program

Behavioral Health Crisis Services

JULY 15, 2020

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SECTION I: SCOPE OF WORK

SECTION 1: SUMMARY

Hospital/ Applicant:	**Behavioral Health System Baltimore**	
Hospital Members and System Affiliations	**Ascension** Saint Agnes Hospital **Johns Hopkins** Howard County General Hospital Johns Hopkins Bayview Medical Center Johns Hopkins Hospital and Health Sys. **LifeBridge** Grace Medical Center Sinai Hospital Northwest Hospital Carroll Hospital	**MedStar** MedStar Good Samaritan Hospital MedStar Harbor Hospital MedStar Union Memorial Hospital MedStar Franklin Square Medical Center **Univ. of Maryland Medical System (UMMS)** University of Maryland Medical Center Univ. of Maryland-St. Joseph Medical Ctr Univ. of Maryland Medical Center-Midtown Campus **No System Affiliation/Independent** Mercy Medical Center Greater Baltimore Medical Center
Track:	Behavioral Health Crisis Program	
Budget:	$44,862,000	

Target Patient Population
The Greater Baltimore Regional Integrated Crisis System (G-BRICS) will serve children and adults who experience a behavioral health crisis in four jurisdictions: Baltimore City, Baltimore County, Carroll County, and Howard County. The four jurisdictions have a combined population of 1.94 million residents. Overall, residents of these jurisdictions (who account for approximately 30% of the state's population) account for 45% of statewide Emergency Department (ED) visits, with behavioral health as a primary diagnosis. For the 65–80% of behavioral health ED visits that do not have a co-occurring medical issue (totaling more than 25,000 annual ED visits across the four jurisdictions), the ED is likely not the most appropriate care setting to treat their needs. See Appendix A for the list of zip codes, hospitals, local jurisdictions, and incorporated cities.
Proposed Activities
With the economic and health pressures facing our communities today, it is more important than ever to provide access to behavioral health services and timely response to people experiencing a crisis. We know the need is great and will likely increase. For this reason, every hospital in these four jurisdictions (17 hospitals, representing nearly 60% of statewide regulated revenue, and more than 50% of inpatient psychiatric beds at acute hospitals) has united to build the Greater Baltimore Regional Integrated Crisis System (G-BRICS). The G-BRICS partners envision building on Maryland's behavioral health crisis response system; helping alleviate existing strains and pain points; and providing people high-quality, cost-effective, and timely patient-centric care in the right setting. G-BRICS will collectively pursue the following two elements of the *Crisis Now* model: (1) Implement a centralized Care Traffic Control (CTC) system, as the cornerstone of transforming how the region responds to people experiencing a behavioral health crisis, and/or struggling with substance use or mental health issues. The CTC will create: • One hotline phone number connected to the CTC for the region;

- A single hub that dispatches the Mobile Crisis Teams (MCT) using real-time GPS tracking, ensuring quick response times and minimizing travel distance;
- Increased accountability by giving Local Behavioral Health Authorities (LBHAs) and other system stakeholders real-time access to data;
- A dashboard showing bed availability and open appointments; and
- Ability to seamlessly schedule appointments to connect people to needed follow-up care.

(2) Increase the availability of the Mobile Crisis Teams (MCTs) to 24 hours a day, 7 days a week.

G-BRICS also seeks funding to help community-based, outpatient behavioral health providers expand same day access (SDA) to immediate-need behavioral health services. SDA is essential to increase the system capacity by ensuring access assessment, de-escalation, treatment, and immediate follow-up, thereby reducing delays in care and reliance on hospital EDs for "just in time" care. Many crisis situations can be managed within existing outpatient clinic settings, if patients had the means to immediately access services in these settings. Therefore, G-BRICS has emphasized increasing SDA as a critical component of this proposal.

Measurement and Outcomes

After launching the CTC and beginning the MCT expansion, hospitals will begin to experience a decrease in ED wait times or boarding times for behavioral health patients. By the end of 2025 (year five of the grant), hospitals will experience an overall decrease in the number of repeat ED cases for behavioral health (three or more ED visits in a calendar year), with the target goal of a 10% reduction. Another goal is to minimize encounters with law enforcement or police for people experiencing a behavioral health crisis. In addition, CTC data will enable use of metrics, such as MCT response time and the rate of scheduled follow-up appointments, which are valuable to a range of stakeholders.

Scalability and Sustainability

This five-year grant from HSCRC will establish a foundation for expanded services that will spur innovation and transform the system to give people experiencing a behavioral health crisis timely access to care and services. The goal of outcome measures described in Section 4 of this proposal is to 1) demonstrate savings across stakeholders in a way that justifies the creation of sustainable funding streams for the CTC and expanded MCTs, and 2) demonstrate the self-sustaining nature of SDA hours that results from appropriate re-engineering of community behavioral health practices. Generating demonstrable savings for hospitals, payors, and public entities through reductions in cost and payments related to unnecessary ED visits; improving throughput; improving patient outcomes; and reducing the burden of emergency response systems will serve as a powerful platform to advocate for the policy, coverage, and reimbursement changes necessary to create new, sustainable funding streams. The grant period will serve as "proof of concept" for these essential components of the crisis response infrastructure that currently struggle to find a pathway to implementation due to lack of startup funding to demonstrate improved outcomes. G-BRICS partners will define the value propositions that justify stakeholder support and long-term investment in this integrated approach.

Changes to standard operating procedures within organizations across the region will help sustain the G-BRICS approach as it is embedded in processes, contractual requirements, unified messaging and communications, and daily operations. Cementing these changes will protect the region from reverting back to the status quo once grant funding ends. At the same time, the CTC system will be a powerful and visible tool, demonstrating the positive outcomes from investing in infrastructure and connectivity. We will advocate for expansion of the CTC to more counties then leveraged statewide, with future operations handled by the State of Maryland as a critical infrastructure element for the entire behavioral health system. As G-BRICS gains experience with expanding MCTs using a

local/regional (decentralized/centralized) approach, we will share lessons and best practices so additional counties can consistently apply the uniform standards to connect to the CTC, while enabling flexibility to account for unique local circumstances.

Governance Structure

As a unified group, the 17 hospital partners will enter into a single services agreement with Behavioral Health System Baltimore (BHSB) to serve as the Regional Administrative Manager to provide overall project management for G-BRICS, including fiscal accountability, procurement and contract management (including sole source contracts for those named in the proposal) for the competitively bid regional CTC and MCT services, SDA consulting, and oversight of G-BRICS day-to-day activities. A multi-stakeholder council will ensure diverse engagement to provide guidance about the overall strategy and implementation of the G-BRICS initiatives.

Participating Partners and Financial Support

Due to the significant number of participating hospitals and community collaborators in this proposal, the list of partners and their contributions and support for G-BRICS is included in Appendix B.

Implementation Plan

Year 1	Year 2	Year 3	Years 4–5
- Secure Regional Administrative Manager, stand-up Council, and staff - Purchase CTC software and procure CTC Ops Center vendor - Complete analysis of current MCT protocols and data streams - Procure SDA consultant and recruit practices for Pilot 1 - Hire firm to develop marketing strategy - Build community engagement structure - Begin sustainability and impact groundwork - Seek additional funding sources, if needed	- Begin to develop local protocols - Launch CTC - Transition local hotlines - Begin outreach and behavior change marketing of CTC hotline, MCTs, SDA, culture change - Set regional MCT standards - Procure MCT vendor(s) - Start SDA pilot (20%) - Continue community engagement, and sustainability analysis and actions	- Expand MCTs to operate 24/7 and meet 60% of anticipated demand - Expand SDA pilot (+40%) and start pilot evaluation - Continue community engagement, coordinated outreach campaign, and sustainability analysis and actions	- Expand MCTs to meet 80% of demand in Yr 4 (100% in Yr 5) - Expand SDA pilot (+40%) in Yr 4 - Finish SDA evaluation in Yr 5 - Continue community engagement and coordinated outreach campaign - Finish sustainability analysis - Secure reimbursement for services and ongoing revenue sources

Budget & Expenditures

The G-BRICS partnership developed a budget to address the five priority areas listed in Section 3, using a data-driven methodology and incorporating experiences of other communities, to build on existing infrastructure and provide the necessary strategic and administrative tools to ensure success. The proposed budget allows for a careful monitoring of existing and proposed services in early years, near-term implementation of the regional CTC, gradual ramp up of MCTs and SDA pilot starting in Year 2, with robust community engagement throughout. It is anticipated that requested funds will be distributed to each of the 17 participating hospitals via an increase in rates. Together, the hospitals will contract with a Regional Administrative Manager to facilitate decision making with stakeholders, and to ensure effective and efficient implementation of the goals outlined in this proposal.

SECTION 2: TARGET POPULATION

The Greater Baltimore Regional Integrated Crisis System (G-BRICS) will serve children and adults who are experiencing a behavioral health crisis (defined as mental health, substance use, or both) across four jurisdictions: Baltimore City, Baltimore County, Carroll County, and Howard County. For the purposes of this grant, the target population is defined as the 1.94 million residents[i] of these four jurisdictions. Residents of these jurisdictions currently account for nearly 11,500 mobile crisis responses[ii] (which is only 20% of the mobile crisis need estimated by Substance Abuse and Mental Health Services Administration guidelines) and more than 58,000 annual visits to hospital Emergency Departments (ED) with behavioral health as a primary diagnosis.[iii] Overall, residents of these jurisdictions (who account for approximately 30% of the statewide population) account for 45% of statewide ED visits with behavioral health as a primary diagnosis and over 45% of statewide public funding for behavioral health.

The G-BRICS approach is guided by the clear trends and disparities that exist within the target population. Residents of the four-jurisdiction area utilize the ED for behavioral health crisis (defined as primary diagnosis of behavioral health) at a rate that is 43% higher than the statewide average (Baltimore City, in particular, is 2.5 times the state average on a per population basis). Review of these visits suggest that as much as 65% to 80% of the outpatient ED patients presenting with behavioral health crisis have minimal co-occurring medical crises.[iv] This means a significant portion of the people who go to a hospital ED because of behavioral health needs could be served in an alternative setting. In addition, nearly 60% of behavioral health crisis ED visits in these jurisdictions are Medicaid participants (nearly 70% in Baltimore City), indicating a population with significant health disparities. Finally, surveys from local community health needs assessments suggest that as many as 13% of residents within these jurisdictions having a behavioral health crisis do not utilize any services because they do not know how to access the system.[v]

Crisis services should be available for anyone, anywhere, at any time. In particular, recognizing that nearly 30% of ED visits for behavioral health crisis are by children (ages 1–14), adolescents (ages 15–17), and ages 65+, we are committed to ensuring that the G-BRICS is responsive to the needs of all age groups. In addition, to reduce health disparities, G-BRICS will work to develop specialized MCTs and CTC/MCT regional standards which reflect and meet the unique needs of populations including people of color, children and youth, the LGBTQ population, people with developmental disabilities, Veterans, and those with vision or hearing impairments.

Appendix A[1] includes the geographic scope of the collaboration, defined by a comprehensive list of ZIP codes, hospitals, local jurisdictions/counties, and incorporated cities.

SECTION 3: PROPOSED ACTIVITIES

Research[vi] and best practices have demonstrated that a well-functioning behavioral health crisis response system helps to resolve the crisis quickly, meets individuals in an environment where they are comfortable, and provides appropriate care and support while avoiding unnecessary law enforcement involvement, emergency department (ED) use, and hospitalization.

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[1]NOTE: Due to the sizeable geographic region covered by G-BRICS, the full table is in Appendix A.

Unfortunately, the lack of structured coordination and connections in the behavioral health system, plus limited capacity and treatment services, puts a strain on individuals and families in crisis. It also strains hospital EDs, law enforcement, and the justice system. Without a well-structured access point (with broad awareness of how to access it across the community) and subsequent coordinated response to behavioral health crisis, the most common points of entry for those with behavioral health crises are emergency services by first responders and walk-ins to hospital EDs. In Baltimore City, it is estimated that more than 30% of 150,000 annual calls to 911 are for low-acuity behavioral health concerns.[vii] A Chicago study indicated nearly 50% of police responses to mental health crises resulted in transportation to a hospital ED, while 6% resulted in arrest, and only 8% were resolved by referral to a mental health or social service.[viii]

The impact of people experiencing a behavioral health crisis seeking care in the ED is far-reaching. First, for the 65% to 80% of behavioral health ED visits by people who do not have a co-occurring medical issue (totaling more than 25,000 annual ED visits across the four jurisdictions), the ED is likely not the most appropriate care setting to treat their needs. In addition to adverse patient experience and outcomes for those experiencing a behavioral health crisis, these visits are costly and disruptive to hospital efficiency. On average in the four jurisdictions, a behavioral health ED visit is more than 40% longer than a medical ED visit[ix] and drives $1,300 in hospital charges per visit.

Due to limited resources, psychiatric patients who present in an overburdened ED are often subject to ED boarding, or the practice of holding patients in the ED or another temporary location after a clinician decides that the patient needs to be admitted or transferred. Behavioral health patients often "overflow" into the traditional ED, consuming time and resources needed for people seeking emergency care for other medical needs. This results in extended ED boarding and wait times. As noted by the HSCRC staff in their development of the Quality-Based Reimbursement program recommendation, "Maryland continues to perform poorly on the ED Wait Time measures compared to the nation," with 85% of hospitals in Maryland having ED wait times higher than national averages.[x] This poor performance, despite recent improvement efforts, indicates a greater systemic problem around ED usage, notably the lack of adequate community-based crisis services. G-BRICS intends to break this cycle by increasing access to community-based care and reducing over-utilization of hospital EDs in the treatment of behavioral health crises. This G-BRICS proposal is designed to increase both the availability of and connection between community-based services to address this issue, with a goal of reducing ED wait times and utilization at hospitals in participating jurisdictions.

The fact that more than 50% of mobile crisis responses in a jurisdiction such as Baltimore City take the people in crisis to hospital EDs, which then divert the patients to community care, is indicative of the opportunity to improve the existing fragmented response to behavioral health crises. G-BRICS will transform the current uncoordinated systems that are stymied by a lack of connectivity, data, and accountability into a high-functioning crisis response system that truly meets the needs of patients and the community.

