



**Massachusetts Behavioral Health Partnership (MBHP)
Emergency Services Program (ESP) RFR**

Organization name: Boston Medical Center

Proposed catchment area name:

Fall River

Contact person: Joanna Buczek, MD **Title:** Vice Chair, Psychiatry

Mailing address: 85 East Newton Street, Suite 802

Boston, MA 02118

Telephone number: 617-414-4708 **Fax number:** 617-414-1975

E-mail address: Joanna.Buczek@bmc.org

Proposed subcontractor(s), if any:

Organization name: Bay Cove Human Services

Contact person: Nancy Mahan **Title:** Senior Vice President, Program Services

Mailing address: 66 Canal Street

Boston, MA 02114

Telephone number: 617-371-3004 **Fax number:** 617-371-3100

E-mail address: nmahan@baycove.org

Organization name: Vinfen

Contact person: Bruce L. Bird, MD **Title:** President and CEO

Mailing address: 950 Cambridge Street

Cambridge, MA 02141

Telephone number: 617-441-1800 **Fax number:** 617-441-1858

E-mail address: birdb@vinfen.org

Service component(s) for which the bidder proposes to subcontract to the above:

Boston Medical Center is providing the following services in collaboration with Bay Cove Human Services and Vinfen:

- Child Mobile Crisis Intervention
- Adult Mobile Crisis Intervention
- Community-based location
- Adult Community Crisis Stabilization (CCS)

Other: (specify) _____



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The primary teaching affiliate of the
Boston University School of Medicine.

September 11, 2015

Shelley Baer, M.S.
Director of Emergency Services
Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Dear Ms. Baer:

The Boston Medical Center (BMC) Department of Psychiatry is pleased to submit this proposal for the Emergency Services Program (ESP) Contract for the Fall River Area. Key partners (sub-contractors) in this bid include Vinfen (V) and Bay Cove Human Services (BCHS), two premier community agencies who have successfully partnered with BMC in the Southeast and MetroBoston communities to provide emergency service programs and recovery services. These agencies have extensive knowledge and experience in delivering high quality, community-based and recovery-oriented crisis assessment, treatment intervention and stabilization services.

BMC proposes to lead a partnership for revitalization of the Fall River Emergency Service Program in which BMC, in conjunction with BCHS, will provide mobile crisis intervention services and urgent care and BMC, in conjunction with V, will provide community crisis stabilization services for these communities. BCHS will also provide technical support in connection with the electronic medical record that will be used by the Fall River ESP.

BMC will provide seasoned clinical leadership, comprehensive program administration, and BEST program technology to assure a revitalized and robust Fall River Emergency Service Program (FR ESP). The medical and clinical infrastructure of the proposed FR ESP is designed to assure that BMC psychiatry has direct involvement in all of the services and a substantive knowledge and oversight of the clinical work overall.

These partners have more than 100 years of experience and considerable competencies in the treatment of complex mental health and substance abuse conditions to meet the needs of culturally diverse children, families, adults, allied providers and community stakeholders. Our proposed model incorporates not only the best practice features of a comprehensive emergency services program as referenced above, but also important philosophical, policy and program practices designed to assure that the FR ESP is focused first and last on the individuals who need our care in psychiatric and social emergencies. These include;

- A FR ESP culture founded on recovery, embracing inclusion rather than extrusion, and diversion, with a robust family partner and consumer provider involvement in the design, oversight and delivery of ESP services;



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The primary teaching affiliate of the
Boston University School of Medicine.

- Alliances with key providers, consumers, families and state agency stakeholders, designed to make navigation across the system, even in crisis, a seamless experience;
- Immediate access to clinical, medical and social information about clients to guide differential diagnosis and intervention choices. This also serves to strengthen what may be frayed linkages to caregivers and/or programs to address treatment adherence and assure continuity of appropriate care;
- Discrete services tailored to the distinct needs of children and youth, and to the family and community contexts in which they live, informed by *Systems of Care* (SOC) philosophy and practices;
- Services are organized to respond to members of the diverse racial, ethnic, and linguistic communities that comprise the Fall River communities, recognizing both the risk of disparities in access to effective care for racial, ethnic, linguistic and cultural minorities, and the significance of culture to the effective treatment of mental health and substance abuse conditions;
- Stakeholder input, as demonstrated by engagement of the Southeast Recovery Learning Community, NAMI MA, JRI, ARC of Bristol County, Gateways, Transformation Center and Compassion Counseling in the preparation of the proposal; and
- Intersystem planning, addressing the complex social, medical and behavioral health needs of our target client population, which are typically met through a diverse, and sometimes not well integrated, array of services in the community.

BMC and its partners are excited by the prospect of putting together our longstanding commitment to high performing emergency services, our clinical and administrative competencies, and the assets of our partners to provide residents of the Fall River area with a revitalized ESP. We have also submitted proposals for the Taunton/Attleboro, Cape Cod and the Islands and Brockton ESPs. We believe that BMC, in conjunction with BCHS and V, have the capacity and expertise to undertake this considerable effort. We also believe that serving multiple catchment areas would provide opportunities for the programs to benefit from economies of scale, in sharing resources (especially during periods of high demand), from standardization of communications and practices and in enhancing access and continuity of care.

Thank you for the opportunity to reply to the solicitation and please do not hesitate to call on us for any questions you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Joanna Buczek, MD". The signature is written over a horizontal line.

Joanna Buczek, MD
Interim Boston University School of Medicine Chair
Boston Medical Center Chief of Psychiatry

Acronym Keys

ACO-Accountable Care Organizations
ALP-Alternative Lock-Up Program
ASL-American Sign Language
B-Brockton
BAMSI-Brockton Area Multi-Services, Inc.
BC-Bay Cove Human Services
BCBA-Board Certified Behavior Analyst
B-ESP-Brockton Emergency Service Program
BEST-Boston Emergency Service Team
BHS-Behavioral Health Services
BMC- Boston Medical Center
BMC-ESP-Boston Medical Center Emergency Service Program
BRC-Boston Resource Center
CARF-Commission on Accreditation of Rehabilitation Facilities
CBFS-Community Based Flexible Supports
CBHI-Children's Behavioral Health Initiative
CBL-Community Based Location
CCI-Cape Cod & Islands
CCI-ESP-Cape Cod & the Islands Emergency Service Program
CCS-Community Crisis Stabilization
CFT-Child Focused Team
CORD-Cape Cod Organization for Rights of the Disabled
CPRP- Certification for Psychiatric Rehabilitation
CPS-Certified Peer Specialist
CSA-Community Service Agency
CS-ESP-Cambridge Somerville Emergency Service Program
DBSA-Depression Bipolar Support Alliance
DCF-Department of Children & Families
DDS-Department of Developmental Services
DET-Department of Employment & Training
DMH-Department of Mental Health
DoP- Department of Psychiatry
DPH-Department of Public Health
DYS-Department of Youth Services
EATS-Enhanced Addiction Treatment Service
ED-Emergency Department
EMR-Electronic Medical Record
ESP-Emergency Service Program
FR-Fall River
FR-ESP-Fall River Emergency Service Program
FTE-Full Time Employees
ICC-Intensive Care Coordinator
IHBT-Intensive Home-Based Treatment
IHT-In-Home Therapy

IOP-Intensive Outpatient Programs
JRI-Justice Resource Institute
MBRLC-Metro Boston Recovery Learning Community
MCI-Mobile Crisis Intervention
MOR-Milestones of Recovery

MOU-Memorandum of Understanding
NAMI-National Alliance on Mental Illness
PACT-Program for Assertive Community Treatment
PES-Psychiatric Emergency Services
PHP-Partial Hospitalization Program
PI-Performance Improvement
PPAL-Parent Professional Advocacy League
PR-Psychiatric Rehabilitation
PSP-Parent Support Program
QA-Quality Assurance
QI-Quality Improvement
QM-Quality Management
QOLO-Quality of Life Outcomes
RAP-Runaway Assistance Program
RCC-Recovery Connection Centers
RFR-Request for Response
RLC-Recovery Learning Community
SERLC- Southeast Recovery Learning Community
SOAP-Structured Outpatient Addictions Programs
SOC-Systems of Care
STARR-Stabilization, Assessment, and Rapid Reintegration
TA-Taunton Attleboro
TA-ESP-Taunton Attleboro Emergency Service Program
TIP-Transition to Independence Project
TPP-Tenancy Preservation Project
UCC-Urgent Care Center
V-Vinfen
VNA-Visiting Nurse Association
WRAP-Wellness Recovery Action Plan

Narrative Response

1. GENERAL QUALIFICATIONS AND INFRASTRUCTURE

The Boston Medical Center (BMC) Department of Psychiatry (DoP) is the bidder for the Emergency Service Program (ESP) Contract for the Fall River (FR) Area. Key partners (sub-contractors) in this bid include Bay Cove Human Services (BC), and Vinfen (V).

BMC will lead the partnership providing seasoned clinical leadership, comprehensive program administration, and Boston Emergency Service Team (BEST) program technology to assure revitalization of the **Fall River Emergency Service Program (FR-ESP)**. BC and V have considerable experience in collaborating with allied providers and community stakeholders and expertise in providing evidence-based Psychiatric Emergency Services (PES) for the treatment of complex mental health and substance abuse conditions among culturally diverse children, families, and adults.

BMC, in conjunction with BC and V, will also provide urgent care, crisis stabilization, clinical triage, and psychiatry services. BC and V will offer Mobile Crisis Intervention and Community Crisis Stabilization (CCS) for this catchment area. BC's subcontract also includes technical support in connection with the Electronic Medical Record (EMR) that will be used by the FR-ESP.

BMC, BC, and V have longstanding track records of building care partnerships to benefit clients. BMC will leverage its competence in building and maintaining the robust, successful BEST and Cambridge Somerville Emergency Services Program (CS-ESP). Productive alliances with consumers, their families, state agencies, local governments, criminal justice organizations, national and local community and social service agencies, religious and cultural organizations, and behavioral, healthcare, and substance abuse providers are a requisite for an effective, integrated, and seamless experience for clients. To that end, BMC is partnering with BC and V – two major providers with clinical expertise and a breadth of experience in developing community programs and collaborations.

1.1 Licensure

1.1.1 Department of Public Health (DPH)-Licensed Outpatient Mental Health Clinic:

BMC/BC/V: Yes/Yes/Yes

1.1.2 Licensed as a Hospital

1.1.2.1 DPH: Yes/No/No 1.1.2.2 Department of Mental Health (DMH): No/No/No

1.2 Accreditation

1.2.1 National Organization: Yes/Yes/Yes 1.2.2 Joint Commission/Commission on Accreditation of Rehabilitation Facilities (CARF) /CARF

1.3 Currently Contracted MassHealth Provider/Applicant Yes/Yes/Yes

1.4 Three Years of Experience Providing Behavioral Health Services (BHS) to Wide Range of Populations Yes/Yes/Yes

1.4.1 # Years Providing Behavioral Health Services to Children, Adolescents, and Families: 31+/12/20

1.4.1.1 # Youth Served CY14: BMC: 9,944 encounters for clinic and ESP combined; BC: 2,169 BEST, 1,113 Early Inter., 300 Family Support Center, 100 Parent Support Program (PSP); V: 300

1.4.2 # Years Providing Behavioral Health Services to Adults: 31/42/38

1.4.2.1 # Adults Served in CY14: BMC: 53,134 encounters for clinic and ESP combined; BC: 1,990; V: 100 programs and 6263 people served; 238 young adults and adults Cape Cod CCS; 2,792 adults Community Based Flexible Supports (CBFS); 166 Program for Assertive

Community Treatment (PACT); 279 homeless services; 1,575 Clubhouse; 108 Recovery Learning Centers; 929 Clinical/Outpatient services.

1.4.3 Behavioral Health Services Provided and Populations Served: BMC provides BHS to children and adults, including emergency psychiatric services, outpatient BHS, consultation and liaison services, peer support and recovery services, refugee mental health services, and disaster mental health counseling services. BMC has been the lead agency in BEST for the past 12 years; participated in the BEST Program as a Designated Emergency Department (ED) since 1995; and been the lead agency for the CS-ESP for six years. BMC's DoP is organized to respond to a racially, ethnically, and linguistically diverse, urban population who faces complex addictions and an array of psychiatric and health conditions.

BC operates eight CBFS teams; a specialized outreach team; a Housing First program (Home At Last); three Clubhouse programs; PACT; Day Treatment; Tenancy Preservation Project (TPP); two specialized residences providing treatment for 12 men with mental illness and problematic sexual behaviors and a former Quarterway residence; 40 community residences with partial and 24-hour care; a Mental Health Clinic, providing psychopharmacology and therapy; a DMH transitional shelter, and four CCS programs. BC has long operated specialty residential and clubhouse programs serving Spanish, Vietnamese, Cantonese, and Mandarin speaking adults. Two bi-lingual BC CBFS who represent these cultures work with these populations. BC, as a BEST partner, provides ESP services to both youth and families in the Boston area, while all other services are available to adults only.

V provides community based services to people with psychiatric conditions, intellectual and developmental disabilities, brain injuries, and behavioral health challenges. V's Psychiatric Rehabilitation (PR) Division is dedicated to the recovery of adults and transitional age youth living with psychiatric disabilities, substance addiction, and/or HIV/AIDS throughout eastern Massachusetts. V's outreach-oriented assertive community treatment serves clients via CBFS Services and PACT. V has removed cultural and linguistic barriers to service by recruiting a diverse staff, accessing translators as necessary, respecting and celebrating cultural differences and linking clients to culturally relevant community supports.

1.5 Presence in and Knowledge of the Catchment Area

1.5.1 Current Location: BMC, BC, and V will work in partnership to establish an ESP Community Based Location (CBL) with welcoming signage and accessibility by public transportation. It will be well-advertised to the community and constituencies. BC and V will also contract with local transportation companies to ease access for clients in crisis. BMC in collaboration with V currently operates RLC programs in the FR area. One of the main Recovery Connection Centers (RCCs) is located in FR. In operating this program, BMC and V have become knowledgeable about the FR community and have established relationships with many key stakeholders including the DMH FR staff, Child and Family Services and SCIL.

1.5.1.1 # of Years Operated in Uninterrupted Physical Location in Catchment Area: 4 years

1.5.1.2 Address of above with Longest Duration: The Empowering Resilience Recovery Connection Center, 66 Troy Street, Fall River, MA was established in 2012 and continues to operate at this site.

1.5.1.3 Rationale for and Plan to Establish a Physical Location: BMC and the V facility and real estate team will prioritize identification of a CBL upon award. V has a proven track record of identifying and locating appropriate program sites in a timely manner by leveraging its strong presence in Southeastern MA and existing relationships with local commercial realtors. V is

already familiar with the FR real estate market and the availability of properties because of their extensive search in the past year for new space for their FR program.

1.5.2 Brief Needs Assessment: Many of the FR-ESP communities have significant community health and mental health services that we will support and access in our efforts to provide emergency services such as but not limited to: Arbour Counseling Services, Fellowship Health Resources, Seven Hills Foundation, Child and Family Services, Solid Ground Psychotherapy Associates, Steppingstone Incorporated, Bay Coast Behavioral, Fall River Psychological Associates, and Riverwood Mental Health Associates.

BMC and V have familiarity with the FR area through their development of recovery learning community services in the area and have become knowledgeable about the needs and strengths of this community. The current FR-ESP has many strengths, yet concerning limitations and gaps need to be effectively addressed in order to ensure that consumers in crisis are responded to in a timely, respectful, and meaningful manner. Historically, the design of the crisis continuum has been designed to be reactive to acute psychiatric emergency issues and not focused on early intervention and prevention. Stakeholders report that the community has for year expressed the concern that the ESP team would not provide MCI services to the client's home, residential program or other human service facilities, and would only evaluate the client at the local ED. Local EDs have been overcrowded by individuals with acute psychiatric and substance abuse problems needing crisis evaluation and treatment. Consumers face long waits which may exacerbate their psychiatric issues and increase the likelihood of hospitalization.

1.5.3 Established Relationships with Stakeholders: BMC, BC, and V are committed to providing early access, upstream interventions, and accessible PES to those in need. Critical to these goals are the development of strong relationships with stakeholders. BC, BMC, and V have longstanding collaborative, collegial, and respectful partnerships with state agencies including DMH, Department of Developmental Services (DDS), Department of Children and Families (DCF), Department of Youth Services (DYS), Department DPH, Department of Employment and Training (DET), MA Commission for the Deaf and Hard of Hearing and MassHealth managed care organizations. BMC and V, in particular, have well-established, effective working relationships with many key FR stakeholders including FR DMH staff and Child and Family Services

V has established, built on, and maintained strong linkages with a variety of community-based resources, including: 1) national and local family support and advocacy groups such as National Alliance on Mental Illness (NAMI); 2) behavioral and other healthcare providers such as Arbour Counseling Services, Seven Hills Foundation, and South Bay Mental Health; 3) substance abuse providers, advocacy groups, self-help and peer groups, and detox facilities such as local AA and NA groups; and 4) homeless providers such as Steppingstone Incorporated.

1.5.4 Interface with Existing Crisis Program: BMC and V staff currently interface with the existing DMH FR ESP staff, collaborating in providing services to shared clients in the FR area.

1.6 Continuum of Care: BMC offers a continuum of complementary programs and services targeted to the unique needs of children, adults, elders and their families in concert with the continuum of BHS offered by BC and V described in section 1.4.3. See Attachment 1.

1.7 Administrative Infrastructure: The BMC DoP leadership team includes: Joanna Buczek, MD, Vice Chair of Psychiatry, BMC; Anna Fitzgerald, MD, Medical Director, PES; Joan Taglieri, MSN, Director, Clinical Operations, Psychiatry and BEST; Sarah Carignan, MBA, Administrative Director, Psychiatry; Marion Burke, MSN, Director of Quality Management (QM) and Training, Psychiatry; Andrea Hall, LICSW, Clinical Director of BEST and CS-ESP,

Tasha Ferguson, LMHC, Assistant Clinical Director and MCI Director; and Cindy Gordon, LICSW, Clinical Director, PES, and Adult Outpatient, Psychiatry. The team is directly involved in the administrative, clinical and financial oversight of the BEST and CS-ESP and will be responsible for the implementation of FR-ESP in partnership with BC and V. BMC, BC and V have considerable experience and competency in behavioral health service delivery, system development/oversight, and delivery of ESPs serving youth and adults.

1.8 Medical and Clinical Infrastructure: BMC's model strives to combine its medical and clinical expertise with the critically important assets and roles of significant providers in the FR community. The medical and clinical infrastructure of the proposed FR-ESP is designed to assure that BMC psychiatry has direct involvement in all of the services and a substantive knowledge of the clinical work overall, coordinating the local capacity and competence to assure the integrity and continuity of care for each child or adult served. Medical and clinical oversight of FR-ESP will be provided through an interrelated committee structure that includes four key elements.

The current ESP Senior Leadership Committee (Buczek, Fitzgerald, Burke, Carignan, Hall, Ferguson, Gordon, and Taglieri) will also serve as the **FR-ESP Senior Leadership Committee** joined by the new FR-ESP Director and MCI Director. In keeping with the BEST/CS-ESP model, the Committee will meet weekly to manage and oversee FR-ESP medical and clinical aspects.

The **FR-ESP Clinical Leadership Committee** will mirror the existing BEST/CS-ESP Clinical Leadership Committee; be comprised of BMC, BC, and V medical and clinical leadership; meet weekly; oversee day-to-day operations, ensure consistency in clinical practice, and manage the system of care; manage quality, including policy and procedure development, compliance with applicable standards, regulations, and utilization review and training.

Based on the BEST and CS-ESP model, the **FR-ESP Advisory Committee**, comprised of key stakeholders, including behavioral health and social service agencies, consumers and family members, child advocacy groups, DCF, DDS and DMH, representatives of special needs citizens and others in the catchment area, will meet quarterly to inform policy issues and practice, and monitor responsiveness and effectiveness of ESP.

The **ESP Medical Leadership Committee**, is comprised of the ESP Medical Director, CCS Medical Director and all the on-call child and adult Psychiatrists, who provide backup consultation for the Southeast ESP. A monthly meeting of all Psychiatric Nurse Practitioners who provide CCS services includes supervision, training, case review, and consultation.

1.9 QM Infrastructure

1.9.1 Key Staff Positions and Infrastructure Elements: The **Director of QM** is responsible for the development and oversight of a fully-integrated Performance Improvement (PI)/QM plan which ensures the quality, appropriateness, and continual improvement of services provided by the BMC-ESP. S/he also provides Quality Improvement (QI) education and information to all components of BEST. Additionally, the Director identifies and creates reports that provide data by which to measure and evaluate the ESP's compliance with performance standards - some of which have been defined by ESP leadership, and others by payers and regulatory groups.

The **Senior Leadership Committee** (see 1.8) meets weekly, functions as the executive group, and oversees the QM Program including: QI activity prioritization; PI activity initiation, oversight, coordination; report review; and approval of PI teams' recommendations. One to two of the monthly meetings also include the Medical Directors of BMC PES and partner designated

EDs, the ESP Assistant Clinical Director/Youth MCI Program Director, and Urgent Care Center (UCC) Managers—the **QM Committee**.

The Clinical Leadership Committee, see 1.8 above, will serve as the **QM Committee** and: 1) establish expectations and performance standards; 2) review volume, activity, and utilization data to identify high-user clients, diversionary and hospitalization rates, barriers to accessing service, etc.; 3) identify opportunities for improvement; make QI/PI recommendations to Senior Management Team; 4) manage the PI process and ensure its implementation to measure, assess and improve performance; 5) resolve problems/complaints that could adversely affect service delivery; and 6) survey stakeholders, review results and identify target areas for improvement.

The FR-ESP Advisory Committee, which will meet bi-monthly to inform QM Committee's work, will be comprised of internal and external stakeholders, e.g. the School Department, Police Department, the Parent Professional Advocacy League (PPAL), Mental Health Court Programs, consumers of mental health services, representatives of homeless shelters and services, DMH, DDS, DSS, DYS, and key community providers.

1.9.2 Current QM Plan: See Attachment 2.

1.9.3 QM Tools and Strategies: The BMC-ESP QM Program focuses on both Quality Assurance (QA) and QI. **QI** examines existing work methods, processes and systems, and develops ways to make them better. Rather than solely problem-based, QI assumes that opportunities for improvement always exist. **QA** seeks to answer the question: what do you do and how do you know you're doing it well? Therefore, each component of BEST considers: 1) the most important aspect(s) of your work, the most important things that you do, and why you are here; 2) how do you know that you're doing those things well/correctly, objective data or information that informs that conclusion; and 3) how those data are collected, how often the data is examined, performance standard (percentage or numeric) set for your service. In addition to each component of the service creating indicators of quality, BEST identifies aspects of its work which are high risk, high volume, or problematic. QA and QI activities and teams may be organized to address these issues; they may also be referred to existing committees for exploration and problem solving.

1.9.4 Data and Information Use: BMC ESP created a web-based EMR into which all encounters are entered and with 40 standing data reports that pull information from client records and encounters. All users can easily see information for any time period and special reports can be requested and quickly generated. Clinicians and Managers can access information and track various aspects of their performance on a weekly and monthly basis. Reports include volume flow by time of day and week, allowing appropriate allocation of resources to meet the changing demand. ESP leadership teams regularly review reports in order to track the program's compliance with performance standards and inform development and improvement decision-making. A detailed description of how various data are used is found in Attachment 2.

2. ESP CORE COMPETENCIES

2.1 Crisis Services

2.1.1 Experience: The contractor and sub-contractors have extensive track records and staff members with long tenure and experience in providing crisis services:

- For more than 12 years, BMC has held the contract with MBHP for BEST and has been a sub-contracted designated ED for BEST since 1995. BMC has held the contract with MBHP for Cambridge/Somerville ESP for more than six years;
- BC has been a BEST sub-contractor for more than 12 years, providing mobile services to Boston's largest, central neighborhoods;
- V operated a crisis unit under BEST prior to 2004 and currently operates one for CCI-ESP.

2.1.2 Success

2.1.2.1 Response Time: BMC has focused on response time as a quality measure with its current ESPs. Please see Attachment 3 for more detailed information.

2.1.2.2 Variable Demand: Please see Attachment 3 for more detailed information.

2.1.2.3 Staff: BMC has had great success attracting leaders and Clinicians with many years of direct experience working as crisis Clinicians, as well as in providing mental health services to all ages in a variety of community settings. Please see Attachment 3 for more detailed information.

2.2 Mobile Services

2.2.1 Experience: Under current BMC ESP contracts, Clinicians have made 33,291 initial evaluation visits to community sites, *excluding hospitals, ESP UCCs and CBLs*, since 2003. Community sites include homes, DMH and DDS group homes, DYS facilities, DCF residential programs, nursing homes, shelters, detox programs, schools, police stations, court clinics, Logan Airport, subway stations, on the street, in primary care/clinic offices, elder service agencies, and in community centers (e.g., boys and girls clubs). For the year ending May 15, 2015, the BEST BC team performed 61.45% of youth and 57.20% of adult evaluations outside of EDs. The number of evaluations in the community was 3,118, excluding follow-up visits. All populations who call the 800# are served by mobile teams, unless there are considerations of dangerousness or imminent risk for self-harm or harm to others; in these cases, BEST facilitates safe transport to a designated ED for evaluation and containment. Home visits are conducted 24/7 for youth and adults on a case-by-case basis, exceeding MBHP ESP performance specifications. Partner agencies BC and V have decades of experience providing community-based services involving outreach and comfort in meeting clients outside of formal settings.

2.2.2 Implementing Strategies to Create a Revitalized Culture: The ESP triage and mobile Clinicians are clear from the time of orientation that the mission is to respond to persons where they are evidencing need or distress. Evaluations in the person's home (or other familiar setting) provide the richest picture of the person's whole self, the context of the crisis (what's happening in his/her environment), and other variables that may help or hinder access to care. Because of the value placed on such practice, staff report high satisfaction with the quality of the service they provide on behalf of youth and adults. In 2015, BC mobile Clinicians completed 987 initial encounters at *private* homes, not including follow-up visits. Staff are trained to understand that people can suffer iatrogenic illness when using 911 ambulances and high stress EDs. People brought into EDs by Section 12 report feelings of coercion, especially when Section 12 may not have been indicated. A frail elder seen in the ED can look far more functional and capable of caring for oneself than during a home visit involving direct observation of self-care, availability of provisions, and general safety of the environment.

These themes are stressed both in training staff and in making community presentations to stakeholders about the value of community-based interventions. Other topics include how the community site offers the opportunity to join with the individual and his or her collaterals and the economies, in time and dollars, achieved outside the ED venue. Relationships with Accountable Care Organizations (ACOs) will stress the common goal of providing coordinated intervention “upstream” in the arc of a crisis, reducing reliance on high-cost EDs.

2.2.3 *Overcoming Challenges to Creating a Revitalized Culture:* In FR-ESP, we anticipate using our integrated BMC/BC partnership to build a well-resourced mobile team with the experience and competencies to win the confidence and trust of stakeholders. The biggest challenge is carrying the message about mobile crisis to potential users and referral sources. Based upon preliminary conversations with agencies and vendors, mobile and CBL evaluations are viewed as a positive alternative to hospital settings and welcomed in many instances.

A challenge in the Fall River area will be introducing clients to a new site, given that the DMH site presently used for CBL will not be available for the next ESP provider. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients in crisis who present at the current FR site are triaged with the ESP and not referred to an ED.

Outreach efforts to community entities will include: presentations/discussion on process and goals of MCIs (See Attachment 4 for a training tool BEST currently uses); setting realistic expectations of what mobile interventions can achieve; and establishing a feedback loop for entities to share experiences with ESP leadership for QI.

2.2.4 *Experience with Community Behavioral Health System for Youth and Families:* Since 2009, BMC and sub-contractor BC have been committed to the delivery of MCI services utilizing the Ten Principles of the Wrap-Around Process as a guiding philosophy shared by the other CBHI services. A high priority is placed on providing MCI services in the least-restrictive community setting, and on collaborating closely with the family’s providers and supports of choice. Outreach to share information on MCI and to encourage collaborative, early intervention is regularly and routinely made to community entities. Problems and barriers are identified and addressed through initiating system-wide dialogue and planning. The goal of such efforts is to assist in stabilizing and supporting youth to be maintained in the community in conjunction with their existing behavioral health providers and natural supports.

