REQUEST FOR PROPOSALS:

Mobile Crisis Response and Stabilization Services

Release Date: July 18, 2025

Pre-Proposal Conference: July 28, 2025, 10:00 a.m.

Proposal Due: August 15, 2025, 4:00 p.m.

Anticipated Award Notification: September 8 , 2025

Anticipated Contract Start: October 1, 2025

Issued by:

Washington County Mental Health Authority

1800 Dual Hwy, Suite 301

Hagerstown, MD 21740

REQUEST FOR PROPOSALS

PROGRAM AREA: Mobile Crisis Response and Stabilization Services

I. PROJECT PURPOSE

Mobile Crisis Response and Stabilization Services is a general term for an on-demand community-based set of activities provided face-to-face and deployed in real time to the location of a person experiencing an urgent behavioral health issue or crisis. The goal of these services is to de-escalate the individual's situation, decrease emotional distress, and ensure their safety, thereby improving behavioral health outcomes. Additionally, these services seek to avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and engagement with the criminal legal system due to behavioral health challenges.

The frontline crisis response team is typically composed of a combination of clinical staff, peers, and trained paraprofessionals. These staff may also conduct follow-up and stabilization support, or a separate dedicated staff may provide these services.

Services must seek to align with the Substance Abuse and Mental Health Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit and subsequent updates. Those services include clinical assessment, crisis stabilization, warm hand-offs and referrals to ongoing treatment services and other supports, and follow-up. All services must be strength-based, person-centered, trauma-responsive, and reflect the cultural and linguistic needs of the individual, including individuals who are deaf or hard of hearing. Services must assist the individual and their support network as appropriate and should be flexible and robust to meet a broad spectrum of needs and presentations across the lifespan. This includes supporting individuals who are at immediate risk of psychiatric hospitalization and providing early intervention to address worsening behavioral health symptoms and prevent the need for future intensive services.

A mobile crisis response team has been an element of the Washington County crisis continuum since its inception in 2015. In fiscal year 2025, the licensed Mobile Crisis Team served 448 unduplicated individuals with an average of 154 interactions per month. This team was dispatched directly to the community from a dedicated call line, through the 988 call center, or in coordination with law enforcement personnel.

Through this Request for Proposals (RFP), the Washington County Mental Health Authority (WCMHA) is seeking one qualified organization to assume the responsibility for the delivery and coordination of mobile crisis response and stabilization services, by

a. serving as a Mobile Crisis Team* or
b. operating a Mobile Response Team** with a focus on attaining the Mobile Crisis Team level of service based on elements listed throughout this RFP and as laid out in COMAR 10.63 and 10.09.16

** A Mobile Crisis Team (MCT) is a specific licensed service type with regulated requirements in COMAR 10.63.20 and operate 24 hours per day, 7 days a week, every day of the year and serve individuals of all ages and special populations.*

Mobile Crisis Teams are composed of two staff members responding in person. A licensed mental health professional must be part of response services either on the in-person team or as a third team member via telehealth. If law enforcement is present, they are not considered part of the two-person response team. Mobile Crisis Team program staff includes at least one licensed mental health professional available at all times, either via telehealth or face-to-face, who is: licensed at the independent practice level, eligible to oversee the staff of the team, and eligible to complete an emergency petition.

***A Mobile Response Team (MRT) is composed of one or two responders, such as licensed mental health professionals, medical professionals, individuals with lived experience (peers), and may include other trained non-licensed staff and paraprofessionals (but not law enforcement). The MRT may support specific populations (e.g. individuals using substances) or they can support individuals across the lifespan. Note: Until a program is licensed as an MCT, they are referred to as MRT.*

II. SPECIFIC PROGRAM REQUIREMENTS

The contractor will build a team comprised of a sufficient number of staff to provide the contracted service and which will include multiple teams of staff sufficient to staff the program seven days per week, 24 hours per day.

The contractor will implement services aligned with the models identified by that of the grantor (Maryland Department of Health Behavioral Health Administration) to include the Mobile Response and Stabilization Service (MRSS) evidence-based model that is outlined in SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care. MRSS provides initial crisis response services for up to three days and stabilization services for up to eight weeks. MRSS programs stabilize the identified client and their caregivers through short term interventions and connections to ongoing community-based services. The core goals of MRSS are to prevent future crises and improve the overall functioning of the identified client and their support network.

The contractor is responsible for carrying out all training requirements established by MDH-Behavioral Health Administration.