G-BRICS envisions a system of care that is responsive to people struggling with substance use, experiencing a mental health crisis, or both—a system that is patient-centric, more informative, and, ultimately, more accountable to everyone. Not only are there benefits for hospitals and behavioral health providers, first responders, and the criminal justice system, there are profound benefits for patients, families, and caregivers who will experience less confusion about where to call for help, increased ability to access services "just in time" with fewer delays in care, and, in most cases, get appropriate care that does not involve a hospital ED or the police, unless absolutely necessary.

Investment in technology, infrastructure, training, and expanding capacity are critical to G-BRICS success. Planning, co-design with stakeholders, and protocol decisions will shape how we will implement and use an integrated crisis response system. We will involve a range of partners in those activities, including individuals with lived experience, community groups, first responders, and community-based providers, as their expertise and involvement are essential to success.

As a group, the 17 hospital partners will contract with Behavioral Health System Baltimore (BHSB) to provide oversight of G-BRICS day-to-day activities, overall project management, including fiscal accountability; managing competitive procurement processes; developing and issuing contracts to vendors for community-based services; and assessing, monitoring, tracking, and course-correcting vendor performance. As a non-profit organization with deep understanding of the Maryland behavioral health system and specialized experience in behavioral health procurement and contract management, BHSB is uniquely positioned for this role. BHSB is one of the four Local Behavioral Health Authorities (LBHA) in the region, each of which is responsible for managing the overall behavioral health system within their local jurisdiction. BHSB is the only LBHA structured as a non-profit organization so it can accept funds from participating hospitals, foundations, government agencies, and other sources; thus, positioning the G-BRICS regional partnership to diversify funding and sustainability options. G-BRICS partners selected BHSB as it has established solid relationships, processes, and systems that can rapidly and efficiently engage the community, build infrastructure, and launch the strategic priorities of G-BRICS:

(1) Establish a regional Care Traffic Control (CTC) system;
(2) Deploy additional Mobile Crisis Teams (MCT) to meet demand; and,
(3) Expand same day access (SDA) to immediate-need behavioral health services (walk-in or virtual).

BHSB will use a competitive procurement process to select the following vendors: (1) CTC operations center; (2) one or more vendors to provide MCT coverage 24/7; and (3) consultant/consulting firm to provide SDA technical assistance and training. Procurement and contracts will give preference to providers/vendors that are community-based, have knowledge and history of serving the target population, and that are located in Maryland. BHSB will also prioritize vendors who have an established history of serving both adults and children, and who have the appropriate staff to continue to serve both populations. This will ensure individuals of all ages have access to enhanced services and are provided alternatives to the hospital ED. We will purchase CTC software and technology from Behavioral Health Link (BHL) or another vendor via a targeted Request for Proposal. BHSB will identify behavioral health providers to participate in the first round of the SDA pilot project via a targeted solicitation. Based on the experience and lessons learned from the first round of the pilot, BHSB (with guidance from the G-BRICS Council) will determine how to identify the second round of providers. BHSB will also manage the sole-source contracting for consulting services named in this proposal.

Organizations that are members of the G-BRICS Council or the Hospital Group will have access to information and knowledge that will give them a competitive advantage over other organizations submitting a bid; therefore, they will not be eligible to become a G-BRICS vendor or contractor.

PRIORITY 1: ESTABLISH A REGIONAL CARE TRAFFIC CONTROL SYSTEM

A Care Traffic Control (CTC) system is the crisis response equivalent of the aviation industry's air traffic control. A CTC is widely considered as the essential building block for implementing and scaling the *Crisis Now* model. States that have implemented the *Crisis Now* model credit their success to embracing CTC

as the central component of transforming how a community responds to people struggling with substance use, experiencing mental health crisis, or both.

While each jurisdiction has existing hotlines and call centers, when viewed as a region, the system is fragmented and without a coordinated approach to behavioral health crisis response. G-BRICS envisions that the CTC will have a single regional hotline to take and manage calls 24/7. This hotline represents a "no wrong door" for people who have questions, need information, are struggling, or who are in crisis. The CTC will be able to dispatch MCTs, provide information about community resources, and seamlessly schedule behavioral health appointments—without the individual having to call a different phone number. G-BRICS believes that linking a person to a behavioral health provider—without additional effort from the person—will dramatically improve access to care and services in a timely manner, thereby helping to prevent individuals from going into crisis.

Currently the behavioral health crisis system lacks an accessible and reliable way to identify which providers have immediate openings for relevant services, which makes it extremely difficult to access and coordinate crisis care. The CTC will have a dashboard that can show if a person has checked-in for their appointment, did not show up, cancelled, or rescheduled. The CTC real-time database can show every referral waiting for care, how long they are waiting, and where they are waiting. By providing real-time information to hospitals, behavioral health providers, and local behavioral health authorities, we will make a significant leap in transparency and accountability from the existing system capabilities.

In the current system, there is no way to assess information about if and how individuals progress through the crisis system; that is, whether needed connections and hand-offs have happened to ensure that each crisis situation is resolved effectively and individuals have successfully connected to the behavioral health services and supports that they need.

G-BRICS' initial focus is to bring the CTC infrastructure to our four jurisdictions; however, we anticipate that other counties will want to seriously consider leveraging the G-BRICS CTC as a valuable resource. The G-BRICS partners are very open to having other communities learn from our experience, and we welcome the opportunity to explore whether the reach of the G-BRICS CTC could expand to other jurisdictions. Ultimately, the CTC should exist statewide to service all communities in Maryland.

Implementation of the Care Traffic Control System (CTC)
Implementing a CTC system is comprised of several distinct but dependent activities. G-BRICS will need to acquire software and technology to enable dispatch of GPS-connected MCTs, real-time bed registry and coordination, digital access to routine or urgent outpatient appointment slots, centralized outpatient appointment scheduling, and creation of the performance dashboard.

G-BRICS partners have had preliminary conversations with Behavioral Health Link (BHL), which developed the software technology backbone for the CTC systems in Georgia and Arizona. Currently, we are exploring whether there are other vendors which could provide software and technology that have comparable experience to BHL, to inform the G-BRICS CTC software purchasing decision in Year 1. The G-BRICS budget for the CTC software and the implementation plan is based on a capacity and cost analysis conducted by the G-BRICS proposal development team in consultation with BHL and a national expert on the *Crisis Now* model, in addition to discussions with organizations which operate CTC systems to draw from their practical experience and lessons learned.

Second, in addition to the CTC software, G-BRICS will contract with an organization to staff and operate the CTC center, which includes running the call center, dispatching and tracking MCTs, collaborating with behavioral health service providers regarding scheduling, and creating the real-time dashboard and performance reports using the CTC software and embedded metrics. The regional CTC dashboard will be accessible to LBHAs, local health departments, and hospitals, at a minimum, to help G-BRICS partners make informed decisions around resource management, performance improvement, and strategic planning. To identify and select a CTC vendor, G-BRICS will use a competitive, equitable procurement process. We will involve hospitals and LBHAs to help set the parameters for the Request for Proposals that is used in the procurement process, to establish the criteria by which a vendor is selected, and to participate in the review committee to select a vendor.

We plan for the CTC to be operational in 2022 (Year 2 of the grant). That year, G-BRICS partners will transition local crisis hotlines to a single behavioral health hotline (which will also be a "helpline") for the region, and the CTC will begin to dispatch all MCTs in the region based on standard protocols developed in 2021 (Year 1 of the grant). A single phone number will help reduce potential confusion and increase awareness among consumers, community partners, and organizations involved in the behavioral health system. G-BRICS will continue to work with the State's 211 system to integrate with the CTC hotline and, eventually, with the national 988 system, if that envisioned federal behavioral health hotline is implemented.

Based on current experience, developing the protocols for how the 911 system interfaces with the CTC is a detailed, resource-intensive process that will take time to ensure that the structures, processes, and training is sufficient to ensure that our region continues to respond to people in need. After MCT capacity begins to expand in Year 3, we hope to begin to develop protocols for 911 call transfers, while ensuring that screening is appropriate and, if police or EMS are not needed, calls to 911 can be transferred to the CTC using a "warm handoff" approach.

G-BRICS partners will collaborate to develop and implement a marketing and communications campaign to promote the regional hotline number, with particular focus on materials and communication channels that reach audiences who currently underutilize crisis services (e.g., people struggling with substance use, children and youth, and families)—see Priority 4 for additional details.

With the implementation of a regional CTC center, each LBHA has committed to modifying their local MCT contracts to reflect the need to operate from a single regional hotline and centralized dispatch from the CTC. LBHAs anticipate reallocating funds that previously supported separate local hotlines and dispatch centers to other aspects of their local crisis response system where the need is greatest. The opportunities for economies of scale due to the new CTC infrastructure represent a significant milestone for the region.

The regional CTC system will be a compelling "proof of concept" that demonstrates the improved outcomes and efficiencies from investing in shared infrastructure which supports connectivity and coordination in behavioral health crisis response. Ultimately, the CTC should exist statewide, as it is a cost-effective strategy to achieve economies of scale. Implementing the G-BRICS CTC will alleviate pressure on other local jurisdictions to try to "re-create the wheel"—instead, we anticipate that others will want to connect to the CTC when ready. G-BRICS will prove that this infrastructure for behavioral health crisis management is a critical element of the system that will benefit all Maryland residents.

PRIORITY 2: DEPLOY ADDITIONAL MOBILE CRISIS TEAMS

Mobile Crisis Teams (MCT) provide in-person, community-based behavioral health crisis assessment, de-escalation, brief intervention services, and referral to treatment and other resources. They respond to people in their homes, on the street, and other community locations convenient to the person in need. Many people could stabilize and/or resolve crises in community settings if more immediate services were available. MCTs also create diversion opportunities for people who go to the ED, but do not require such a high-level intervention.

Each of the four jurisdictions has local mobile crisis response in place, accounting for nearly 11,500 mobile crisis responses annually (which is only 20% of the needed mobile crisis response with a CTC in place, as estimated by SAMHSA guidelines for the four-jurisdiction area). This proposal will increase annual mobile crisis responses in the region to 55,000–60,000, in line with SAMSHA estimates.[xi]

Regional Standards for Mobile Crisis Teams (MCTs)

Implementation activities in Year 1 will include an analysis of the similarities and differences in how the four jurisdictions currently operationalize MCTs. G-BRICS partners will work to understand the current data elements that are routinely collected, staffing levels, implementation of best practice standards, involvement of peers with lived experience, degree to which MCTs with special expertise (children and adults with disabilities or special needs, LGBTQ residents, children and youth, etc.) may be needed, and other issues or opportunities to improve person-centeredness and efficiency. This analysis will help inform planning and development of local protocols and regional standards.

To establish MCTs as a behavioral health service that Medicaid and other payers cover and reimburse, it is important to show a compelling value proposition and to have consistency in key aspects of the approach to mobile crisis services. For that reason, LBHAs and other G-BRICS partners, with input from key stakeholders, will define regional standards for MCTs to ensure connectivity with the CTC, a minimum standard for staffing, common performance metrics, and application of best practices. This will position MCTs for long-term sustainability as a key part of an integrated behavioral health crisis system. We will engage local jurisdiction leaders in the process to create regional standards that apply across all four jurisdictions, while enabling flexibility needed to conform with local circumstances. BHSB will embed the regional standards in the MCT vendors' contracts funded by G-BRICS, while strongly encouraging LBHAs to incorporate the regional standards into their local MCT vendor contracts as well.

Some of the regional standards will be required of all MCTs—whether contracted using G-BRICS funding or contracted locally through an LBHA—to set expectations for a number of substantive issues, including that the regional CTC center connect with and dispatch all MCTs. Per the required regional standards, MCT data will be included in the CTC database to provide a more complete picture of crisis system performance, while increasing accountability and improvement opportunities.

As G-BRICS gains experience with expanding MCTs using a local/regional (decentralized/centralized) contracting approach, we will share lessons learned and best practices so other regions will have the ability to apply the uniform MCT standards, while allowing for flexibility to account for unique local circumstances. The G-BRICS approach to MCT expansion could be adapted and leveraged across additional local jurisdictions and eventually a statewide basis.

After we develop local protocols and regional standards, and select the CTC operations center vendor, BHSB will follow its established procurement process to solicit competitive bids from multiple

organizations to provide MCT services and award contracts in 2022 (Year 2). All MCTs in the region, whether they are operating under an LBHA or a G-BRICS contract, will be dispatched via the CTC.

Expanding Mobile Crisis Teams
All four local jurisdictions in the region vary in terms of how MCTs are currently staffed, their daily and hourly availability, operational protocols, contractual expectations, and the performance data that is routinely collected. The SAMHSA National Guidelines for Behavioral Health Crisis Care[xii] indicate that an MCT must: (a) include a licensed and/or credentialed clinician; (b) respond to individuals in need, no matter where they are in the community (home, work, school, public places, etc.); and (c) connect individuals to care as needed through "warm handoffs" and coordinating transportation when necessary. G-BRICS partners view these guidelines as a minimum standard of care; therefore, we will align the regional standards and local protocols for MCTs, and MCT dispatch from the CTC, with these best practices to the extent possible.

Local LBHAs will retain the ability to contract for MCTs to serve their jurisdiction. LBHAs will also have the option to pool purchasing power by merging their local MCT funding with G-BRICS MCT funding. This balances the opportunity to create economies of scale and savings, with the interest in retaining local flexibility and autonomy.

Expansion to ensure that MCTs are available 24/7 in the four jurisdictions is a critical strategy to reduce unnecessary ED utilization and contact with police for people experiencing a behavioral health crisis. Currently, use of MCTs varies across the four local jurisdictions. Under G-BRICS, the combination of local and G-BRICS funded contracts for MCTs will result in availability of MCTs 24/7 everywhere in the region.