2.3 Diversion

2.3.1 *ED Diversion*

2.3.1.1 *Experience and Strategies:* From July 2003 to Dec. 2008, in a catchment area with nine major hospitals with EDs, BMC’s BEST performed just under 14,000 (2,545 annually) adult and child community evaluations, or 28% of its total encounters. From Jan. 2009 to June 2015, that number grew to 33,181 (5,105 annually) initial community evaluations, or 31.2% of total encounters. Volume includes providing commercial evaluations in a busy ED; therefore, MBHP data for public payers would show a higher percentage of community evaluations.

In FR-ESP the percentage of community evaluations for youth indicates the DMH MCI team has had success in providing mobile intervention for the MCI population. BC has demonstrated ability to exceed the standard of 60% MCI intervention in the community and would maintain and hopefully improve this measure in the subject catchment area. In addition, BEST as a whole currently sees 27% of all adults in the community.

BMC and BC would seek to build on the current DMH team’s success in providing adult interventions in the community and, in addition, would aim to decrease the current high rate of

inpatient hospitalization of adults. A challenge in the Fall River area will be introducing clients to a new site, given that the DMH site presently used for CBL and CCS will not be available. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients who present at Dr. John C. Corrigan Mental Health Center in crisis are triaged with the ESP and not referred to an ED.

Strategies employed to date by BMC/BC: 1) 800# Call Center master's level Clinicians assess every case for opportunity to conduct the evaluation in the community; only those cases in which acute risk to self or others is present and cases involving potentially acute medical issues are transferred to an ED; 2) BEST continues to do significant outreach to schools, behavioral health providers, primary care clinics, shelters, housing agencies, Visiting Nurse Association (VNAs), police, and many others, promoting the value of community-based evaluations; 3) By working with the Boston Police and EMS, BEST police co-responders and BEST 800# have diverted more than 500 people from "automatic" ED visits since August 2011 by offering on-site and telephonic clinical support for first responders; many of these diversions did not require a full ESP evaluation and are therefore not reflected in BEST MBHP data reports; 4) Regular engagement in crisis and risk management planning with clients of Community Service Agency (CSAs), DMH, DCF, DDS, DYS, and other entities; and 5) Outreach to ACOs to coordinate "upstream" interventions early in arc of crisis.

2.3.1.2 Strategies to Create Culture: The culture of diversion from EDs is already present in BMC, V and BC, and its development will continue to be nurtured. All leadership firmly believe that in the majority of cases, the best outcomes happen outside of the ED and, more specifically, that community interventions allow for better care coordination. Community-based mobile response is part of the training, orientation and annual performance reviews for staff and trainees. By educating partners, consumers and families about a wide range of community resources, encouraging early intervention, and providing timely, competent crisis response, efforts to move crisis care away from the hospital setting are reinforced. As an example of success, BMC's own ED has been able to reduce youth coming to the ED by 16% for the year ending June 30, 2015, by educating users about the mobile alternative and by "handing" interventions back to the BEST BC mobile team for youth who originally presented at the ED.

2.3.1.3 Strategies to Shift Away from ED: 1) Work with behavioral health and primary care provider networks to steer clients in crisis to the ESP and away from EDs. This would involve encouraging providers to routinely share information about the ESP with their clients, and in particular, to promote on their websites, in their voicemails, and in off-hours consultation the use of the ESP when in crisis; 2) Outreach to major holders of CBHI, DMH, DDS, DCF, and CBHI contracts to form alliances, create Memorandum of Understanding (MOUs), and develop protocols for managing crisis situations that prioritize use of ESP; 3) Outreach to ACOs to develop MOUs for involving the ESP early in the trajectory of a crisis; 4) Work with EDs to identify major sources of referrals to their venues and join with ED leadership in developing alternative strategies with referral sources 5) Further develop crisis planning and risk reviews for persons served by CSAs, DCF, DMH, DDS, and DYS; and 6) Utilize the 800# Call Center to assess every case for the opportunity to conduct the evaluation in the community.

2.3.1.4 Challenges to Create Culture: Strategies to address the following challenges are outlined in 2.3.1.1 and 2.3.1.3 above. Challenges include difficulty transforming long-held practices in a community that relies heavily upon ED resources; addressing referring professionals' personal and agency liability concerns; and lack of education regarding efficacy and benefits of community-based interventions.

2.3.2 ED-Specific Diversion Plans

2.3.2.1 Collaboration with Hospital: See Attachment 5 (including 2.3.2.1.1, 2.3.2.1.2, 2.3.2.1.3, 2.3.2.1.4, 2.3.2.1.4.1) for collaboration plans/existing agreements. Outreach has been made to St. Anne's Hospital, and efforts are continuing to collaborate with Corrigan Mental Health Center and Charlton Memorial Hospital.

2.3.3 Diversion from Unnecessary Psychiatric Hospitalization and Other Placement

2.3.3.1 Experience: BMC's BEST has a strong history in diverting clients from inpatient psychiatric hospitalization. For the year ending June 30, 2015, BEST overall diverted 69% of clients evaluated to other, less restrictive resources. Six of nine hospitals in BEST's current ESP area screen all psychiatric cases before contacting BEST; therefore, the cases referred to BEST represent the most acute presentations and are less likely to be diverted from hospitalization. This contributes to BEST's overall hospitalization rate being somewhat inflated. BEST BC's adult hospitalization rate is 24.33% for the year ending June 30, 2015. Despite a high acuity in the population seen, BC has kept youth inpatient hospitalization rate to 22.69%. BMC's own designated ED has kept youth hospitalization rate to 17.71% for the year ending May 31, 2015.

BEST uses urgent psychopharmacology and accelerated intakes via its partners' outpatient departments, to intervene quickly and lower the risk of out-of-home placement. BEST utilizes other community-based interventions to the extent these are accessible; the ESP's own CCS programs; structured outpatient addictions programs (SOAP), partial hospitalization program (PHP), in-home therapy (IHT), intensive home-based treatment (IHBT), and intensive outpatient programs (IOP).

2.3.3.2 Strategies to Create Culture and Educate: In the current BEST ESP, BMC has worked to promote a philosophy of recovery using community resources, holding the following principles: 1) Crisis evaluation focuses on engaging patient and family in treatment; 2) Crisis evaluation is not solely triage but also treatment; 3) The best crisis work reveals and utilizes patient's strengths, inspires hope, and meets the patient where he or she is; 4) Hospitalization is more often treatment of last resort; 5) Hospitalization can be regressive, traumatizing, and cost inefficient; 6) Good clinical care may involve taking risks and it is the thoroughness and communication of awareness of risk that protects patients and treaters alike; and 7) Responsibility for care of self and avoidance of risk is shared by the patient, provided he or she is not grossly psychotic or cognitively impaired.

Education of families and providers is important and ongoing. The following methods of working with people in crisis are stressed: offering choices; engaging concentrically for individuals who are scared or threatened; using an easy, non-direct, increasingly deeper process; seeking collateral perspectives; remaining aware of one's own frustration and inevitable potential for projective identification; and sharing and documenting risk.

2.3.3.3 Strategies and Resources to Maximize Use of Diversionary Services: These include offering high-quality, accessible CCS services within the ESP; access to urgent outpatient intakes and psychopharmacological appointments; and seamless coordination with vendors who provide the continuum of services, including the new CBHI levels of care serving youth.

2.3.3.4 Designated ED Model: BMC does not plan to use the designated ED model.

2.4 Recovery-Oriented Services

2.4.1 Hiring Practices

2.4.1.1 Experience: BMC DoP leadership has actively promoted the principles of recovery, resilience, and strength-based treatment for many years in its behavioral health ambulatory service and in its PES. We work with Managers of all of ESP components to develop ways to

facilitate the hiring of Clinicians who share our beliefs in this area and who have experience practicing the principles of recovery and resilience. The orientation and ongoing education of staff includes a focus on recovery and strength-based treatment approach. In 2008, BMC was awarded the contract to be lead agency for the creation of the Metro Boston Recovery Learning Community (MBRLC). In 2012, BMC became the lead agency for the Southeast Recovery Learning Community (SERLC). BMC continues its active lead agency role to maintain and develop services in these RLCs, which work closely with ESP leadership and clinical staff.

The SERLC under the auspices of BMC has a network of five RCCs which are located in Brockton, Taunton, Hyannis, Plymouth, and Fall River. Support groups are also run in the New Bedford community. All five centers are staffed and run entirely by Peers, persons with lived mental health experience. The leadership of SERLC is comprised of five RCC Directors/Coordinators, the SERLC Director, and the SERLC Chair. The leadership team meets bi-weekly to address concerns. The SERLC will work closely with the proposed BMC Southeast ESPs as it helps publicize the program, recruit Peers for employment, and connect individuals served by the ESP to the RCC and the SERLC. The Fall River RCC, located at 66 Troy Street, is open four days per week.

It has long been the practice of BC to recruit highly trained applicants, advertising in language that is recovery oriented in nature, whose experience has been with the mental health recovery movement by way of education, internship and/or past employment. The recovery community has educated universities and job sites where recruits receive training, thereby creating an applicant pool rich in experience with a community-based treatment philosophy. The mobile team has recruited and hired clinical staff with lived experience for a variety of positions both in the ESPs and elsewhere in the agency. This allows for greater understanding and compassion toward the clients served.

V's dedication to helping people recover through state-of-the-art rehab services started in the late 1980s. V is person-centered and has a proven record of positive client outcomes: improved symptom management; increased self-reliance and independence; improved daily living skills and housing stability; reduced hospitalization rates; and progressive improvements in quality of life. V is a founding member of MassPRA, an advocacy organization of clients, providers and funders dedicated to promoting rehab and recovery-focused services. MassPRA's first President was a V leader; and a V leader currently serves on the Board of Directors. In 2006, it began providing fee assistance and training to enable staff to sit for their Certification for Psychiatric Rehabilitation Practitioners (CPRP) exam. Today, it has 55 CPRPs on staff.

2.4.1.2 Recruitment Strategies: BMC's academic partner, Boston University, has a master's degree program in Counseling Psychology which leads to LMHC licensing. The curriculum of this program has a strong focus on recovery. Many students, in the first and second year of their program, do six month-long clinical placements in BEST. BMC has hired many of the graduates of this program into positions within BEST. BEST also provides clinical placements/ internships for students from area schools of social work. These programs have successfully included principles of recovery and strength-based treatment into their curricula. During students' time with us, their knowledge and understanding of recovery is enhanced through hands-on clinical experience and staff training. Upon graduating from their programs, we can select for hire those people who we feel have truly incorporated the recovery philosophy into their practice.

BC fosters an environment where all served can recover. BC currently employs 8 full time staff members who have completed the Certified Peer Specialist (CPS) training program. These Peers are deployed across CBFS teams and ESPs and bring tremendous value through their lived

experience with severe and persistent mental illness. The Peer Specialists work one-on-one with clients, educate other team members, and help promote the organization's philosophy of hope, recovery and resilience. BC also employs Peers who facilitate groups at the Wellness Center.

The first step in V's recruitment screening includes questions that specifically assess a candidate's recovery oriented perspective. If a candidate moves on to the interview phase for a position then V Managers are trained to recruit staff with a strong foundation in PR and recovery practices. The interview process is multifaceted and includes a client interview component. This helps obtain the client's perspective, as well as observe the candidate in a similar environment in which they will be working. V provides clinical placements/internships for students from area schools of social work. It has had a similar experience as BMC as described above.

2.4.2 Integration of Peers and Family Members

2.4.2.1 Commitment to Recovery-Oriented Services: Peers are represented on a number of BMC committees, including the DoP Ambulatory Services Core Managers group, the Peer Navigator Project, and the BEST and Cambridge/Somerville ESP Advisory Committees. BMC invites MBRLC leadership and Peers to participate in key meetings and committees and to have a voice in decision-making and in program design. MBRLC leaders participate in many community, state, and national boards related to mental health and recovery movement programs. Additionally, the SERLC has agreed to work with BMC and its partners in the planning and implementation of ESP services, in the recruitment, hiring and training of Peer Specialists, and in providing trainings for ESP staff.

BC welcomes consumer and parent participation throughout all services. Consumers and parents are active participants in the BC Human Rights Committee, and the Board of Advocates.

V understands the tremendous value people with a lived experience bring to the company. Its current Director of Recovery Services has published articles and book chapters to advance this field. V's two PACT teams employ recovery Specialists. The Cambridge/Somerville RLC employs one person in recovery and the SERLC employs 13. Each of the CBFS assertive action teams has at least one recovery Coordinator, for a total of 20. V has 15 CPS staff employed in various programs. The Director of Recovery holds monthly peer supervision groups regionally for all staff employed in peer positions within the organization. All people in recovery who work at V are encouraged to attend monthly "Lunch and Learns" with the Director of Recovery to learn together and support each other. Peer Workers are encouraged to participate in regional or statewide groups for CPS, PACT Recovery Specialists and other focus groups and obtain CPS training as a key credential for their work.

2.4.2.2 Current and Planned Peer Engagement: Currently, the Peer Director of the MBRLC is a member of the Core Planning group for this ESP proposal, and is integral to the design of a program model that incorporates Peer Workers. For more than a year, Peers from the MBRLC have worked with clients in the BEST CCS and on DMH inpatient units in the Solomon Carter Fuller Mental Health Center, conducting support groups and providing information about recovery and treatment resources. At least annually, members of the RLC do presentations for the BMC DoP Grand Rounds series and for the all staff training sessions for staff of the BEST and Cambridge/Somerville ESPs.

Since the inception of the recovery movement in the state of Massachusetts, it has been BC's practice to hire Peer Specialists in the ESP; and since the 2009 advent of CBHI, Family Partners. Peers and Family Partners act as consultants to the team on recovery based experience and treatment, working with Clinicians in all phases of the evaluation and follow up. Peers act as a

resource in the referral process, maintaining a database of recovery oriented resources in the greater Massachusetts area.

The numerous Peers within V's workforce provide training to their co-Workers on topics related to recovery and resiliency. V has several active Family Councils throughout the CBFS programs. These Councils are in place to advise leadership as to what is going well and what isn't in services. Clients are active participants in the V Human Rights Committees. The role of the Peer Worker in the CCS will be to ensure the environment is one that promotes safety, recovery, and treatment. The CPS staff will also provide a peer-to-peer support and psycho-education about wellness and recovery.

2.4.2.2.1 Hiring and Integration Strategies: An important recruitment strategy BMC, BC and V employ is requesting that Peer leaders in the community identify potential candidates. All post opportunities on web-based sites such as Idealist and Craigslist. Other targeted efforts include postings in the Transformation Center's bi-monthly Recovery Network News (RNN) e-bulletin, Boston Resource Center (BRC) and SERLC websites and emailing opportunities to neighboring RLCs for distribution within their networks. RNN is a significant resource, as many of its e-bulletin subscribers are CPSs. RNN's job posting is regarded as the most comprehensive listing of peer jobs in the Commonwealth. MBRLC leadership is well-connected to other organizations that post job opportunities and have access to potential candidates: NAMI, VA, Depression Bipolar Support Alliance (DBSA)-Boston, Casa Primavera, the Ruby Rogers Center, the Friends of Metro Boston, and its partners by subcontract (V and BC), with DMH Case Managers and on the new MBRLC website job page.

Family Partners and Peers will be active members of the ESP teams. As such, they will attend staff meetings and trainings with their clinical team-member colleagues. They will also attend weekly peer-facilitated support groups for Family Partners and CPS/Peers. Family Partners and Peers will also have regular individual supervision.

BC has hired, trained and retained many CPSs in programs such as CBFS, the Wellness Center, the Peer Education Resource Center and the BEST program. Family Partners have worked as part of MCI since the start of the CBHI. The BC CPSs meet as a group on a weekly basis and provide and receive peer supervision in this and other settings.

V's recruiting staff, accompanied by one of its Peer Workers, visits the GIFT (Gathering and Inspiring Future Talent) Training graduations to discuss opportunities available at the agency. GIFT has become desirable training that young adults seek prior to moving into the CPS training program. Peer Workers will be Mental Health Workers on the CCS. They will attend staff meetings and trainings with their colleagues. They will have individual supervision with the Lead Nurse or CCS Director. They will participate in the regional peer supervision provided by the Director of Recovery and have the option to attend the "Lunch and Learns".

2.4.3 Adherence to Recovery Principles

2.4.3.1 Professional Development Activities and Trainings: Please see Attachment 6.

2.4.3.2 Integration of Recovery Principles into Practice: BMC has involved Peers in various aspects of program planning and delivery since the establishment of the peer-run BRC in September 2005. The commitment BMC made at that time was to integrate the philosophy of recovery, strength-based approaches to treatment, and consumer choice and decision-making into every program within the BMC DoP. We have made much progress in this regard over the years. BMC received the DMH grant to lead both the MBRLC and the SERLC. There are Peers on the ESP Advisory Committee and on the Ambulatory Services Core Managers group. Peers participate in the orientation of ESP staff. When ESP Clinicians and other treaters convene to

develop crisis plans for clients, those clients are strongly encouraged to participate and to lead the development of a plan to guide future care. Peer members of MBRLC who will be integrated into the ESP assist consumers to develop Wellness Recovery Plan (WRAPs).

The treatment approach of BC is based on the belief that all individuals have the potential to grow, acquire skills and develop strategies to better manage everyday life and the effects of a mental health condition. This approach is demonstrated as BC works with individuals to assess their present strengths, preferences, goals and needs and incorporate them into the interventions. When available, natural or generic community supports, such as family or friends, are incorporated into treatment plans. BC embraces the tenants of the SAMHSA consensus statement on recovery.

V has taken significant steps to measure the degree to which its staff act in ways that promote the recovery of people it serves. It developed and instituted a data collection system focused on Quality of Life Outcomes (QOLO) to measure the effectiveness of the rehabilitation strategies and support it provides to clients. One of the measures included in the QOLO data is the Milestones of Recovery (MOR) rating. This scale is completed monthly and measures a person's progress in his/her path to recovery using a 1-8 scale. Effective planning requires true collaboration with the client and targets interventions of the correct type and intensity. The goal is not to plan *for* clients, but to plan *with* clients. All new employees participate in 10 training modules (39 hours), with skill outcomes and learning objectives for all trainees. V has recently completed a two year process of mapping the competencies needed.

2.4.3.3 Anticipated Challenges and Mitigation Strategies: The medical and clinical leadership of BMC Psychiatry have been strong and vocal proponents for strength-based and recovery-oriented treatment for many years. In the spring of 2005, our Medical Director approached MPower and individual Peer leaders to enlist their assistance in establishing a formal presence at BMC. With BEST they have continued to nurture these efforts. The advances we have made over the intervening years make us optimistic that our ongoing challenges will continue to be minimal, as staff response and buy-in to our efforts has been enthusiastic.

BC and V anticipate minimal challenges to recovery-oriented services. The agencies will continue to promote this value through person-centered care planning, the inclusion of Peers and Family Partners in its programming, and ongoing teaching, training, and supervision of staff. BC and V will consider the cultural and linguistic needs of clients, staff, and community partners in the implementation of these practices.

2.5 Culturally Competent Services: BMC, BC, and V individually and collectively have long delivered culturally competent services. These providers recognize both the risk of disparities in access to effective care for racial, ethnic, linguistic and cultural minorities, and the significance of culture to the effective treatment of mental health and substance use conditions.

2.5.1 Population and Related Experience

2.5.1.1 Demographics: Between 40 and 50% of the residents of Fall River identify themselves as being of Portuguese descent. Nearly 20% of all residents in Fall River were born outside the United States. Other cities in this catchment area have an average immigrant population of 8%. 66% of Fall River residents speak English only; residents of other cities in the catchment area average nearly 90% English only. In all cities, about half of all people who do not speak English as a primary language do still speak English "very well".

2.5.1.2 Experience Providing Services to Populations: BMC's BHS reflect the culturally rich ethnic populations it serves. More than half of BMC patients have an annual income at or below \$20,420. About 75% of BMC patients come from under-served populations, including low

income families, elders, people with disabilities, minorities and immigrants. A first-of-its-kind program nationwide, the Boston Center for Refugee Health and Human Rights at BMC treats over 400 patients from more than 70 countries each year providing comprehensive health, social and legal services to refugees, asylum seekers and survivors of torture. Thirty one percent of BMC patients do not speak English as their primary language. BMC's medical interpreter staff provides in-person coverage for 24 languages to assist in emergency psychiatric evaluations. Approximately 190 additional languages are available for telephone interpreting. BC has overseen services to cultural and linguistic minorities since the 1990's. BMC will link with its partners, BC and V, to address the ethnic minorities identified in the FR-ESP area.

The demographics of the FR-ESP population are well known to V. The staff has experience working with clients from different cultures and has designed rehab plans to meet specific cultural beliefs and practices, including Western European, Cape Verdean, Sub-Saharan African, and Brazilian newcomers. These practices have included adjusting engagement strategies and developing culturally relevant community supports for clients. V hires staff to reflect the cultural diversity of the communities served and ensures that there is full integration in both direct service and management roles. Staff assist clients in making connections back to resources within their cultural communities, a powerful tool in a person's recovery.

2.5.1.3 Culturally and Linguistically Appropriate Programs and Staff: BMC has no specific culturally- and linguistically-tailored program models that are currently operated, with the exception of Latino team in the child ambulatory services. Though BMC has considered pursuing this approach to treatment services, it was not thought to have been feasible because of the sure number of ethnic minorities seen at BMC and/or its affiliated health centers. Also, BMC believes it crucial to increase the cultural competency of all providers.

V's La Casa Hispania residential program serves people who share similar cultural heritages, most of whom do not speak English. La Casa staff are Spanish-speaking and bicultural. The services are designed and delivered with cultural sensitivity. V runs the CBFS in Lowell, home to the second largest number of newcomer Cambodians in the country (10.37%), and to a large number of those of Hispanic descent (14.01%). As many Cambodian refugees have experienced significant trauma in their homeland, V's trauma-informed approach has enhanced its work with residents who may have relocated experienced trauma in doing so. They have hired Cambodian and Hispanic staff to work with these clients. V provides staff with historical and cultural information (attitude, family influence) and how these impact the client's mental health. V currently serves individuals who are Hispanic, Latino, Haitian, or Asian in many of its sites and employs this approach in each program it operates.

BC has long operated specialty residential and clubhouse programs serving Spanish, Portuguese, Vietnamese, Cantonese, and Mandarin speaking adults. The programs are staffed by employees from the respective cultures who are minimally bilingual. BC also operates two specialty CBFS teams who work with these populations.

2.5.1.4 Efforts to Engage Populations Who Underutilize ESP Services: BMC will use natural community resources to outreach to ethnic and linguistic minorities. This will include outreach to entities such as faith communities, schools, and local newspapers. BMC will also utilize educational opportunities such as health fairs to educate individuals regarding PES and mental health issues and will seek input directly from communities regarding outreach strategies.

2.5.2 Organizational Capacity

2.5.2.1 Capacity to Provide Culturally and Linguistically Competent Services

2.5.2.1.1 Current Composition of Governance and Senior Management: BMC recognizes the importance of diversity at all levels of the institution, including the Board of Directors and the senior leadership responsible for the governance and oversight of this ESP. Twenty five percent of BMC Senior Management Team and the Board of Directors are of cultural/ethnic minority. Ethnic minorities compose approximately 15% of the senior leadership team responsible for the oversight of the ESP program.

2.5.2.1.2 Board of Directors' Initiatives to Strengthen Cultural Diversity: During the past several years, BMC has undertaken several initiatives to increase cultural diversity in its workforce and management team. These are described in Attachment 7.

2.5.2.1.3 Number of Bilingual/Bicultural Staff and Reflection of MassHealth-Enrolled Population: Forty-two percent of the BMC ESP Mobile Teams and CBL staff are bilingual, as are 24% of the Call Center staff and 45% of the clinic staff. Spanish is the most common linguistic capacity reflected in the BMC behavioral health staff. Minorities represent 64.2% of V's staff (Black/African American are 52.8%; Hispanic/Latino are 6.8%; Asian are 1.4%). In addition American Indian/Alaska Native, Hawaiian/Other Pacific Islander and those with two races are represented as well. White/Caucasian represent 35.8% of V's workforce.

2.5.2.1.4 Interpreter Services: BMC recognizes that it is necessary to maintain a stellar interpreter service in order to provide excellent medical care. In addition to providing face-to-face interpreters on-site in 24 spoken languages, American Sign Language (ASL), and Certified Deaf Interpreting, the department utilizes the latest advances in technology such as telephonic and video interpreting, in order to provide around the clock interpreting services to patients in 190 languages. V and BC arrange external consultation to staff; provide ongoing site based training to improve staffs' cultural competence; continuously work to build relationships with community agencies; and use family/social supports with client consent for translation/interpreter services. They are also committed to hiring bilingual/bicultural staff who speak clients' languages.

2.5.2.1.5 Professional Development Activities and Trainings: Please see Attachment 6.

2.5.2.2 Delivering Culturally- and Linguistically-Competent Care: BMC's DoP has a rich and longstanding history of providing care to a diverse patient population. Their approach to diversity and commitment to cultural competency can best be expressed in BMC's diversity statement, "the Medical Center remains committed to creating and sustaining a work place and a hospital where employees, patients, and patients' families are respected and valued not in spite of, but because of the differences in their backgrounds and cultures". Honoring the diversity of communities will promote and ensure mutual respect, collaboration, and productivity necessary to provide the highest quality care. This perspective that has informed BMC's psychiatric services. Please see Attachment 7.

V's staff receive ongoing site based training on cultural competence to ensure sensitivity to the impact of culture on clients' identity, beliefs and experience of their illness. V ensures that staff are sensitive to each client's unique needs and prepared to adapt clinical interventions and treatment based on culture and ethnicity. V recruits a diverse staff, accesses translators when necessary, respects and celebrates cultural differences, and links clients to culturally relevant community supports.

BMC, BC and V anticipate the need to serve clients who are diverse in terms of gender identity and sexual orientation. They orient, train and supervise staff to respect all clients, and to demonstrate sensitivity and acceptance of their sexual orientation and gender identity.

2.5.2.3 Institutional Initiatives to Strengthen Cultural and Linguistic Competency: Efforts in this area are documented in Attachment 7.

2.5.3 Experience Partnering with Minority, Community-Based Organizations: BMC and its DoP have extensive experience in linking with other community-based organizations and in meeting the service needs for refugee/immigrant populations. BEST has as a key element of its design linkages with community based organizations. BMC also has a multi-service Center for Refugees which was founded and organized within the DoP at BMC.

BC and V have partnered with community organizations that teach English as a second language, provide cultural connection and social options for clients, and translation services, including community action committees, public libraries, community colleges, counsels on aging, churches and other faith based organizations, and the Massachusetts Commission for the Deaf and Hard of Hearing.

2.6 Other Special Populations

2.6.1 Elders: In 2010, ESP clinical staff acquired online certification in the assessment of elders from the Boston University Institute of Geriatric Social Work. This was initially sponsored by MBHP and additional training slots were paid for by BMC to solidify core competency of BEST clinical staff. BEST has continued to provide services to elderly clients and agencies serving elders and various other programs, especially when a home-based assessment is the most comfortable and most appropriate for the client.

BC, through Kit Clark Senior Services, has an integrated continuum of services that provide support for about 4,000 elders each year. Services include Adult Day Health, residential support, Meals on Wheels and the Medeiros Center for Change, the first and only shelter for older adults in Boston. Staff conduct the programs in five different languages.

The existing V services and programs have a solid record and strong commitment to providing BHS to individuals in place as they age. As clients grow older, V honors their desire to "age in place" by enhancing services with ongoing access to nursing staff. V staff know how to modify sites, convert their use, and adjust interventions to meet the developmental needs of older clients.

2.6.2 Veterans: The metro Boston area has a dense population of veterans, including homeless and/or disabled veterans and has a significant array of behavioral health, medical, and housing/shelter services for this population. BMC has strengthened its understanding of the needs of this population and the resources available. BMC's role with the MBRLC offers an important resource. BMC psychiatry residents do rotations at both Bedford and Boston VA Medical Centers. Those residents also treat BMC patients through the ESPs and clinics.

From 2003-2011, V ran the Peer Education and Support program for veterans (Vet to Vet). The critical components of the Vet to Vet program are mutual support, promotion of individual responsibility, leadership, self-advocacy, self-determination and participation in the recovery process. V provided this service in 41 sites to approximately 1200 veterans.