The contractor will maintain documentation of all services and submit accurate reports in the manner and timeline identified by MDH-BHA and WCMHA.

The contractor will be expected to collaborate with county stakeholders and coordinate across agencies to support the ongoing development and sustainability of a comprehensive crisis

services continuum that reflects the shared vision of the community and its partners.

Regulatory

To apply for this RFP, an organization must be licensed by the Maryland Department of Health Behavioral Health Administration under COMAR 10.63. If not already licensed to do so, the contractor will immediately begin working towards accreditation, compliance with COMAR 10.09.16 and billing for eligible services. Billing revenue is expected to support sustainability.

Additional criteria used to evaluate an organization's eligibility to contract for this project:

- The applicant's staffing plan must include a behavioral health provider licensed in the state of Maryland, either LCPC or LCSW-C.
- Documented experience billing through Medicaid.
- Demonstrated experience working with people with co-occurring disorders.
- Demonstrated experience working within a broad system, as well as with outpatient/community-based providers.
- Demonstrated experience working with diverse populations .
- Demonstrated experience in quality management.
- Demonstrated history of contractual compliance, including responsiveness to past performance concerns such as improvement plans or sanctions.

Services to Be Offered

1. To support patient care and outcomes, mobile crisis response and stabilization programs must work closely with a variety of provider and community entities. The program is responsible for seeking out and fostering these relationships. Formal relationships (i.e., MOUs) are required with at least any other regional licensed and/or BHA-funded crisis services - including but not limited to 988, Behavioral Health Crisis Stabilization Centers, any other mobile crisis response and stabilization teams behavioral health urgent care, and crisis beds.
2. Additionally, efforts must be made to establish protocols with other key partners including but not limited to local first responder agencies, Public Safety Answering Points (PSAPs), hospitals, inpatient units, schools, and other relevant local providers (e.g., ACT teams, Developmental Disabilities Administration group homes, Adult Protective Services). Outreach and education must be conducted regularly with all other crisis services stakeholders such as local service providers, individuals with lived experience, neighborhood organizations, religious group representatives, caregiver groups (i.e., Head Start parents and guardians), homeless coalitions.

3. Establish and implement policies and procedures for collecting information about the individuals involved in the situation and for dispatching mobile crisis response services as quickly as possible from time of first contact. This must include an established process for 988, any local warmlines, and PSAPs to connect with mobile crisis response provider(s) for dispatch. If there is more than one mobile crisis response staffing model

in the jurisdiction, the policies and procedures must include a dispatch protocol with criteria to determine which staffing model is dispatched.

4. Immediately after dispatch or referral, begin conducting screening of the situation. Gather all collateral information enroute and on scene in order to complete triage and intake. As part of triage and throughout the service, the mobile team establishes scene safety and monitors for changes to determine whether law enforcement is needed on scene. Once on scene, complete a crisis assessment and determine the level of risk and care needed for each individual involved.

5. Crisis service components include de-escalation, stabilization, and intervention, including reducing any immediate risk of harm to self and others. Services should include psychoeducation and skills building for identified clients and their support network. This service/activity almost always includes the completion and active implementation of a safety plan and, when indicated, includes determination of whether criteria are met for a Petition for Emergency Evaluation.

6. Whenever possible, crises should be resolved in the community. Best practice guidelines prioritize resolution of crises with the least disruption (e.g. minimizing out of home placement of children, referring identified clients to the least restrictive and least invasive level of care). The opinions, preferences, and needs of any identified clients are explored and taken into account in determining disposition of services.

7. Identified clients and their support networks are provided with warm hand-offs (i.e., direct facilitation/connection) and referrals (i.e., provided with resource information and contact information) to immediate and/or ongoing services and community support. Best practice guidelines prioritize warm handoffs to higher levels of care and to longer term service providers. There should be active support and ongoing contact with the identified client and their support network to ensure connection is made to referral entities.

8. Transportation must be a part of initial crisis response and follow-up/stabilization services when indicated. The mobile crisis response and stabilization program may provide the transportation or program staff may coordinate the transportation externally (e.g. agreement with a contracted entity, warm handoff to a local transport service, taxi voucher).

9. After an initial crisis response service, follow up services are provided to the identified client and their support network to ensure connections are made to ongoing services and community support to stabilize acute and chronic crisis situations. These services may be completed by the same staff that completed the response service or by dedicated follow-up, outreach, or stabilization staff. These services can be most effective in person, but may be completed by telehealth and by phone as appropriate. Follow-up services should include support networks when appropriate and service providers to which individuals have been referred. Follow-up services should be provided for at least two weeks after an initial crisis response.