We will phase in expansion of MCTs to ensure adequate coverage throughout the region as demand grows due to more people and organizations using the CTC's regional behavioral health hotline. In addition to ensuring 24/7 coverage, the MCT expansion will begin in 2023 (Year 3), with full expansion projected[xiii] to increase capacity to:

Baltimore City:	5 times the existing daily MCTs
Baltimore County:	3.2 times the existing daily MCTs
Carroll County:	1 additional daily MCT
Howard County:	1.5 times the existing daily MCTs

PRIORITY 3: EXPAND CAPACITY TO OFFER SAME DAY ACCESS TO BEHAVIORAL HEALTH SERVICES
Maryland has a robust network of community-based outpatient behavioral health providers within the broader system of care. To build on this existing network and support community-based behavioral health providers, G-BRICS will expand access to immediate-need behavioral health services offered to adults and to children on a walk-in or same-day access basis, either in-person or virtually using telehealth.[xiv]

The overarching goal of G-BRICS Same Day Access (SDA) pilot program is two-fold: (1) Expand access to same day services for immediate behavioral health needs, particularly involving a prescriber, offered virtually and in-person, which will always be needed due to a lack of access to technology and/or internet connectivity (i.e., the "digital divide"), plus respecting client preferences; and (2) Position community-based behavioral health providers to be able to bill Medicaid and other payers for this enhanced access to services, to sustain their SDA hours even after their participation in the pilot program. For SDA, clinicians have time reserved to see individuals who present, without an appointment, at the clinic or practice. The array of services typically offered include counseling, de-

escalation if needed, screening and assessment, prescribing if appropriate, and ensuring that clients engage in ongoing treatment.

Same-day access to behavioral health care operates much like urgent care clinics: individuals of any age come in when a need arises and receive assessment, triage, short-term targeted intervention services, prescriptions, and referrals for ongoing care. Stand-alone, community-based crisis facilities can offer urgent behavioral health services, or existing community-based outpatient behavioral health clinics which provide a range of therapeutic and medical care can integrate behavioral health services into their practice. The goal of SDA is to resolve immediate behavioral health needs for adults and children, preventing further escalation and the need for more intensive services.

As a result of the COVID-19 pandemic, telehealth has become vitally important to increase access to mental health and substance use resources, particularly licensed and/or credentialed clinicians, as well as psychiatrists and psychiatric nurse practitioners. The greater Baltimore area has recently seen behavioral health providers implement innovative approaches, such as launching a virtual walk-in clinic that offers access to online urgent therapy[xv] to any individual in need of psychiatric triage and referrals.

To bolster this trend, we will use G-BRICS funds for a SDA pilot program that provides technical assistance, training, and seed funding to behavioral health clinics or practices that want to expand or begin to offer virtual and/or walk-in, same-day access to immediate-need behavioral health services. The intent is to increase capacity for behavioral health assessment, de-escalation, treatment, and follow-up in the region. We will assess the pilot outcomes to inform providers, policymakers, and payers regarding an anticipated cost-effective, patient-centered approach to meet the immediate needs of children, adults, and families struggling with mental health issues or substance use.

Traditionally, behavioral health providers have been hesitant to deviate from the standard appointment model. Yet, often behavioral health providers have non-billable time resulting from missed appointments (i.e., as many as 30% of scheduled appointments are “no shows”), so by offering same-day access to services, providers can build more productive and financially viable practices. We want to ensure that providers offering SDA effectively utilize current reimbursement structures and address administrative barriers. For example, outpatient behavioral health providers (e.g., outpatient mental health centers) can use Medicaid billing codes to secure reimbursement for crisis services. However, BHSB’s review[xvi] of claims data shows that few providers bill for SDA services, which could be due to several reasons, such as: difficult billing or practice requirements (i.e., too high burden or not worth the cost to the provider), lack of awareness of billing feasibility for these services, and overly restrictive billing or service protocols. The SDA pilot program will create an opportunity to understand why this funding stream is not fully utilized, and G-BRICS partners plan to advocate for changes to make Medicaid reimbursement more accessible to providers offering SDA to immediate-need services.

Community-based behavioral health practices will directly benefit, as well, as data indicates that implementing SDA approaches results in: (1) better utilization of existing provider and staff capacity; (2) reduced average client wait time; (3) increased average intake of clients; and (4) increase in provider practice net income. However, the hurdles perceived by clinics and practices to do this should not be underestimated: addressing workflow changes, training clinicians and staff, increasing adaptability, and accepting the risk of potential fluctuations in reimbursement and cash flow. G-BRICS takes on this challenge by offering individualized technical assistance and seed funding to providers, and by evaluating outcomes and return on investment for providers and payers alike.

By establishing and quantifying the value proposition, payers will notice that covering and providing sufficient reimbursement for SDA to immediate-need services is a higher value approach to care, improving outcomes for adults and for children and reducing overall cost to the payer (e.g., avoid ED cost). If the region needs more SDA locations beyond those funded by the G-BRICS budget, BHSB and the G-BRICS Council will work to secure funding from additional sources. We are adopting the "fail fast and move on" model from other industries to test and determine if the approach adds value for patients, providers, and payers; even if this SDA "proof of concept" does not work, that will be informative for all (although we are confident that it will result in better outcomes and value for everyone).

Implementing Expanded Same Day Access (SDA) to Immediate-Need Behavioral Health Services
First, starting in Year 1, G-BRICS partners will work to identify high-need areas where SDA to behavioral health services will be most valuable (and, once the CTC launches, the dashboard data will augment this "hot spotting" process). At the same time, with the use of telehealth and more payers now reimbursing for virtual visits, participating behavioral health practices that offer virtual SDA are no longer bound by geography.

Second, G-BRICS will contract with an organization with SDA experience and expertise to provide technical assistance (TA) to behavioral health clinics and practices, addressing both the strategic and practical application of best practices for the provider to expand or begin to offer SDA. We will determine the G-BRICS contract for this SDA technical assistance based on a competitive bid process, with preference for a Maryland-based vendor. Based on the experiences shared with us by a national SDA consulting firm, we expect that community-based outpatient behavioral health providers will benefit from assistance with the following issues:

- Developing the requisite clinic infrastructure and operating processes;
- Estimating costs associated with offering SDA to immediate-need services;
- Receiving training to build necessary skills and competencies;
- Managing clinician and staff productivity;
- Addressing current and future workforce capacity;
- Calculating business metrics to 1) plan, 2) implement, and 3) sustain the ability to offer SDA; and,
- Identifying the right number of days and hours to offer SDA to immediate-need services.

In tandem to identifying an SDA consultant via a competitive procurement process, BHSB will conduct a targeted solicitation to identify providers that want to receive technical assistance, training, and seed funding to expand or begin to offer SDA on a virtual or walk-in basis. G-BRICS partners anticipate that eligible practices will include community-based outpatient behavioral health clinics or Federally Qualified Health Centers.

We estimate that G-BRICS will provide seed funding, on average of $50,000 per clinic, to cover a portion of the transition cost (e.g., technology, staff time for training) and augment revenue to reduce or eliminate the risk (real or perceived) of holding hours "open" for walk-in or virtual behavioral health services. Approaching this as a pilot program, we anticipate two rounds of offering the opportunity for clinics to apply for seed funding and technical assistance, with the bulk of the expansion efforts happening in Years 3 and 4. In Year 5, G-BRICS will finalize an analysis of the pilot program to assess and report impact to providers, payers, and policy makers. We anticipate collecting data to measure how SDA services met individuals' immediate behavioral health needs, and how it helped providers: better

utilize existing capacity, reduce average client wait time, increase average intake of clients, increase in provider practice net income, reduce average provider practice cost, and reduce average cost per client.

If the value proposition is proven, community-based behavioral health providers will have a positive experience (e.g., client experience, revenue generation), and G-BRICS will be positioned to advocate for sustainable funding and/or public- and private-sector reimbursement sources in Year 5 to support the continued expansion of SDA to immediate-need behavioral health services in the region.

PRIORITY 4: BEHAVIOR CHANGE MARKETING AND COMMUNICATION

Surveys conducted as part of local community health needs assessments suggest that as high as 13% of residents experiencing a behavioral health crisis within these jurisdictions do not utilize any services because they do not know how to access the system. Data suggests that another high percentage of residents in the region default to calling 911 or using the emergency department to access behavioral health crisis services. For the G-BRICS model to be successful, we must change the way people access behavioral health crisis care. It is critical that residents know how to access both the CTC and SDA services, and know what to expect when a MCT arrives. Building and launching the CTC, expanding MCT capacity, and implementing the SDA pilot program are components of G-BRICS' vision that require regular and consistent communication throughout the region. Behavior change marketing and communication to the broader public and to stakeholder organizations are essential tactics if we hope to achieve the set impact and outcome goals.

Many segments of our target population have historically faced systemic challenges and inequities in getting the behavioral health care they need. G-BRICS, along with our community engagement and marketing partners, will ensure that those who are most vulnerable to mental illness and substance abuse (and often least served) are at the center of our communications efforts across the board—in our messaging, community engagement, behavior change marketing, and material preparation and distribution (i.e., language translation, literacy level, and channels and ways in which we reach people). We hope to offer a refreshing change from more traditional communication campaigns in how we talk about the integrated crisis response system and how it will help meet people's needs, where they are and how they need it. Not only will we need to "turn up the volume," but we also need to talk in a way that engages and resonates. Further, one message may not resonate with everyone; we will explore whether we need to segment audiences (e.g., children and youth, parents of children with disabilities, LGBTQ individuals, etc.) in order to target messages and channels that reach each group effectively.

One of our primary goals of this proposal is to change the way people access behavioral health services. Awareness of and use of the single regional CTC hotline and SDA services are critical to meeting G-BRICS outcome goals. In addition to the communication efforts described above, G-BRICS will partner with community organizations that are trusted intermediaries of information (e.g., the faith-based community, social service agencies, health care providers, etc.) to bridge the gap between people who need help and the systems that can provide it. By leveraging existing communication vehicles and trusted sources, G-BRICS will align credible voices that will help leverage and reinforce the content and impact of shared key messages. In its marketing and communication strategy, G-BRICS will leverage, reinforce, and maximize value from existing stakeholders and G-BRICS partners across the region, thereby increasing the likelihood that individuals, family members, and communities receive consistent messages from multiple sources.

G-BRICS will also develop and implement a robust strategic engagement plan as a catalyst for broad culture change regarding behavioral health crisis response. We need to shift long-standing assumptions

about the "ways things are done" within and between individuals, groups, agencies, and organizations that interact with people struggling with substance use, mental illness, or experiencing a behavioral health crisis. For example, engagement strategies, messaging, and marketing materials directed toward organizations (leaders and staff) will inform them about the transformation taking place in our behavioral health system infrastructure and highlight their unique role in those changes, including actions that will help to reduce disparities and inequities experienced by some of our community's most vulnerable members. By each doing our part in a strategic manner, we can change organizational and community culture while influencing processes that drive day-to-day actions.

In 2021 (Year 1 of the grant), we anticipate outlining a scope of work around strategic communications and behavior change marketing, which will include market research, message development, testing, audience segmentation, and identifying traditional and innovative communication channels, including a coordinated approach with all G-BRICS partners. Through a competitive procurement process, BHSB will engage behavior change marketing firms to help develop and implement a comprehensive five-year plan, including developing common messaging and marketing materials, and supporting advertisement and promotions. Often niche firms can meet a specific need extraordinarily well at a competitive price, so BHSB may engage multiple vendors rather than just one.

PRIORITY 5: CONSUMER AND COMMUNITY ENGAGEMENT

Across the region, G-BRICS partners are committed to taking action and prioritizing strategies that will reduce stigma associated with mental illness, help people seek and access treatment earlier, and get the help they need to stay well. There is much room for innovation in behavioral health to tackle the issue from multiple angles and better meet communities' needs. By ensuring that those who are most vulnerable to mental illness and substance abuse are at the center of these solutions, we can strengthen the ability to reduce shame and stigma around behavioral health, and we can ensure that everyone is able to access the help they need.

G-BRICS will ground all consumer and community engagement efforts in an evidence-based, peer-reviewed framework which defines patient and family engagement as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy making—to improve health and health care."[xvii] Because authentic engagement entails two-way interaction and mutual learning, G-BRICS will involve people with lived experience from the outset, including family members, community groups, and community-based behavioral health providers in a number of activities to inform, shape, and guide the planning and implementation of the G-BRICS project. The G-BRICS Council will include three seats for consumer representatives, which will infuse the individual community member's voice into strategic implementation decisions. In addition, G-BRICS' standing committees and workgroups will include individuals with lived experience, community groups, and community-based behavioral health providers. (See Section 6 for details on decision-making process.)

In our view, people with lived experience, including family members, are content experts: their experience and background are critical for the G-BRICS work to have the intended impact. We envision that people with lived experience will help BHSB develop the various Request for Proposals for competitive procurement and the criteria for selection of the final vendor, and they will serve on review committees to select vendors. Inclusion of people with lived experience in this G-BRICS process will help to integrate the needs and experiences of the ultimate end-user.

To ensure that G-BRICS uses an effective approach to patient and family engagement that is both evidence-based and innovative, we applied the peer-reviewed framework referenced above to identify multiple ways to integrate community members in shaping G-BRICS. The table below illustrates how we will involve community members (individuals and groups) at all points along the engagement continuum (consultation, involvement, and partner in leadership) and at all levels of engagement (direct service, organizational design and governance, and policy making). This may include, for example, interviewing individuals and families about their experiences in calling the CTC, interacting with a MCT, or accessing care—either on a walk-in or virtual basis—to address their immediate behavioral health needs.

		Engagement Continuum		
		Consult	***Involve***	***Partner in Leadership***
Level of Engagement	***Direct Service***	Gather consumer input to inform how G-BRICS can better meet their needs	Help develop messages to promote single hotline and SDA to immediate-need care	
	Organizational Design and Governance		Help develop regional standards (CTC, MCTs, SDA). Ensure that people with lived experience help shape performance standards.	Seats on G-BRICS Council, Community Engagement Committee, and ad hoc workgroups
	Policy Making		Participate in coordinated advocacy for policy changes	Seats on Policy and Advocacy Committee

By integrating community members into each of these processes, G-BRICS will "walk the talk" of true community partnership. This will require deliberate attention, deep listening, and respectful collaboration because this degree of community engagement—from the "front room to the board room"—will be a new experience for some. Even in the process of developing the G-BRICS proposal, we cast a wide net to involve a wide range of individuals and organizations to share their perspectives and experiences to help shape the G-BRICS approach, receive updates on the proposal development, and offer reactions and suggestions. See Appendix C for a list of community members and groups, behavioral health providers, and other stakeholders who participated in one or more of those activities.