Veterans receiving services through the ESP will be referred to housing programs, addiction services, community based treatment and more acute services when presenting with high acuity.

2.6.3 Persons Who are Homeless: In 2015, 30% of BEST encounters were for homeless individuals and/or families, as is typically characteristic of the urban environment. Consequently, the metro Boston area is rich in resources for this population. BEST recently partnered with the Pine Street Inn by deploying an ESP Clinician on a regular walking route with one of the Inn's street outreach Clinicians in order to help address the emergency mental health needs of high risk homeless individuals. This initiative proved successful in terms of reaching out to difficult-to-

engage mentally ill (and typically untreated) individuals; strengthening the assessment capacity of these homeless outreach initiatives; and enhancing the core competency of the ESP vis-à-vis homeless populations.

Both V and BC have more than 30 years of experience engaging homeless adults with serious mental illness and co-occurring addiction in housing and supports through PACT, clubhouses, CBFS, and specialized rehabilitative and employment supports. V's Dudley Inn Safe Haven uses a "Housing First" philosophy to help people who have experienced long-term homelessness to live at the Inn and eventually work toward permanent housing. It offers medical and psychiatric care on site and helps with daily living skills, and housing search services. V's Homeless Outreach Team serves 140 homeless people each year with psychiatric conditions on Cape Cod helping connect people in need with supports. BC has extensive experience serving homeless adults with psychiatric and addiction disorders, operating the Boston Night Center, the Albany Street "wet" shelter comprising 100 beds in Cambridge and other programs.

2.6.4 Persons with Substance Use Conditions: About 35% of BEST encounters involve individuals with substance abuse or dependence disorders. As such, BEST clinical staff have well-honed assessment and intervention skills. Within BEST's partner agencies' cadre of services there is a rich continuum including: outpatient addiction services and dual diagnosis outpatient treatment services, inpatient detoxification, outpatient methadone, Enhanced Addiction Treatment Services (EATS), SOAP, Adolescent SOAP, school-based addiction education and support, and residential treatment. Close collaboration with ESP has enhanced its effectiveness in needs-appropriate linkages and care access for patients. Ongoing trainings on substance abuse assessment, treatment and motivational interviewing have been provided to BEST Clinicians. Several Psychiatrists within BMC's behavioral health clinic are certified to provide Suboxone treatment.

Approximately 10% of individuals presenting at the CCS at Cape Cod are struggling with substance use conditions. BMC will employ a harm reduction approach and access substance treatment programs services as indicated and desired by the stage of readiness of the client

2.6.5 Persons with Co-Occurring Mental Health and Substance Use Conditions: In 2015, 65% of BMC ESP encounters involved persons with co-occurring mental health and substance abuse conditions. ESP Clinicians have a strong orientation toward assessing and understanding the needs for this patient population. Training for this population has been included in program wide and component-specific trainings. Treatment integrates engagement strategies, medication assistance, psychosocial education, supportive counseling, and peer support, available to all clients regardless of "readiness" for abstinence or interest in treatment. V and BC have relevant experience and expertise in the implementing such programs.

2.6.6 Persons who are Deaf and Hard of Hearing: BC utilizes DPH interpreter services for persons who are deaf and hard of hearing. V also provides services to such individuals. It uses interpreters to assist in ensuring culturally competent, person centered services are provided. It has had clients in its CCS, CBFS, outpatient, and DDS services access these supports.

2.6.7 Persons who are Blind, Deaf-Blind, and Visually Impaired: The BMC ESP does not currently have expertise in this area; however, to further develop competencies in serving special populations, it would seek consultation from the Massachusetts Commission for the Blind, including its Deaf/Blind Multi-Handicapped Services. Also, the Director of the peer-run BRC is sight impaired and has provided consultation and training to ESP staff.

2.6.8 Persons who are Department of Mental Health (DMH) Involved: BMC ESP has a very close collaborative relationship with DMH in the metro Boston Area. Communication and

collaboration are enhanced by virtue of BMC Psychiatry and ESP senior administration, the Call Center, CBLs and CCSs being located in two of the state office buildings that house DMH services. ESP provides consultation and MCI to DMH programs and vendors throughout the area. Mobile team supervisors and the ESP Clinical Director participate in risk review meetings and crisis planning for DMH-eligible individuals. BEST provides a DMH-specific respite bed on its CCS. BMC's close collaborative relationship with DMH has resulted in smooth and efficient delivery of services to DMH clients and greater satisfaction from DMH and vendor providers. The BMC ESP MCI Director works closely with DMH/DCF Caring Together program.

V's PR Division is dedicated to the recovery of more than 5,000 adults and transitional age youth living with psychiatric disabilities, substance addiction, and/or HIV/AIDs. Much of the service provided to these individuals is funded by DMH. The majority of services are outreach-oriented assertive community treatment serving 2,700 clients via CBFS and PACT services. V provides many other services including CCS, RLC, and Safe Haven, among others.

BC provides many services to people also served by DMH. PACT staff provide needed services in a personalized and integrated way. The PACT model is uniquely responsive in that the team operates seven days a week and is available by telephone twenty-four hours a day. BC's CBFS serves 1,100 adults living in Boston. Additional services offered by BC are the Safety New Outreach Team, the Michael G. Gill Wellness Center, the Gill Clinic, Center House Day Treatment, Transitions of Boston and The Boston TPP.

2.6.9 Youth and Families who are Department of Children and Families (DCF) Involved: BMC ESP has significant involvement in providing crisis services for DCF-involved children and families. In order to ensure effective and efficient coordination of services, the ESP and the four Boston area DCF offices collaborate on a crisis planning initiative (recognized by former DCF Commissioner Angelo McLain as a best practice). Monthly and as-needed meetings facilitate coordinating care and planning for individuals who have been high utilizers of services or identified as high risk. Often, these meetings may take place at the point the client is being discharged home from a hospital. All involved providers, family members, and the child/adolescent are encouraged to participate. The written crisis plan remains in the ESP EMR system, and in the DCF online records system, for easy access when a crisis evolves. Overall, providers and consumers have reported positive satisfaction, and data has indicated a significant drop in re-admission rates. This process has improved lines of communication and collaboration between BMC ESP and DCF area offices. The BMC ESP MCI Director works closely with the DMH/DCF Caring Together program.

V staff work with youth in the Transition to Independence Program (TIP) who are in DCF custody and with adults whose children are in custody of DCF in CBFS. Staff maintain a collaborative relationship with DCF staff, as allowed by the client and/or guardian, often to coordinate care and plan for individuals who have been high utilizers of services or identified as high risk.

2.6.10 Youth and Families who are Department of Youth Services (DYS) and/or Juvenile Court System Involved: BMC ESP sees a significant number of youth in the DYS system. Within the current catchment area there are two DYS locked facilities, which utilize the ESP on a frequent basis. Meetings are held on a regular basis between the ESP UCC Directors and the DYS Clinical Coordinator and other family members and providers to develop crisis plans often centered on hospital diversion. BC has worked with DYS in developing risk management and screening protocols for high risk clients. Overall the relationship with DYS has been very strong and has resulted in effective service delivery and excellent client care. V staff have similar

experience with DYS as described above in 2.6.9 with DCF. BC BEST and DYS have a close collaborative partnership. After two completed suicides in DYS facilities, BEST was invited to help create screening protocols for detained and committed youth in DYS. To date this partnership is one of the closest collaborations BEST has with community providers.

2.6.11 Youth who are on the Autism Spectrum: BMC's Autism Resource Program assists and empowers those affected by autism spectrum disorders through direct patient support, provider education and community based trainings in a culturally competent manner by offering high quality and comprehensive care to all. The program also provides psychosocial support and resource assistance to families in the program. The in-clinic and online comprehensive Resource Libraries compile various resources to educate, inform, and support providers and families in navigating an autism diagnosis, and subsequent issues or concerns that may arise.

2.6.12 Persons receiving services from the Department of Developmental Disabilities (DDS): The BMC ESP's distinct, dedicated 24/7 crisis intervention team for recipients of DDS services receives partial funding from DDS. Individuals with developmental disabilities generally benefit from a specialized intervention. Inpatient admissions can often be diverted by linking the natural support system with increased formal supports, or by troubleshooting and addressing environmental issues that may be causing behavioral outbursts or other high risk behavior.

V offers a comprehensive array of services for individuals with intellectual and developmental disabilities, autism, visual and hearing impairments, and physical disabilities. It partners with individuals, their families, their employers, and their communities to help people receive the services they need to achieve their goals and attain independence. V supports nearly 1,000 individuals in 80 service settings in Massachusetts.

Both BC and V offer extensive residential and day services for adults with development and intellectual disabilities, including specialized group homes (intensive medical, behavioral, addiction, and forensic), day habilitation, and employment and community based day services. BC also offers family support, supported housing and individual support services for youth and adults with development and intellectual disabilities. Both V and BC have board certified behavior analysts (BCBAs) that direct their behavioral and clinical services.

2.7 Intersystem Planning and Affiliation: The target consumer populations have complex social, medical and behavioral health needs which are typically met through a diverse, and sometimes not well integrated, array of services in the community. BMC and its partners have been talking with a variety of community agencies within the FR-ESP area. In these discussions, we have shared our philosophy and experience in delivering ESP services in metro Boston, and have asked them to inform us about the attributes of the population they serve, their service needs, and any gaps identified in the current ESP delivery model. This information has helped inform the program design for this proposal. We have also asked representatives from these agencies to continue to work with us, should we be successful in our bid; this includes being represented on our ESP Advisory Committee. Below we describe our approach to engaging these diverse parties in planning efforts and developing working affiliations.

2.7.1 Experience Convening Collaborative Structure: BMC has successfully developed Advisory Committees for its ESPs, to review trends, service gaps, and barriers, and to identify potential remedies for identified issues. The committees also provide direct feedback to ESP leadership on performance. BMC ESPs also convened area CBFS vendors and other stakeholders in a Safety Forum to create and communicate inter-agency protocols across 24/7/365 systems. BMC ESP representatives regularly participate in newly forming and existing community forums where system strengths, barriers, trends, and opportunities are identified and discussed.

2.7.2 Processes and Structures to Collaborate with Other Stakeholders: If successful in this bid, BMC will replicate its effective model of intersystem planning and collaboration in BEST for the past 12 years. That is, the ESP Clinical Director, MCI Manager, and the Managers of the CBL/Mobile teams will meet regularly with DMH (including participation in risk management meetings), DCF (including regular development of crisis plans for shared clients), staff and leaders of DYS facilities, DDS, medical Directors of the EDs in our service areas, school personnel, police officials, courts, and shelter system representatives. In these meetings, we invite feedback on services provided and will engage with our community partners.

BMC will convene an Advisory Committee, as BEST has been doing, comprised of representatives of key stakeholders, including agencies in the service area, consumers, the Parent/Professional Advocacy League, the Massachusetts Chapter of NAMI, homeless services, substances abuse services, DCF, DYS, DMH, public schools, area police departments, and ESP leadership staff. The committee will provide the essential stakeholder perspectives and expertise necessary for continued ESP quality and service improvement. We would also be involved in existing area forums and lead developing forums as issues present.

2.8 Initial and Ongoing Training, Monitoring, and Evaluating Staff and ESP Program: Program goals, mission and philosophy are clearly described to candidates during recruitment for each ESP component. We emphasize the investment and belief in the power of community-based evaluation and the use of diversionary services to best serve clients and stakeholders. Hiring Managers seek applicants with strong community experience and commitment to these shared values. All new ESP hires are oriented to all ESP components, the content of which is reinforced through required monthly all-ESP staff meetings devoted to training or continuing education. For several years, consumers have trained ESP staff (e.g. "In Our Own Voice" and "Principles of Recovery" presentations) and staff have worked with consumers and Peers from the BMC-led MBRLC and SERLC. ESP clinical staff members receive regular supervision during which each Clinician's cases and records are reviewed. This vehicle serves both as a teaching opportunity (e.g. around assessment and clinical decision-making) and as a way to review the staff member's knowledge of community resources and diversionary services for ESP patients. The ESP electronic record has embedded reports that allow the Clinician and supervisor to review data elements. Call abandonment rates and other information is available in the electronic call log for the Call Center. This information is available both by team and by Clinician, provides timely feedback, and can facilitate practice improvements.

Emergent needs for additional policies, systems and programs are discussed at the weekly Clinical Leadership Committee meeting. Any changes to the goals, philosophy, and business approach must be discussed and approved by the committee to ensure consistency of practice across all components of the ESP. The committee devotes time to discussing strategies to improve diversion rates from ED and inpatient hospitalization. Similar conversations occur at staff meetings. The Clinical Leadership/QM Committee reviews ESP performance in relation to key performance specifications required by payers ongoing. Data collection and report mechanisms built into the EMR system facilitate BMC's review of current and factual information. This year, BMC began an annual review of the ESP and staff members based on the BMC Universal Performance Standards, including putting the patient first, customer service, teamwork, communication, and professionalism.

3. ESP SERVICE COMPONENTS

3.1 Emergency Services Program (ESP)

3.1.1 ESP Program Model: Prior to seeking the BEST contract for Boston in 2003, BMC surveyed key consumer, advocacy, provider and public safety stakeholders to request their input in the proposed program design. The ongoing Advisory Committee comprised of stakeholders meets bi-monthly to provide continuous feedback on BEST performance and to generate solutions to questions and challenges that arise. If this bid is successful, we plan to replicate this process of engaging with stakeholders to carry our ESP model, described in more detail below, into the Fall River area.

Our program is based on the principles of: 1) upstream timely access and response; 2) seamless integration of ESP components; 3) community knowledge and linkages; 4) strengths-based and person-centered interventions; 5) services congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served; 6) recovery, empowerment and peer support; and 7) staff competencies in community-based crisis management and resolution. These principles are embedded within all elements of our program and their linkages.

The strength of BMC BEST is the partnerships we have developed with our sub-contractors and leverage to provide seamless services. Strong oversight by BMC as the lead agency emphasizes cohesion, communication, and uniform practices. Services are delivered via specialized components that work as a team to manage crisis encounters. These components for FR-ESP will be the centralized 1-800 BMC Call Center number staffed by master's level Clinicians; BMC Psychiatry clinical leadership providing 24/7/365 supervision, consultation and administration; the BC mobile team that will dispatch from CBLs; and a seven-bed CCS operated by V, co-located with BC at the primary CBL site.

Our model uses a "discrete level of care" for individuals in behavioral crisis that is more robust than a simple screening and triage program. BMC BEST provides a highly integrated system of acute behavioral services with clear linkages to other elements of the system of care. Our program cares for individuals for discrete periods of time until the acute behavioral crisis ends or until the individual can be safely connected to other levels of care, often within the ESP itself and such as follow-up visits, urgent psychopharmacology and crisis stabilization at our voluntary unit. When medically necessary, persons in crisis are connected to the appropriate level of care within the broader community continuum, as well as social services and natural supports.

Our experiences over the past 12.5 years in caring for individuals until they are bridged to community supports helped establish our family and youth-focused seven-day crisis stabilization option using MCI. It enables our ESP to respond to the evolving nature of the community-based behavioral health system for people of all ages.

3.1.2 Changing Perceptions: We will build upon our success in the current Boston ESP (BEST) to promote the principle of ESP as a discrete level of care in the FR area. Already, we have met with representatives of major community-based providers, peer and essential services working with children, adolescents and adults in the catchment area. They have made initial commitments to collaborate on a comprehensive crisis response system as reflected in the Letters of Support attachment. Building a community continuum of crisis response helps all parties understand the individual's needs, preferences and history; intervene earlier in the crisis; and resolve the crisis in the least restrictive manner thereby enhancing the individual's self-efficacy and community tenure.

3.1.3 Realizing the Vision and Managing ESP: In order to realize our vision for a robust FR-ESP and manage this critical service effectively, we will employ the following strategies:

- Use of regular communication regarding policies and practice across all components of the ESP; meetings, supervision, daily phone contact, trainings, utilization review, case conferencing;
- Documented policies and procedures as reviewed and endorsed by all component leadership; and
- Emphasis on hand-off protocols. See Attachment 8 for BC Report as an example of existing protocols for shift change and coordination between teams. See Attachment 9 for de-identified BC Case Tracking sample. The case tracking document is accessible by all BC staff to ensure coordinated assignment and follow up.

3.1.4 Fluidity among Service Components: Our cross-functional team will support each other to cover upward fluctuations in volume. The Call Center serves as the central information and support component, aware of case flow and assisting mobile teams in juggling their responsibilities. Supervisors with administrative duties will support cases as required by demand.

Similarly, mobile team Clinicians, when available, will provide additional clinical services to CCS as well as support to psychopharmacologists providing urgent bridge medication appointments.

The EMR will track response times to help identify outliers and barriers that need attention. The Call Center will triage every request for service, and in those instances of lower acuity, will work with the caller to arrive at a mutually agreed upon opportunity for assessment and early intervention.

3.1.5 800# and Triage Function: Our toll-free number serves callers 24-hours a day, seven days a week. By using the 1-800-981-HELP Call Center, a caller is provided with support, information, referral or evaluation. Calls made to the Call Center are screened for intake, evaluation, and assessment. The Call Center may dispatch a crisis intervention mobile team to the site of the crisis, direct the individual to an UCC/CBL, or, when unavoidable due to safety or medical acuity, direct the party to an ED.

The Call Center serves as the nerve center of the ESP. The Call Center maintains live management of cases being seen throughout the ESP system and works to triage new cases according to availability of staff. In addition, the Call Center provides support, information and referral for the many callers who are not requesting evaluations. The Call Center works closely with the Metro Boston/SERLC Peer Support Line which also serves the FR-ESP area. The Call Center links callers who need to talk to the Peer Support Line. In times of high demand, Call Center Clinicians support the mobile teams by completing the final assessment stages (e.g., bed searches, linkages to community-based programs, and shift change transfers).

The Call Center is staffed by master's level Clinicians to offer exceptional clinical expertise and crisis management. Staffing is at the highest level during peak hours of calls, 9 a.m. to 11 p.m., with two Clinicians answering calls from 11 p.m. to 7 a.m. The first day-shift Clinician takes over at 7 a.m. and is quickly supported by the next, who arrives at 8 a.m. Additional staff is staggered throughout the day, with peak hours served by a minimum of six Clinicians on weekdays and four on weekends.

3.1.6 Covering the Entire Catchment Geography: We anticipate establishing one CBL in the catchment area. However, opportunities exist to use the continuums of care of our partners V and BC, as well as other community-based services as described throughout this application, to establish "outposts" for mobile team utilization. Clinicians will also be dispatched from home.

3.1.6.1 One-Hour Response Time: In the Fall River area, variables concerning geography and effects of longer driving distances will be considered during response time analyses. Using ESP and other community partners' locations as outposts will be further developed. Clinicians will not always report to an office but rather will be dispatched directly from home. Having a web-based EMR and other technology, such as cell phones and iPads, offer great flexibility for locating staff throughout the catchment area.

3.1.7 Rationale for Variances in Service Model: BMC's current ESPs operate an 800# Call Center that is situated with a CBL of the Boston ESP. In serving the FR area, we propose to expand the Call Center's responsibilities to the new area. Though not co-located with the CBL under this proposal, use of the existing Call Center represents an efficiency gained through economies of scale. Given that the entire ESP is connected by an EMR that operates in real time, and with other technological options for communication, we believe the skill and experience of Call Center staff outweighs benefits gained from co-location. The call volume, triaging and dispatching duties of the Call Center, as well as the additional responsibilities involved in backing up mobile teams (e.g., coordinating bed searches and accessing consultation resources), can all be integrated for multiple catchment areas. The ESP Cost Report details additional new call center staff.

3.1.8 Location of Services

3.1.8.1 Locations and Hours of Operation: While the ESP will have a primary CBL, we will also try to partner with community agencies to establish "outposts" in the catchment area where mobile Clinicians can be staged in order to reduce response time.

Service Component	Address Where Service will be Delivered/ Dispatched from	Days/Hours of Operation		Other Services at this Location
		Of the Service Component	Of the Physical Site	
ESP Senior Management Functions	85 E. Newton St. Boston, MA 02118	24/7/365	8A-5P, M-F	800# and Triage; existing BEST CBL/CCS
ESP Director; MCI Manager	TBD	24/7/365	8A-5P, M-F	TBD
800# and Triage	85 E. Newton St. Boston, MA 02118	24/7/365	24/7/365	ESP Senior Management; existing BEST CBL/CCS
CBL	TBD	24/7/365	24/7/365	Mobile teams; CCS
MCI	TBD	24/7/365	24/7/365	Adult mobile team; CCS; CBL
Adult MCI	TBD	24/7/365	24/7/365	Youth mobile team; CCS; CBL
Adult CCS	TBD	24/7/365	24/7/365	Mobile Teams; CBL

RAP (Runaway Assistance Program)	TBD	4:30P-8A, 24 hours/day weekends and holidays	NA	
----------------------------------	-----	--	----	--

3.1.8.2 Location and/or Substantive Physical Plants Changes: The current Fall River ESP is located in DMH space that will no longer be available. In the time span between the potential award of the contract and the date of operation of the ESP program, our partner V's facility and real estate staff would make the location of a site for this program a priority. V has a proven track record of identifying and locating program sites under pressure with limited time available. Furthermore, V has a strong presence in the Southeastern MA area and is familiar with local commercial realtors.

3.1.9 ESP Management

3.1.9.1 Qualifications/Resumes

3.1.9.1.1 ESP Director (not yet hired): Per requirements of the Massachusetts Privatization Law, recruitment for a qualified ESP Director will include consideration of individuals working with the current ESP and terminated as a result of DMH no longer providing the ESP services. Full qualifications of the ESP Director are described in Attachment 10.

3.1.9.1.2 Quality/Risk Management Director (not yet hired): Per requirements of the Massachusetts Privatization Law, recruitment for a qualified Quality/Risk Management Director will include consideration of individuals working with the current ESP and terminated as a result of DMH no longer providing the ESP services. Full qualifications of the Quality/Risk Management Director are described in Attachment 11.

3.1.9.1.3 Medical Director: See Attachment 12.

3.1.9.2 Organization Chart: See Attachment 13.

3.1.10 Psychiatry Staffing: BMC BEST currently meets the psychiatry standards of the Request for Response (RFR) performance specifications and will use this experience of providing 24/7/365 services to staff the FR-ESP. BMC will provide all needed psychiatry services, including both direct and on-call services. BMC has adult and child-qualified Practitioners as well as Psychiatrists and Clinical Nurse Specialists on-staff through its DoP and will hire as needed to provide expanded ESP services. The CCS unit will have daily face-to-face rounding with either a Clinical Nurse Practitioner or Psychiatrist. A Psychiatrist will be on-call 24/7 for consultation with CCS and mobile teams, both adult and child. Clinical Nurse Specialists will provide urgent psychopharmacology appointments for ESP referral.

BMC possesses within its ranks, a broad range of discrete capabilities to treat children, adults, elders and their families. BMC DoP is highly regarded for its staff competencies to treat trauma, neurological conditions, other co-occurring behavioral and medical conditions, and acute care situations.

3.1.11 Safety: The proposed FR-ESP will employ several strategies to assure safety, including:

- The Call Center assesses risk by report of referral source, person(s) on-site with individual to be evaluated, and by reference to past electronic records;
- Use of two-member teams when needed clinically or due to question of safety;
- Request for police to meet at community site, if situation merits;
- No fewer than two staff will be onsite at the CBL at any given time; and

- Adherence to current BEST Policy, *Response to Requests for Community-based Evaluation in Situations Felt to be Dangerous*, Attachment 14, with said policy to be amended to reflect catchment area.

3.2 Community-Based Location: BMC and its partners are well known for their practice of providing highly accessible CBLs for even the most acute and secure services to children, adults, elders and their families. We recognize that both unique characteristics of our client populations and best treatment practices demand accessible, community-based care settings.

3.2.1 Community-Based Locations

3.2.1.1 General Description: The current ESP site serving the Fall River Area is located in a state-owned building and will not be available for use upon the award of this contract. Given some uncertainty regarding the exact start date of the contract for these services it is not feasible to establish site control at present. Any ESP site should include the following qualities and features: a welcoming appearance and atmosphere, parking, signage, waiting and treatment areas and staff work space. As of this writing there are at least fifteen commercial sites available for lease in the Fall River central business district that would provide a setting for developing a high quality site in a convenient location. The South Main Street area will be one possibility considered. Upon contract award an intensive search to locate a suitable process would be undertaken in collaboration with at least one local realtor.

3.2.1.2 Rationale for Location: This site is located in the most populous city in the catchment area. Fall River is not only easily accessible by I-195 and multiple state highways; it is also a hub for the region's transit authority.

3.2.1.3 Rationale for Perception of Community-Based Location: A site near the South Main Street area would be located near numerous commercial establishments, churches, and parks.

3.2.1.4 Proximity and Access to Public Transportation: Proposal for a yet unidentified site: This area is served by the Southeastern Regional Transit Authority. Several bus lines connect Freetown, Somerset, Swansea and Westport to the South Main Street area of Fall River.

3.2.1.5 Physical and Interpersonal Climate: The CBL will be painted in soothing colors and decorated to create a warm, calming environment. Care will be taken to decorate and purchase furniture which provides a comfortable environment, as opposed to an institutional feel. Food and beverages will be available at all times. Space will be dedicated for a play area for children, which will include toys and books. Creating a positive interpersonal climate begins with our staff. Every employee of the ESP and CCS will be encouraged to focus on the following principles in their work with people in crisis: putting consumers first, trust, teamwork, open communication, integrity, professionalism, flexibility, adaptability, and accountability. Peer Specialists will be especially well-placed to offer support regarding the process of assessment and what to expect as matters unfold.

3.2.1.6 Differentiating and Communicating Crisis Behavioral Health Services: Access to the site will be controlled in a humanized way (e.g. minimal to no use of intercoms or door buzzers to allow entry), individuals entering the site will be greeted in a reception area where they will be welcomed and the purpose of their visit, if not already known, will be determined. What each person entering the site can expect during their time there will be explained to them, indicating in a compassionate way that they are there for a particular reason, and should expect an organized response to their presence. Individuals who present for the apparent purpose of social support will be directed to other resources, e.g. RLC, Peer Support Line, parent support line, or Clubhouse program.

3.2.2 Community-Based Locations Supporting Goals of ESP

3.2.2.1 Community-Based Location's Support of ED Diversion: One of primary goals of our current ESPs is to divert behavioral health utilization from the hospital EDs. As part of this effort, it is critical to provide a CBL that is well-publicized, accessible, and welcoming. The fact that the site is not located in a hospital setting is known to have a positive effect on diverting activity away from EDs. It has been demonstrated that community-based dispositions occur at a significantly higher rate when the ESP is community--not hospital--based. Transportation services will be arranged for in advance to deal with times when the volume of individuals presenting for ESP services is so great that services at the ESP site will be the preferred option. This strategy is another way to divert from EDs, even when the ESP is operating at high capacity. The location creates opportunity to calmly focus on the issues at hand without the pressures of a high intensity, potentially trauma-infused medical emergency setting.

A challenge in the **Fall River** area will be introducing clients to a new site, given that the DMH site presently used for CBL and CCS will not be available. In large part, success in seeing clients in the community will depend on effective collaboration with DMH to ensure that clients who present at Corrigan Mental Health Center in crisis are triaged with the ESP and not referred to an ED.

3.2.3 Staffing

3.2.3.1 Flexible Use of Staff: All staff within the ESP will be cross-trained to serve multiple functions within the entire ESP and flex between components as part of the daily expectation. Co-location of the CCS with the CBL and the use of fluidly trained staff will enhance the ability to respond to varying levels of demand and share resources. For example, the CPS may run a group at the CCS, then accompany a mobile Clinician for an evaluation at a client's home.

3.2.3.2 Certified Peer Specialists: In many instances the most important intervention is the one in which the client is seeking help for the very first time. The clinical transaction that takes place can determine whether that individual continues on his or her path to recovery or walks out feeling less than hopeful. Our Peer Specialists work side by side with Clinicians to create a welcoming and hopeful intervention. Our Peers are essential team members and help Clinicians visualize and engender hope on behalf of the clients and families we serve. Peers function flexibly on the service facilitating interventions at the CBL and in the community alongside mobile crisis Clinicians. For example, a Peer followed up with a client who had been made frequent 911 calls to communicate her distress to police. Once it became clear that the client was not in need of clinical resources, the Peer and patient came up with a list of resources that the client felt would be helpful to her when she was distressed. After this intervention, her 911 calls stopped altogether.