10. After an initial two week stabilization period, additional stabilization services may be indicated to ensure connection is made to ongoing services and community supports and to stabilize chronic crisis situations. This often includes intensive psychoeducation and skills building for identified clients and their support network. This activity/service may be completed by the same staff who completed the response service or by dedicated follow-up, outreach, or stabilization staff. These services are most effective in person but can be completed by telehealth and by phone as appropriate. These services should include support networks and service providers and occur for up to eight weeks after an initial crisis response. **(NOTE: THIS IS BEST PRACTICE. FOR MCT, REIMBURSEMENT IS AVAILABLE FOR UP TO 2 WEEKS.)**

11. Identified clients and their support networks should receive a Consumer Satisfaction Survey to collect feedback on their experience with the service, opportunities for improvement, and their perception of their ability to manage a future behavioral health crisis. The survey should relate to both the initial crisis response and stabilization services.

12. Participation in meetings that promote community collaboration and quality of care for individuals served, such as: Local Care Team, Community Planning Team, Adult Protective Services/Multi-Disciplinary team, or any other meeting deemed appropriate by the local authority.

13. Serve all consumers regardless of insurance status. The MCT/MRT operator will be expected to seek reimbursement for services through Maryland Medicaid or commercial insurers, when those options are available.

Target Population

The target population for this program is any of Washington County's 155,000 residents experiencing an urgent behavioral health issue or crisis. The Mobile Response Team/Mobile Crisis Team must develop the capacity to serve individuals regardless of complex circumstances or intersecting identities: intellectual and developmental disabilities (IDD), physical illness, LGBTQ identity, speaking English as a second language, being deaf/hard of hearing, immigrant/refugee status, domestic violence (DV) experience, homelessness, and criminal justice involvement.

Location

Services will be provided primarily at locations in the community as determined by the need of the call, not to include hospital or detention institutions. (e.g., home or similar setting, school, workplace or a public area)

Program Integration

The Contractor must agree to participate with the Washington County Mental Health Authority, on an ongoing basis, in the areas of: systems planning, quality assurance, client movement through the system, accountability and system wide meetings. This is intended to help integrate the provider's services into a county-wide continuum of mental health care.

The Contractor must develop and maintain formal written service coordination agreements with other relevant participant agencies in the mental health system as appropriate.

III. STAFFING REQUIREMENTS

Proposed staff shall be appropriately credentialed pursuant to COMAR 10.21.17.11 and 10.63.03.20

Must include:

- Mobile Crisis Team: A behavioral health professional licensed at the independent practice level, eligible to oversee staff of the team, and eligible to complete an emergency petition
- Mobile Response Team: A behavioral health provider licensed in the state of Maryland (for example, LMSW, LCSW-C, LGPC, LCPC, etc)

Teams may include other trained non licensed staff and paraprofessionals who can appropriately support the outlined deliverables. Use of peer support workers with lived experience are encouraged, as are medical professionals.

Clinical supervision must be provided for all providers who are not licensed to practice independently.

Supervisors must be available during all shifts to support staff and resolve consumer/community complaints.

IV. SPECIFIC CONDITIONS AND OUTCOME AND PERFORMANCE EXPECTATIONS

Mobile Crisis Response and Stabilization Data Dictionary July 9 2025

V. PROGRAM REPORTING REQUIREMENTS

The Contractor shall adhere to all reporting requirements of the WCMHA and all other parties that may have legal, fiscal or monitoring responsibilities for the program and services encompassed by this contract.

The Contractor must submit monthly invoices for payment on services rendered along with data reports on program activities to support evidence of compliance with contract deliverables.