SECTION 4: MEASUREMENT AND OUTCOMES

The proposed activities include a set of discreet process measures to guide implementation in the earlier years of the grant. Over time, we will replace these process measures with efficiency and outcomes measures that will define return on investment (ROI) and, ultimately, the sustainability of the interventions.

To ensure the sustainability of our initiatives, G-BRICS will dedicate staff time, starting in Year 1 and continuing throughout the grant period, to assess the impact of each initiative (CTC, MCT, or SDA) and the collective impact of all three. In particular, where possible, we will develop the infrastructure and

metrics to collect data on cost savings, gained efficiencies, and improved outcomes that accrue across care systems and impact several types of stakeholder organizations. The G-BRICS Council will include representatives from key sectors, and our hope is that we will have a better ability to identify clear ROI and value propositions across sectors once the infrastructure and CTC technology is in place.

In terms of measurement and outcomes, it is important to highlight that implementing a CTC system will create a huge leap forward in the accessibility of real-time data, allowing G-BRICS partners to better understand the behavioral health crisis response system's capacity to meet the community's needs. We intend to share G-BRICS' intermediate outcome information with public and private sector payers to spur dialogue about changes in coverage and reimbursement to support both scalability and sustainability. For example, the CTC database and real-time dashboard can provide information about a number of metrics which will allow us to evaluate G-BRICS' impact in the region.

Examples of process, efficiency, outcome, and experience measures pertaining to the G-BRICS priority areas—establish the CTC center, expand MCTs, and expand SDA—are outlined in the table below:

Timeframe	Examples of Potential Process, Efficiency, and Outcomes Measures
Year 1–2	• Contracts procured (for CTC, MCT, SDA consultant) • Selection of providers to participate in SDA pilot • Regional standards developed for MCT and CTC
Year 3–5 **(Implemented Programs)**	CTC/MCT Utilization and Efficiency Measures • # calls and trend per jurisdiction • Survey call demographics: ethnicity, economic status, payer, age, social determinants of health to assess disparities and improve equity • Mobile crisis responses per region • Mobile crisis response rate per team per shift • Call to scene time • # EMS/Police BH interventions/region • # follow-up appointments scheduled/completed SDA Utilization Measures • # open access hours • # walk-in visits per hour
Year 4–5 **(Mature Programs)**	Hospital Efficiency and Outcome Measures • Decreases in ED wait times or boarding times • Overall decreases in the number of repeat ED cases for BH, defined as three or more ED visits in calendar year; the HSCRC has set 10% reduction as the target • Denial rates; # denials ED visits with BH primary diagnosis • # OP ED visits with BH as primary diagnosis • # BH diagnosis admitted to ED • # BH re-admissions • ED throughput times • Cost per case/diagnosis • # suicides Mobile Crisis/CTC • Mobile crisis response resolution by type • Satisfaction scores

	SDA Measure • Revenue generated by SDA walk-in visits Experience • Consumer satisfaction • Provider satisfaction Value Proposition/Return on Investment • Savings by payor • Cost savings of avoided visits

The *Partnership Catalyst Grant Request for Proposal* notes that HSCRC will work with CRISP to develop and refine metrics that accurately assess outcomes associated with implementing the *Crisis Now* model. One primary goal of the proposed investments is to reduce hospital utilization of patients experiencing a behavioral health crisis as their primary medical issue, including reduction of ED wait times and boarding times, number of ED visits, and potentially inpatient admissions or readmissions. It is important to note that this change in hospital utilization could potentially impact hospital performance on a number of HSCRC payment policies under the "Total Cost of Care All Payer Model", including, but not limited to, considerations around market shift adjustment, readmissions, and quality-based reimbursement metrics. The G-BRICS partnership will work with HSCRC staff to ensure that hospitals are not penalized through other payment policies as a result of these interventions and the anticipated program outcomes.

Finally, to fully assess the impact of G-BRICS, it is vitally important that HSCRC and CRISP use Medicaid data, in addition to Medicare data. G-BRICS partners also hope to work with HSCRC on the longer-term goal of assessing impact for all stakeholders, including community members, hospitals, payors, and State and local entities. We are committed to assessing the impact of G-BRICS for a range of stakeholder types to identify the definitive value proposition that CTC, MCT, and SDA offer to diverse stakeholders. Identifying and quantifying improvements in value (better outcomes, lower cost) for payers and other partners like emergency responders is vitally important to the sustainability of G-BRICS.

SECTION 5: SCALABILITY AND SUSTAINABILITY

In early 2019, hospitals, LBHAs, law enforcement, EMS, and other community stakeholders began to discuss how the region could improve service access and coordination for people struggling with substance use, mental illness, or experiencing a behavioral health crisis. One of the galvanizing factors that cemented interest from this extraordinary multi-sector collaborative spanning four jurisdictions was the early philanthropic support of the Horizon Foundation. In particular, the Horizon Foundation agreed to cover the travel costs for State and community leaders to visit Arizona to see how another state implemented the *Crisis Now* model—a critical turning point that invigorated stakeholders to see the possibilities for Maryland.

All 17 hospitals in the region and the Horizon Foundation also provided funding during the proposal development process, which enabled the engagement of three outside experts, one with expertise in multi-sector facilitation and project management, a national expert in the *Crisis Now* model, and a financial and data analyst that could model the impact on revenue and utilization. Without this body of experience and the funding from the hospitals and the Horizon Foundation, the collaborative work developing G-BRICS would not have been possible, and this proposal—and the vision of transforming the behavioral health crisis response system—would have languished.

G-BRICS' partners want to leverage the five-year grant from HSCRC to further spur innovation and transform the system by which people experiencing a behavioral health crisis access care and services. The goal of the outcomes measures described in Section 4 is to demonstrate: 1) savings across stakeholders in a way that justifies the creation of sustainable funding streams for CTC and MCT expansion; and, 2) the self-sustaining nature of SDA hours that results from appropriate re-engineering of behavioral health clinics and practices. Generating savings for hospitals, payors, and public entities through reducing costs and payments related to unnecessary ED visits, improving throughput, improving patient outcomes, and reducing the burden of emergency response systems will serve as a powerful platform to advocate the policy and reimbursement changes needed to create new, sustainable funding streams. The grant period will serve as "proof of concept" for expanded services that currently struggle to find a pathway to implementation due to lack of startup funding and ability to measure outcomes.

Sustainability of these programs also depends on policy advocacy across stakeholders (based on the value proposition demonstrated by the grant), which will start in Year 1 and continue across all five years. G-BRICS partners anticipate dedicating a significant amount of time toward understanding, demonstrating, and measuring the value proposition of each of our strategic initiatives, both the individual and cumulative impact (i.e., CTC, MCTs, and SDA), then using that information to motivate change. For example, expanding the geographic reach of the CTC may prove a cost-effective strategy that maximizes economies of scale and alleviates pressure on other regions to "re-create the wheel." The CTC as a key element of infrastructure in the statewide behavioral health system will benefit all Marylanders. Medicaid and other payers may change their own policies (e.g., cover and reimburse) to help sustain services provided by MCTs. G-BRICS partners will also use the demonstrated value of these programs to pursue funding through available State and local funding sources.

We will develop and apply standards for the CTC and MCTs across the region, described in detail in Section 3 (Priority 2). Consistently following best practices as a standard approach, with clear performance expectations and a well-articulated value proposition, will better position all MCTs to be eligible for coverage and reimbursement by payers. As organizations across the region change how they operate, this new approach will become embedded into their standard processes, expectations, contractual requirements, unified messaging, and culture. Cementing these changes becomes powerful in its own right and, indeed, protects the regional crisis response approach from "backsliding" once the grant ends.

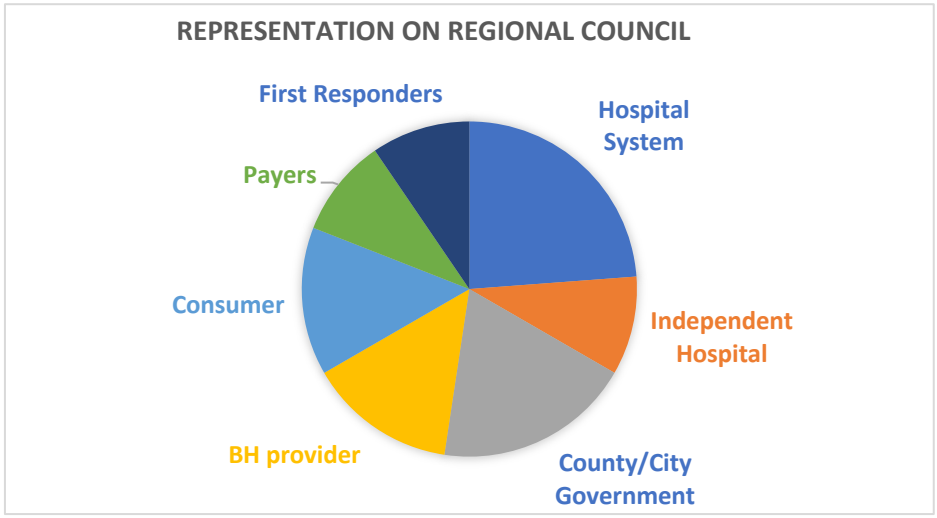
G-BRICS Element	High Level Summary of Plans for Scalability and Sustainability
Care Traffic Control	**STANDARD OPERATING PROCEDURES** will have changed for hospitals, behavioral health providers, LBHAs, first responders, etc. that are connected to and/or using the CTC system **ADVOCACY BY G-BRICS PARTNERS** will pursue policy change to require behavioral health providers participating in Medicaid to connect with the CTC system; and, expand the geographic reach of the CTC system to interested adjacent counties at a minimum and eventually statewide as an MDH-supported initiative **FUNDING** for CTC will be a shared task for hospitals, payors, and State/local entities. Ongoing funding will be secured through policy advocacy based on the savings for each stakeholder demonstrated by the above outcomes measures

	TRACK COST SAVINGS AND GAINED EFFICIENCIES for stakeholders, including first responders, to justify sharing a portion of savings as long-term CTC funding **DEVELOP AND SHARE EVIDENCE-BASED VALUE PROPOSITION** (cost savings, outcomes) for hospitals, public, and private payers to contribute to ongoing CTC services
Mobile Crisis Team Expansion, with regional standards	**STANDARD OPERATING PROCEDURES** will have changed for LBHAs that contract for MCTs, including applying regional standards and local protocols. Following regional standards will better position all MCTs to be eligible for coverage or payment by payers due to consistency and accountability **FUNDING** for MCTs will be a shared task for hospitals, payors, and State/local entities. Ongoing funding will be secured through policy advocacy based on the savings for each stakeholder demonstrated by the above outcomes measures **TRACK COST SAVINGS AND GAINED EFFICIENCIES** for stakeholders, including first responders, to justify sharing a portion of savings as long-term funding for expanded MCT capacity **DEVELOP AND SHARE EVIDENCE-BASED VALUE PROPOSITION** (cost savings, outcomes) for public and private payers to cover and reimburse for MCT services **LEVERAGE PROOF OF CONCEPT** as G-BRICS gains experience with expanding MCTs using a local/regional (decentralized/centralized) approach. We will share lessons and best practices so other local jurisdictions can apply the uniform standards, while retaining flexibility to account for unique local circumstances. Our MCT expansion approach could be adapted and leveraged on a statewide basis.
Technical Assistance to Expand Same Day Access to Immediate-Need Services	**STANDARD OPERATING PROCEDURES** will have changed for behavioral health providers that set up and offer SDA using the seed money and the technical assistance. **ADVOCACY BY G-BRICS PARTNERS** to pursue policy change through private- and public-sector discussions and/or legislative action to set appropriate payer reimbursement levels and address first-responder drop off at SDA locations, network inclusion, quality, medical necessity determinations, accessible reimbursement policies, etc. **FUNDING** after the initial investment provided through the grant is expected to come from the open-access hours that will generate enough walk-in volume to be self-funding over time and require no additional funding beyond the initial investments.
Community Outreach and Engagement	**STANDARD OPERATING PROCEDURES** of G-BRICS partners and stakeholders will promote common messaging to increase awareness and use of the single hotline for the region and the availability of SDA services to meet immediate behavioral health needs. **FUNDING**, if needed beyond the amount in the G-BRICS grant, will be secured through alternative public, private, and philanthropic sources.

SECTION 6: PARTICIPATING PARTNERS AND DECISION-MAKING PROCESS

Given the number of partners involved with the G-BRICS initiative, we have included the list of participating organizations and the roles they will play in the regional partnership in Appendix B.

We designed the structure described below to support meaningful, intentional collaboration across a diverse group of stakeholders who each bring specialized expertise to the table. We are mindful that multi-sector collaboration means sharing power and decision-making authority more broadly. We also intentionally developed this structure to ensure accountability to all stakeholders for achieving project goals and outcomes. This decision-making process involves a multi-stakeholder G-BRICS Council that balances the need to factor in diverse perspectives while ensuring that the size of the group is not unwieldy.



ACCOUNTABILITY STRUCTURE

The multi-stakeholder G-BRICS Council (Council) will provide strategic guidance, support, and advocacy for the implementation and sustainability of the G-BRICS project. This group is responsible for high-level decisions that set the overall strategic direction for the project. The Council will be comprised of twenty-one (21) seats, each designated for a specific stakeholder perspective.