3.3 Adult Mobile Crisis Intervention

3.3.1 Adult Mobile Crisis Intervention Services: BEST is governed by the philosophy that most behavioral health crises can be effectively addressed in the community. There is an ingrained culture among the current emergency services staff that unless there is an emergent medical or safety concern, evaluations should occur in the client's natural setting. BEST recognizes that providing emergency services on a mobile basis requires a special set of skills on the part of the Clinician, accessibility and support from the supervisory level and an understanding within the community as to the benefits of providing this service outside of an ED. We will expand this existing philosophy and culture throughout the new catchment area.

Mobile Clinicians will be based at the CBL between the hours of 7a.m. and 11p.m. Between the hours of 11p.m. and 7a.m., two Clinicians will be available to respond on an on-call basis.

Calls for services will arrive at the Call Center, staffed 24/7/365 by Masters-level Clinicians trained in crisis intervention and management. Triage Clinicians will respond to the needs of the caller and, following an assessment, make a decision whether to dispatch a Mobile Clinician. The triage Clinician will document in the web-based system the person's demographic information, location in the community and description of the presenting problem. This information will be instantly accessible to the Mobile Clinician. Mobile Clinicians will then drive to the location of the individual and provide crisis intervention, evaluation and stabilization services. Depending on the location and severity of the presentation, Mobile Clinicians will team up with a Master's Level Intern, Bachelors Level Staff or CPS. In some circumstances they may request the support of the local police department.

Mobile Clinicians will be equipped with cell phones and laptop computers with secure/encrypted wireless internet access. Clinicians will have the capacity to document their evaluations on the web-based system from any location in the community. If the Mobile Clinician needs to immediately dispatch from one location to another, their evaluation will be instantly accessible to other members of the team, who can proceed with a bed search or assist with any follow up. All consultations are either provided by a licensed clinical mental health professional or are reviewed by a licensed clinical mental health professional. If Clinicians are considering utilizing a locked inpatient psychiatric hospital, an on call Psychiatrist is contacted to review the intervention to be certain that patient meets criteria for Section 12. Philosophically, the team leadership and Clinicians in the field are committed to providing ready access to acute care services and the default intervention is one which happens in the community where the collateral providers deliver services and can contribute to the intervention in real time.

The team is also committed to meeting patients where they are at emotionally; when a crisis occurs, patients, providers and families can be stressed and the crisis intervention offers the patient a safe space to talk through their experience and put a plan in place for crisis management. The team is committed to affect tolerance and provides high level risk management during the course of intervention. The team does not believe in hospitalization if it serves to make the provider or worried family member feel better. It must truly be the intervention of last resort. The BC mobile crisis team is comprised of staff who have language capacity including: Spanish, Haitian-Creole, Russian, French, ASL, and Cantonese. Once a case is triaged the Clinical Manager can assign a Clinician to the intervention who would provide the best clinical fit for the intervention. Clinicians on the team have trauma-informed training and are trained around risk mitigation and use of natural resources.

3.3.2 Staff and/or Certified Peer Specialists: BMC plans to provide adult mobile services to the entire catchment area served under this proposal. Some mobile visits may require the assistance of a second staff person for several purposes: added support in situations where safety considerations could make a lone Clinician uneasy about providing outreach; assistance with cultural and language issues for which the second staff member has expertise; help with making phone calls to supports or coordinating access to diversionary treatment programs; and periods when the team is busy and a second person's assistance would facilitate moving the intervention forward in a timely way.

Similarly, the CPS and bachelor-level staff/master's level interns, perhaps credentialed with CPS, will be important team members in some mobiles to community sites, just as CPS staff will be integral players at the CBL. Peer Specialists offer individuals in crisis and the clinical staff working with them another perspective on the process and potential ways to help stabilize the situation. Their training in the rehabilitation and recovery model will help cultivate a strengths

approach during the intervention. BMC BEST has successfully integrated Peers into its current ESP and will seek to replicate this process in the subject catchment area. Additionally, the MBRLC is active in ongoing development of the CPS role for BEST, and its expertise includes being able to introduce the development of WRAPs with individuals seen by the crisis team. We will encourage our CPS staff to request permission of persons seen in crisis to have follow-up for the purpose of creating a WRAP to help guide any future crisis interventions.

Our current ESPs have a robust system of training for master's-level students. For example, BEST BC CBL/mobile team had from September 2014 to August 31, 2015, a total of 12 interns: one for 12 months, seven for nine months and four for four months. Their weekly internship consisted of 16-20 hours, and interns trained on week day, evening and weekend shifts. These placements translated into four Full Time Employees (FTEs). Students are invested in their training, and because of longstanding relationships we have with various field placement personnel, we request applicants who have experience in the field predating their master's programs or who can demonstrate the level of professionalism and poise required to do the challenging fieldwork. Prior to placement, students are interviewed by either the program Director, Assistant Program Director or Team leader. They receive scheduled, weekly supervision from licensed supervisors. BC Mobile Team interns attend the agency's two-day orientation, the two-day PREVENT Training, and, if not currently certified, First Aid/CPR. They also attend a four-hour overall BEST orientation. In essence these social work and mental health counselor trainees carry out many tasks that meet and exceed the criteria of bachelor-level staffing. The program has welcomed students who are in recovery. We anticipate that the FR-ESP will likewise develop a strong training program, bringing additional resources to the team and staff, likely in the amount of two FTEs.

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 Program Description: V will provide a staff-secure, safe, and structured crisis stabilization and treatment service in a CBL that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. Admissions and discharges will occur 24/7/365. The CCS will be primarily used as a diversion from inpatient services. However, the service may be used as a transition from inpatient services when there is sufficient service capacity, and admission criteria are met. The CCS will serve adults ages 18 and older, including youth ages 18-21 under the Children's Behavioral Health Initiative (CBHI). The CCS will serve up to seven adults at one time. This program will be co-located with the Emergency Services Program (ESP) and will work collaboratively with the ESP to develop short-term, effective interventions to help each client resume their everyday life and facilitate short length of stays. The CCS will provide nursing supports on each shift and have access to psychiatric support 24/7. While clients are in the CCS, further evaluations will be made by nursing and medical staff (MD/CNS/NP), including medication evaluation. Appropriate follow-up services will be initiated so that once the crisis for the client has passed; s/he will progress successfully to a less intensive level of care. A crisis/safety plan will then be created. Peer Specialist staff will help each client to create a WRAP when needed; these plans will be given to the client to take with him/her at discharge. Also, WRAPs will be entered into the client's electronic record so that they are available to ESP providers in future. The final essential function of the CCS team is to stabilize the client and coordinate follow-up services with Primary Providers, Therapists, day program staff and Psychiatrists in his/her community.

The primary service objectives of the CCS multi-disciplinary team are to:

- Restore functioning;

- Strengthen the resources and capacities of the client, family, and other natural supports;
- Support a timely return to a less restrictive community setting;
- Develop and/or strengthen the client's individualized risk reduction/safety plan; and
- Link the client to ongoing, medically necessary treatment and support services.

The flow of the service is as follows:

1. The CCS operates 24/7/365 for adults ages 18 and older. The CCS provides staff secure, safe and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary placement.
2. The CCS services are short-term, providing 24-hour observation and supervision and daily re-evaluation and assessment of readiness for discharge.
3. The CCS provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services.
4. CCS services include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; mobilization of and coordination with family and other natural supports, community providers and resources; psycho-education, including information about recovery, rehabilitation, crisis self-management and how to access recovery and rehabilitation services available in the individual's specific community.
5. Individuals admitted to the CCS will have a community based disposition plan upon admission to the CCS.
6. The CCS will work closely with the ESP in order to enhance service continuity and fluidity between services.
7. The CCS will have a home-like, calm and comfortable environment that is conducive to recovery.

The CCS will be staffed by a lead RN, LPNs, Mental Health Workers and Peer Specialists. One RN will be designated as the lead/charge Nurse for the unit. S/he will receive support from the Nurse Manager of the BMC ESP. Medical coverage will be provided by a Clinical Nurse Specialist/Nurse Practitioner with MD backup, and treatment rounds that include the CNS/NP will occur daily. The CNS/NP/MD will meet with each client daily. Clients served by the CCS may have a range of psychiatric and behavioral symptoms yet cannot exhibit psychotic symptoms to the point of being disorganized or acutely/actively suicidal. Clients may have chronic medical conditions, but must be medically stable.

3.4.2 Physical Plant: The CCS will be configured in double bedrooms, with some limited single bedroom capacity. There will be kitchen space for the maintenance and preparation of snack food and meals. The space will include a lounge/living area and office space to provide for individual meetings with clients and to provide workspace for staff. A secure medication room will also be included.

3.4.2.1 Space: The site for the Fall River CCS is currently co-located with the ESP team in a state operated facility. It is our understanding that we will not be able to use this space in any capacity during the transition of the program. Therefore, we will seek a space that is located in a commercially zoned area in Fall River, MA. It will be in an area that will tolerate high traffic and night use of the space, and has outdoor space and a large parking area. The ESP will be able to operate in this building with sufficient resources for staff, meetings, and waiting areas.

3.4.2.2 Strategies to Create Environment and Culture: Creating a positive interpersonal climate begins with our staff. Every employee of the ESP and CCS will be encouraged to focus on the

following principles in their work with people in crisis: putting clients first, trust, teamwork, open communication, integrity, professionalism, flexibility, adaptability and accountability. Peer Specialists will be especially well-placed to offer support regarding the process of assessment and what to expect as matters unfold. As mentioned in the RFR itself, we have also found that small measures of comfort, such as snacks, refreshments, periodicals, music and other modest amenities are important. We will use our experience in creating a cheerful, efficient and useful space in operating current CCS programs to continue the operation of this CCS.

3.4.3 Co-Location of the Adult CCS with the ESP Community-Based Location: The UCC for walk-ins and the office space that serves as home to the Mobile Team will be located within the same building as the CCS. Thus, following the crisis evaluation, the staff may easily escort the client to the CCS for admission if indicated. The co-location will be in place at the point of implementation of the contract.

3.4.3.1 Co-Located CCS and ESP Space: Given the resources of BMC, BC and V, we anticipate the ability to identify and secure the appropriate space for the CCS and ESP program by the start date of the contract. The space will be used for the UCC, walk-ins and an office space that serves as home to the Mobile Team. Likewise, CCS staff will work closely with the ESP team for seamless communication about clients and program components. Our goals will be to provide adequate space for efficacy and comfort, and to allow all parties to work closely together collaboratively.

3.4.3.2 Co-Location Status at Implementation of ESP: Co-location shall be in place upon implementation of the ESP contract.

3.4.3.3 Not Co-Located at Implementation of ESP: Not applicable.

3.4.4 Recommendations and Rationale for Reallocation of CCS Capacity: We plan to negotiate with MBHP to increase the capacity from six to seven beds due to an experience of an ability to manage a capacity of that level, as well as an assessment of need of the area based on past experience of the sub-contractor V. We will manage utilization by tracking and regularly reviewing average daily census and length of stay, as we currently do in all BMC ESP programs. Given the staffing intensity of RN and MD resources to the unit, we are able to serve higher acuity patients, including those in need of detox, who are psychotic, have suicidal ideation and who have more active medical co-morbidities.

3.4.5 Communication Plan between Adult CCS and Other ESP Service Components: The weekly Clinical Leadership meetings described elsewhere in this proposal will include Managers of the UCC/Mobile Team and CCS, so that they are at the table with the Medical Director, the ESP Clinical Director, the QM/RM Director and other clients of Senior Leadership. The Managers will have a voice in overall decision-making for the ESP. Also, these Managers will meet weekly in Operations meetings for case review and utilization management review. There will be all-ESP staff meetings monthly where procedural issues will be discussed and trainings will be presented. On a daily basis, the ESP Clinical Director and UCC/CCS Managers will collaborate around staffing needs and volume flow so that resources may be shared and assigned accordingly.

3.4.6 Strategies to Shift Culture: We will draw on our experience in the existing BMC ESP programs and meet with potential referrers and agencies within the ESP area to educate them about the capabilities of the CCS. As they are able, we will encourage community providers to visit the CCS to observe the program design and services offered. We have found this to be helpful in our other ESP programs in order to create a level of confidence in the CCS's ability to

manage clients who a referral source may have previously thought required inpatient hospitalization.

3.5 Mobile Crisis Intervention (MCI)

3.5.1 Statement of Intention: The ESP intends to enter into a subcontract arrangement with another entity that meets the requirements of subcontractors outlined in Section V.C. of this RFR. Enter the name of the agency (additional information will be requested in narrative response section 4.3. below). The competency of the proposed subcontractor agency is demonstrated in the section that follows.

3.5.2 Rationale for 3.3.1 and Subcontractor Qualifications: BMC and BC have demonstrated a strong partnership and mutual commitment to the provision of quality MCI services as evidenced by the ongoing delivery of said services for the BEST. Since 2003, BMC and BC have collaborated to provide urgent, mobile and community-based responses to youth and their families experiencing behavioral health crisis. With the initiation of CBHI services in June 2009, those responses expanded to emphasize the Wraparound principles which inform the philosophy behind MCI services, and to include Family Partners in order to provide a bi-disciplinary team which is maximally responsive to family voice and choice. BC has also shown both flexibility and creativity in order to meet the rigorous standards of MCI, most notably with the creation of a Child Focused Team (CFT) within the larger mobile team, whose primary responsibility is to ensure that every family served has access to seven days of ongoing stabilization activities as needed.

3.5.3 Readiness to Provide Mobile Crisis Intervention

3.5.3.1 Behavioral Health Services to Children and Adolescents: As outlined above, BMC and BC have a demonstrated ability to provide behavioral health assessment and resolution focused interventions to youth and their families as the MCI provider for the Boston area since the outset of CBHI in 2009. During the previous fiscal year, the BC BEST team served 2,234 youth. These youth were each provided with an average of more than three days of ongoing stabilization activities by the MCI team, with up to 110 families receiving ongoing support and resolution focused care for up to seven days during the course of one month. BMC additionally oversees the provision of MCI services for the remaining communities in Suffolk County under the BEST contract, as well as the cities of Cambridge and Somerville for the Cambridge/Somerville Emergency Services Program—a combined 5,451 youth served in FY15.

BMC is also home to a robust outpatient Child and Adolescent Psychiatry clinic, serving over 4,500 youth annually under guiding principles which include care that is family-focused, culturally competent and prevention oriented. In operation since 1956, the ethnically-diverse, multidisciplinary team of child and adolescent Psychiatrists, child Psychologists and child-trained Social Workers provides specialized services including comprehensive assessment, advanced psychopharmacology, trauma-focused therapy, social-emotional skills-training groups, psychoeducational testing and parenting skills training.

Also since 1956, BMC Child and Adolescent Psychiatry has provided consultative services to primary care Practitioners and hospitalists in the BMC Department of Pediatrics around the psychiatric assessment and management of physically ill or injured children. Through educational symposia, collaborative rounds and informal consultation, consulting child Psychiatrists also play a major role in increasing the capacity of primary care Practitioners to deliver basic mental health services in the context of pediatric practices.

Since 1997, the BMC South Boston Collaborative Center has provided intensive outpatient substance abuse treatment services to youths in the South Boston community. The Center

provides a broad range of outreach, prevention and treatment services in collaboration with its lengthy roster of community partners. Beginning in 2005, BMC Child and Adolescent Psychiatry also has provided consultation to Clinicians providing mental health services in school-based health clinics in Boston Public Schools high schools, and has placed child and adolescent Psychiatrists and Clinical Nurse Specialists in community health centers linked to BMC, including Whittier Street Health Center, Dorchester House and South Boston Community Health Center.

In addition to providing MCI services through BEST, BC operates three community-based programs which provide a range of BHS and support to youth and their families: The Family Support Center, BC Academy and the Early Intervention Program. The Family Support Center provides both information and support to approximately 300 families per year who identify themselves as struggling with mental or behavioral health concerns. The culturally diverse staff at this center offer seven different service components for family members to participate in depending on their needs: information/referrals, trainings, support groups, parent networking, community connections/resources, and service navigation. Imbedded within the Family Support Center, and serving an additional 100 families per year, is the PSP. The PSP is staffed by parents and caretakers with lived experience navigating the behavioral health system on behalf of their loved ones, and in addition to the services offered at the Family Support Center, the PSP provides both online and in person parent groups, one-on-one support from a parent partner and educational advocacy.

BC Academy is a therapeutic school setting which served 27 students during the last academic year. BC Academy provides a high-intensity program that addresses the individual academic, social, behavioral and career development needs of its students. The entire school serves as a therapeutic milieu where students focus on individual emotional development, while at the same time completing a comprehensive academic program. Students are offered a comprehensive academic program, career development and transition services and individual and group therapy.

The BC Early Intervention (EI) program serves children under three years of age who are developmentally delayed, have a known disabling condition or are at risk of developmental delays due to biological or environmental factors. The program's goal is to promote the physical, mental and emotional development of eligible children. Services are provided in the children's homes, in the community and at the program site on Victory Road. Last year the Early Intervention program served 1,113 youth and their families across these settings. BC's EI program has been providing such services to children and their families for the past twenty years. Depending on the needs of the individual child, interventions can include:

- Multidisciplinary developmental assessments;
- In-home developmental play stimulation;
- Toddler developmental play groups, including transportation, if needed;
- Parent education and support groups;
- Individual or family therapy;
- Speech therapy, occupational therapy and physical therapy; and
- Service coordination and advocacy.

3.5.3.2 Knowledge, Commitment, and Experience Implementing Services to Children, Adolescents, and Families Consistent with Systems of Care and Wraparound Principles: As a current provider of MCI services to the Boston area, BC has a thorough knowledge of Wraparound principles, and over six years of experience providing services utilizing the System

of Care philosophy as a guiding principle. BC staff, as well as clinical leadership from BMC, have attended trainings on the implementation of MCI beginning with the initial roll out of CHBI services in 2009, where an emphasis on care that is child-focused and family-driven was made from the outset. Since that time staff have continued to improve their fidelity to the Wraparound model with additional trainings on the Crisis Continuum, Resolution-Focused Interventions, and the best practice utilization of the seven-day period following an initial evaluation. BCMCI providers have also received Technical Assistance trainings from consultant Kappy Madenwald on multiple occasions, most recently in June of this year. In practice, BC provides a bi-disciplinary response including a child-trained Clinician and Family Partner to youth and families in a variety of community-based settings including homes, schools, provider offices, community centers and an UCC which is available to families 24 hours a day. BC employs an ethnically and linguistically diverse staff, and interventions are delivered in a manner consistent with a family's individual cultural considerations. Under the supervision of the MCI Program Director at BMC, continual efforts to improve the quality of the services delivered are made, including the use of daily record reviews and in-the-moment consultation to staff providing MCI services.

3.5.3.3 Competence Working in Partnership with Youth, Parents, and Other Caregivers of Youth with Mental Health Needs: Recognizing the unique knowledge and contributions that Family Partners have made since being introduced to the provision of emergency services, the BCMCI team has shown a commitment to youth and families by continuing to increase the staffing level of this valuable position. Both BC mobile staff and the clinical leadership at BMC have observed the positive shift toward family-focused practice and the increase in shared decision making that occur when a caregiver's voice and choice are amplified by the MCI Family Partner. Family Partners have also proven to be an effective bridge to reaching families that might otherwise be reluctant to engage in MCI services, but who could benefit from additional support to maintain their youth in the community. For example, there have been numerous occasions where the BC MCI team has been contacted by a community based provider working with a family; the provider believes the family might benefit from MCI intervention, but they have been reluctant to engage due to lack of knowledge about the service, misperceptions about what it will entail, or both. In those circumstances a BC Family Partner has offered to meet with the family before an MCI intervention is ever requested in order to answer any questions a parent or caregiver may have, and to talk to them about the family-directed nature of MCI practice. When these meetings have occurred families have almost unanimously given the feedback that they would feel more comfortable in calling the MCI team than they had previously, and very frequently the outcome is a request for MCI intervention from the family themselves.

3.5.3.4 Policies, Procedures, and/or Clinical Protocols for Provision of Behavioral Health Services to Youth and Families: Please see Attachment 15: Child Focused Team Description which describes the composition and responsibilities of the CFT, a subset of the larger MCI team that carries out stabilization activities on days 2-7 of the MCI intervention; Attachment 16: Youth Consultation Protocol which outlines the consultation requirements for all evaluations of youth ages 0-20; Attachment 17: Youth Boarding Protocol which describes the clinical interventions and consultation requirements for youth boarding in the community for a 24 hour level of care; Attachment 18: MCI Hand off Protocol which outlines the procedure for the BMC ED to request ongoing clinical intervention for a youth being discharged from the ED, to be completed by the MCI team.

3.5.3.5 Outcomes Data, Quality Improvement Processes, Satisfaction Survey Instruments and Results Focused on Services for Youth and Families:

BCMCI Quality Indicators for FY 15

- Community Based Interventions Youth Ages 0-20 - 61.82%;
- Disposition-Inpatient Youth Ages 0-20 - 22.34%;
- Response Time in Minutes Youth Ages 0-20 - 35min; and
- Response Time % Within 60 minutes Youth Ages 0-20 - 82.53%.

Quality Indicators of MCI Service Tracked by BMC

- Documentation of best effort to reach parent/guardian prior to evaluation;
- Children/adolescents who are boarding evaluated every 24 hours after initial evaluation; and
- Increased use of youth boarding at home (vs in EDs) while awaiting CBAT placements, when deemed safe and with caregiver agreement.

As part of ongoing efforts to improve the quality of MCI services delivered to youth and families, the BMC MCI Program Director conducts daily reviews Monday-Friday of documented MCI service delivery by the BC mobile team within the preceding 24 hours. Feedback is given verbally and/or via e-mail to the BC MCI Team leader or CFT designee. Areas of review include:

- Quality and completeness of clinical information documented;
- Evidence of parent/guardian engagement and family-driven resolution; and
- Clear resolution focused goals for ongoing MCI involvement, if agreed upon by the family.

3.5.3.6 Training, Licensing, Certification, Accreditation, and/or Other Documented Verification of Expertise and Experience in Providing Behavioral Health Services to Children, Adolescents, and Their Families:

Child/Adolescent In-Service Trainings

- July 2015: *Community Practice Competencies: Higher Level Skills of a BEST Professional*, BEST Clinical Leadership staff
- December 2014: *Peer-Driven Recovery and Resources*, MBRLC, various staff
- March 2014: *The Art of Triage: A humanistic approach to case presentations for the Emergency Services Professional*, Hsila Bates, MD, Associate Medical Director, Massachusetts Behavioral Health Partnership
- January 2014: *Overview of Psychotropic Medications*, Catalina Melo, MD, Associate Director, BMC PES
- December 2013: *Separating the "T" from LGBT: Working with Transgender and Gender Non-Conforming Clients*, Chris Miller, BSW, MBA
- September 2013: *MCI in Action*, Tasha Kornell, LMHC, Youth MCI Program Director, BEST/Cambridge Somerville Emergency Services Program

Child/Adolescent External Trainings

- May and June 2015: *MCI Technical Assistance Training*, Kappy Madenwald, LISW-S, Madenwald Consulting
- April 2015: *Advancing MCI Practice*, Kappy Madenwald, LISW-S, Madenwald Consulting
- April 2012: *MCI Model Enhancement Regional Forum*, MBHP staff
- January 2012: *Statewide CBHI Family Partner Forum: The Voice of Family Partners*, MBHP staff

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention:

BMC	BC
On-call Psychiatrist	MCI Team Leader
Director of Quality/Risk Management and Training	Child-trained mobile Clinicians
Clinical Director	CFT Clinician
Assistant Clinical Director/MCI Program Director	Family Partner
	Child and Adolescent Trained Nurse Practitioner

3.5.3.7.1 Résumés: Current Staff Member(s) in Director-Level Positions and Above with Five Plus Years of Experience: Please see Attachment 19.

3.5.3.7.2 Job Descriptions Mobile Crisis Intervention Team: Please see Attachment 20.

3.5.3.8 Experience Integrating Youth and Family Voice in Organization Governance: Individuals with lived experience including CPSs and Family Partners assist both BMC and BC in integrating youth and family voices into our organizational governance. Membership at a weekly Operations Meeting, which brings together leadership from the various ESP components working under BMC, includes a CPS. Peer Specialists and Family Partners also serve a unique and valuable role in the training of new staff and Masters level internship students working for the BC mobile team. Ongoing efforts to highlight family and youth voice will also be made, including extending additional invitations to parents as well as transitional age youth to participate in formal Advisory Committee meetings.

3.5.3.9 Relationships with Child- and Family-Focused Community Resources in Service: As a provider of MCI services since the launch of CBHI in 2009, BMC—in collaboration with BC—has worked to build relationships with partners from across the System of Care in each community we serve, believing that these relationships are an essential component of improving access to high quality services and supports for youth and families. The foundation of these community relationships is to create opportunities to meet with consumers, schools, behavioral health providers and state agencies alike to discuss the individualized needs of each group. Leadership staff from BMC, as well as the MCI Team Leader from BC, participate regularly in multiple interagency forums where child and adolescent resources are the focus, most notably five monthly System of Care meetings that cover the various communities which comprise Boston. These Systems of Care (SOC) meetings are attended by staff from the host CSA as well as providers of other CBHI services, state agency staff from DCF, DMH, and DCF, staff from social service programs working directly with the community, and parents and caregivers of youth. The MCI leadership personnel from both agencies have also gained experience partnering with state agencies through a combination of regularly scheduled meetings, providing MCI related trainings to state staff, mutual participation on community advisory boards and crisis planning meetings to address the needs of specific individuals. One example of these partnerships is the School Based Mental Health Providers Collaborative, attended monthly by the MCI Program Director from BMC as well as the Assistant Director of Behavioral Health for the Boston Public Schools, the Director of Child and Adolescent Services for Metro Boston DMH, leadership staff from DCF and supervisory and Director-level staff from multiple community-based mental health agencies providing services to youth within the Boston Public School system. In addition to creating a document outlining the standards of care for mental health provision in schools, this group has also worked to remedy service gaps for students in need of

behavioral health treatment, as well as facilitating an annual day-long training for school-based mental health staff.

Relating specifically to agencies serving the Fall River area, BMC and BC have an established working relationship with South Bay Mental Health, which provides Early Intervention and outpatient BHS to that area as well as both clinic and home-based therapy in the Boston area. BC MCI staff have made South Bay a frequent partner when referring for community-based services as agreed upon by the family served, with consistently positive feedback from parents and caregivers. BC staff have also attended trainings on special education provided by South Bay, and the MCI Program Director from BMC works regularly with various clinical leadership personnel from South Bay at both the School Based Mental Health Collaborative as well as System of Care meetings.

BMC and BC staff also work very frequently with all aspects of the Arbour Health System, which serves the Fall River area with its in-home therapy and therapeutic mentoring services. BC mobile staff make numerous referrals per year to the Arbour system for youth and families requesting outpatient counseling and psychiatry care, as well as IHT and TM services. BC staff also access the Arbour system's inpatient psychiatric units for children and adolescents requiring that level of care for stabilization before returning to the community.

3.5.3.10 Membership in Child Advocacy and/or Child-Focused Trade Organizations: BMC, BC and V staff are members of the PPAL.

3.5.4 Mobile Crisis Intervention

3.5.4.1 Mobile Crisis Intervention Service and Bi-Disciplinary Intervention: Since 2009, BMC has been committed to the delivery of MCI services utilizing the Ten Principles of the Wrap-Around Process as a guiding philosophy. Throughout an intervention, family voice and choice play a central role in the provision of services, including the need for a culturally competent approach which addresses a family's preferences for setting, language, communication method and inclusion of natural supports. We prioritize providing MCI services in the least-restrictive community setting and on collaborating closely with the family's providers and supports of choice. Requests for MCI intervention will be received at a 24-hour 800# Call Center which will coordinate a response with the UCC located in the caller's community. As often as possible, a bi-disciplinary team including a youth-trained Clinician and Family Partner will be dispatched from the UCC to respond to the requested location, promoting the use of community-based settings whenever possible. The MCI team will gather information from the youth, parents and/or guardians and other collaterals as permitted by the guardians—including both formal providers and natural supports—to gain an understanding of the present crisis and the family's preferences for resolution. During the course of the intervention, the Family Partner will act with particular emphasis on supporting the parents or guardians in their experience of the crisis, as well as the MCI intervention itself, taking care to answer questions about the process and amplify the family's voice and choice. In consultation with appropriate team supervisors, a consensus agreement will be reached with the family regarding next steps to resolve the crisis, including referral to a range of formal and informal supports inclusive of 24hr inpatient care if indicated.