The contractor will be required to track data as determined by MDH-BHA and recipients are expected to engage with all data collection, management, and analysis systems led and monitored by the MDH-BHA. Refer to Section IV for current data collection requirements, which are summarized below:

individuals served – adults and children

% of mobile responses and stabilization services resolved in the community

% of final mobile response and stabilization services dispositions to the ED (broken out by reason, e.g. somatic or voluntary behavioral health)

% of individuals who received a safety plan

% of mobile responses involving law enforcement on scene (broken out by reason and level of involvement)

% of mobile responses and stabilization services involving petition for emergency evaluation (broken out by entity that completed the EP e.g. MCT provider, other community provider, law enforcement, court ordered)

% of individuals diverted from potential criminal legal system involvement (captured in data based on (1) Transfers from 911 to mobile crisis, including through 988; and (2) Responder assessment of likelihood of criminal legal involvement in the absence of a mobile response)

% of individuals diverted from potential emergency department visit (captured in data based on (1) Transfers from 911 to mobile crisis, including through 988; (2) Responder assessment of likelihood of emergency room visit in the absence of a mobile response)

% of individuals referred to services (broken out by higher level of care, lower level of care, ongoing, mobile crisis, etc.)

% of referrals that involved warm handoff/linkage (broken out by service type) (warm hand off is defined in data dictionary)

% referred to or transported to the hospital or inpatient unit at the hospital (by any entity)

% referred to or transported to a higher level of care not the ED (e.g., BHCSC, walk-in urgent care) (broken out by entity that transported)

% of individuals voluntarily transported away from location of call (broken out by entity providing transport)

% that receive mobile crisis follow-up and/or stabilization services (includes attempted and completed; report also on incomplete information for follow-up)

% of follow-up conducted in person

% presenting to mobile crisis repeatedly within 12 months (and number of times presenting)

# of in person stabilization service per week per individual (reporting also on attempts)

# of contracted individuals reported improved ability to manage future crisis (individual and support network self report)

# of contacted individuals who reported improved community connection and/or wellbeing (individual and support network self report) (e.g. school attendance, peer engagement, hobbies, religion/spirituality)n

% of cases where an out of home placement occurred during 2-8 week stabilization period

% of cases where an ED visit occurred during the 2-8 week stabilization period (broken out by reason/entity transporting)

% of cases where an individual would have been involved in the criminal legal system if not engaged with this services (e.g. contact with law enforcement, criminal charge)

VI. CONTRACT PERIOD

The contract entered into pursuant to this RFP shall begin on or about October 1, 2025 and shall expire June 30, 2026. The WCMHA reserves the right to extend the program through additional one year contracts shall the contractor remain in compliance with contract deliverables and performance expectations. If the WCMHA extends the period of the contract, compensation will be renegotiated for the extended period. All extensions of the contract term are subject to available funding and satisfactory contractor performance.

VII. PRE-BID CONFERENCE

There will be a virtual Pre-Bid Conference (PBC) for interested potential bidders.

Date: Monday, July 28, 2025
Time: 10:00 AM
Location: Microsoft Teams meeting:
PBC: Mobile Crisis Response and Stabilization | Meeting-Join | Microsoft Teams

While attendance is not mandatory it is strongly advised that interested bidders attend. Parties intending to attend the PBC are requested to notify WCMHA by 5:00 pm on July 27, 2025, via email at CarrieT@wcmha.org

Questions related to the RFP may be submitted in advance of or during the PBC. Questions received after this conference will not be answered. Questions and answers will be provided to attendees/those who submitted questions and may otherwise be obtained by email request to CarrieT@wcmha.org

After Tuesday, July 29, 2025, a recording of the PBC will be available for listening upon request.

VIII. REQUIRED PROPOSAL ELEMENTS

Each proposal must contain all of the following elements and should be framed in terms of the eligibility requirements described in the RFP.

Technical Proposal:

- Name, address, telephone and fax numbers, and e-mail address of contact person

- Organizational Capacity:
    - Description of the organization and relevant experience managing similar projects, meeting contract deliverables and obligations, and the capacity to manage the programmatic and financial requirements of the grant.
    - Description of how the project fits into bidder's organization.
    - Description of the organization's history forming partnerships with organizations and community stakeholders. Details that support this experience is encouraged and three letters of support should be included as addendums to the proposal.

- Work Proposal
    - Description of knowledge of Washington County systems, resources, and culture relevant to the scope of this project.
    - Detailed description of services to be offered as outlined in Section II which should include:
        - method of dispatch
        - how an interpreter language line will be used effectively for providing service access to people who speak other languages or need ASL interpretation
    - Proposed staffing
        - position titles
        - full time equivalency for each position
        - position summaries
        - minimum qualifications
        - staffing patterns
    - Data collection and documentation methods
    - Description of how the contractor will partner with county stakeholders and cross-sector agencies to advance a shared vision for a cohesive and effective crisis response system.
    - Schedule for project implementation and efforts for pursuing fee-for-service billing
    - Plan for evaluating the project

Cost Proposal

- Budget for the project will be submitted on DHMH Form 432.
- Budget narrative

IX. COST PROPOSAL AND FISCAL MANAGEMENT

Cost Proposal

It is expected that bidders will seek to partially fund this project through sources of funding other than this contract. Bidders shall submit a price proposal that delineates the costs of the project by line item and the anticipated sources of revenue other than the WCMHA that will

support the project. Costs that are not anticipated to be reimbursed by an alternative payer will form the substance of the price proposal to WCMHA.