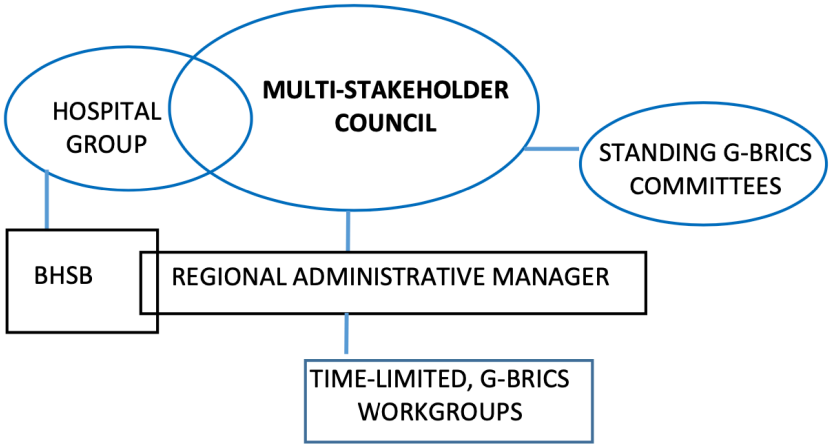
- Seven (7) seats held by **hospitals** (one for each hospital system and independent hospital)
- Three (3) seats held by groups that **represent behavioral health providers**
- Three (3) seats held by **consumer/community advocacy** groups
- Four (4) seats held by a **county or city administration** (one from each local jurisdiction)
- Two (2) seats held by **first responders** (e.g., law enforcement, emergency medical services, etc.)
- Two (2) seats held by **payers**, such as private- or public-sector employers, Medicaid, or health plans
- To avoid conflict of interest, no seat will be held by any organization that participates in competitive bidding to secure one or more contracts funded by G-BRICS.

The G-BRICS partners intend that the mix of Council members will be geographically diverse. To help achieve this, the five participating hospital systems will each have one vote, but they may each designate two representatives per system. We will invite Medicaid to hold one of the payer seats. In addition, as ambassadors to the broader community, Council members will ensure widespread awareness of the goals and outcomes of G-BRICS, and will leverage the financial and political resources to support project implementation. G-BRICS—through the Council and BHSB as the Regional Administrative Manager—will actively work to identify and secure additional funding over the five-year

grant period. However, to ensure the viability and long-term sustainability of the project, the Council will develop the policy agenda and advocate for necessary policy and reimbursement changes.

DECISION-MAKING STRUCTURE

The 17 G-BRICS hospitals will develop a single management services agreement with Behavioral Health System Baltimore (BHSB) to provide overall project management for G-BRICS. BHSB will be fiscally accountable for the funding received for G-BRICS during the grant period, manage day-to-day activities, and support collaboration among stakeholders. As the administrative manager, BHSB will be responsible for competitively procuring G-BRICS activities for the region, such as CTC, MCTs, SDA technical assistance, marketing strategy services, etc. The hospitals' funding support and advocacy for the implementation and sustainability of the G-BRICS project are critical to both a successful start and to the project's ongoing sustainability.



Before the end of 2020, the 17 hospitals and BHSB will develop and execute a single management services agreement that adheres to this proposal: the scope of the project, role of the regional G-BRICS Council, role of the regional administrative manager, role of participating hospitals, funding methodology and flow, financial reporting parameters, and program implementation reporting parameters.

To further describe the decision-making process, an ad hoc workgroup will draft bylaws in Year 1 to guide the Council, including defining details such as structure and processes, roles and responsibilities, and member recruitment with particular attention to geographic and other diversity. To ensure transparency and open communication, we will open Council meetings to anyone interested in attending. We anticipate holding semi-annual budget meetings and an annual budget review meeting.

The workgroup will submit the final bylaws to the Council for approval. This decision-making model supports G-BRICS implementation and the operational milestones we have committed to achieving, with a decision-making structure and process that will work together effectively. In addition, because the Council will have a key role in championing policy and reimbursement changes in both public and private sectors, BHSB, as the Regional Administrative Manager, will support the advocacy planning and coordination among G-BRICS partners.

Below, we have outlined the responsible decision-maker, plus key decisions and how they will be made.

The ***Regional Administrative Manager (RAM),*** established via a services agreement with Behavioral Health System Baltimore (BHSB) by the participating hospitals, will conduct the following activities:

- Staff and support the work of the Council and committees
- Staff and support the work of the Hospital Group

- Work with the Council to identify and secure additional funding
- Develop and update work plan to keep project on target to meet deliverables for HSCRC funding
- Collect and manage G-BRICS funding from hospitals and other funding sources (foundations, local jurisdictions)
- Competitively procure and manage contracts (e.g., develop RFPs, oversee contract bidding and selection process, and manage vendors) for CTC, regional MCT services, consulting support for behavioral health providers to expand SDA, and strategic marketing services
- Contract with vendors identified in this proposal, including StollenWerks, LLC for transitional project management support; and Berkley Research Group to perform data analysis, issue reports to HSCRC (according to the timeframe set forth in the RFP and committed to in the G-BRICS proposal), and develop a centralized approach for reporting to the HSCRC (aggregate and for each of the hospitals)
- Convene LBHAs, Council members, and other stakeholders to develop regional standards and dispatch protocol for MCT services funded by G-BRICS, and apply these standards to G-BRICS contracts
- Work with other LBHAs to ensure that all four participating regions contractually obligate local, non-G-BRICS funded MCTs to be dispatched through the CTC
- Encourage the four LBHAs to include agreed-upon regional standards in their local MCT contracts
- Work with other LBHAs, the identified SDA consultant, and other stakeholders to implement SDA at outpatient provider locations throughout the G-BRICS geographic area. Develop SDA standards to include a minimum set of services and a basic level of consistency
- Report financials, program implementation data, and other information as needed to hospitals and the regional G-BRICS Council at a minimum
- Develop operationally focused communications strategy, messaging, and media outreach for CTC hotline, regional MCT, and SDA service rollouts
- Develop a plan for community engagement in collaboration with the Community Engagement Committee of the Council, and leverage the support and resources to implement the plan

G-BRICS Hospitals commit to engage in the following activities:

- Ensure that each independent hospital or hospital system has knowledgeable, collaborative, and engaged representation on the G-BRICS Council and subcommittees
- Ensure timely payment to the RAM
- Ensure adequate representation from hospitals on procurement review committees, actively participating in committees as needed
- Communicate with the RAM for feedback or concern about the overall direction of the project or accountability in meeting project deliverables
- Leverage political capital to support the G-BRICS project goals

Local Behavioral Health Authorities, which manage the overall public behavioral health system in their local jurisdiction, commit to engage in the following activities:

- Learn and implement SAMHSA's best practices for behavioral health crisis response, including system development and the national *Crisis Now* model
- Ensure that all four participating regions contractually obligate local, non-G-BRICS funded MCTs to be dispatched through the CTC
- Work with the RAM and other stakeholders to develop regional standards for MCTs, and incorporate the standards into local MCT contracts
- Work with the RAM, the identified SDA consultant, and other stakeholders to develop SDA standards that include a minimum set of services and a basic level of consistency, and implement SDA at outpatient provider locations throughout the G-BRICS geographic area
- Participate on procurement review committees for G-BRICS procurements
- Support the RAM with community engagement
- Help inform key local leadership to ensure continued support of the G-BRICS project, paying close attention to transitions in leadership positions

DECISION MATRIX

Decision Type	Decision Content	Decision Maker	How	When
Strategy	What is the overarching content and approach to G-BRICS?	Hospital Group (all 17 hospitals)	Shape and approve proposal to HSCRC	Nov 2019–July 2020
Management	What is the administrative management approach and accountability including funding flow and fiscal and contract management expectations for Regional Administrative Manager (RAM/BHSB)?	Hospital Group and BHSB	Shape one agreement between all hospitals and BHSB, for BHSB as a non-profit to be G-BRICS RAM	July–Dec 2020
Strategy	What is the overall strategy for the G-BRICS collaborative partnership to guide implementation and ensure sustainability?	Council	Regular meetings (monthly/quarterly) staffed by RAM	2021–2025
Strategy	What policy and advocacy agenda will support G-BRICS' implementation and sustainability?	Council	Regular meetings staffed by RAM	2021–2025
Strategy	What committees do we need, who should be on them, and what is their charge? (At a minimum: policy and advocacy; community engagement)	Council	Regular meetings staffed by RAM	2021–2025
Management	How do we ensure timely and coordinated implementation of all G-BRICS activities, consistent with strategy and guidance from the regional Council?	RAM	Develop and manage annual work plan, community engagement plan, and operational communications plan	2021–2025
Management	How do we ensure multi-stakeholder engagement in shaping the approach to G-BRICS implementation (e.g., regional standards, local protocols, communications strategy development)?	RAM	Convene and staff focused workgroups to address components of G-BRICS annual plans	2021–2025
Implementation	What are the regional standards for Mobile Crisis Teams (MCTs) working with the Care Traffic Control Center (CTC)?	Local Behavioral Health Authorities (LBHAs) and other key stakeholders	Workgroups staffed by RAM	2021–2022

Decision Type	Decision Content	Decision Maker	How	When
Implementation	How do we ensure that residents and organizations change behavior by calling the CTC hotline for behavioral health needs (crisis and other) and know how to access SDA services when needed?	LBHAs, hospitals, and other key stakeholders	Workgroups staffed by RAM in collaboration with behavior change marketing firm(s)	2021–2022
Implementation	What are the local protocols for the CTC to use when dispatching MCTs in each local jurisdiction?	LBHAs and other key stakeholders	Workgroups staffed by RAM	2021–2022
Implementation	What are the regional standards for SDA, including the minimum set of services and performance expectations?	LBHAs, hospitals, and other key stakeholders	Workgroups staffed by RAM	2021–2022
Management	How do we ensure an equitable, legal, and financially sound approach to procurement and competitive bidding, G-BRICS vendor selection, and contract management?	RAM	Done via BHSB Procurement Review Committee with added hospital and LBHA members	2021–2025
Implementation	How do we ensure that G-BRICS procurement follows the equitable, legal, and financially sound approach established by BHSB?	Hospital and LBHA representatives	BHSB's Procurement Review Committee	2021–2023
Implementation	What is the content and approach to local MCT contracting including applying regional standards?	Each LBHA in their own local jurisdiction	Local procurement and contract management	2021–2025
Management	How do we ensure hospitals, LBHAs, and key stakeholders are informed about G-BRICS financials, program implementation, and impact?	RAM	Monthly reports and written updates as needed	2021–2025
Management	What is RAM's performance in managing overall direction of G-BRICS and accountability for meeting project deliverables?	Hospital Group	Annual review with RAM, plus ad hoc input	2021–2025

SECTION 7: IMPLEMENTATION WORK PLAN

A. Operations and Planning

- A 1 Establish BHSB as G-BRICS Regional Administrative Manager (RAM)
- A 2 Establish Regional Multi-stakeholder Advisory Group (MAG) and committees
- A 3 Transitional project management activities (contracted support)
- A 4 Develop 5-year work plan
- A 5 Update detailed work plan as needed
- A 6 Policy advocacy activities (contracted support)
- A 7 Convene implementation workgroups as needed
- A 8 Analytic activities (contracted support)
- A 9 Audit activities (contracted support)

B. Community Engagement and Outreach

- B 1 Establish Community Engagement Committee of MAG
- B 2 Hire Community Outreach Coordinator
- B 3 Procure contract with Community Engagement and Strategic Marketing firm
- B 4 Develop 5-year community engagement campaign
- B 5 Develop communications strategy and plan to change behavior
- B 6 Develop coordinated plan to promote CTC call line and SDA
- B 7 Implement/execute community engagement campaign and update as needed

C. Priority 1: Care Traffic Control (CTC)

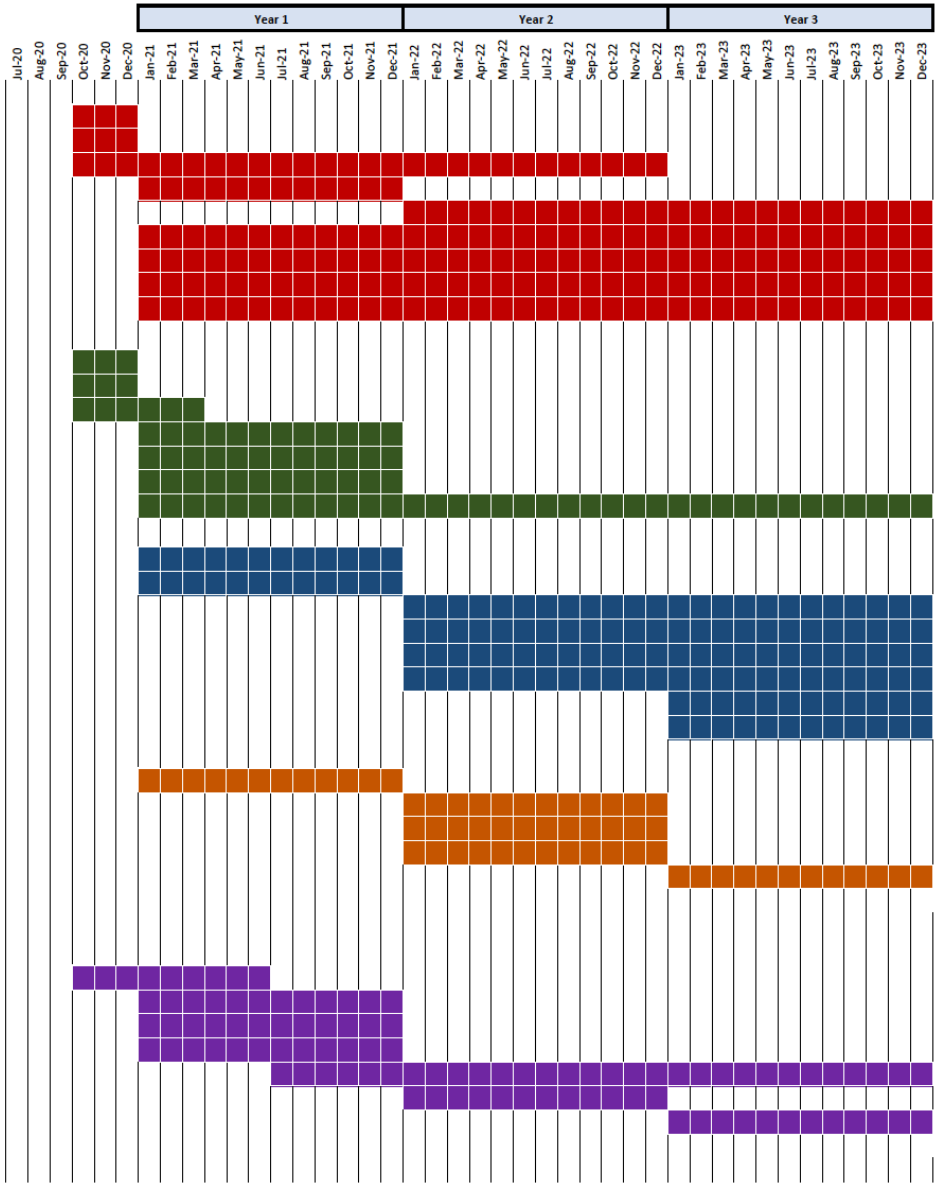
- C 1 Procure CTC vendor and purchase software
- C 2 Develop transition plan for existing call lines
- C 3 Subscriptions and ongoing support for CTC modules
- C 4 CTC is operational
- C 5 Promote single call line
- C 6 Begin dispatch of local MCTs
- C 7 Complete transition to single call line
- C 8 Begin dispatch of regional MCTs