3.5.4.2 Managing Staff Resources to Meet Service Fluctuations in Intensity and Duration: In order to provide maximum flexibility, BMC plans to hire master's level Clinicians for the entire ESP who meets the MCI competency standards or who will acquire competency via ongoing training in the areas of expertise highlighted by the RFR (e.g., comprehension of grief and trauma in adolescents and children, risk assessment, and management skills in working with children, adolescents, and families). We will also seek to staff with primarily full-time

employees, as opposed to part-time, to allow for fullest development of the program and to provide for consistently high quality interventions.

The ESP will use Family Partners and/or other youth-trained paraprofessionals to deliver MCI services in conjunction with Clinicians, and to help coordinate care with natural supports and community-based providers. These staff will interface with families during initial evaluations, and will also be available for ongoing stabilization activities for up to seven days following the initial encounter depending on the volume and intensity of services needed by youth and families in the community.

3.5.4.3 Continued Intervention to Assure Coordination of Care Stabilization and Follow-Up Services: In order to meet the needs of youth and families for up to seven days of crisis stabilization support following an MCI encounter, BMC has developed a bi-disciplinary team of youth-trained Clinicians and Family Partners within the larger group of ESP Clinicians referred to as the CFT. The primary responsibility of CFT staff is to interface with youth and families subsequent to the initial encounter with MCI to develop an individualized and resolution-focused plan to determine which continued interventions will occur, if any. Each family that indicates a desire for continued intervention is assigned a CFT Clinician, Family Partner or both depending on their needs, who will remain the primary contact person throughout the course of the stabilization activities in order to maximize effective communication with the family. CFT staff will work with the youth, their caregivers and other system providers to ensure that the family's goals within the resolution of the crisis are met. During periods of high intensity and duration of MCI stabilization activities, CFT Clinicians and Family Partners maintain a primary focus on working with families for up to seven days following their initial encounter with MCI; when demand for these activities is lower, CFT Clinicians will become more available to conduct first-day evaluations and interventions with youth and families. CFT Clinicians will also become available to conduct initial adult face to face evaluations as needed.

3.5.5 Linkages with Other CBHI Services: BMC has a strong history of partnering with CBHI providers in its provision of MCI services, both during the course of urgent requests for evaluation, as well as building relationships with providers that encourage prevention and early intervention with families served. Attendance and active participation at the System of Care committee facilitated by the area CSA is an important building block for these relationships. It allows the MCI team to develop a strong alliance not just with Intensive Care Coordinator (ICC) and Family Partner providers, but also with other partners who attend the SOC with the intention of improving the health and well-being of the families that make up the community. BMC has also made it a practice to reach out to providers of child BHS including IHT, TM and outpatient counseling, and to offer trainings to the staff of those services in collaborating with MCI to ensure the best care for their clients. With permission from parents or guardians, attendance at CPT meetings or other crisis planning meetings held by providers can also be a means to create positive relationships with both staff and families served, and can aid in the creation of a plan which emphasizes early intervention and least restrictive care.

3.6 Runaway Assistance Program (RAP): As a partner in the RAP, the FR-ESP will make available 24-hour access to designated UCCs to allow police drop offs of runaway youth outside juvenile court hours "Non-Court Hours" being defined as hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically M-F, 4:30 p.m.-8:30 a.m. weekends and holidays. The goal of this program is to provide a temporary and safe place for youth to stay on a voluntary basis, until said youth is transferred to an Alternative Lock-Up Program (ALP) or other appropriate level of service. For

the Fall River area of service, the designated non-secure ALP is Community Care Services at 508-226-6031. The Manager is Tasha Ferguson, LMHC, Assistant Clinical Director and MCI Director.

We will employ the BEST RAP protocol which follows:

After determining that a parent/guardian cannot be located to take custody of the youth in question, police officers will initiate this process by contacting 211 and speaking with the "RAP Specialist," who will then do the following:

- Arrange a 4-way conference call between the requesting police officer/dispatcher, ESP Call Center, and a representative from the non-secure ALP;
- Provide the police with the name and address of the closest UCC;
- Request that a representative from the ALP proceed to the UCC where the youth will be dropped off in order to take custody and transfer the youth to the ALP; and
- Relay any known information about the youth to both the on-call RAP Clinician and the ALP, including name, DOB, last known residence, guardian's contact information, etc.

ESP responsibilities after notification by 211 of a RAP request:

Call Center

- Determine if mobile team staff is present on site at requested UCC—if present, notify that a RAP drop off will occur;
- If mobile team staff is not present, notify CCS staff at the appropriate site that a drop off will occur;
- Contact the on-call RAP Clinician to respond to the UCC; and
- Create a triage with any available information.

CCS

- Greet the police officer and youth upon arrival, and supervise the youth until the on-call RAP Clinician arrives. Of note, the youth is not permitted to be on the CCS unit at any time.

On-Call RAP Clinician

- Respond immediately to the UCC after notification from the Call Center;
- Conduct a brief evaluation of the youth and note any behavioral health or safety concerns to be relayed to the ALP staff upon arrival;
- If the youth is determined to require an acute psychiatric admission (i.e. inpatient or CBAT) attempt to facilitate admission, including contacting DCF hotline as needed if a parent/guardian is unable to be located;
- If not in need of an acute admission, continue supervising youth until pick up by ALP staff, or until the youth is transferred to another appropriate setting, i.e. guardian/DCF custody; and
- Complete documentation of assessment.

Youth will remain at the UCC on a voluntary basis until transfer to the ALP/other appropriate setting. If a youth leaves the UCC after drop off by police has occurred, the following steps will be taken if there is reason to believe the youth met Section 12 criteria during the brief assessment: contact the Psychiatrist On-call to complete Section 12 consultation process as usual. If the youth does not meet the criteria, the referring police department will be notified for the UCC if different from the referring department, the RAP Specialist will be notified at 211, and the ALP Program will be notified at 877-457-3210. Finally, emails with any details regarding the circumstances of the youth's departure will be sent to Tasha.Ferguson@bmc.org and an Incident Report will be submitted to MBHP on the next business day.

For on-call support contact Tasha Ferguson at 603-498-3093.

3.6.1. Experience Collaborating with Local Police Departments, Court Clinics and DCF Relative to Youth: BMC and BC have worked closely with the police departments serving our area—both at an administrative level and with individual area stations—to form mutually beneficial relationships that serve to increase access to appropriate supportive services for youth and families. Most notably, BMC employs two full-time Clinicians who co-respond with police officers in Boston to provide on-scene assessment and intervention for youth and families with behavioral health concerns that come to police attention. The goal of these interventions is to divert individuals from legal involvement when connection with mental health services is the more appropriate response. In collaboration with BC, the BMC co-responding Clinicians can also directly facilitate connection to the MCI team for more intensive stabilization activities by transporting the youth and family to the BC UCC, or by requesting an MCI response to the family's home to continue the intervention in that setting. BMC has also provided informational trainings on MCI services to school police officers, as well as collaborating with multiple different police departments including the Massachusetts State Police to provide a RAP response as requested.

BMC also employs 2.5 full time equivalent Clinicians who work with individuals facing legal charges as members of the Criminal Justice Diversion team. This team works within three Mental Health Specialty Court sessions in the Boston area providing assessment, connection to services and case management support to transitional age youth and adults referred by the court due to ongoing behavioral health needs.

Both BMC and BC collaborate regularly with the DCF around youth and families in the areas we serve. Most frequently this comes in the form of requests for MCI intervention with youth engaged in DCF services—this includes youth residing at home with family, in foster care, at Stabilization, Assessment, and Rapid Reintegration (STARR) programs and at Caring Together residential or group home programs funded jointly by DCF and DMH. In addition to these urgent responses, BC MCI staff participate in DCF crisis planning meetings for youth in the community, as well as in ongoing care planning for youth in DCF custody who are boarding for psychiatric placement with the goal of stabilizing the youth who can then be maintained in the least restrictive setting. BMC leadership staff have also provided informational sessions and training for DCF staff regarding MCI services, and participate in a number of interagency forums with DCF supervisory staff including community System of Care meetings.

4. ADDITIONAL RESPONSE REQUIREMENTS

4.1 Hospitals as Bidders

4.1.1 Why BMC is in a Strong Position to Achieve Goals of the Procurement: BMC's commitment to community-based programs and accomplished leadership have demonstrated success with programs such as BEST, CS-ESP, MBRLC, and SERLC. BMC is a founder and current partner of Boston HealthNet, a vertically integrated network comprised of 14 community health centers, BMC, and Boston University School of Medicine, and which serves Boston's underserved, diverse neighborhoods. BMC is the lead partner of BEST, partnering with two premier community-based behavioral health service providers in Greater Boston, North Suffolk Mental Health Association and BC. BMC is also the lead partner of CS-ESP, partnering with North Suffolk Mental Health Association and Cambridge Health Alliance. BMC has leveraged the knowledge and capability of the community-based providers in combination with its organizational leadership in administration, finance and medical/clinical services to create and implement a community-based ESP model that benefits adults and families in Boston. BMC has also led the development and implementation of successful ED diversion strategies. BMC's proposed Fall River ESP in partnership with BC and V—experienced and knowledgeable community-based ESP providers—will similarly establish a robust community-based ESP in the Fall River area.

In the Southeast Area, BMC developed and has overseen the SERLC programs in conjunction with two capable community-based service providers, Brockton Area Multi-Services Incorporated (BAMSI) and Vinfen. As the lead agency for this important DMH-funded, peer-led recovery service, BMC has helped establish recovery service sites across the Southeast area. The Fall River RCC, is located at 66 Troy Street and is open four days a week. These programs will partner with the Fall River ESP to support persons in crisis.

4.2 Bidders Submitting Responses for Multiple Catchment Areas

4.2.1 Vision, Organization, Implementation and Staffing Plan: Strong partnerships with providers experienced in delivering community-based BHS for youth and adults and with deep community roots, trust, and knowledge are paramount to the delivery of high quality crisis services. BMC therefore proposes to partner with providers that possess these qualities and will provide them with a proven infrastructure necessary to support ESPs, including clinical and medical oversight, QM, financial management, an electronic web-based medical record system, and information technology support. Existing infrastructures such as on-call psychiatry, QM systems, a call center, etc. would support well-staffed community-based urgent care and CCS sites along with enhanced mobile capacity in the Fall River area. Strong collaborations with key stakeholders in the Southeast Area is critical to the efficacy of Southeast Area ESPs. BMC, BC and V have well-established working relationships with many Southeast Area community-based providers and other stakeholders including, BAMSI, Child and Family Services, Growthways, Inc., DMH Southeast Area Office, Justice Resource Institute (JRI), NAMI MA, Arbour Counseling, Fellowship Health Resources, Seven Hills, Child and Family Services, Solid Ground Psychotherapy, Steppingstone, Bay Coast Behavioral, Fall River Psychological Associates and Riverwood Mental Health Associates. BMC also has a strong, effective working relationship with the DDS Regional Director, Rick O'Meara as well as the Area Director, Buddy Baker-Smith, and Site Director, Daniel Fisher of the DMH.

4.2.2 Strengths Realized by Serving Multiple Catchment Areas: We will realize economies of scale in more costly aspects of providing emergency services such as medical and clinical

leadership, on-call systems, call center functions, information technology support, and QM. Economies of scale allow the allocation of more resources to clinical services and staffing thereby meeting the ESP service needs of more individuals and families in the community. The new Fall River ESP will also benefit from BEST's and Cambridge Somerville ESP's intellectual capital, established recovery-oriented culture, community-based support, leadership and peer-inclusive infrastructure, expertise, and lessons learned. Additionally, existing and proposed partners from all four catchment areas will work collaboratively to support each other across catchment areas in times of high demand. Serving multiple areas across the Southeast also provides the opportunity to standardize communication, data collection, policy, procedure and practice which will enhance access and continuity of care for consumers across the Southeast Area. For example, utilization of a web-based EMR on a southeast area-wide basis allows access to client information even if a client is seeking crisis services in other than their own community.

4.3 Subcontracts

4.3.1 ESP

4.3.1.1 Subcontract Names and Rationale for Partnership: BMC plans to subcontract with two organizations in providing ESP services to the Fall River ESP communities.

BC was selected to be a subcontractor because it: 1) is a premier provider of community-based mental health and rehabilitation services for seriously mentally ill adults and children, those with intellectual and developmental disabilities, and persons with substance abuse problems in the Southeast, South Shore and Metro Boston areas; 2) has significant knowledge and expertise in the provision of ESP services as a BEST partner since 2004; 3) has a high degree of expertise in information technology and EMRs; and 4) has a proven track record of valuing consumer leadership and choice, peer support, and family-driven and youth-guided care.

V was selected to be a subcontractor because it: 1) is a premier provider of community-based mental health and rehabilitation services for seriously mentally ill adults, those with intellectual and developmental disabilities, and persons with brain injuries in the Southeast and Metro Boston areas; 2) has a proven track record of valuing consumer leadership and choice, peer support, and family-drive, youth-guided care as demonstrated while a BMC Psychiatry partner in the MBRLC since 2008 and in the Southeast Recover Learning Community since 2012; and 3) has expertise in the provision of ESP CCS services, as evidenced by currently operating the Cape and the Islands DMH ESP CCS in Hyannis and as a BEST CCS provider in the past.

4.3.1.2 ESP Service Components to Be Subcontracted with Each Agency: BC, in conjunction with BMC; will provide the Fall River ESP MCI, adult mobile, and CBL services. In addition, BC will develop, implement and maintain/improve the information technology programs to support the Fall River ESP.

V, in conjunction with BMC, will provide the CCS services for the Fall River ESP.

4.3.1.3 Service Components and/or Populations Covered by Each Subcontractor: BC and V will provide their respective service components for the entire catchment area and population.

4.3.2 Management and Accountability of Subcontracted Providers: BMC has a successful track record in the development, implementation and oversight of the BEST program, the Boston ESP program which has three key partners: North Suffolk Mental Health Association, BC, and Massachusetts General Hospital Acute Psychiatry Services. A management structure similar to that of BEST, including Senior Leadership, Clinical Leadership, and Operations and Advisory Committees, will be developed to provide internal and external oversight and monitoring of service delivery, including administrative, financial, clinical, and quality. The Senior Leadership, comprised of the administrative and clinical leaders of the BMC DoP, will be fully accountable

for the Fall River ESP and meet on a weekly basis to monitor the subcontracted services and will regularly participate in the other key committees as well.

4.3.3 How BMC Will Directly Provide the Majority of ESP Services: BMC, as the Fall River ESP contracted ESP provider, will provide a majority of the ESP services: 1) in conjunction with BC staff, will provide the Fall River ESP CBL, MCI, and adult mobile services; 2) Call Center/Triage 24/7/365 staff and functions; 3) all on-call child and adult psychiatry back-up services, telephone and face-to-face, and all direct psychiatry services for the CBL/CCS services; 4) complete financial oversight and claims processing services; 5) the majority of key leadership positions directly involved in the day-to-day operations, including Fall River ESP Director, MCI Program Manager, Medical Director, and QM Director; and 6) the support, expertise and guidance of the BMC Psychiatry ESP Senior Leadership Team.

Fall River

BMC

Attachments

Narrative Response Attachments

ATTACHMENT 1: CONTINUUM OF CARE

Boston Medical Center

The *Comprehensive Care Program* in the Department of Pediatrics integrates primary care with specialty care and social services for children with neurodevelopmental and emotional/behavioral needs related to pre-term birth, congenital syndromes and chronic health conditions, and/or have experienced trauma as a result of abuse/neglect, parental abandonment, domestic violence, and parental substance abuse. Most of the children seen in the CCP have complex overlapping health, development and emotional/behavioral issues. Many low-income parents of special needs children tend to engage haphazardly and episodically with the healthcare system and fail to receive appropriate follow-up care and intervention. These parents often face economic hardships, educational barriers, psychosocial stigma, and social isolation as they try to cope with their children's needs and attempt to maintain stability for their families. The CCP, with its multidisciplinary approach, sees from 4 to 6 patients per hour, considerably less than the 8 patients per hour in a regular pediatric clinic. Additionally, during their primary care visit patients also can see a neurologist, pulmonologist, nutritionist, gastroenterologist, and/or a pediatric endocrinologist. This "one stop shopping" model of care promotes communication between all members of the child's healthcare team.

The *Child Witness to Violence Project*, a nationally recognized, award-winning counseling, outreach and consultation program that focuses on young children who are exposed to domestic or community violence, providing trauma-focused counseling services to children and telephone consultations and referrals to agencies and individuals throughout Massachusetts, including the Department of Children and Families, the courts, other hospitals, neighborhood health centers, Head Start, and schools. The program provides a flexible combination of services, including resource advocacy to link families to basic services including health care, child care, housing, and after-school programs.

The *Child Protection Team*, consisting of a pediatrician, nurse practitioner and social worker, files reports of suspected child abuse or neglect. The on-call consultation services are available 24/7 to BMC and Boston HealthNet providers.

The *Elders Living at Home Program* (ELAHP) helps older adults locate and maintain a permanent residence and allow them to live as independently as possible. ELAHP provides housing search, stabilization, nutrition, and homelessness prevention services. All of the elderly men and women placed in housing and provided housing stabilization services have remained successfully housed.

The *Margaret M. Shea RN Adult Day Health Program*, licensed under MDPH, is a holistic medical intervention program that provides services in an ambulatory, home-like setting for adults who do not require 24-hour institutional care, but because of physical and/or mental impairment, are not completely able to live independently. Services include nursing, social services, activities, and transportation.

The *Center for Infectious Diseases* (CID) provides comprehensive HIV medical care and support services. Many patients experience mental health and substance abuse comorbidities, and approximately 30% utilize behavioral health services. Of these patients, approximately 58% have mood disorders, 80% are dually-diagnosed with substance abuse disorders, 60% meet the criteria for PTSD, and 24% of these patients have reported a history of intravenous drug use. In the CID one-stop-shop model of care, patients receive behavioral health services in the clinic and are referred to FAST Path (described below) for substance abuse treatment.

Facilitated Access to Substance Abuse Treatment with Prevention and Treatment of HIV (FAST Path) provides substance abuse and HIV risk reduction services within primary care settings at BMC for both HIV-infected patients and HIV-negative patients who engage in HIV risk behaviors. FAST Path targets racial/ethnic minority men and women whose alcohol or drug dependence places them at increased risk of transmitting (HIV-infected) or contracting (HIV-uninfected) HIV.

Project ASSERT, (Alcohol and Substance Abuse Services, Education, and Referral to Treatment), has been an ongoing component of safety net services at BMC's Emergency Department (ED) since 1998. During patients' initial point of service, Health Promotion Advocates offer "in-reach" services by consulting and collaborating with hospital staff to offer ED patients alcohol and drug screening, brief intervention, and referrals to health and social resources, such as substance abuse treatment and primary care services. By incorporating substance abuse services within the healthcare setting, Project ASSERT provides patients with comprehensive care in an emotionally supportive and non-judgmental manner. In December, 2014 Project ASSERT celebrated its 20th anniversary from its start as a demonstration grant with over 80 attendees including hospital staff, patients, community agency representatives, and government officials. To date, the Project ASSERT model has been replicated at hospitals throughout Massachusetts, including Addison Gilbert Hospital, Gloucester, Mercy Medical Hospital, Springfield, St. Anne's Hospital, Fall River, and South Shore Hospital,, Weymouth. In addition, it has been replicated at the MidMichigan Hospital System, Michigan.

The *Boston Center for Refugee Health and Human Rights (BCRHHR)* is a collaboration of the clinical and academic departments of BMC and Boston University Schools of Medicine, Public Health, Dentistry and Law; the National Center for PTSD; and Global Lawyers and Physicians. The multidisciplinary program provides comprehensive health care for refugees including primary care, behavioral health services, social services, and medical subspecialty referrals. BCRHHR also provides asylum evaluations, dental care, legal services, and a vocational rehabilitation program for survivors of torture and related trauma. In addition to clinical care, BCRHHR educates and trains agencies and professionals who serve these communities; advocates for the promotion of health and human rights; and conducts research.

Bay Cove Human Services

Bay Cove Human Services (BCHS) offers a comprehensive array of clinical mental health services that respond to the varying levels of consumers' needs including: eight Community Based Flexible Supports (CBFS) teams; one specialized outreach team, a Housing First program

(Home At Last); three Clubhouse programs; a Program for Assertive Community Treatment (PACT); Day Treatment; Tenancy Preservation Project (TPP); two specialized residences providing treatment for 12 men with mental illness and problematic sexual behaviors and a former Quarterway residence; 40 community residences with partial and 24 hour care; a Mental Health Clinic, providing psychopharmacology and therapy; a Department of Mental Health (DMH) transitional shelter, and four Community Crisis Stabilization (CCS) programs. BCHS also provides a full continuum of care for those receiving DD services and Child and Family Services including Early Intervention and a High School. Substance Abuse services include a Methadone Clinic with counseling and a 60 bed Transitional Support Services (TSS) program. Kit Clark Senior Services provides Adult Day Health, a Memory Loss Center, in-home services, and a senior drop in center.

PACT: PACT provides state-of-the-art treatment for individuals with mental illness who are unable to participate in traditional services, often because of severe cognitive challenges, discomfort in social situations, significant addiction to drugs and alcohol, homelessness, and court involvement. The PACT model is one of the most extensively researched options and is commonly regarded as the most “evidence-based” approach for community support of people with severe psychiatric disabilities.

The PACT model is empowering in its implementation because it offers clients only what they need, when they need it, usually at the setting where they live and in a manner that is most acceptable to them. In addition to more conventional mental health treatment, assistance is also provided in areas of housing, careers, meaningful relationships, symptom alleviation, and accessing medical care.

PACT provides its psychiatrist, nurses, therapists, and rehabilitation support staff with a manageable caseload so that they can provide needed services in a personalized and integrated way. The PACT model is uniquely responsive in that the team operates seven days a week and is available by telephone 24 hours a day. The level of contact can vary widely – from a single visit each week to several contacts per day during times of crisis. PACT clients are not required to visit the program offices for services. Instead, staff members often make visits to them at home, at work, in local coffee shops and other familiar community settings. Over 75% of services are provided outside of the office. In practice, this means that PACT may provide services such as daily medication delivery to a homeless client on the street, or regular supportive therapy while grocery shopping.

TPP: TPP assists individuals and families with mental illness, addiction disorders, or developmental disabilities who are at risk for possible eviction. This program prevents homelessness by helping these people stay in their current housing, or by helping them access more appropriate housing that better meets their needs.

TPP services are offered to Boston residents who come to the attention of the Boston Housing Court due to serious lease violations that jeopardize their tenancy. Approximately 200 hundred people comprise a routine “Thursday’s docket” at the Boston Housing Court, and approximately 25% of these people are estimated to have significant disabilities that jeopardize their tenancy and put them at imminent risk of homelessness.

Represented in the population that comes to the Housing Court's attention weekly are Boston Housing Authority (BHA) residents, veterans, and female headed families. Participants range in ages from young parents with young children to elders. Income levels served include the very poor, who are eligible for transitional assistance from the state, and the working poor, who have very low paying jobs. Given the impact that permanent disabilities have on earning potential, most clients in this program fall in the very poor category (with annual earnings for a single adult estimated at under \$7000 per annum). TPP services can mitigate the tragic consequences of eviction and ensuing homelessness for the majority of these people.

CBFS: CBFS are designed to help people with psychiatric disabilities thrive, and not just survive. The process begins with an appreciation of everyone's unique talents, hopes, and dreams. CBFS provides a comprehensive system of supports based on a close partnership between the person served and members of a flexible support team. These supports are continued throughout each person's recovery journey as they progress from structured and highly supported settings, to more independent and integrated ones.

For many people, the journey begins with housing in group homes and support in structured day programs, and then becomes increasingly less restrictive as the individual moves into independent apartments, attends school, or gets a job. However, each person's journey is different and the partnership with the flexible support team staff member helps tailor and coordinate services according to the individual's own values and aspirations. They receive the supports that best fit their needs and talents so that they can gradually regain control over their lives.

By identifying talents and ability, rather than focusing on disability, the CBFS team is able to support high aspirations. As people develop community connections and reestablish relationships with family and friends, they are able to use this growing "social capital" as a substitute for paid supports. Many are eventually able to graduate from services.

The flexible support team structure provides a variety of skilled resources, including peer specialists, nurses, and licensed mental health and substance abuse clinicians. BC's CBFS team serve 1100 adults living in downtown Boston, South End, Chinatown, South Boston, Dorchester, Roxbury, and Mattapan neighborhoods.

BCHS works in partnership with South End Community Health Center and Paul Sullivan Housing, a division of Pine Street Inn, in providing the following services:

- Nine Flexible Support Teams
 - Five by BCHS serving 506 people
 - Three by South End Community Health Center serving 294 people
 - One by Paul Sullivan Housing / Pine Street Inn serving 83 people
- The Unique Safety Net Outreach Team provides Enhanced Urgent Care to 217 people
- Staffed residences
 - 40 are operated by BCHS serving 430 people.
 - Eight are operated by Paul Sullivan Housing/Pine Street Inn serving 83 people

Safety Net Outreach: Some individuals with psychiatric disabilities do not engage in full CBFS services. These people generally prefer to live independently and to have full control over their daily lives. However, they are occasionally in need of short-term support during those times when they are experiencing acute distress or a crisis that requires staff intervention. Some of these individuals are homeless and also reluctant to engage in services or supports that assist them in securing housing.

BCHS has created a Safety Net that provides an innovative and cost effective method of meeting the critical needs of the approximately 200 people in the inner city area who have psychiatric disabilities but are living adequately on their own, and who are either unwilling to engage in services, or are only willing to utilize supports in an intermittent manner.

The Safety Net team includes a Program Director, a full time Peer Specialist, two Outreach Workers, a full time Employment Specialist and two Licensed Clinicians. This team provides a less intense level of case management to people who either need a lower level of support or who are not willing to engage in a recovery partnership, yet can benefit from a connecting relationship so that they are able to access services immediately in times of necessity.

The Safety Net Team helps people with concrete supports, such as securing benefits, providing representative payee arrangements, exploring and finding work, developing crisis plans, and helping those who are homeless access shelter and food. They work to facilitate connections with treatment, rehabilitative, health, legal, and recovery focused services to meet clients' needs. The Team tracks people with at least a once a month contact (face to face, by telephone, or through collateral contact), and maintains a record of each client's status. Though many clients utilize the team much more frequently, Safety Net Outreach offers support seven days a week so that if a client needs back up on a weekend they can readily access services.

The Michael J. Gill Wellness Center: The Michael J. Gill Wellness Center is born out of the CBFS holistic approach to recovery. It is a sad fact that the individuals served are dying on an average of 25 years earlier than other Americans. The Wellness Center has the vision to create opportunities for individuals to achieve the fullest of health and well-being. Groups are open to explore individual choices for lifestyle modifications in the areas of stress management, smoking cessation, physical activity, and nutrition. A peer-run healthy cooking group leads participants in the planning and cooking of a simple healthy meal. An evidence-based nutrition curriculum from the Center for Psychiatric Rehabilitation at Boston University will be offered twice yearly. Community acupuncture for clients is currently being offered at the Wellness Center to promote stress reduction, mood regulation, smoking cessation, and addiction recovery support. Other offerings include Yoga, Peer Recovery, and Substance Recovery groups. The Gill Wellness Center is currently growing and expecting to offer other services in the near future including Tai Chi, nutrition and diabetes education, and expressive therapies. It is open to clients served in the Fuller / BCBS CBFS Program and clients served throughout BCBS's other Mental Health Services.