There is a potential for asset reallocation from the current grantee to include a vehicle and police band radios which require licenses for use. The full scope of asset reallocation may not be known by the proposal submission date.

Price Limitation

All cost proposals for WCMHA funds must be: $391,463

Availability of Funds

The contractual obligation of the WCMHA and final award amount under this contract is contingent upon the availability of appropriated funds from which payment for this contract can be made.

Method of Payment

Under the terms of this cost reimbursement grant, payment is contingent upon the submission and approval of both an invoice for actual expenditures and all required performance reports.

X. SUBMISSION INSTRUCTIONS

Proposals must be received in the offices of the Washington County Mental Health Authority by Friday, August 15, 2025 at 4:00 p.m. Proposals received after this deadline shall not be considered.

Proposals shall be submitted in two parts; a technical proposal and a cost proposal.

- One digital copy of each shall be submitted via email to: CarrieT@wcmha.org
- Three hard copies of the proposal, in two parts, shall be delivered to the above address and clearly labeled to indicate the name of the provider agency and the Request for Proposal (RFP) to which it corresponds.

WCMHA reserves the right to request clarification of information submitted and to request additional information from one or more providers as deemed necessary.

XI. METHOD OF AWARD

The Selection Committee shall first review all proposals for compliance with the requirements expressed in this RFP. Acceptable proposals will then be rated for both technical merit and cost. Preference will be given to proposals from Maryland-based providers.

Responsibility

The respondent has the burden of affirmatively demonstrating its ability to meet the deliverables and expectations of the project as described in this RFP. As may be determined at the discretion of the selection committee, a respondent may automatically be considered not eligible for consideration of this solicitation if the organization is under debarment, has documented poor performance, has questionable reputation, lacks the required years of operation, lacks integrity or key personnel, has previously failed to perform properly, or has failed to complete timely contracts of a similar nature.

Evaluation Method

An evaluation will be completed by each member of the selection committee, which will be comprised of the WCMHA Executive Director, a member of the WCMHA Board of Directors, and at least two other individuals which represent a relevant stakeholder organization.

The following elements will be weighted as follows:

A. Organizational background and Capacity: **20 points**
    a. Description of the organization and relevant experience managing similar projects, meeting contract deliverables and obligations, and the capacity to manage the programmatic and financial requirements of the grant.
    b. Description of how project fits into bidder's organization.
    c. Description of the organization's history forming partnerships with organizations and community stakeholders. Details that support this experience is encouraged and three letters of support should be included as addendums to the proposal.
B. Understanding and Description of Services to be offered: **30 points**
C. Proposed Staffing: **15 points**
D. Community Collaboration: **10 points**
    a. Understanding of Washington County systems, resources, and culture relevant to the scope of the project and
    b. Described methods of partnering with county stakeholders and cross-sector agencies to advance a shared vision for a cohesive and effective crisis response system.
E. Implementation strategy and performance evaluation: **15 points**
    a. Data collection and documentation methods
    b. Schedule for project implementation
    c. Plan for evaluating the project
F. Cost proposal: **10 points**

XII. NOTIFICATION OF CONTRACT AWARD

The successful bidder will be notified in writing of the WCMHA intent to award the contract by September 8, 2025.

XIII. OTHER CONDITIONS OF AWARD

A. WCMHA reserves the right to reject any or all proposals or to award the contract to the next recommended bidder if the successful bidder does not execute a contract by October 1, 2025.

B. WCMHA reserves the right to terminate the RFP process at any time prior to execution of a contract.

C. WCMHA reserves the right to terminate the RFP process at any time, to modify the scope of this RFP at any time, and to modify any resulting contract if the project evolves in such a way as to make such actions necessary.

D. WCMHA reserves the right to negotiate the budget submitted by the successful bidder.

E. Unsuccessful bidders have the right to appeal the contract award decision and must follow the WCMHA Grievance Policy.