D. Priority 2: Mobile Crisis Team (MCT) Expansion

- D 1 Assess existing MCT protocols and infrastructure
- D 2 Develop regional standards for all MCTs
- D 3 Procure regional MCT contract
- D 4 Apply regional standards to local MCT contracts
- D 5 60% expansion to regional MCT
- D 6 75% expansion to regional MCT
- D 7 100% expansion to regional MCT

E. Priority 3: Same Day Access

- E 1 Procure contract for SDA consultant
- E 2 Evaluate/identify areas of highest need
- E 3 Develop outreach materials
- E 4 Recruit community behavioral health practices
- E 5 Consultant to evaluate participating practices
- E 6 SDA pilot implementation: initial 20% of practices
- E 7 SDA pilot implementation: additional 40% of practices
- E 8 SDA pilot implementation: remaining 40% of practices
- E 9 Evaluate program for sustainability



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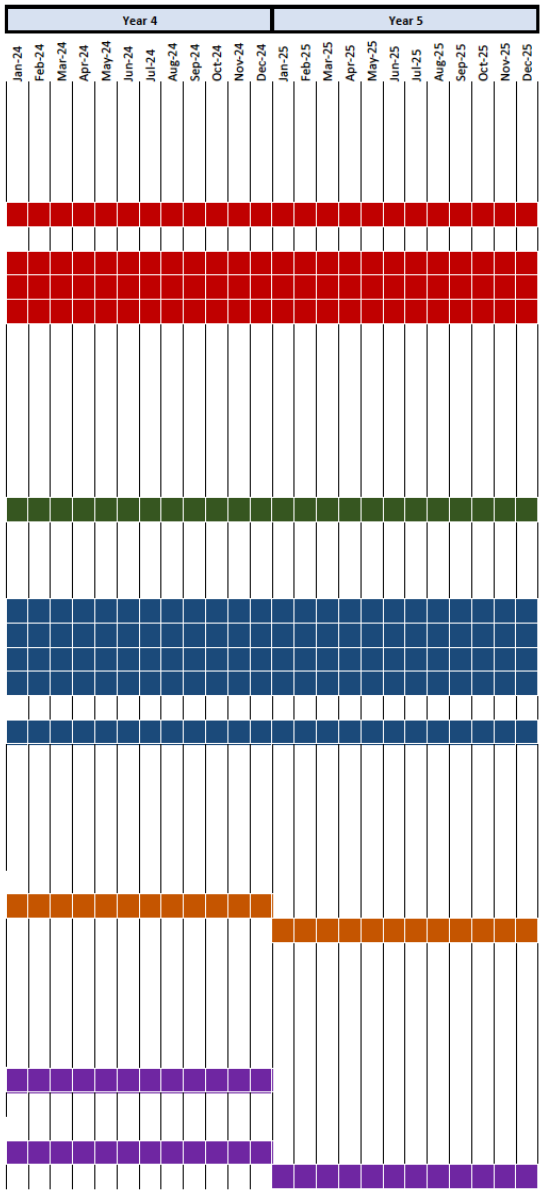

SECTION II: FINANCIAL PROJECTIONS

BUDGET

Hospital / Applicant	Behavioral Health System Baltimore
Regional Partnership Members:	Partner Hospitals and System Affiliation: Ascension Health: Saint Agnes Hospital Johns Hopkins Health System (JHHS): The Johns Hopkins Hospital Johns Hopkins Bayview Medical Center Howard County General Hospital LifeBridge Health: Sinai Hospital Northwest Hospital Carroll Hospital Grace Medical Center MedStar Health: MedStar Good Samaritan Hospital MedStar Harbor Hospital MedStar Union Memorial Hospital MedStar Franklin Square Medical Center University of Maryland Medical System (UMMS): University of Maryland Medical Center UM Saint Joseph Medical Center UMMC Midtown Campus No System Affiliation/Independent: Mercy Medical Center Greater Baltimore Medical Center Local Behavioral Health Authorities: Behavioral Health System Baltimore (Baltimore City) Baltimore County Health Department Carroll County Health Department Howard County Health Department See Appendix B for the full list of the G-BRICS Regional Partnership members
Funding Track:	Behavioral Health Crisis Program
Total Budget Request:	$44,862,000

Workforce/Type of Staff	Description		Amount					
	Proposed Activity	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Care Traffic Control Call Center	Priority 1: Care Traffic Control	1 FTE (salary): Program Oversight (@$100k salary)	-	$105,100	$107,700	$110,400	$113,200	**$436,400**
	Priority 1: Care Traffic Control	4 FTE (Salary): Team Lead/Supervisor (@$90k salary)		378,000	387,500	397,200	407,100	**1,569,800**
	Priority 1: Care Traffic Control	18 FTE (salary) Masters level Agent (@$75k salary)		1,734,300	1,777,700	1,822,100	1,867,700	**7,201,800**
	Priority 1: Care Traffic Control	Fringe (33% of salaries)		732,000	750,300	769,100	788,300	**3,039,700**
	Priority 1: Care Traffic Control	Telephony software ($175 per month per FTE)		46,200	47,400	48,600	49,800	**192,000**
	Priority 1: Care Traffic Control	Computers/phones ($1,000 per FTE, inflated)		12,600	12,900	13,200	13,500	**52,200**
	Priority 1: Care Traffic Control	Rent/utilities/housekeeping/etc. (5% of incremental salaries + fringe)		147,500	151,200	154,900	158,800	**612,400**
	Priority 1: Care Traffic Control	Indirect costs (10% of incremental salaries + fringe)		294,900	302,300	309,900	317,600	**1,224,700**
230% increase in Mobile Crisis Teams (MCT)	Priority 2: MCT expansion	Salaries (based on existing MCT salary structures by jurisdiction, inflated)	-	-	1,954,000	2,503,600	3,421,500	**7,879,100**
-60% implementation Year 3	Priority 2: MCT expansion	Fringe (33% of salaries)	-	-	644,800	826,200	1,129,100	**2,600,100**
-75% implementation Year 4	Priority 2: MCT expansion	Indirect costs (10% of incremental salaries + fringe)	-	-	259,900	333,000	455,100	**1,048,000**
-100% implementation Year 5	Priority 2: MCT expansion	Rent/utilities/housekeeping/etc. (5% of incremental salaries + fringe)	-	-	129,900	166,500	227,500	**523,900**
	Priority 2: MCT expansion	Travel/communications (proportional increase)	-	-	51,300	65,700	79,400	**196,400**
	Priority 2: MCT expansion	Insurance/legal (proportional increase)	-	-	31,300	40,200	54,900	**126,400**
	Priority 2: MCT expansion	Computers/phones ($1,000 per FTE, inflated)	-	-	51,700	11,000	11,000	**73,700**
	Priority 2: MCT expansion	Supplies/equipment (proportional increase)	-	-	9,600	12,300	16,700	**38,600**
		Subtotal	**-**	**$3,450,600**	**$6,669,500**	**$7,583,900**	**$9,111,200**	**$26,815,200**
IT/Technologies	**Description**		**Amount**					
	Proposed Activity	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Setup: Call Management	Priority 1: Care Traffic Control	BHL quote based on projected calls and scheduling needs	$365,900	-	-	-	-	**$365,900**
Setup: Electronic Referral and Bed Tracking	Priority 1: Care Traffic Control	BHL quote based on number of facilities and beds	261,400	-	-	-	-	**261,400**
Setup: Electronic Mobile Crisis Dispatch	Priority 1: Care Traffic Control	BHL quote based on projected mobile crisis dispatches	41,000	-	-	-	-	**41,000**
Ongoing: Call Management	Priority 1: Care Traffic Control	BHL quote: $14,280 estimated monthly subscription	-	180,000	184,500	189,100	193,800	**747,400**
Ongoing: Electronic Referral and Bed Tracking	Priority 1: Care Traffic Control	BHL quote: $11,770 estimated monthly subscription	-	148,400	152,100	155,900	159,800	**616,200**
Ongoing: Electronic Mobile Crisis Dispatch	Priority 1: Care Traffic Control	BHL quote: $3,750 estimated monthly subscription	-	47,300	48,500	49,700	50,900	**196,400**
		Subtotal	**$668,300**	**$375,700**	**$385,100**	**$394,700**	**$404,500**	**$2,228,300**
Wrap Around Services	**Description**		**Amount**					
(That are not captured above)	**Proposed Activity**	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
SDA technical assistance to clinics and practices	Priority 3: Expand SDA	Contracted services (MTM Services quote of $21,000 per practice)	$185,100	$379,500	$389,000	$199,400	-	**$1,153,000**
SDA seed funding	Priority 3: Expand SDA	Seed funding of $50,000 per practice	-	451,800	926,100	1,898,500	-	**3,276,400**
		Subtotal	**$185,100**	**$831,300**	**$1,315,100**	**$2,097,900**	**$0**	**$4,429,400**
Other Indirect Costs	**Description**		**Amount**					
	Proposed Activity	**Description**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Robust community engagement campaign	Consumer & Community Engagement	Paid community engagement	-	$735,400	$753,800	$772,600	$791,900	**$3,053,700**
-100% in Years 2-4, 75% level in Year 5	Consumer & Community Engagement	PR firm & market research	250,000	128,100	131,300	134,600	103,500	**747,500**
Community Outreach Coordinator	Consumer & Community Engagement	Salary (based on BHSB salary structure, inflated)	92,300	94,600	97,000	99,400	101,900	**485,200**
	Consumer & Community Engagement	Fringe (33% of salaries)	30,000	31,000	32,000	33,000	34,000	**160,000**
Contracted support	Contracted Support	Analytics	250,000	256,300	125,100	128,200	131,400	**891,000**
-Priced at $250 per hour	Contracted Support	Transitional project management	250,000	256,300	-	-	-	**506,300**
(adjusted for annual inflation)	Contracted Support	Audit	10,000	10,300	10,600	10,900	11,200	**53,000**
	Contracted Support	Policy advocacy	10,000	10,300	10,600	-	-	**30,900**
Management Service Organization (MSO)	Administration of Grant	1 FTE (salary): Program Implementation Director	102,500	105,100	107,700	110,400	113,200	**538,900**
-Budget assumptions consistent with BHSB	Administration of Grant	1 FTE (salary): Policy Director	102,500	105,100	107,700	110,400	113,200	**538,900**
structure	Administration of Grant	2 FTE (salary): Program Administrator	184,500	189,100	193,800	198,600	203,600	**969,600**
	Administration of Grant	1 FTE (salary): Finance Program Coordinator	92,300	94,600	97,000	99,400	101,900	**485,200**
	Administration of Grant	2 FTE (salary): Program Analysts	205,000	210,100	215,400	220,800	226,300	**1,077,600**
	Administration of Grant	Fringe (33% of salaries)	227,000	232,000	238,000	244,000	250,000	**1,191,000**
	Administration of Grant	Supplies/equipment (source: BHSB)	4,500	2,300	2,400	2,500	2,600	**14,300**
	Administration of Grant	Travel/communications (1,000 per FTE, inflated)	7,200	7,400	7,600	7,800	8,000	**38,000**
	Administration of Grant	Training (source: BHSB)	1,400	1,400	1,400	1,400	1,400	**7,000**
	Administration of Grant	Rent/utilities/housekeeping/etc. (5% of incremental salaries + fringe)	46,000	47,000	48,000	49,000	50,000	**240,000**
	Administration of Grant	Indirect costs (10% of incremental salaries + fringe)	69,000	70,000	72,000	74,000	76,000	**361,000**
		Subtotal	**$1,934,200**	**$2,586,400**	**$2,251,400**	**$2,297,000**	**$2,320,100**	**$11,389,100**
TOTAL			**$2,787,600**	**$7,244,000**	**$10,621,100**	**$12,373,500**	**$11,835,800**	**$44,862,000**

BUDGET AND EXPENDITURES NARRATIVE

The G-BRICS has developed a proposed budget that addresses the five priority areas outlined in Section 3. The budget is data-driven based on the experiences of other communities, builds on existing infrastructure, and provides the necessary strategic and administrative tools to ensure success. In general, the proposed budget allows for a careful evaluation of existing and proposed services in early years, near-term implementation of the CTC system, gradual ramp-up of MCTs and SDA in Years 3–5, and a robust community engagement strategy throughout the duration of the grant. We anticipate distribution of the requested funds to each of the 17 participating hospitals via an increase in rates that they will share with the RAM (and subsequently shared via contracted services) in accordance with this proposal. The following priorities set forth the key drivers of the proposed budget. Unless otherwise noted, all budget items include 2.5% compounded annual inflation for Years 1–5 of the grant funding.

PRIORITY 1: ESTABLISH A REGIONAL CARE TRAFFIC CONTROL (CTC) SYSTEM

The proposed budget includes one-time implementation costs, as well as ongoing monthly subscription fees for three CTC modules, which represents the technology and software that we must purchase to support data exchange, dispatching of GPS-enabled MCTs, and linking open-appointment availability to client need. These three CTC software modules are:

1. Electronic referral and bed tracking system
2. Electronic MCT dispatch and monitoring system
3. Call management system

We based the implementation and ongoing subscription fees for these IT modules on quotes for pricing we received from Behavioral Health Link (BHL), which provides these technologies to support the Georgia and Arizona crisis services systems. Costs for this software varies based on anticipated volume. The proposed budget for the CTC software is based on a capacity analysis conducted by the G-BRICS proposal development team in collaboration with BHL, which considered the size of jurisdictions, number of participating providers and facilities, number of beds, and number of calls and mobile crisis responses anticipated by the *Crisis Now* model.