Michael J. Gill Mental Health Clinic: BCBS assumed operations of the Michael J. Gill Mental Health Clinic in February of 2009. It serves many individuals in Jamaica Plain, Roslindale, Roxbury, and in the general Metro Boston area. The staff of psychiatrists, clinical nurse

specialists, and therapists provide a full range of diagnostic and behavioral health treatment services to adults (21 +), including psychopharmacological, counseling, and psychotherapy for individuals and groups. The clinic specializes in working with people with severe and persistent mental illness, dual-diagnosis, and other related psychiatric disorders. This behavioral health clinic works in close collaboration with the primary care clinic at Lemuel Shattuck Hospital and the Goldfarb Ambulatory Care Center, and therefore ensures optimal integrated health care.

BEST: BEST is a 24-hour emergency services program for people requiring acute psychiatric intervention. Under the direction of BMC, BCHS is one of four providers who comprise the BEST service network (along with the BMC, Massachusetts General Hospital and North Suffolk Mental Health Association). BEST responds to well over 1,000 “calls” each month from a service area that spreads across metropolitan Boston, Brookline, Chelsea, Winthrop, and Revere, and includes seven hospitals, schools, detoxification programs, jails, community health centers and residences for people with mental illness. The demand for services has steadily increased, as the number of people seeking mental health services has grown.

Working with family members, human services providers, public safety and emergency personnel, and school administrators, BEST responds directly to the site of a crisis situation. The program goal is to keep people who are experiencing a psychiatric crisis out of the hospital by redirecting their care to community based programs like addiction services or family support services, where a successful outcome is more likely. Although hospitalization may often be viewed as the "gold standard," it is not necessarily the best treatment option. BCHS is a critical partner in the BEST operation as it provides crucial services including the Mobile Crisis Team and Urgent Care Center and a CCS unit.

CCS: The CCS unit is an unlocked crisis unit that helps people in an acute behavioral health crisis to stabilize, strengthen their coping resources and supports, and develop a plan to live a better life. CCS offers rehabilitative and recovery focused services that enable people to get through such crises without needing to rely on more costly and unnecessarily restrictive inpatient psychiatric services. As a critical component of the BEST, CCS is operated by BCHS and BMC and offers state of the art diversionary care and provides:

- Psychiatric evaluation and assessment
- Medical, psychiatric, and addiction treatment (including detoxification)
- Psychopharmacology assessment and treatment
- Peer-to-peer support through the Boston Resource Center
- A safe, structured environment
- Education about behavioral health concerns
- Step-down from inpatient treatment
- Referrals to psychiatric and addiction services outpatient treatment, health, social services, etc.
- Coordination and collaboration with treatment providers

House Day Treatment: This adult psychiatric day treatment program offers a variety of specialized groups in a supportive community. These groups provide structure within which to address each consumer’s individual, clinical rehabilitation needs. The program is designed for

consumers who are either transitioning from higher level of care (e.g. inpatient hospitalization) or would benefit from additional support and structure to prevent the need for such a level of care. The program works well for people with a wide range of diagnoses and treatment needs. Each consumer participates in individualized treatment and specialized groups, including groups for:

- Dual Diagnosis
- Dialectical Behavior Therapy (DBT) Skills
- Post-Traumatic Stress Disorder (PTSD) / Trauma Survivor Support
- Independent Living Skills

BCHS Day Treatment operates with the philosophy of achievable mental health recovery and offers groups facilitated by consumers of mental health services. The goal of the program is to help consumers transition to less treatment-intensive settings as they are ready. These include educational/ vocational programs, clubhouses, and volunteer settings. Sample activities include sobriety check-in, mental health recovery, goal planning, yoga, expressive therapies, symptom awareness, fitness, and bereavement counseling.

Clubhouses: Transitions of Boston and Center Club Boston are clubhouses for adults with psychiatric disabilities, dedicated to the principles of self-help, peer support, and empowerment. The Clubs offer a safe and supportive environment in which members of the program can work towards building meaningful lives, connecting to the larger community, assuming valued roles in the communities of their choice, and ultimately living as independently as possible. The services provided by the Clubs are individualized and based on each member's needs, strengths, and choices, which are assessed at the time a person joins the program. Each member participates in individualized goal planning with their key staff member at the Club.

Vinfen

CBFS Programs: Since July 2009, Vinfen (V) has been the largest provider of CBFS services for the DMH in the state of Massachusetts. All of V's CBFS services are standardized and based on the evidenced- based practices of Assertive Community Treatment (ACT) and the Individualized Placement and Support Model of supported employment. V operates 18 Collaborative Action for Recovery (CAR) Teams within eight CBFS contracts with DMH. These DMH Sites are Cape Cod and Islands, Plymouth, Metro Suburban, Mass Mental, Cambridge Somerville, Essex North A, Essex North B, and Lowell. The model provides four interlocking components: Collaborative CAR Team(s), Operations Support (includes housing specialty staff), Congregate Settings, and Organizational Support. The CBFS model is a system in which the CAR team and the congregate sites function as one integrated component.

CCS Program: In March of 2012 V was asked to assume the operation of the Cape and Islands CCS program. This program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community based location that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older; including youth ages 18-21 under the Children's Behavioral Health Initiative (CBHI). This program currently has capacity to serve 10 adults any given time. The 10

beds include six CCS beds and four DMH respite beds. The CCS Program works closely with the DMH ESP to develop short term, effective interventions that will assist the individual client in resuming their everyday life. In addition, the CCS team provides nursing on each shift and has access to psychiatric support through the Cape Cod & Islands Community Mental Health Center 24 hours a day. These medical personnel are primary service providers at this program. One of the major functions of the CCS team is to stabilize the individual client and coordinate follow-up services with Primary Care Providers, therapists, day program staff, and psychiatrists in the community.

Program for Assertive Community Treatment (PACT): Since February 2003, V has operated a PACT Team for 80 clients in DMH's Essex North Site; and since July 2007, a team for 80 clients in the Cape Cod & Islands Site. The staff provide support and services in a collaborative effort with clients in a variety of community settings. The PACT program has recruited and hired qualified staff from diverse backgrounds, produced positive outcomes with clients who have the highest challenges/needs, and successfully operated the programs according to DMH and National ACT Standards cited in "*A Manual for ACT Start-Up*" (Allness and Knoedler, 2003). By establishing a trusting and mutually respectful relationship with clients, PACT staff have engaged clients, many of whom had previously refused services of any kind. PACT staff have also helped clients secure part-time or full-time employment, dramatically reduced their use of psychiatric hospitals and emergency services, helped formerly chronically homeless clients secure and maintain housing for the first time in their lives, and collaborated with clients to establish or re-establish meaningful social supports that bring joy and hope to their lives.

Young Adult Services: An emerging priority population for the DMH is Transition Age Youth (TAY) and young adults. V was awarded a contract to provide an evidence-informed practice to TAY called Transition to Independence Process (TIP) in 2005. TIP, a research supported model of support serving an emerging population of TAY, is a strength-based process of working with young people. V began serving this population in the early 1990's and designed supported housing specifically for these young people to avoid group home placement whenever possible.

Clinical Services: V provides a wide range of clinical services to thousands of DMH clients each year. A full range of outpatient services are offered through People Care Clinic, the licensed outpatient clinic, a not-for-profit subsidiary of V for nearly 26 years. Small and specialized, the People Care Clinic serves clients with complex conditions, including Co-Occurring Disorders (COD), and Borderline Personality Disorder.

Psychosocial Rehabilitation: More than 1575 DMH clients a year attend V's seven Clubhouse programs. V also operates six residentially-based day programs. The programs are focused on skills and residents' mutual support.

Recovery and Other Peer Initiatives: In 1993, V was the first provider in the state to hire a Director of Recovery. The Director of Recovery is a member of V's senior management team and has a lived experience of mental illness. V's Director of Recovery, Lisa Halpern, provides guidance on policies and practices, works directly with staff and clients, and offers her valued perspective in staff training and as a teacher. V operates Recovery Learning Community

services, through a subcontract with Metro Boston Recovery Learning Communities, in Somerville, Plymouth, Hyannis, Fall River, and New Bedford.

Family Initiatives: For the past 16 years, V has hosted and coordinated National Alliance on Mental Illness (NAMI) Family to Family groups in several service areas. The NEA's TIP project has benefited from the successful family engagement models designed by Dr. Rusty Clark, developer of the TIP model. TIP offers practical approaches for family members on setting reasonable expectations for their loved one, the recovery and relapse processes, collaborative family problem-solving, and long-term planning.

Developmental Services Division: V offers a comprehensive array of services for individuals with intellectual and developmental disabilities, autism, visual and hearing impairments, and physical disabilities. The Developmental Services Division partners with individuals, their families, employers, and communities, to help them receive the services they need to achieve their goals and attain independence. V supports nearly 1,000 individuals in 80 service settings in Massachusetts.

Brain Injury Services: V provides a variety of services for people with acquired or traumatic brain injury, and partners with individuals, their families, providers, and communities, to assist the individual in receiving the services that will help them accomplish their goals. Integrated into V's Brain Injury services are the latest developments in clinical and rehabilitation intervention, including cognitive, behavioral, and computer-assisted technologies delivered by caring and highly trained staff.



ATTACHMENT 2

BMC ESP Quality Management Plan

Quality Management Philosophy

The BMC ESP Program is committed to a program-wide plan for Performance and Quality Improvement that focuses on improving the important functions and processes of the Program in order to

- Improve the quality of care and patient outcomes
- Enhance the value of all services provided
- Improve the Program's operational efficiency

The definition, measuring, monitoring and improvement of quality service are the responsibility not only of the Quality Management Director and QM Committee, but also of every person in the ESP Program.

We believe that there is always room for improvement in all processes, systems and services and reject the adage, "If it's not broken, don't fix it".

Decisions are based not on whim or intuition, but rather on the consideration of facts and data.

When a problem is identified, we will not jump to a solution. Instead, we will define the problem clearly; collect data to better understand the extent of the problem, its causes, and the contributing factors; based on the analysis of the data, develop a possible solution, implement it and go back later to monitor its effectiveness in solving the problem. This approach has a greater likelihood of solving the problem permanently, rather than being a "quick fix", and it can be done in a timely manner.

When we encounter a conflict or thorny issue, or when we receive a complaint, we will talk about these openly and with detail. Most often these issues are the result of a flaw in one of our systems, not the result of incompetence by an individual. Therefore, the frank discussion of issues must be viewed not as finger pointing and blame-placing, but as an opportunity to fix the system and allow the people within it to succeed.

The BEST Quality Management Program includes a focus on both Quality Assurance and Quality Improvement:

Quality Improvement examines existing work methods, processes and systems and develops ways to make them better. It is not necessarily problem-based, but rather assumes that there are always opportunities for improvement.

Quality Assurance looks to answer the question: what do you do and how do you know you're doing it well? (i.e. assuring quality)

Therefore, each component of the ESP considers:

- What do you define as your most important aspect(s) of work? What are the most important things that you do? Why are you here?
- How do you know that you're doing those things well/right? What objective data or information do you look at that tells you that?
- How do you collect that data? How often do you examine it? What performance standard (percentage or numeric threshold) have you set for your service?

In addition to each component of the service creating indicators of quality, the ESP program as a whole identifies its aspects of work which are high risk, high volume, or problematic. Quality Assurance and Quality Improvement activities and teams may be organized to address these issues; also, such issues may be referred to existing committees for exploration and problem solving.

Purpose and Goals of the Quality Management Plan

The Quality Management Plan provides a framework for a systematic, comprehensive approach to planning, measuring, analyzing, and sustaining improved performance of BMC ESP program-wide systems and processes; it supports the ESP mission of providing comprehensive emergency behavioral health services for the defined service area.

The goals of the QM Program and Plan include:

- To provide mechanisms for the identification, assessment, maintenance, and improvement of organizational performance and patient care/treatment outcomes for person served by the ESP.
- To ensure timely and practical resolution of identified problems or issues using the quality management process and principles.
- To ensure that valid and reliable data are gathered, reviewed, analyzed and utilized in the identification and resolution of problems and improvement in quality of services.
- To identify and prioritize system issues that impact the quality of patient care and of the patient's experience.
- To establish an organization-wide forum in which to pursue all identified opportunities to improve the service provided by the ESP.
- To ensure that the services provided by the ESP meet all standards and regulations set by:
 1. Department of Public Health
 2. Department of Mental Health
 3. Affiliated Managed Care Organizations
 4. Massachusetts General Laws and Regulations
 5. All other relevant licensing, accrediting or certifying bodies

Structure of the Program

Senior Management Team consists of the Department's Vice Chair for Clinical Services, ESP Medical Director, the Director of Clinical Operations for the BMC Department of Psychiatry, the Clinical Director of the ESP, and the Director of Quality/Risk Management. It functions as the executive group for the ESP program. Among its functions is the oversight of the Quality Management Program, including the prioritization of Quality/Improvement activities; initiating, overseeing and coordinating PI activities, and receiving reports and approving recommendations from PI teams

ESP Operation Group includes the ESP Medical Director, the Director of Clinical Operations for BMC Department of Psychiatry, the ESP Clinical Director, the Director of Quality/Risk Management, the Medical Directors of Psych Emergency Services from BMC and partner designated EDs, and the Managers of the UCCs. It meets weekly. This same group also comprises the **Quality Management Committee** and meets monthly in that capacity. Its functions include:

- Establish expectations and performance standards for all components of the ESP program

- Reviews volume, activity and utilization data to identify high-user clients, diversionary and hospitalization rates, barriers to accessing service, community services with high/low utilization of the ESP
- Identify opportunities for improvement based on this and other data; make recommendations to Senior Management Team regarding QI/PI activities
- Manage the PI process; ensure the implementation of processes to measure, assess and improve performance
- Resolution of problems and complaints that could adversely affect the delivery of services
- Stakeholder survey; review results and identify target areas for improvement

Advisory Committee meets bimonthly and consists of a representative group of internal and external stakeholders, e.g. the area's School Department, Police Department, Court Clinic, consumers mental health services, homeless shelters and services, DMH, DMR, DSS, DYS, etc. Issues raised by this group inform the work of the Quality Management Committee. There are separate Advisory Committees for each BMS-led ESP (BEST and Cambridge/Somerville).

The Director of Quality Management is responsible for the development and oversight of a fully integrated performance improvement/ quality management plan, which ensures the quality, appropriateness and continual improvement of services provided by the ESP program. This position supports the quality/performance work of the ESP and coordinates the activities of the aforementioned groups and chairs the Quality Management Committee. (S)he also provides Quality Improvement education and information to all components of the ESP.

Data collection and Measurement

Data collection is key in translating information into opportunities for improvement by quantifying a situation, tracking a process, identifying gaps in performance, and in verifying whether the objectives of various improvement strategies have been met. Objective data allows us to make the best possible decisions regarding the delivery of quality services to our patients and other stakeholders.

Sources of data include:

- Weekly and monthly Activity Reports which include data on encounters by team and ED, hospitalization and diversion rates, types of services and levels of care to which patients were referred (dispositions), CSU utilization (admissions, discharges, average daily census, average length of stay, declined admissions)
- Encounter and clinical documentation on patients is website based. This allows for flexible queries and reports on a variety of metrics, including response time of teams, volume trending, demographic attributes of patients served, etc.
- Risk Management findings (e.g. incident reports, complaints)
- Internal and external customer needs and expectations
- Stakeholder and consumer satisfaction surveys
- Medical record review for quality, timeliness, appropriateness of documentation
- Case reviews to identify patterns of utilization, barriers to service, treatment outcomes, and the development of system-wide crisis plan for the patient

Methodology

On small scale, leaders of teams identify opportunities for improvement in daily work and use the PDCA cycle of QI:

- What am I trying to improve? (to define the problem)

- How will I know if my change is an improvement? (to pick the right metric)
- What change can we make?
- Then plans the change (**Plan**); carries it out on a small scale (**Do**); checks the results (**Check**); extends the change to the whole operation with modifications as necessary (**Act**)

When confronting larger scale issues that cross components and involve a task group or PI team, we use the FOCUS/PDCA method:

F= find an opportunity to improve

O= organize a team that knows the aspects of the existing problems; define the problem and write a problem statement

C= clarify the current process to all team members; define desired outcome and what information is needed to understand the problem, its root causes and possible solutions

U= understand the sources of variation in the process being studied; collect and analyze pertinent data

S= select the improvement action from the ones that may have been identified

Prior to implementing a new program or process, we conduct a FMEA (**F**ailure **M**odes and **E**ffects **A**nalysis). This analysis is conducted by a team consisting of the primary stakeholders of the new process/program. The team identifies all the steps involved in the proposed process/program that could fail or go wrong. Each of possible “failure modes” is assigned a numerical value, that indicates its criticality in terms of how severe it is, how detectable it would be and the probability of its happening. This process prioritizes where the team should turn its attention first. The team identifies causes and potential fixes for each of the failure modes, so that intervention can be made before the process/program is implemented. It is prospective and preventative, versus traditional approaches of analyzing events after they occur.

Annual Evaluation

The Quality Management Committee evaluates the QM Plan annually, reviewing its effectiveness in achieving the goal of assuring that the most appropriate quality of care was provided to patients. Also, the Committee:

- Reviews the annual summary report of the past year’s QI/PI activities, improvements made, care delivery processes modified, and projects in process
- Defines performance indicators for the next year and numerical/percentage thresholds for each
- Identifies additional data which should be collected to demonstrate performance, the frequency of data collection and analysis,
- Makes recommendations for change to the QM plan

All findings and recommendations are sent to the Senior Management team for review and approval.

Examples of Quality/ Performance Indicators by service

Call Center

- Incidence of neither mobile team being available for an evaluation in a non-designated ED within 1 hr
- Incidence of neither mobile team being available to a community-based site within 1 hr, resulting in client being sent to an ED

Designated EDs

- Wait time to be seen by psychiatry
- Youth cases handed off the ESP following ED contact/evaluation
- Hospitalization rate
- Referrals to CSU
- Referrals to other diversionary services
- Contact with collateral treaters/ PCP

UCC Mobile teams

- Response time from when request received to when clinician begins evaluation
- Hospitalization rate
- Referrals to CSU
- Referrals to other diversionary services
- Community-based evaluation by site (residential, home, school)
- Contact with collateral treaters/PCP
- Documentation of best effort to reach parent/guardian prior to evaluation
- Children/adolescents who are boarding evaluated every 24 hours after initial evaluation

UCC Walk-in

- Client wait time to receive psychopharmacology appointment
- Contact with collateral treaters/PCP

CCS

- Rate of patients being stepped up to hospital level of care
- Contact with collateral treaters/PCP
- Follow-up appointment with treater/program scheduled to occur within 5 days

Other

- Indicators based on results of the Stakeholder Satisfaction Survey
- Evaluation of program by every member and level of the ESP, using the 360 degree method
- Focus groups of clients through RLC regarding satisfaction with services, service needs and gaps
- Stakeholder surveys through Advisory Committee
- Case reviews in Operations meeting and in Kids Services meetings
- Patient satisfaction surveys in CSU
- Sampling review of patient records by QM Director to monitor quality of documentation and appropriateness of assessment and decision-making

Examples of recent QI activities and improvements

- Implementation of DocuSign system whereby backup psychiatrists can use phone or tablet to complete and sign Sect. 12 forms for clinicians in the field, following consultation with clinician. Allows document maintenance and storage as well as more timely response to request.

- Institution of monthly all-ESP trainings. Recent topics include MI/PSB; patient presenting with intoxication and SI; child sex trafficking; motivational interviewing; impact of racism on provision of MH services.
- Creation of Community Outreach Clinician in Cambridge/Somerville to analyze community demographics and services utilization to assist with targeted outreach efforts, increase ESP utilization and decrease ED utilization
- Refined handoff processes shift-to-shift within programs, and day-to-day between program components
- Increased presences of Recovery Learning Community staff in CCSs
- Medication education for RN staff in CCSs
- Increased use of youth boarding at home (vs in EDs) while awaiting CBAT placements, when deemed safe and with caregiver agreement
- Increased number of Mental Health Court sessions and number of clinicians in those courts
- Participated in MBHP-sponsored CQI consumer satisfaction effort
- Conducted a survey of BMC and MGH EDs regarding reasons patients choose EDs for care

BMC ESP Data Management Grid

Type of Report	Who's the Audience	How to Use the Information	Frequency of Reporting	Responsible Person
Response time to non-designated EDs	ESP Operations group; Senior Leadership	Identify/analyze trends and the variables which may impeded and/or facilitate response time) especially those greater than 1 hour from time patient is ready	Quarterly	Dir. QM
CCS patient satisfaction	CCS staff; BEST Senior Leadership	Identify areas of the program with which patients are/aren't satisfied; create QI action plans to improve the areas identified as in need of same	Quarterly	CCS Program Managers
Psychopharm utilization by both UCCs	Senior Leadership;	Examine patterns/trends of utilization (volume vs. capacity, no shows, initial and follow-up appointments	Monthly	ESP Clinical Dir.
Calls to Call Center which did not lead to an evaluation	Senior Leadership;	Identify volume of calls; sources of, reasons for and appropriateness of calls. Risk Management purposes	Quarterly	Call Center Dir.
Monthly Activity and utilization Reports	ESP Operations group; Senior Leadership; Advisory Committee	Describes all aspects of activity in all components of ESPs (volume, location, disposition, hospitalization rates, etc.). Allows analysis of utilization and other aspects of compliance with ESP standards	Monthly	ESP Clinical Dir.
Incident report and complaints tracking	Senior Leadership; ESP Operations group	Identify serious incidents which require immediate change in policy/procedure/process. Analyze trends to identify opportunities for improvement	Quarterly	Dir. QM
Patients boarding in EDs	ESP Operations group; Senior Leadership	Monitor volume of boarders; analyze reasons for same, with a goal of making systemic changes to decrease boarding rate	Monthly	ESP Clinical Dir.
High users of ESP services	ESP Operations group;	Identifies clients seen more than twice in a month so that Crisis Plans may be created and attempts may be made to hook client up with ongoing treatment	Monthly	UCC managers
CCS utilization	Senior Leadership; ESP Operations group	Analyze volume, LOS, trends of issues dealt with, post-discharge treatment and follow-up; allows future program modification and improvement	Monthly	CCS Nurse Mgr

DMH Southeast Emergency Services Program Privatization Analysis

CCS unplanned discharges	Senior Leadership; CCS Leadership	Analyze reasons patients leave the CCS prematurely; facilitates program improvements to decrease unplanned discharges	Quarterly	CCS Nurse Mgr
Use of diversionary services	ESP Operations group; Senior Leadership	Look at the degree to which each team is using CSU, Detox, EATS, ART, PHP, FST diversionary services	Monthly	ESP Clinical Dir.
Results of client and stakeholder satisfaction surveys	ESP Operations group; Senior Leadership; Advisory Committee	Identify areas of satisfaction and dissatisfaction with services; informs planning and decision-making for quality improvement activities	Annually	Dir. QM
Clinician profiles	Senior Leadership; UCC managers	Looks at number of encounters done by each clinician and use of diversionary services (vs. hospitalization). Sample of each clinician's case write-ups are also reviewed, for quality of assessment and documentation. Informs clinical supervision by team managers	Semiannually	Dir. QM

ATTACHMENT 3: ESP RESPONSE TIME

BEST/
Cambridge Somerville ESP
Information System
[Give Us Feedback](#)
[Give me 20 more minutes](#)

ESP RESPONSE TIME
[Back to Main Menu](#)
(Help Desk 817.271.3039)

[Click Here to Log Out](#)
[Resource Directory](#)
[PsychoPharm Calendar](#)

Start Date: End Date:
07/01/2015 through 07/31/2015 [How do I read this report?](#)

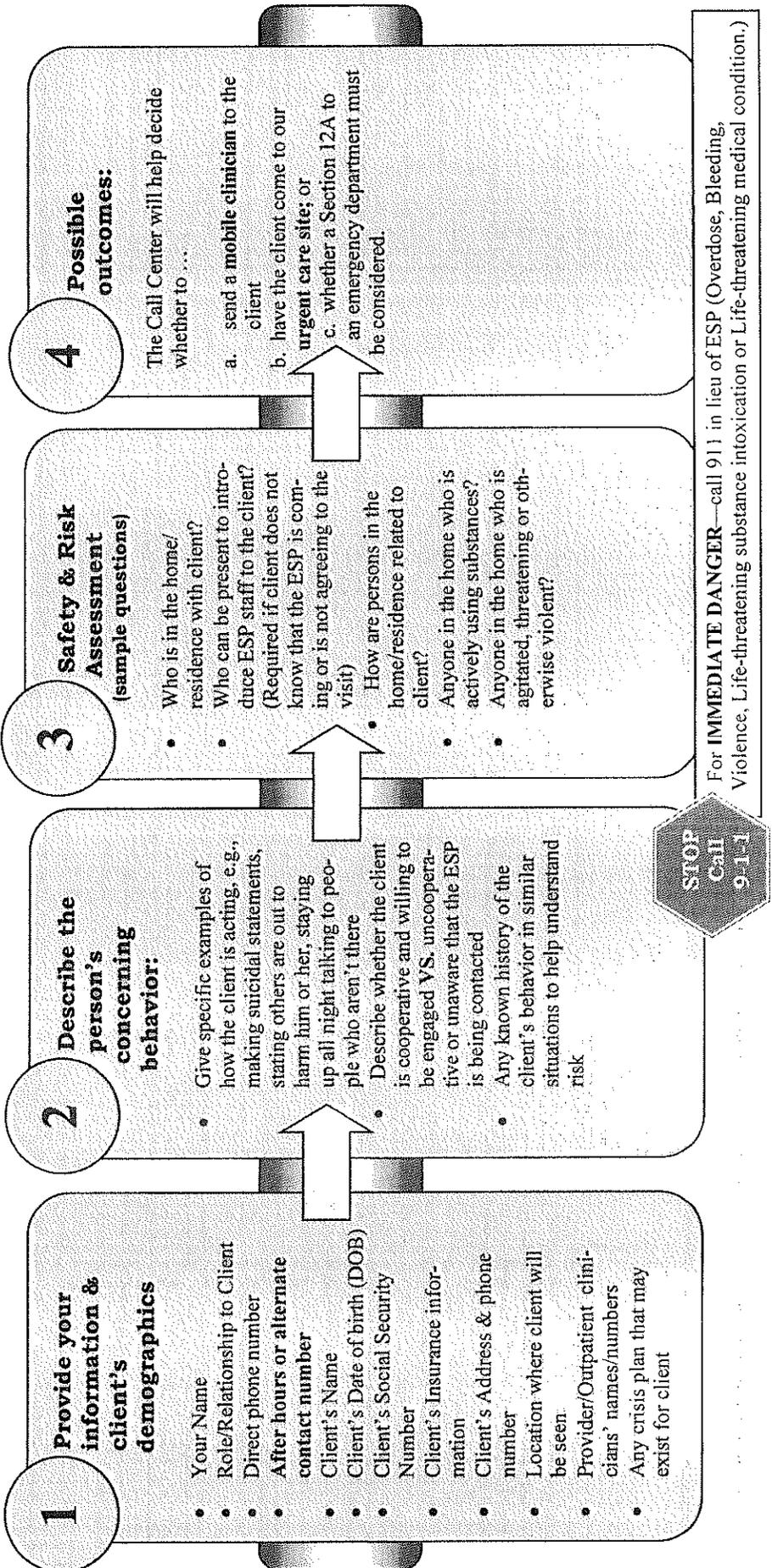
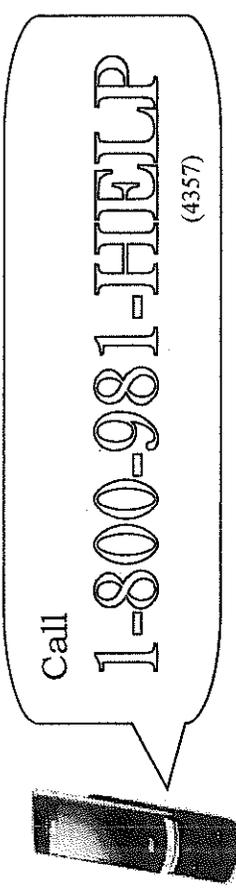
ClientID	Team	Date/Time Eval Began	Location/Date/Time of Readiness	Response Time	Readiness Time
[REDACTED]	BEST-BMC 800 BEST BayCove UCC	07/01/15 06:00PM 07/01/15 07:00PM	E At Home 07/01/15 06:30PM	1 hrs	0.5 hrs
[REDACTED]	BEST-BMC 800 CS ESP North Suffolk UCC	07/04/15 10:15AM 07/04/15 11:00AM	D At Home 07/04/15 10:15AM	0.75 hrs	0.75 hrs
[REDACTED]	BEST-BMC 800 CS ESP North Suffolk UCC	07/07/15 02:30PM 07/07/15 03:30PM	D At Home 07/07/15 03:30PM	1 hrs	0 hrs
[REDACTED]	BEST-BMC 800 CS ESP North Suffolk UCC	07/17/15 11:15AM 07/17/15 02:00PM	D At Home 07/17/15 01:00PM	2.75 hrs	1 hrs
[REDACTED]	BEST-BMC 800 BEST BayCove UCC	07/13/15 03:00PM 07/13/15 04:15PM	E At Home 07/13/15 03:45PM	1.25 hrs	0.5 hrs
[REDACTED]	BEST-BMC 800 BEST North Suffolk UCC	07/17/15 12:30PM 07/17/15 02:00PM	D At Home 07/17/15 12:30PM	1.5 hrs	1.5 hrs
[REDACTED]	BEST-BMC 800 BEST North Suffolk UCC	07/29/15 12:15PM 07/29/15 04:45PM	D At Home 07/29/15 04:30PM	4.5 hrs	0.25 hrs
[REDACTED]	BEST-BMC 800 BEST North Suffolk UCC	07/14/15 03:15PM 07/14/15 05:00PM	E At Home 07/14/15 04:00PM	1.75 hrs	1 hrs
[REDACTED]	BEST-BMC 800 BEST BayCove UCC	07/14/15 02:45PM 07/14/15 03:45PM	D At Home 07/14/15 03:15PM	1 hrs	0.5 hrs
[REDACTED]	BEST-BMC 800 BEST North Suffolk UCC	07/10/15 11:00AM 07/10/15 12:00PM	D At Home 07/10/15 11:30AM	1 hrs	0.5 hrs
[REDACTED]	BEST-BMC 800 BEST BayCove UCC	07/15/15 11:45AM 07/15/15 01:00PM	D At Home 07/15/15 12:00PM	1.25 hrs	1 hrs
[REDACTED]	BEST-BMC 800 BEST BayCove UCC	07/28/15 12:15PM 07/28/15 01:00PM	D At Home 07/28/15 12:30PM	0.75 hrs	0.5 hrs
[REDACTED]	BEST-BMC 800 BEST BayCove UCC	07/30/15 09:45AM 07/30/15 11:30AM	D At Home 07/30/15 11:00AM	1.75 hrs	0.5 hrs

ATTACHMENT 4

When and How to Request a Crisis Evaluation

Reasons to Call

- To help determine whether the person is safe
 - To access additional treatment
 - To consult on what to do
- Remember: Follow your agency's crisis protocols which may include consultation with your supervisor or admin on-call



For IMMEDIATE DANGER—call 911 in lieu of ESP (Overdose, Bleeding, Violence, Life-threatening substance intoxication or Life-threatening medical condition.)