In addition to the necessary software, G-BRICS will contract with an organization to staff and operate the CTC, which includes running the call center, dispatching and tracking MTCs, collaborating with behavioral health service providers regarding scheduling, and creating the real-time dashboard and performance reports using the BHL software and embedded metrics. The proposed budget is based on the number of monthly expected calls to the CTC. The current call center serving Baltimore City staffs three agents and one supervisor per shift (15 FTEs annually). Based on the expansion to serve three additional jurisdictions (a 215% increase in covered population), the anticipated increase in the number of calls received, and the anticipated economies of scale, the proposed budget includes 26 FTEs (22 agents and 4 supervisors) and 1 oversight FTE. Call center software is estimated based on a survey of available products. We based budget numbers on the existing budgets and team makeup for the local call center. We assume that this cost will begin when the CTC is operational in Year 2 and will continue through the remainder of the five-year grant.

The proposed CTC budget represents 38% of the five-year cumulative funds, and 36% of Year 5 funds (fully mature operation). The proposed budget assumes software implementation and procurement of the operating contract will occur in Year 1, with the CTC fully operational in Years 2–5. Because this is a new service, we assume that the catalyst grant will cover 100% of the costs associated with operating the CTC during the five-year period. The sustainability plan includes securing sources of funds for the CTC beyond the five-year grant period.

PRIORITY 2: MOBILE CRISIS TEAMS (MCT) EXPANSION

The MCT budget represents the incremental regional MCTs needed to provide a 230% expansion of existing mobile crisis responses (above and beyond the existing local MCTs) by Year 5 of the grant. This projected increase is based on the SAMSHA *Crisis Now* Calculator, which uses population-based measures to estimate crises and mobile crisis responses anticipated once the CTC infrastructure is in place. The projected mobile crisis expansion includes: 1) regional coverage beyond existing hours to ensure 24/7 coverage where necessary, 2) increased productivity (over time) of local and regional MCTs to response-per-team levels indicated by the SAMSHA *Crisis Now* Calculator, and 3) expanded MCTs to achieve a 230% increase in overall responses (see proposed activities in Section 3 for more detail regarding the proposed MCT expansion). In addition to ensuring regional MCT coverage beyond existing hours to ensure 24/7 coverage, the following expansion of daily MCTs during existing hours is assumed by Year 5:

1. Carroll County: 1 additional daily MCT
2. Baltimore City: 5x the existing daily MCTs
3. Baltimore County: 3.2x the existing daily MCTs
4. Howard County: 1.5x the existing daily MCTs

The proposed budget is calculated by jurisdiction based on the existing budgets and team makeup for the local MCTs. It represents only the amount related to the incremental MCTs funded by G-BRICS. The proposed budget assumes the following:

1. Incremental MCTs will reflect local MCTs (by jurisdiction) in terms of FTE mix
2. Salaries, supplies, travel, communication, insurance, and legal costs projected on a per-FTE basis using existing local MCT budgets (with appropriate annual inflation applied)
3. Fringe assumed to be 33% of incremental salaries
4. Computers/phones projected as $1,000 per incremental FTE ($800 for computer, $200 for phone)
5. Other overhead items such as rent, utilities, depreciation of office furniture, etc. estimated to be 5% of incremental salaries plus fringe
6. 10% of incremental salaries plus fringe to account for other indirect costs (such as administrative oversight)

The proposed MCT budget represents 27% of the five-year cumulative funds, and 44% of Year 5 funds (fully mature operation). The proposed budget assumes that development of standard protocols, procurement of a regional MCT vendor, and establishment of the CTC will occur in Years 1 and 2. Ramp-up of the regional MCT will occur as the *Crisis Now* operational model matures (60% implementation in in Year 3, 75% in Year 4, and 100% in Year 5). The proposed budget includes only the incremental costs of the regional MCT, which will represent an estimated 70% of total costs related to MCTs in the four jurisdictions after the 230% expansion in Year 5. We anticipate that State and local funds will continue to support the local MCTs (30% of total costs). The sustainability plan includes securing sources of funds for the expanded MCTs beyond the five-year grant period.

PRIORITY 3: EXPAND CAPACITY TO OFFER SAME DAY ACCESS (SDA) TO BEHAVIORAL HEALTH SERVICES

To expand access to immediate-need behavioral health services offered on a “walk-in” or same-day access (SDA) basis, the proposed budget includes: 1) funds to technical and strategic assistance to behavioral health clinics and practices (via a contracted organization with experience in SDA

implementation), and 2) provide seed funding to participating clinics to cover a portion of the transition costs (e.g., technology, staff time for training) and augment revenue to reduce or eliminate the risk of holding hours "open" for walk-in or virtual behavioral health services.

The proposed budget assumes $21,000 for technical assistance and $50,000 in seed funding per participating provider. We based the technical assistance cost on a pricing estimate from MTM services, a national consulting firm with experience in this process (the contract for these services will be competitively bid). The $50,000 in seed funding represents funding two behavioral health therapists at $30/hour to support open access hours two days a week ($30/hour, 16 hours for 52 weeks).

This expansion will occur on a pilot basis over Years 2–4 of the grant. The proposed budget assumes piloting at nine participating providers in Year 2, and 17 incremental providers in both Years 3 and 4, totaling 43 providers (disbursed across jurisdictions based on identified need). It is assumed that grant funding will support 100% of the pilot program. However, after the initial investment, we expect the open-access hours will generate enough walk-in volume to fund itself over time and require no additional funding beyond the initial investments. The proposed SDA budget represents 10% of the five-year cumulative funds, and 0% of Year 5 funds (fully mature operation).

PRIORITY 4: CONSUMER AND COMMUNITY ENGAGEMENT

The proposed budget includes a full-time Community Outreach Coordinator (1 FTE at BHSB salary structure plus 33% fringe), as well as a competitively-bid procurement of marketing firm(s) to develop and implement a five-year strategic communications plan. The budget assumes $250/hour pricing for the firm (100% utilization in Year 1, 50% in Years 2–4, and 35% in Year 5), and a $700,000 per year paid community engagement campaign in place for Years 2–5. We based the community engagement campaign figures on recent experiences with jurisdiction-wide community engagement campaigns, extrapolated to cover the entire four-jurisdiction area (1.94 million population). It is assumed that the catalyst grant will cover 100% of the costs associated with the community engagement strategy during the five-year period. The sustainability plan will include securing sources of funds for community engagement beyond the five-year grant period. The proposed community engagement budget represents 10% of the five-year cumulative funds, and 9% of Year 5 funds (fully mature operation).

CONTRACTED SUPPORT AND ADMINISTRATION OF GRANT

The proposed budget includes contracted support (at $250/hour) for transitional project management, policy advocacy, analytics, and auditing. We expect to more frequently utilize these services in early years of the grant period (100% utilization in Years 1–2, 25%–30% in Years 3–5). Contracted services represent 3% of the five-year cumulative funds, and 1% of Year 5 funds (fully mature operation).

We will contract with Behavioral Health System of Baltimore (BHSB) to provide overall project management for G-BRICS, including fiscal accountability, procurement, and contract management for the competitively bid regional MCT and CTC services, and oversight of G-BRICS day-to-day activities. The proposed organizational structure includes 7 FTEs, priced according to BHSB's salary structure. Assumptions regarding fringe, supplies, training, travel, communications, rent, office equipment, and other indirect costs mirror those described in the MCT expansion. Program administration represents 12% of the five-year cumulative funds, and 10% of Year 5 funds (fully mature operation).

APPENDICES

APPENDIX A: Geographic Region Zip Codes

ZIP Codes: 20701, 20723, 20759, 20763, 20777, 20794, 21013, 21020, 21022, 21023, 21027, 21029, 21030, 21031, 21036, 21041, 21042, 21043, 21044, 21045, 21046, 21048, 21051, 21052, 21053, 21055, 21057, 21065, 21071, 21074, 21075, 21080, 21082, 21087, 21088, 21092, 21093, 21094, 21102, 21104, 21105, 21111, 21117, 21120, 21128, 21131, 21133, 21136, 21139, 21150, 21152, 21153, 21155, 21156, 21157, 21158, 21162, 21163, 21201, 21202, 21203, 21204, 21205, 21206, 21207, 21208, 21209, 21210, 21211, 21212, 21213, 21214, 21215, 21216, 21217, 21218, 21219, 21220, 21221, 21222, 21223, 21224, 21225, 21227, 21228, 21229, 21230, 21231, 21233, 21234, 21235, 21236, 21237, 21239, 21241, 21244, 21250, 21251, 21252, 21260, 21261, 21263, 21264, 21265, 21268, 21270, 21273, 21274, 21275, 21278, 21279, 21280, 21281, 21282, 21283, 21284, 21285, 21286, 21287, 21288, 21289, 21290, 21297, 21298, 21723, 21737, 21738, 21757, 21764, 21765, 21776, 21784, 21787, 21791, 21794, 21797

Hospitals (17): Carroll Hospital, Grace Medical Center, Greater Baltimore Medical Center, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, Medstar Franklin Square Medical Center, Medstar Good Samaritan Hospital, Medstar Harbor Hospital, Medstar Union Memorial Hospital, Mercy Medical Center, Northwest Hospital, Saint Agnes Hospital, Sinai Hospital, University of Maryland Medical Center, University of Maryland Medical Center Midtown Campus, University of Maryland St. Joseph Medical Center

Local Jurisdictions (4): Baltimore City, Baltimore County, Carroll County, Howard County

Incorporated Cities:

Baltimore City

Baltimore County: Baldwin, Boring, Brooklandville, Butler, Catonsville, Chase, Cockeysville, Dundalk, Essex, Fork, Fort Howard, Freeland, Garrison, Glen Arm, Glyndon, Gwynn Oak, Halethorpe, Hunt Valley, Hydes, Kingsville, Long Green, Lutherville Timonium, Maryland Line, Middle River, Monkton, Nottingham, Owings Mills, Parkton, Parkville, Perry Hall, Phoenix, Pikesville, Randallstown, Reisterstown, Riderwood, Rosedale, Sparks Glencoe, Sparrows Point, Stevenson, Towson, Upper Falls, Upperco, White Marsh, Windsor Mill

Carroll County: Finksburg, Hampstead, Henryton, Keymar, Lineboro, Linwood, Manchester, Marriottsville, New Windsor, Sykesville, Taneytown, Union Bridge, Westminster

Howard County: Annapolis Junction, Clarksville, Columbia, Cooksville, Dayton, Elkridge, Ellicott City, Fulton, Glenelg, Glenwood, Highland, Jessup, Laurel, Lisbon, Savage, Simpsonville, West Friendship, Woodbine, Woodstock

APPENDIX B: Members of the G-BRICS Regional Partnership

HOSPITALS

Name of Collaborator	**Carroll Hospital (LifeBridge Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,023,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Grace Medical Center (LifeBridge Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	*See allocation listed for Sinai Hospital below*
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Greater Baltimore Medical Center**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$2,110,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Howard County General Hospital (Hopkins Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,350,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Johns Hopkins Bayview Medical Center (Hopkins Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$3,057,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Johns Hopkins Hospital (Johns Hopkins Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$11,064,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**MedStar Franklin Square Medical Center (Medstar Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$2,488,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**MedStar Good Samaritan Hospital (Medstar Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,162,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach and promoting regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**MedStar Harbor Hospital (Medstar Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$819,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**MedStar Union Memorial Hospital (Medstar Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,823,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Mercy Medical Center**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$2,445,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Northwest Hospital (LifeBridge Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,200,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Sinai Hospital (LifeBridge Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$3,760,000 over five years (total for Sinai and Bon Secours/Grace)
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Saint Agnes Hospital (Ascension Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,897,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**University of Maryland Medical Center (UMMS Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$7,975,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Univ. of Maryland Medical Center Midtown (UMMS Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$977,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

Name of Collaborator	**Univ. of Maryland St. Joseph Medical Center (UMMS Health System)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Hospital
Amount and Purpose of Direct Financial Support, if any	$1,716,000 over five years
Type and Purpose of In-Kind Support, if any	Assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Hospital Group (see Pg23: Decision Matrix)

LOCAL JURISDICTION LEADERS

Name of Collaborator	**Baltimore City Health Department**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Local Health Department
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Assist with coordinated engagement and outreach to promote the regional hotline
Type/Purpose of Resource Sharing Arrangements, if any	Promotion of crisis services via BCHD public education platforms and community outreach
Roles/Responsibilities within the Regional Partnership	Continue promotion of the crisis hotline, distribution of informational material, and participate in planning process as needed

Name of Collaborator	**Baltimore County Health Department**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Local Health Department, LBHA
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Staff time to assist with coordinated engagement and outreach to promote the regional hotline, implement regional MCT standards in the county, and SDA
Type/Purpose of Resource Sharing Arrangements, if any	Fund and manage local MCT contracts with county general and State funds
Roles/Responsibilities within the Regional Partnership	Manage local behavioral health system, help shape regional standards and local protocols, and support SDA in outpatient providers (See Decision Matrix)

Name of Collaborator	**Behavioral Health System Baltimore**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	LBHA (non-profit)
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Staff time to: strategically guide and supervise G-BRICS-funded staff working on the project; support advocacy efforts that advance G-BRICS sustainability; and assist with coordinated outreach to promote regional hotline, MCT & SDA
Type/Purpose of Resource Sharing Arrangements, if any	Fund and manage local MCT contracts
Roles/Responsibilities within the Regional Partnership	Manage local BH system; Regional Administrative Manager, help shape standards and protocols (see Decision Matrix)

Name of Collaborator	**Carroll County Health Department**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Local government, including LBHA
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Staff time to assist with coordinated engagement and outreach to promote the regional hotline, implement regional MCT standards in the county, SDA
Type/Purpose of Resource Sharing Arrangements, if any	Fund and manage local MCT contracts with county general funds
Roles/Responsibilities within the Regional Partnership	Manage local behavioral health system, help shape regional standards and local protocols, and support SDA in outpatient providers (See Decision Matrix)