ATTACHMENT 5: ED-SPECIFIC DIVERSION PLANS AND HOSPITAL COMMUNICATION PROTOCOL FOR CASE RESPONSE

2.3.2 ED-Specific Diversion Plans

2.3.2.1 Collaboration with Hospital

Dr. John C. Corrigan Mental Health Center

Though the DMH site at Corrigan Mental Health Center (CMHC) does not have an emergency department, it will nevertheless be important to establish a close working relationship with the site's leadership and staff. Areas to address include the impact of moving the CBL and CCS out of the center and any potential concerns DMH staff may have in working with a non-DMH ESP program.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of CMHC to discuss referrals and overall communication. The move of ESP CBL to another location will require building a close collaboration to serve those clients accustomed to receiving crisis intervention at the current ESP's CMHC site.
- Discuss and confer with center staff regarding best practices:
 - Processes for early notice of evaluations of people presenting to the center in crisis;
 - Assessing when patients under the influence of substances can be interviewed onsite;
 - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with CMHC staff across clinical, case management and PHP services to develop crisis plans with clients and processes for crisis intervention at the site.
- Work with CMHC to redirect its walk-ins to the Call Center and BC for future interventions. Help the center's staff educate users about options in the community for future use.
- Develop procedures for making timely, efficient referrals to the center's acute inpatient unit, helping to alleviate boarding situations in other area hospitals.
- Collaborate with CMHC's clinical, case management, and partial hospitalization staff in meeting with key community services regarding redirection of crisis situations to the ESP and away from hospital emergency departments such as St. Anne's Hospital or Charlton Memorial Hospital.

2.3.2.1.3 Minimizing Boarding

Not applicable for this site.

2.3.2.1.4 Rapid Response

Rapid response to CMHC will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

St. Anne's Hospital

BMC anticipates making formal arrangements with St. Anne's Hospital (SAH) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP.

2.3.2.1.1 Ongoing Work with Hospital

- Plan to meet regularly with representatives of SAH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.

- Discuss and confer with ED staff regarding best practices:
 - Processes for early notice of evaluations coupled with notification of client readiness;
 - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
 - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
 - Protocols for how B-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response*);
 - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 Tailored Strategies

- Work with SAH ED to identify sources of referral to ED and develop plan for educating referral sources about ESP's community services.
- Work with SAH ED to redirect its walk-ins to the Call Center and UCC for future interventions. Help the ED staff educate users about options in the community for future use.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 Minimizing Boarding

Boarding can be kept to a minimum by diligent attention to the following strategies, processes, and resources:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients.
- ED interventions will emphasize client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client.
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements.
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services (presentations at staff meeting, onsite tours of CCS programs, etc.).
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff.
- ESP will conduct regular, thorough bed searches.
- ESP will engage in regular dialogue with SE area providers of inpatient services
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 Rapid Response

Rapid response to SAH ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Charlton Memorial Hospital

BMC anticipates making formal arrangements with Charlton Memorial Hospital (CMH)

Emergency Department (ED) regarding the transition of mobile ESP services to BMC if this proposal is awarded by MBHP.

2.3.2.1.1 *Ongoing Work with Hospital*

- Plan to meet regularly with representatives of CMH ED to discuss operations. BMC already holds such meetings with hospitals in the Boston ESP.
- Discuss and confer with ED staff regarding best practices:
 - Processes for early notice of evaluations coupled with notification of client readiness;
 - Assessing when patients under the influence of substances can be interviewed in keeping with current MBHP ESP Alerts;
 - Streamlining medical clearance procedures in keeping with current MBHP ESP Alerts;
 - Protocols for how B-ESP clinicians visiting the ED will maintain communication with psychiatric and medical staff during the pendency of a case (See attached current policy in place with Boston EDs, *Hospital Communication Protocol for Case Response*);
 - Protocols for handling complaints and challenges routinely and quickly.

2.3.2.1.2 *Tailored Strategies*

- Work with CMH ED to identify sources of referral to ED and develop plan for educating referral sources about ESP's community services.
- Work with CMH ED to redirect its walk-ins to the Call Center and UCC for future interventions. Help the ED staff educate users about options in the community for future use.
- Collaborate with ED colleagues in meeting with key community services regarding redirection of crisis situations to community-based evaluations.
- Identify individuals who regularly seek behavioral services in ED settings, particularly in repeated or exclusive fashion, using the electronic information system and refer for individualized treatment plans.

2.3.2.1.3 *Minimizing Boarding*

Boarding can be kept to a minimum by diligent attention to the following strategies, processes, and resources:

- ESP ongoing efforts to intervene earlier in crises through education of community stakeholders, referral sources, and clients;
- ED interventions will emphasize client strengths, natural supports, activation of existing service providers to respond to the crisis, consideration of client's history of risk and use of services, and consultation with client and ED staff regarding diversionary options available to the client;
- ESP will ensure robust CCS and MCI services as alternatives to 24-hour level of care placements;
- Collaboration with ED staff will include ongoing education about CCS, MCI, and other diversionary services (presentations at staff meeting, onsite tours of CCS programs, etc.);
- ESP will continue to assess any boarding individual's needs over time and communicate findings with ED staff;
- ESP will conduct regular, thorough bed searches;
- ESP will engage in regular dialogue with SE area providers of inpatient services;
- Youth boarding for CBAT will be maintained via MCI at home whenever possible.

2.3.2.1.4 *Rapid Response*

Rapid response to CMH ED will be a priority for the team. The Call Center 800# will coordinate response in consultation with mobile team supervisors. Initial volume is expected to be

manageable with the staffing model for BC attached hereto. Response time will be monitored via the electronic medical record.

2.3.2.1.4.1 Sub-Contract

Not at this time

Hospital Communication Protocol for Case Response

Please maintain contact with the emergency department or medical floor referral source (the referring psychiatrist or social worker) throughout the process of arrival, evaluation and placement. Please adhere to these guidelines:

1. Page the referring psychiatrist or social worker **upon arrival** to inform that you are on site and starting your evaluation.
2. Contact them **at the point you have made your assessment** to discuss case and to collaborate upon the planned intervention. A mutually agreed upon plan is necessary.
3. Contact them **when the patient is ready for transfer** and a receiving facility/accepting physician has been identified. In some cases, it will be necessary to report that NO immediate placement is available and will be necessary for the patient to board until a later point in time...in some cases it will be necessary to involve the medical team, for example, if the receiving facility requests a nursing report, but the proper protocol is to channel these requests through the referring psychiatrist or social worker.

In general, please maintain good communication and contact throughout the process. It's especially important to remember that your main point of contact should be with the referring individual/department...It's ok to keep the other medical staff who are caring for the patients informed and updated, but your main point of contact should be with the referring psychiatrist or social worker.

Follow-up Assessments of Persons Who are Boarding

We may need to place people, but inpatient beds are not always available.

MBHP and other payers require a follow-up assessment, and it is good practice that we do one every 24 hours for anyone who is boarding and awaiting a placement.

At a minimum, such follow-up assessments need to include the following:

1. Current mental status examination, including a summary of client's behaviors over the past 24 hours and any interventions (e.g., medication, putting additional supports in place) over the past 24 hours
2. Description of alternative dispositions that were explored and results
3. Full bed search, if placement remains necessary, including referencing the use of Massachusetts Behavioral Health Access website
4. Communicate client's current status to appropriate contacts at the boarding site (e.g., consult liaison psychiatrist on medical floor, psychiatry resident in ED)
5. Communicate results of visit to the payer (e.g., MBHP) access line
6. Documentation of 1-5 above in the BEST/CSERP IT system, either as an addendum in the original encounter (adults) or Unit of Work (youth, within seven days of initial evaluation)

Clinician Checklist of Boarding Procedures

Please initial each item indicating that you have completed the listed task. Please use this as your fax cover sheet for paperwork you send to the office

BEST (617) 523-1207 CSESP (617) 616-5410

For Initial Evaluations:

___ **Exhaustive Bed Search Completed.** Bed Search thoroughly documented in the “follow-up” section, including reasons why facility declined referral

___ **Insurance Pre-certification completed and documented in the appropriate section**

___ **Labwork and other printed material faxed to BEST or CSESP office.** *On Weekends, faxed to the call center.*

___ **Written Evaluation/Electronic Record Updated** *including all pertinent components of the “client summary section” completed.*

___ **Communication with Referral Source Emergency Room Contacts** *(psych resident, attending, etc. informed of status of the placement)*

For 24-hour re-evaluations

___ **Specific to MCI Cases** *all MCI (age 20 and under), all work which takes place within 7 days of the initial encounter is documented as a unit of work...not as a new encounter*
For Adult cases: *do not enter a new encounter. All follow-up notes are written in the follow-up section.*

___ **New MSE, thorough assessment, and summary of and pertinent changes since the most recent (usually the day before) evaluation is clearly documented in your written evaluation, in the “follow-up” section**

___ **Labwork and other printed material faxed to BEST or CSESP office.** *On Weekends, faxed to the call center*

___ **Communication with Referral Source Emergency Room Contacts** *(psych resident, attending, etc. informed of status of the placement)*

___ **Written Evaluation/Electronic Record Updated** *including all pertinent components of the “client summary section” completed.*

___ **Insurance Company** *is contacted is updated and you have documented who you spoke with. Informing them if the client is still boarded, or if they will be discharged, sent to CCS, etc.*

ATTACHMENT 6: PROFESSIONAL DEVELOPMENT ACTIVITIES AND TRAININGS OVER LAST TWO YEARS

BMC trainings:

The below trainings were held at BMC over the past two years.

- Peer-Driven Recovery and Resources, Metro Boston Recovery Learning Community, various staff
- The Power of Peer Support, RLC leaders for Grand Rounds
- The Principles of Recovery and the Role of Peer to Peer Services
- Motivational Interviewing

Bay Cove trainings:

Below is a sample list of available trainings.

- Principles of Rehabilitation and Recovery
- Person Centered Planning
- Motivational Interviewing
- Development of Rehabilitation Plans
- Health and Wellness: Building a Wellness Vision
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Thomas Brown Trauma Informed Training—developed as part of a graduate program by a BC Peer Specialist, it relies on the presenter’s personal experiences with trauma, as well as those of the trainees and the neurological effects of repeated trauma on the survivor

Vinfen trainings:

- Recovery Milestones (Milestones of Recovery) – 2 hours
- Co-Occurring Disorders – 3.5 hours
- Partnerships for Recovery – 4 hours
- The Practice of Psychiatric Rehabilitation – 4 hours
- Ethics and Human Rights – 4 hours
- Developing Great Wellness and Recovery Action Plans (WRAPs) – 3 hours
- Wellness Recovery Action Plan (WRAP) Facilitator Trainings – 5 day/8 hour training
- Hearing Voices That Are Disturbing – 4 hours

ATTACHMENT 7: COMMITMENT TO CULTURAL DIVERSITY

MEMORANDUM

TO: All BMC Employees

FROM: Kate Walsh, President and CEO

DATE: March 2014

RE: Diversity Statement

Boston Medical Center is proud to be an integral part of the diverse community of Boston. It is this community, comprised of people from a wide variety of cultures and backgrounds, that BMC draws upon as a resource for its employees and its patients.

As part of its stated mission and values, BMC remains committed to creating and sustaining a work place and a hospital where we respect and value employees, patients, and patients' families not in spite of, but because of, the differences in their backgrounds and cultures. We believe there is strength in diversity, not only of race, gender, age, religion, and disability, but also of education, politics, family status, national origin, sexual orientation, gender identity and/or expression and all of the other factors that make people individuals.

Honoring the diversity of our community will promote and ensure the mutual respect, collaboration, and productivity that is necessary to provide the highest quality health care.

ATTACHMENT 8

**Bay Cove Urgent Care Center/CBL
RE.P.O.R.T.
(Reviewing Every Patient and Offering a Reliable Transition)**

Please note the following requirements for responsible patient handoff for all people evaluated through the CBL (mobile and at the UCC).

Situation/ disposition	Communication Procedure	Documentation requirements
Day to evening clinician	<ul style="list-style-type: none"> • Communicate verbal information to pass the incomplete evaluation and disposition work from one C to another C where possible. • If another C not available, communicate to supervisor in charge • If another C or supervisor in charge are unavailable, communicate to Call Center staff • Reminder — with children and adolescents, be sure to review with BMC MCI (weekdays) or Attending on call (evenings and nights) • Inform patient and family if you are passing along their information and what they can expect 	<ul style="list-style-type: none"> • Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.
Evening to night clinician	<ul style="list-style-type: none"> • Communicate verbal information to pass the incomplete evaluation and disposition work from one C to another C where possible. This should be accomplished by telephone. • If the night clinician has already been dispatched for another evaluation, communicate all needed information to the Call Center staff. They will pass this information along to the night on-call C when they are available. • Reminder — with children and adolescents, be sure to review with the Attending on call (evenings and nights). • Inform patient and family if you are passing along their information and what they can expect. 	<ul style="list-style-type: none"> • Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.
Night to morning clinician	<ul style="list-style-type: none"> • Communicate verbal information to pass the incomplete evaluation and disposition work to the Call Center staff. This should be accomplished by telephone. The Call Center staff will pass along to day staff. • Reminder — with children and adolescents, be sure to review with the Attending on call (evenings and nights). • Inform patient and family if you are passing along their information and what they can expect 	<ul style="list-style-type: none"> • Complete all information you have collected thus far in the evaluation. • The next clinician will work to complete the write up. • Document specific follow up activities in the follow up section of the evaluation.

Situation/ disposition	Communication Procedure	Documentation requirements
Clinician to ED staff	<ul style="list-style-type: none"> • Inform them of status of evaluation and any patient safety concerns. • Inform them about disposition or expected outcome. • Request any medical support needed (labs, etc.). 	<ul style="list-style-type: none"> • Complete the evaluation. • Make a copy of the eval and file in the medical chart.
Clinician to CCS	<ul style="list-style-type: none"> • Communicate reason for admission and facilitate nurse to nurse report (if Pt was evaluated in the ED). • Secure medical clearance as needed. • Introduce patient to the CCS staff. • Notify DMH police regarding pending admission to CCS. 	<ul style="list-style-type: none"> • Complete evaluation so that CCS staff can access through BEST IS at admission.
Clinician to patient and family	<ul style="list-style-type: none"> • In all circumstances where a handoff is needed, inform the patient and their family regarding what they can expect. <ul style="list-style-type: none"> • If the eval is done and the person returns home, inform them of follow up appointments or how to access follow up support if needed 	<ul style="list-style-type: none"> • Include in the eval and chart. Complete discharge plan and hand to patient or family.
Clinician to community care providers	<p>If the eval is complete and the disposition is for the person to go home or to outpatient or partial services, notify community providers by telephone.</p>	<p>Document collateral contacts in the pt's eval.</p>
Clinician to Call Center stall	<p>At end of each shift notify Call Center staff of the status of all evaluations.</p>	<p>Document notification in evaluation.</p>

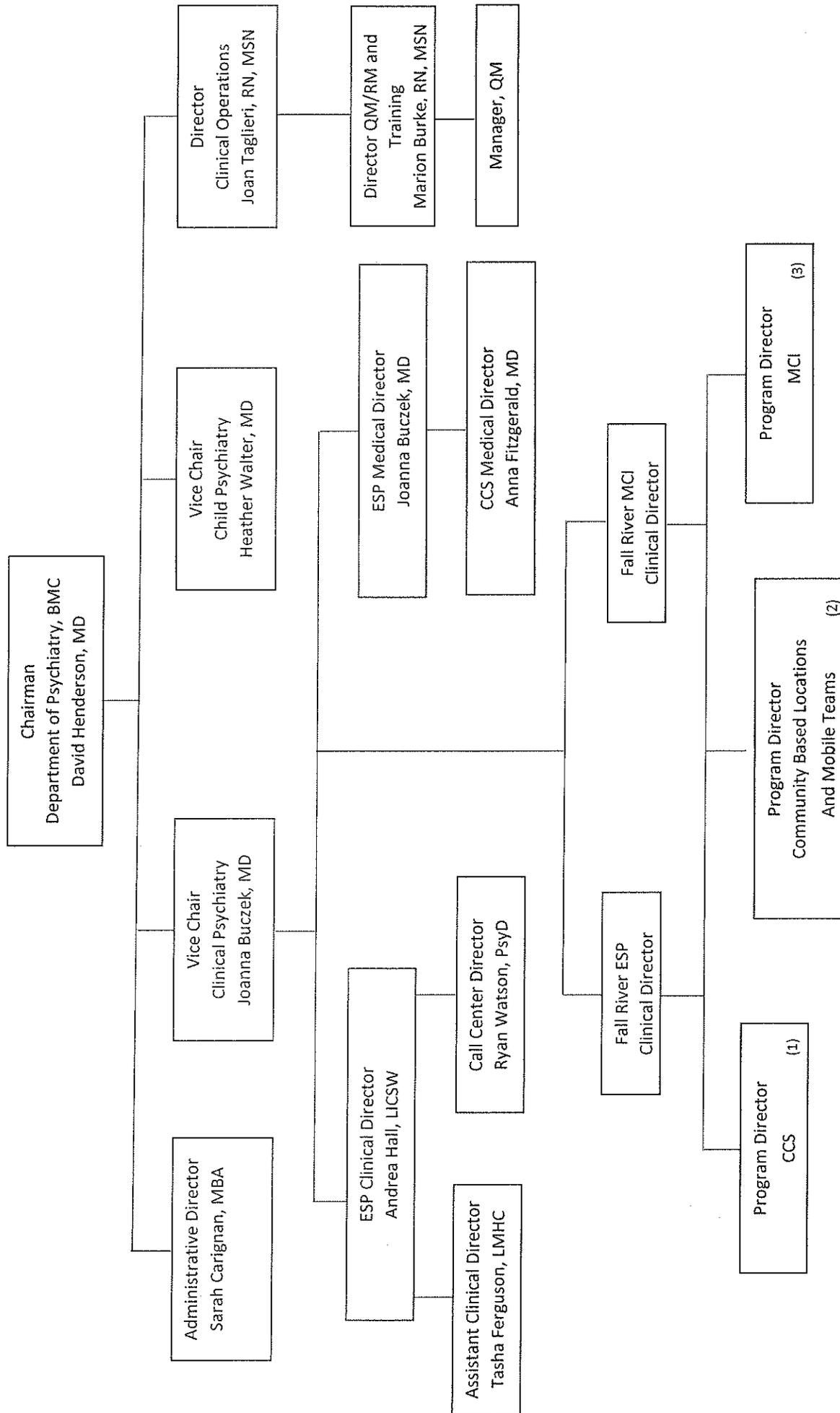
ATTACHMENT 9: BAYCOVE TRACKING SAMPLE

COLOR CODING	Awaiting call back	Any text in just BOLD is a f/u contact	On site pending cases for clients who have arrived yet	A case that is scheduled for a future date	A case that is ready to be seen and waiting to be assigned	Scheduled community visits later (today)	Case information incorrect in BEST system	MCI hand-offs from other teams	Not seen yet but assigned
Date	Time	CC Clinician	Client	Location	Clinician Assigned	Clinician Informed	x-Initials When Case Completed	Clinician Return/End Time	Notes
6/15/2015	6:15 PM	Laurent	CT	CHB ED	Crystal				
6/15/2015	6:02 PM	Laurent	CT	bayview inn	Elie				
6/15/2015	5:05 PM	Laurent	CT	Yawkey Bldg 4th Flr	Crystal				
6/15/2015	4:24 PM	MCI hand off	CT	Dorchester	Patrick & Ashley				
6/15/2015	4:21 PM	walk in	CT	on site	Elie & Marty				
6/15/2015	3:46 PM	laurent	CT	HV Matt	Heidi				
6/15/2015	3:41 PM	Joanne	CT	Carney ED	Ben				
6/15/2015	3:23 PM	Daphna	CT	on site	alex & marty				
6/15/2015	2:14pm	paul	CT	campus)	Alex				
6/15/2015	1:43 PM	Joanne	CT	on site 3-3:30 PM	Jaime/Ashley				
6/15/2015	1:11 PM	Don	CT	Dorchester-Grp Home	Heidi				
6/15/2015	12:44 PM	Paul	CT	HV Dorchester	Erin				
6/15/2015		MSE	CT		no longer considering d/c for today see UOW				
6/15/2015		MSE	CT	CHB 9E	Cancelled				
6/15/2015		MSE	CT	CHB ED	Michael				
6/15/2015		MSE	CT	CHB ED	Michael				
6/15/2015		MSE	CT	CHB 9NE	Michael				
6/15/2015		MSE	CT	CHB 7W	Michael				
6/15/2015		MSE	CT	CHB 6NE	Michael				
6/15/2015	11:24 AM	Paul	CT	Carney 3NE	Ben				
6/15/2015	11:24 AM	Paul	CT	ICU Carney	Francesca 2				
6/15/2015	11:09 AM	Joanne	CT	ICU Carney	Francesca 3				
6/15/2015	11:09 AM	Joanne	CT	Carney [moving from ICU to 3NE]	Ben				
6/15/2015	10:58 AM	Paul	CT	Coonomy Accademy	Mike				
6/15/2015	10:30 AM	Walk-in	CT	Dorchester	Olga/Marty				
6/15/2015	10:08 AM	Paul	CT	on-site	Heidi				
6/15/2015	10:07 AM	walk in	CT	The Spot--Roxbury	Jaime/Olga				
6/15/2015	10:07 AM	walk in	CT	On-site	Erin				
6/15/2015	9:15 AM	Walk in	CT	On-site	Erin				
6/15/2015	9:15 AM	Joanne	CT	Carney	Francesca 1				
6/15/2015	9:00 AM	Don	CT	onsite	Erin				

ATTACHMENT 10: ESP DIRECTOR QUALIFICATIONS

- Level of knowledge equivalent to Master's degree in Psychology, Social Work, Nursing or in Counseling. Requires current Massachusetts Licensure.
- Minimum of five to seven years of supervisory experience in a psychiatric setting. Experience in the provision of emergency services strongly preferred.
- Demonstrated clinical and supervisory skills.
- Demonstrated ability to work with key stakeholders, including funders, subcontractors, state agencies
- Ability to provide leadership and coordinate the work of a team of assigned team members.
- Excellent oral and written communication skills; ability to be detailed oriented in all notes and documentation.
- Demonstrated ability and experience in areas such as grant management, training, team building, program development/management, problem solving, and community building.
- Ability to analyze needs and apply resources effectively to meet those needs.
- Ability to achieve targeted results through motivating, mobilizing, and delegating to others.
- Ability to work in a multicultural environment.
- Experience with Windows, Word, Excel, Outlook, Internet and web page usage/updating, social networking and other technologies that can be used to further carry the program's mission.

Attachment 13: Boston Medical Center Fall River Emergency Services Program Organizational Chart



**ATTACHMENT 14: RESPONSE TO REQUESTS FOR COMMUNITY-BASED EVALUATION
IN SITUATIONS FELT TO BE DANGEROUS**



**DIVISION OF PSYCHIATRY
BEHAVIORAL HEALTH SERVICE
BMC BEST/ Cambridge-Somerville ESPs**

Policy: Response to Requests for Community-based Evaluation in Situations Felt to Be Dangerous

Policy number: 023

Date issued: 11/05

Date revised:

Date reviewed: 5/10

Mission Statement and Non-Discrimination Policy:

We will provide consistently excellent and accessible health service to all in need of care, regardless of status or ability to pay. Patients' diversity is respected and we are sensitive to ethnic, cultural, gender, sexual orientation, and religious differences.

Purpose of Policy:

To define the process to be followed when BEST/C-S ESP receives a request to perform a community-based evaluation and the BEST clinician raises a question of potential danger in meeting such a request.

Scope of Policy:

All team members within the BEST/C-S ESP program

Substance of Policy:

If the BEST/C-S ESP Call Center receives a request to perform an evaluation in the community (e.g. a home) that is felt by the Call Center clinician and/or the Mobile Team clinician to pose a potential threat to the clinician's safety (or to the safety of the person him/herself, a family member or other person in the situation), the clinician in question will call his/her supervisor who will contact the Clinical Director of the BEST/C-S ESP Team to discuss the particulars of the situation. If necessary, the Clinical Director will confer with the Medical Director. Following discussion, a determination of how to respond shall be made. . If the Clinical and Medical Directors feel that it is unsafe for the clinician to respond to the community site, several options are possible:

- Provide a two-person response if this is sufficient to alleviate safety concerns
- the requester of the evaluation will be directed to have the patient brought to BMC Emergency Department for BEST and Cambridge Hospital PES for CSESP

- the Call Center at BMC can assist with a Section 12 for instances in which the client's presentation is the source of the safety concern and Section 12 criteria is met
- the BEST/C-S ESP Team will request that a member of the Police force meet them at the site as stand-by

A log of requests not met due to the danger posed shall be maintained by the BEST Call Center. This shall also be documented in the patient's electronic record, generated when the call is received by the Call Center.

Documentation Requirements:

As described above

Implementation:

The Clinical Director of the BEST/C-S ESP Team is responsible for the implementation of this policy.

Policy Review:

The Director of Quality/Risk Management for the BEST/C-S ESP Program shall ensure biannual review of this policy.

ATTACHMENT 15: CHILD-FOCUSED TEAM DESCRIPTION

BEST and CS-ESP mobile teams (as well as MCI teams across the state) have the ability to provide up to 7 days of service to youth under age 21 and their families following an initial encounter. This increase from the former 72 hour standard was initiated by the MassHealth Office of Behavioral Health with the intention of providing greater opportunities for stabilization in the community to youth and families experiencing crisis.