Name of Collaborator	**Collaborative Planning and Implementation Committee (CPIC) for Baltimore City Consent Decree**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Multi-Stakeholder Committee (see Appendix C for full member roster)
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help ensure that G-BRICS implementation is aligned with the Consent Decree goals; bring key community advocacy groups to the table
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Give input to engagement and outreach strategies

Name of Collaborator	**Howard County Government** Howard Co. Executive's Office Howard Co. Police Department Howard Co. Dept. of Fire & Rescue/911 Howard Co. Dept. of Community Resources and Services
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Local Government
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote public's use of the regional hotline, MCT and SDA; Work with the partnership to align local program goals and metrics with G-BRICS to ensure alignment and consistency with the regional continuum
Type/Purpose of Resource Sharing Arrangements, if any	Ensuring that local and regional programming is collaborative and complimentary, both in terms of funding and data sharing
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**Howard County Health Department**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	LBHA (local government)
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Assist with coordinated engagement and outreach to promote hotline, MCT, and SDA
Type/Purpose of Resource Sharing Arrangements, if any	Fund and manage local MCT contracts
Roles/Responsibilities within the Regional Partnership	Manage local behavioral health system; help shape regional standards and local protocols (See Decision Matrix)

Name of Collaborator	**Howard County Local Health Improvement Coalition**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	LHIC
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote regional hotline, MCT, and SDA; assist with general crisis services education of Howard County community; connect G-BRICS to key community groups and leaders in Howard Co.
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer engagement and outreach strategies and messages, and with consumer engagement implementation

PHILANTHROPY

Name of Collaborator	**The Horizon Foundation of Howard Co, Inc.**
Type of Organization (i.e. LHIC, Non-Profit, LBHA)	Philanthropy
Amount and Purpose of Direct Financial Support, if any	The Foundation helped fund pre-submission G-BRICS planning ($75,000) and commits to an additional $60,000 to: 1) support continued project management during the post-submission/pre-funding period; 2) stand up the G-BRICS Policy Committee in preparation for the 2021 Maryland General Assembly session; and 3) provide legal support to BHSB as it begins to draft funding agreements with G-BRICS hospitals (should funding be approved).
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote the regional hotline, MCT, and SDA in Howard County; provide technical assistance to BHSB on the selection and oversight of a social marketing firm (e.g., the Foundation manages 3 media firms and spends nearly $1M annually on social marketing); and connect G-BRICS with regional funders via Maryland Philanthropic Network (MPN) and sponsor MPN educational sessions on future G-BRICS needs.
Type/Purpose of Resource Sharing Arrangements, if any	Grant agreement
Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer engagement and outreach strategies and messages, and with consumer engagement implementation; help coordinate Howard County collaborator and partner response to G-BRICS requests.

CONSUMER ADVOCACY AND COMMUNITY ORGANIZATIONS

Name of Collaborator	**AARP Maryland**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-Profit Membership Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote

	the public's use of the regional behavioral health hotline, MCTs and SDA services; help connect G-BRICS to local AARP leaders and others important to project success; and assist with general crisis services education of AARP members
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer and provider engagement, outreach strategies and messages, and consumer and provider engagement implementation

Name of Collaborator	**Bmore Clubhouse**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping engagement and outreach strategies and messages to reflect the needs and interests of individuals and families

Name of Collaborator	**FreeState Justice**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote the G-BRICS regional hotline, MCT, and SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping engagement and outreach strategies and messages to ensure resonance with the LGBTQ community

Name of Collaborator	**Maryland Citizens' Health Initiative/Health Care for All!**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote regional hotline, MCT, and SDA; help connect G-BRICS to key faith-based community leaders and others important to project success
Type/Purpose of Resource Sharing Arrangements, if any	

Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer engagement and outreach strategies and messages, and with consumer engagement implementation

Name of Collaborator	**MedChi, The Maryland State Medical Society**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-Profit Professional Membership Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to physicians to promote the public's use of the regional hotline, MCT and SDA; assist with general crisis services education for providers and the public; and connect G-BRICS to key physician leaders who are essential to project success.
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer/provider engagement, outreach strategies and messages, and consumer/provider engagement implementation

Name of Collaborator	**Mental Health Association of Maryland**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Assist in shaping and outreach and engagement strategies and provide broad stakeholder input in the development, implementation, and oversight of G-BRICS to address the needs and interests of individuals and families
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**National Alliance on Mental Illness (NAMI) – Howard County**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Connect G-BRICS with consumer and community groups important to success; engage in coordinated outreach to promote regional hotline and SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer engagement and outreach strategies and messages, and with consumer engagement implementation

Name of Collaborator	**On Our Own**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Assist in shaping engagement and outreach strategies, and messaging to reflect the needs and interests of individuals and families
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**The Trill Foundation/Greg Riddick Sr.**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Non-profit Community Organization; Community leader with lived experience
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to promote regional hotline, MCT, and SDA
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping engagement and outreach strategies and messaging

EDUCATION

Name of Collaborator	**Baltimore City Community College**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Community College
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Provide advice and ideas to help ensure G-BRICS' relevance to meeting the needs of students and educational institutions
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**Carroll Community College**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Community College
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Provide advice and ideas to help ensure G-BRICS' relevance to meeting the needs of students and educational institutions
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**Howard County Public School System (HCPSS)**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Local School District
Amount and Purpose of Direct Financial Support, if any	

Type and Purpose of In-Kind Support, if any	Help with coordinated outreach to families in Howard County to promote their use of the regional hotline, MCTs, and SDA providers; assist with general crisis services education of the public through the HCPSS Mental Health Community Advisory Committee (MHCAC)
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	Assist in shaping consumer and provider engagement, outreach strategies and messages, and consumer and provider engagement implementation

PAYERS/PURCHASERS

Name of Collaborator	**CareFirst**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Health Plan
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Provide advice from the health plan perspective, including ideas to help ensure G-BRICS' value and relevance to payors
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**Cigna**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Health Plan
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Provide advice from the health plan perspective, including ideas to help ensure G-BRICS' value and relevance to payors
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**Kaiser**
Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Health Plan
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Provide advice from the health plan perspective, including ideas to help ensure G-BRICS' value and relevance to payors
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

Name of Collaborator	**Mid-Atlantic Business Group on Health (John Miller)**

Type of Organization (i.e., LHIC, Non-Profit, LBHA)	Association of Employer Healthcare Purchasers
Amount and Purpose of Direct Financial Support, if any	
Type and Purpose of In-Kind Support, if any	Provide advice regarding perspectives of employers and issues of primary concern to help ensure G-BRICS' relevance to purchasers
Type/Purpose of Resource Sharing Arrangements, if any	
Roles/Responsibilities within the Regional Partnership	

APPENDIX C: Multi-Stakeholder Engagement in Development of This G-BRICS Proposal

We developed this G-BRICS proposal with input from a wide range of consumer and community organizations, behavioral health providers, first responders, local jurisdiction leaders, hospitals, and other key players. Engagement activities during the development of this proposal began in late 2019 and involved: (1) six monthly forums to share information and seek input and ideas; (2) a full-day symposium with interested community members to learn about the *Crisis Now* Model and the current crisis system, and engage in brainstorming sessions to identify approaches and priorities for G-BRICS; and, (3) briefings for individuals and organizations to share information about the G-BRICS proposal as it was being developed, and to gather general reactions and specific information to inform and refine the approach.

In addition, we briefed many of the local elected officials and members of the General Assembly from all four of the local jurisdictions, which resulted in more than twenty-five letters of support for this G-BRICS proposal being submitted to the HSCRC.

The following organizations participated in one or more of these engagement activities during the proposal development process:

- AbsoluteCARE Inc. Patient Centered Ambulatory ICU Medical Centers
- Affiliated Santé
- Baltimore Child & Adolescent Response System (BCARS)
- Baltimore City Community College
- Baltimore City Health Commissioner
- Baltimore Crisis Response Inc.
- Baltimore City Police Department
- Baltimore County Police Department
- BUILD
- CareFirst
- Carroll Community College
- Carroll County Senior Opioid Policy Planning Committee, including Health Officer
- Chase-Brexton
- Cigna
- Collaborative Planning and Implementation Committee (CPIC) for the Baltimore City Consent Decree
    - Associated Catholic Charities
    - Baltimore City Fire Department
    - Baltimore City Health Department
    - Baltimore City Public Schools
    - Baltimore City State's Attorney
    - Baltimore Crisis Response, Inc.
    - Baltimore Transgender Alliance
    - Behavioral Health Administration, Office of Consumer Affairs
    - Behavioral Health Administration, Office of Crisis and Criminal Justice Services
    - Black Mental Health Alliance
    - Morton K. and Jane Blaustein Foundation
    - B'more Clubhouse
    - Bmore POWER
    - Bon Secours
    - Catholic Charities of Baltimore
    - Circuit Court for Baltimore City (Mental Health Court)
    - Chase Brexton
    - Department of Juvenile Services
    - Department of Public Safety and Correctional Services
    - Disability Rights Maryland
    - District Court for Baltimore City

  - Family League of Baltimore
  - Hearts and Ears
  - Health Care for the Homeless
  - Helping Other People through Empowerment
  - Hope Health Systems
  - Housing Authority of Baltimore City
  - IBR Reach
  - Johns Hopkins (Bayview Medical Center, JH Medicine, School of Public Health)
  - Maryland Coalition of Families
  - Maryland Hospital Association
  - Maryland Recovery Organization Connecting Communities (M-ROCC)
  - Mayor's Office of Criminal Justice
  - Mental Health Association of Maryland
  - MedStar Health Inc. Harbor Hospital
  - Mercy Health Services
  - Mosaic Community Services
  - NAMI Metro-Baltimore
  - Office of Public Defender
  - Open Society Institute
  - Power Inside
  - Roberta's House
  - The Leonard & Helen R. Stulman Charitable Foundation
  - The Next Step
  - The Trill Foundation
  - University of Maryland (Downtown, Innovations Institute, Sch. of Social Work)
  - Weinberg Foundation
  - Behavioral Health System Baltimore, Inc.
  - Baltimore Police Department
  - Baltimore City Department of Law
  - Mayor's Office of Human Services
  - U.S. Department of Justice
  - Civil Rights Division - Special Litigation Section
  - Baltimore Police Department Monitor
- Community Behavioral Health Association of Maryland
- CRISP – Chesapeake Regional Information System for our Patients
- Disability Rights Maryland
- FreeState Justice
- Grassroots
- Helping Up Mission
- Hopkins Regional Advisory Committee (Howard Co & Baltimore)
- Howard Community College
- IBR/REACH
- Kaiser
- Maryland Association for the Treatment of Opioid Dependence (MATOD)
- Maryland Health Care Commission
- Maryland Independent Colleges and Universities Association (MICUA)
- MedChi, the Maryland State Medical Society
- Medicaid
- Mental Health Association of Maryland
- Mid-Atlantic Business Group on Health
- National Alliance on Mental Illness
- On Our Own
- People Encouraging People
- Regional Howard Health Partnership
- Sheppard Pratt
- Sisters Together and Reaching
- Trill Foundation
- Tuerk House

APPENDIX D: End Notes and References

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[i] All population statistics per Claritas Pop Facts Premier 2020 population estimates.

[ii] As reported by the Local Behavioral Health Authority ("LBHA") in each of the four jurisdictions

[iii] All ED statistics, including charges, visits, payer, and age are per HSCRC abstract dataset (CY2019 final data).

[iv] "Minimal co-occurring medical crises" defined as having a behavioral health diagnosis code as a primary diagnosis, 0-1 medical diagnoses in positions 1-3, and medical diagnoses representing less than half of total diagnosis codes on the record.

[v] Johns Hopkins Community Health Needs Assessment, 2018.

[vi] SAMHSA, National Guidelines for Behavioral Health Crisis Care, Best Practices Toolkit: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[vii] Behavioral Health System of Baltimore. Baltimore City's *Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System*, June 2019.

[viii] Watson, Amy C, Wood, Jennifer D. *Everyday Police Work During Mental Health Encounters: A Study of call resolutions in Chicago and their implications for Diversion.* Behavioral Sciences and the Law. 2017 September; 35(5-6): pg. 422-455.

[ix] Nordstrom, Kimberly A. *Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document.* The Western Journal of Emergency Medicine. 2019 July; 20(5): pg. 690-695.

[x] *Final Recommendation on Quality-Based Reimbursement (QBR) Policy for RY2022.* December 2019 HSCRC Public Session, pg. 11.

[xi] This proposal utilized the *Crisis Now Calculator* provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* (2020) to develop a projection of mobile crisis responses with a Care Traffic Control system in place. Estimates are based on population counts and are risk-adjusted by jurisdiction according to behavioral health ED visit rates per population (calculations based on national rates are increased proportionally if jurisdiction ED visits per population are higher or lower than the Statewide average): *Jurisdiction mobile crisis need = national experience * (jurisdiction behavioral health ED visits per population/State behavioral health ED visits per population)*

[xii] SAMHSA, National Guidelines for Behavioral Health Crisis Care, Best Practices Toolkit: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[xiii] Capacity needs were determined using the *Crisis Now Calculator* (https://crisisnow.com/ under "tools") with adjustments in the analysis to reflect local circumstances based on current MCT performance data provided by each LBHA

[xiv] Use of virtual services or telehealth has grown during the COVID-19 pandemic, and is backed by IOM: Innovation and Best Practices in Health Care Scheduling: https://nam.edu/wp-content/uploads/2015/06/SchedulingBestPractices.pdf

[xv] Sheppard Pratt example of a Virtual Crisis Walk-in Clinic, see: https://www.sheppardpratt.org/care-finder/virtual-crisis-walk-in-clinic/

[xvi] Page 17. Behavioral Health System Baltimore Crisis System Report. Accessed June 27, 2020. https://www.bhsbaltimore.org/wp-content/uploads/2019/06/BHSB-Behavioral-Health-Crisis-System-Plan-Final.pdf

[xvii] Kristin L. Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel and Jennifer Sweeney "Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies" Health Affairs, 32, no.2 (2013): 223–231