The mobile team offices (BayCove, NorthSuffolk, and Cambridge/Somerville) house a Child Focused Team, which monitor youth follow-ups in the community, and ensure a high standard of care for both planning and carrying out interventions. Each Child Focused team consists of a youth team leader, full-time clinician(s), and family partner(s) who work together to meet the needs identified by the youth and family.

- The system for triaging and responding to requests for new evaluations remains unchanged—the Child Focused Team will be primarily responsible for providing interventions to youth and families after the point of the initial evaluation, including MCI Hand-offs from the EDs;
- ED staff can continue to request community-based follow-up for youth clients through the BEST Call Center;
- When documenting CBHI-eligible cases (MassHealth and uninsured clients) please open a new encounter **only every 7 days**, using units of work to document activity on days 2-6; and
- For non-CBHI eligible cases (Harvard Pilgrim and Commonwealth care clients) please open a new encounter daily—as with adult clients—and **do not use units of work**.

This expanded length of service to youth and families gives an exciting opportunity for BEST and CS-ESP to continue to provide more comprehensive community-based care, thereby allowing families to be served in the least restrictive and most individualized way possible.

ATTACHMENT 16: YOUTH CONSULTATION PROTOCOL

BEST/CSESP On-Call Consultation Protocol for Youth (age 0-20) – for Mobile Teams

This protocol assures that every youth case will be reviewed with a licensed supervisor, *either* at the BMC attending level or mobile team supervisor.

1. Review with BMC Attending

The BMC attending (weekdays – clinical director or MCI manager; off-hours – psychiatrist) should be contacted in real time for youth encounters when they involve any of the following:

- The initial complaint alleged acute safety issues – e.g., suicidal ideation, homicidal ideation, or question of psychosis
- The clinician wants to refer the youth to a 24-hour level of care
 - This would include youth who will board in the community awaiting CBAT
- Review for issuing Section 12A
- For youth 18 and older, review for CCS placement (**with CCS APRN weekdays**)
- The evaluating clinician has not been able to reach consensus about disposition with youth, family and collaterals, and the situation cannot be resolved at the team supervisor level (e.g., Doc-to-Doc is required; MCI Manager needed to provide guidance)
- All individuals being discharged to community from Somerville ED and Carney ED.
- Medical-related questions
- 51A filings against a program or employee of a program
- On an as-needed basis; clinicians should always feel free to seek consultation from the BMC attending

2. Review with Mobile Team Supervisor

When **ALL** the following conditions are met, the clinician will review with licensed mobile team supervisor and is not required to contact the BMC attending:

- No acute risk factors have been reported
- A 24-hour level of care is not indicated
- All parties to the evaluation are in agreement about the proposed disposition and follow-up
- 51A filings except as described above

ATTACHMENT 17: YOUTH BOARDING PROTOCOL



**DIVISION OF PSYCHIATRY
BEHAVIORAL HEALTH SERVICE
BMC BEST/Cambridge-Somerville ESP Program**

Policy: Boarding Youth in the Community

Policy number:

Date issued: 12/10

Date revised: 8/15

Mission Statement and Non-Discrimination Policy:

We will provide consistently excellent and accessible health service to all in need of care, regardless of status or ability to pay. Patients' diversity is respected and we are sensitive to ethnic, cultural, gender, sexual orientation, and religious differences.

Purpose of Policy:

To define the standards and procedures for managing and maintaining safety of a youth boarding in the community as they await a 24 hour level of care placement

Scope of Policy:

All components of BEST and Cambridge-Somerville ESPs

Substance of Policy:

Whenever a decision is made by the ESP mobile team that a youth waiting for a bed in a 24-hour level of care may be safely managed in the community until placement in that bed, the procedure outlined below shall be followed.

Procedure:

The following steps shall be taken by MCI/mobile team clinicians following the decision to maintain a youth in the community as s/he awaits placement in a 24-hour level of care:

- Review the clinical assessment of the youth with the designated attending psychiatrist on-call and obtain that psychiatrist's agreement to community boarding
- Document the details of the initial bed search that resulted in the need to board the youth. If a bed had been available, but parent/guardian declined that placement, include that fact and the reason for the declination in the documentation
- Document the guardian/family and receiving facility's agreement to the community boarding plan. Complete a Youth Risk Management Safety Plan,

- detailing a plan for safely managing the youth for the duration of community boarding
- In the web-based clinical encounter, check client boarding box and indicate “community” in answer to the query, “If boarded, where?”
 - In the “follow-up” section of the encounter, specify the following:
 - Youth must be reassessed daily for purpose of assessing safety and for determination that 24-hour level of care is still appropriate. These reassessments shall be documented as a Unit of Work until the youth is placed or a period of 7 days has passed. A new encounter shall be completed after 7 days of community boarding.
 - All other interventions by clinicians or family partners that occur within the 7 days shall also be documented as Units of Work.
 - A bed search shall be conducted every shift during the boarding period And shall be documented as a Unit of Work
 - During daily MCI rounds, the responsible team shall discuss all youth boarding in the community
 - Each time the decision is made to board a youth in the community, the responsible clinician shall notify the Medical Director for ESPs, Joanna Buczek, MD, (Joanna.Buczek@bmc.org) by email. That clinician shall also copy the email to the respective team’s Youth Director/Team Leader and to the MCI Program Manager (Tasha.Ferguson@bmc.org). In the email, include
 - Name of youth
 - Exact name of where boarded (e.g. home, with address; name/address of group home or other facility)
 - Indication that a Risk Management Safety Plan was completed and was left with the family or facility staff member

Documentation Requirements:

As described above

Implementation:

The Clinical Director for ESPs and the MCI Program Manager are responsible for the implementation of this policy.

Policy Review:

The Director of Quality/Risk Management for the BEST Program shall ensure biannual review of this policy.

ATTACHMENT 18: MCI HAND-OFF

CHECKLIST FOR HAND-OFFS BETWEEN BEST/CSESP Designated EDs, CALL CENTER, and MOBILE TEAMS

Responsibilities of ED clinicians

- Prepare family for follow-up
- Clearly state purpose of MCI intervention in the encounter recommendations (e.g., ongoing safety assessment, involving Family Partner to support parent)
- Triage hand-off with Call Center (1-800-981-4357)
- Provide full encounter
 - Goal: simultaneous entry in BEST/CSESP electronic system
 - If not in electronic system, fax paperwork to Call Center

Responsibilities of Call Center

- Write triage in BEST/CSESP IT system
- **It is particularly important to get all contact information to ensure successful follow up.**
- Use “Handoff to MCI” as primary disposition
- Use appropriate mobile team as “disposition where”
- Request of ED clinician calling that encounter be entered simultaneously in electronic system
 - Obtain faxed copy of assessment if not available yet in BEST/CSESP system
- Convey hand-off to appropriate mobile team child focused team via e-mail—see **Attachment A** for list of e-mails by team
 - Hand-offs for next day will be held on Call Center follow-up board
- Provide faxed evaluation to mobile team, only if not in electronic system

Responsibilities of Mobile Team

- Arrange follow-up as requested in encounter recommendations
- Monitor and take ownership of MCI cases until resolved
- If case will require weekend response/contact, be sure to “loop” back to Call Center for coordination of weekend follow-up
- Review status of all hand-offs with MCI Manager during rounds

ATTACHMENT 20: JOB DESCRIPTIONS OF MCI STAFF

Position Description: Child Focused Clinician

Responsibilities:

The BEST Urgent Care/Mobile Team provides direct services to children and adults in crisis through assessment of each person's need for services and development of a treatment plan that best ensures for their safety and optimizes effective resolution of the crisis. Facilitates the person's engagement or re-engagement in behavioral health services through referral to community based services that are consonant with the person's needs and preferences. As needed, the Clinician facilitates the person's admission to acute treatment services.

In addition to responsibilities of the general service noted above, the Child Clinician focuses on nuanced interventions with youth and families. Youth under the age of 21 are eligible for Mobile Crisis Intervention (MCI), which is a short-term service for those experiencing a behavioral health crisis that focuses on stabilization and reduction of risk. The role of the Child Clinician is to carry out the ongoing follow up associated with the intervention for up to seven days. Responsibilities include:

- Engagement in an ongoing crisis planning process
- Advance communication with treatment providers, schools, natural supports, and other youth-serving systems
- Referrals/linkages to behavioral health services and supports
- Telephonic and/or in person therapeutic response to the youth and their family

Qualifications:

Licensed Master's level clinician. License eligible acceptable. Minimally 3 years experience working in a mental health setting. Excellent writing and oral communication skills. Current Massachusetts Driver's License and use of reliable personal vehicle for work related travel.

BAY COVE HUMAN SERVICES, INC.

Position Title: BEST Mobile Crisis Child Team Leader

Department: BEST

Reports To: Service Director, BEST

Mission Statement:

Our Mission is to provide high-quality services to children and adults who face the life-long challenges of mental illness, drug and alcohol dependency, and developmental disabilities.

Job Summary:

The BEST Mobile Crisis Child Team Leader provides direct services to children and adults in crisis. This Clinician assesses each person's needs for services and develops a treatment plan that best ensures for their safety and optimizes their effective resolution of the crisis. S/he facilitates the person's engagement or re-engagement in behavioral health services through referral to community based services that are consonant with the person's needs and preferences. As needed, the Child Team Leader facilitates the person's admission to acute treatment services.

The Clinician works as part of an Urgent Care Center that provides on site assessment and support, as well as mobile capacity to conduct assessments at the person's home, school, or agency in Greater Boston. S/he works as a partner in an integrated urgent care/emergency support services network (and as a result may provide services in the CSU or sister Urgent Care Center/Mobile Team). Given the nature of crisis services, provision of holiday and weekend coverage are expectations for staff working in this position. This position is non-exempt.

Essential Functions of Position:

- Ensure completion of tasks, follow up, and case assignments pertinent to MCI (Mobile Crisis Intervention)
- Conduct assessments and provide oversight of ongoing case management of active MCI cases
- Provide support to Service Director and Assistant Program Director with supervision of staff, supervision and training of students in busy Urgent Care Center/Mobile Crisis Service (affiliation with B.E.S.T.)
- Sharing of administrative on call in rotation with Service Director/Asst. Director (24/7/365 coverage).

- Provides services in a manner that is consonant with program, BayCove, and collaborative agencies' standards, policies, and procedures
- Completes assessments of children and adults who are in crisis in a comprehensive manner attending to their safety and needs
- Develops treatment plans with and for the person in crisis that utilize community based health, behavioral health, and social services that will ameliorate the presenting crisis
- Works with the person in crisis and their support network to fortify their strengths and coping skills
- Works collaboratively with members of the BEST team and collateral helpers in the service of strengthening and integrating support and treatment supports and to accomplish the overall program's mission
- Assists the person in crises with engagement or reengagement in needed services
- Documents all assessments and interventions in accordance with program and BayCove standards
- Secures as needed financial and insurance related information to facilitate billing and payment for services rendered
- Recognizes the importance of individual and cultural differences that influence behavior and applies such understanding to each person's situation
- Utilizes individual supervision and team meetings in the service of optimizing the program's overall mission
- Maintains requisite continuing professional education as required by licensure, professional standards and BayCove policies
- Works effectively with police, DSCFMHC Security, and other law enforcement personnel to ensure the client's safety
- Facilitates admission to acute inpatient care on an as needed basis
- Relates to clients, family members, and colleagues in a professional, hopeful, and respectful manner
- Provides brief treatment and support until requisite community services can be accessed in order to minimize reliance on acute inpatient services
- Performs all other duties and projects as assigned by the Program Director.

Job Responsibilities/Job Related Competencies and Skills

- Demonstrated assessment and treatment skills in the provision of emergency services for children and, as needed, adults.
- Demonstrated ability to de-escalate crises in a manner that ensures safety for all involved and provides for the best care and welfare of the person in crisis
- Able to assess needs and implement interventions in accordance with best practice standards for emergency care, crisis resolution, and recovery
- Demonstrated professional writing, communication, and organizational skills

- Ability to assess crisis emergency situations and address with appropriate clinical treatment for clients.
- Demonstrated knowledge of risk assessment specific to acute psychiatric conditions for children and adults.
- Demonstrated assessment and treatment skills in the provision of emergency services for children and adults
- Demonstrated knowledge of varying social and behavioral health services and the nature of the treatment, rehabilitation, and supports that they offer. Can determine the persons needs for services, refer to the appropriate resource(s), and facilitate the person's engagement in these services
- Demonstrated knowledge of the evaluation process, including presenting problem, social, family, psychiatric, legal, and medical history. Capacity to effectively assess mental status, formulate a plan, and develop an implement an appropriate disposition for all clients
- Demonstrated ability to identify needs and strengths, assist in planning, implementing and evaluating care of individuals and their families in conjunction with an array of community resources.
- Demonstrated professional documentation skills

Physical Requirements

- Must be able to drive to different locations.
- Must have the ability to assess children and adults in their homes and apartments with stairs.
- Must be able to observe the person in crisis, noting symptoms and nonverbal behaviors

Qualifications:

- Licensed Master's level clinician.
- Minimally 3 years experience working in a mental health setting.
- Excellent writing and oral communication skills.
- Current Massachusetts Driver's License and use of reliable personal vehicle for work related travel

Personal Characteristics:

- Demonstrated ability to work in a pressured situation and maintain clarity, focus, judgment, and compassion
- Flexibility
- Ability to work with people in crisis in a hopeful and compassionate manner
- Ability to communicate concerns effectively to other team members and ask for help as needed
- Ability to work independently

This job description is intended only to provide general guidance. It is understood that the position may evolve over time, and that additional or different duties may be added at management's discretion. It is the policy of Bay Cove Human Services, Inc., to review and update job descriptions annually; however, updates or revisions may occur within a given year as indicated.

Division: Boston Emergency Services Team
Category: Professional - Other
Program: BEST UCC
Position: Family Partner
Requires resume: Yes
Requires Professional License: No

Responsibilities: The Family Partner works with other members of the ESP Urgent Care and Mobile Crisis teams and provides peer support to parents served by the program. Peer support is defined as using personal and professional life experiences to establish credibility and infuse hope for a better future, to demonstrate unconditional acceptance, and to assist with problem solving. Additionally, the Family Partner serves as a “values speaker”, specifically, but not limited to providing a parent’s perspective in the routine operations and development of the program. The Family Partner uses personal and professional life experience to provide consultation and training for staff and others to increase awareness and improve the effectiveness of parent-professional partnerships to meet the needs of families, and to participate in program and community meetings to maximize parent voice, choice, and involvement throughout the service delivery process.

The family partner will be involved in the ongoing follow up for families served by the mobile team. This includes telephonic and face-to-face interventions, identifying resources for families, initiating referrals in service of establishing wrap around supports, and acting as a liaison with current providers, schools, and state agencies.

The parent partner provides parents and caregivers with information about the ESP and the wraparound process and resources to assist them to successfully engage; Learns the family’s story, culture, strengths, and concerns; Provides non-judgmental, unconditional support to parents and caregivers; Participates in implementing a variety of support services for parents/care givers; Produces and maintains accurate and timely documentation.

Qualifications:

- Lived experience as the primary caregiver for a youth who has received mental health or behavioral health services.** This can be as a biological parent, foster parent, or another familial relationship in which the applicant is in a primary parental role.
- Ability to work collaboratively as a member of multi-disciplinary and cross-functional teams.
- Demonstrated ability to work in a pressured situation and maintain clarity, focus, judgment, and compassion
- Ability to work with people in crisis in a hopeful and compassionate manner and

model this for others
-Ability to work independently
-Basic computer skills
-Language capacity strongly preferred

**Drivers License
Required:** Yes

Hours:
TBD

Schedule:
40 hrs, some weekend/evening/holiday coverage

Salary: TBD

New Position: No

**Employee
Signature:** _____

BOSTON MEDICAL CENTER

JOB TITLE:	<u>Program Director, Youth Mobile Crisis Intervention</u>	DEPARTMENT:	<u>Psychiatry</u>
CODE:	<u>50001021</u>	FLSA STATUS:	<u>Exempt</u>
REPORTS TO:	<u>Clinical Director, BEST and CESP</u>	GRADE:	<u>M16A</u>
	<u>Clinical: Masters Level Trainees; Unlicensed Masters Level Clinicians</u>		
SUPERVISES:	<u>Administrative: staff and trainees</u>	DATE:	<u>05/26/2009</u>
BLDG/LOCATION:		UNION STATUS:	<u>Non-Union</u>

APPROVALS		
DIRECTOR:	VP:	HR:

POSITION SUMMARY:
Manages clinical operations for youth for Emergency Service Programs (ESPs); provides clinical care to children and adolescents; provides teaching and supervision to staff clinicians and trainees; acts as liaison with internal and external entities; engages in mental health advocacy activities.

ESSENTIAL RESPONSIBILITIES / DUTIES:
Works collaboratively with Clinical Director of ESPs and the Medical Director of ESPs to create and manage a seamless system of child mental health services for Boston Medical Center's emergency services programs.
<ol style="list-style-type: none"> 1. Plays a key role in developing the vision, mission, and strategic objectives of BMC ESP services for youth. 2. Works collaboratively with ESP leadership to create seamless coordination between emergency, crisis stabilization, urgent care, outpatient, and consultation services in child psychiatry. 3. Manages the day-to-day clinical activities of the ESPs in relation to youth, including assessment, treatment, transfer, and discharge of patients. 4. Together with the Clinical Director of ESPs and Director of QM/RM, develops and implements quality initiatives, including staff training, medical record audits, monitoring/reporting of significant clinical events, monitoring/recording patient/family satisfaction, and monitoring/recording satisfaction of referral sources. 5. Manages complaints from all key constituent groups; triages complaints to Medical Director and Clinical Director of ESPs as indicated. 6. Provides clinical care in outpatient, urgent care, crisis stabilization, emergency, and consultation settings. 8. Together with the Clinical Director of ESPs, functions as a key clinical liaison with BMC child psychiatry and pediatric services. 9. Together with the Clinical Director of ESPs, functions as a key clinical liaison with MBHP, DMA, DMH, DSS, DYS, and other state and city agencies. 10. Together with the Clinical Director of ESPs, meets with key stakeholders to communicate the vision, mission, and strategic goals of the program. 11. Together with the ESP programs, maintains an up-to-date listing of and liaison with mental health service providers, including hospitals, family stabilization teams, outpatient facilities, residential facilities and shelters. 12. Maintains an up-to-date listing of and liaison with social service resources for families. 13. Together with the Clinical Director of ESPs, Medical Director, and Director of QM/RM, develops policies and procedures for outpatient mental health services; facilitates adherence to policies and procedures among clinical staff. 14. Facilitates compliance with all regulatory imperatives, including Joint Commission, hospital, and professional. 15. Maintains personnel files for all clinical staff, including current CV, current job description, core competency ratings, mandatory education requirements, continuing education requirements, and yearly performance evaluation/goals and objectives. 16. Monitors clinician productivity on a monthly basis; creates action plans to address productivity deficits. 17. Participates in key administrative, quality management, and clinical leadership committees. 18. Together with the Clinical Director of ESPs and ESP leadership, creates orientation and training programs for ESP staff. 19. Together with the Clinical Director of ESPs and ESP leadership, hires, orients and evaluates staff performance. 20. Together with the Medical Director, provides orientation to trainees around program policies and procedures. 21. Provides clinical supervision to master's level trainees and unlicensed masters level clinicians as assigned. 22. Manages office space. 23. Maintains time off records for staff clinicians. 24. Maintains clinician work schedules. 25. Conforms to hospital standards of performance and conduct, including those pertaining to patient rights, to ensure that exceptional customer service and patient care may be provided.

BOSTON MEDICAL CENTER

- 26. Utilizes hospital's values as the basis for decision-making and to facilitate the hospital's mission.
- 27. Follow established hospital infection control and safety procedures.

OTHER DUTIES:

Perform other duties as needed.

(The above statements in this job description are intended to depict the general nature and level of work assigned to the employee(s) in this job. The above is not intended to represent an exhaustive list of accountable duties and responsibilities required).

JOB REQUIREMENTS

EDUCATION:

Masters degree in Social Work.

CERTIFICATES, LICENSES, REGISTRATIONS REQUIRED:

Current Social Work licensure in the Commonwealth of Massachusetts

EXPERIENCE:

Minimum of five to seven years of clinical and supervisory experience in a psychiatric setting

KNOWLEDGE AND SKILLS:

1. Demonstrated clinical, supervisory, collaborative, team building, and interpersonal skills.
2. Demonstrated skill in the provision of services in a multicultural environment.

AGES OF POPULATION SERVED:

Employees in this position must be competent to provide care to the following age groups: Check all that apply:

<input type="checkbox"/> Neonatal: Birth to 1 month	<input type="checkbox"/> Infant: To 1 yrs	<input checked="" type="checkbox"/> Toddler: 1 to 3 yrs	<input checked="" type="checkbox"/> Pre-school: 3 – 6 yrs
<input checked="" type="checkbox"/> School age: 6 – 12 yrs	<input checked="" type="checkbox"/> Adolescent: 12 – 18 yrs	<input type="checkbox"/> Young Adult: 18 – 30 yrs	<input type="checkbox"/> Middle age: 30 – 60 yrs
<input type="checkbox"/> Elderly: 60 – over	<input type="checkbox"/> Not Applicable		

SPECIAL WORKING CONDITIONS (RESPONSIBLE FOR ON-CALL, 24 HR. COVERAGE, ETC.):

External and internal applicants, as well as position incumbents who become disabled as defined under the Americans With Disabilities Act, must be able to perform the essential job functions (as listed) either unaided or with the assistance of a reasonable accommodation to be determined by management on a case-by-case basis.

BOSTON MEDICAL CENTER

PHYSICAL AND ENVIRONMENTAL DEMANDS

This form is used to assist departments in identifying the physical and environmental demands of the position .

Physical Demands Without Accommodations	Hours at one time					Total Hours per day				
	0	<1/2	1/2-1	1-2	2-4	<1	1-2	2-4	4-6	6-8
Sitting					√				√	
Walking		√				√				
Standing		√				√				
Bending Neck		√				√				
Twisting Neck		√					√			
Bending Waist (Forward or sideways)		√				√				
Twisting Waist		√				√				
Squatting	√					√				
Climbing	√					√				
Kneeling	√					√				
Crawling	√					√				
Repetitive Movement: Hand		√							√	
<input type="checkbox"/> Simple grasping: 1 hand __ both __		√						√		
<input type="checkbox"/> Power grasping: 1 hand __ both __	√					√				
<input type="checkbox"/> Fine Manipulation: 1 hand __ both __	√					√				
<input type="checkbox"/> Pushing/Pulling: 1 hand __ both __	√					√				
Reaching above shoulder height	√					√				
Reaching below shoulder height	√					√				
Moving items weighing up to 10 lbs.		√				√				
Moving items weighing 11 – 25 lbs.		√				√				
Moving items weighing 26 – 50 lbs.	√					√				
Moving items weighing 51 – 75 lbs.	√					√				
Moving items weighing 76 – 100 lbs.	√					√				
Moving items weighing over 100 lbs.	√					√				

Environmental Demands (Check all that apply)

- Extreme Cold (below 32 degrees) Source _____
- Extreme Heat (above 100 degrees) Source _____
- Noise (Need to shout to be heard) Source _____
- Vibration Source _____
- Exposure to dust, gas, fumes, steam, chemicals Source _____
- Work outdoors (no effective protection from weather)
- Work at heights (such as scaffolding or ladders)
- Protective equipment required (Respirator, earplugs, mask, gloves, eyewear, etc) _____
- Potential exposure to infectious diseases.
- None (Not substantially exposed to adverse environmental conditions).

Technology Response Attachments

Fiscal Response Attachments

DMH Southeast Emergency Services Program Privatization Analysis

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 1

ORGANIZATION: FALL RIVER-ONE AREA

FY END: 2016

This schedule provides supplemental information for selected programs on an aggregated basis for use by the Commonwealth's Division of Health Care Finance and Policy in the establishment of so called "Class Rate" prices for certain M

1. UFR Program Numbers providing Mental Health Class Rate Services:

2. Program Staff and Expense Breakout by Service Component

Note: Schedule B positions not listed below are non-reimbursable for MH Class Rate services.

	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE		ESP Admin		
	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	FTE	DOLLARS	
1S Program Director	0.75	60,571	0.080	7,200	0.250	18,821	0.120	10,575	0.050	4,725	0.25	19,250	
2S Program Function Manager	0.78	53,780	0.025	2,500	0.100	10,030			0.250	16,250	0.40	25,000	
3S Asst. Program Director	1.00	62,204	0.320	19,905			0.470	29,236	0.210	13,063			
4S Supervising Professional	1.50	93,306	0.175	10,886			0.325	20,216	1.000	62,204			
5S Psychiatrist	0.10	22,000									0.10	22,000	
7S N.P., Psych N.,N.A., R.N. - MA	0.50	60,000			0.500	60,000							
8S R.N. - Non Masters	1.00	70,266			1.000	70,266							
9S L.P.N.	3.20	130,134			3.200	130,134							
11S Occupational Therapist	0.00	0											
21S Psychologist - Doctorate	0.00	0											
22S Clinician-(formerly Psych.Masters)(UFR Title 1)	1.00	53,500									1.00	53,500	
23S Social Worker - L.I.C.S.W.	6.83	367,830	2.175	117,037			3.200	172,589	1.450	78,204			
24S Social Worker - L.C.S.W., L.S.W	0.00	0											
25S Licensed Counselor	0.00	0											
26S Cert. Voc. Rehab. Counselor	0.00	0											
28S Counselor	0.00	0											
29S Case Worker / Manager - Masters	1.00	54,139			1.000	54,139							
30S Case Worker / Manager	0.00	0											
31S Direct Care / Prog. Staff Superv.	0.00	0											
32S Direct Care / Prog. Staff III	0.00	0											
33S Direct Care / Prog. Staff II	6.90	226,324	0.600	22,051	4.200	127,096	0.400	14,700	1.700	62,477			
34S Direct Care / Prog. Staff I	0.00	0											
35/36S Prog. Sec/Clerical/Maint./H-Gmds/Keep.	0.75	23,772	0.250	7,924	0.500	15,848							
38S Dir. Care O.T., Shift Differential & Relief	XXXXXX	0	XXXXXX	0	XXXXXX	0	XXXXXX	0	XXXXXX	0	XXXXXX	0	
39S Total Direct Program Staff	25.30	1,277,826	3.625	187,503	10.750	486,334	4.515	247,316	4.660	236,923	1.75	119,750	
2E Chief Executive Officer	0.00	0											
3E Chief Financial Officer	0.00	0									0.50	22,500	
4E Accting/Clerical/Support	0.50	22,500											
5E Admin Maint/House-Gmdskeeping	0.00	0											
6E Total Admin Employee FTE/Exp.	0.50	22,500	0.000	0	0.000	0	0.000	0	0.000	0	0.50	22,500	
7E Commercial Products & Svs/Mktg	0.00	0											
8E Total FTE/Salary/Wages	25.80	1,300,326	3.625	187,503	10.750	486,334	4.515	247,316	4.660	236,923	2.25	142,250	
9E Payroll Taxes 150		83,046				33661		32,362		17,003			
10E Fringe Benefits 151		214,011				56957		59,626		30,784		67,644	
11E Accrual Adjustments		0											
12E Total Employee Compensation & Rel. Exp.		1,597,383		187,503		576,982		338,324		284,710		209,894	
13E Facility and Prog. Equip. Expenses 390			XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX
14E Facility & Prog. Equip. Depreciation 301			XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX
15E Facility Operation/Maint./Fum.390			XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX
16E Facility General Liability Insurance 390			XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX		XXXXXXX
17E Total Occupancy - Allocated		138,740		Expense		138,740		Dollars		Dollars		Dollars	
18E Direct Care Consultant 201		92,900										92,900	
19E Temporary Help 202		7,500				7,500							
20E Clients and Caregivers Reimb./Stipends 203						0		0		0		0	
21E Subcontracted Direct Care 206													
22E Staff Training 204		8,808				7,658		863		288		0	
23E Staff Mileage / Travel 205		11,160				5,040		4,590		1,530		0	
24E Meals 207		14,126				14,126						0	
25E Client Transportation 208						0						0	
26E Vehicle Expenses 208						0						0	
27E Vehicle Depreciation 208						0						0	
28E Incidental Medical /Medicine/Pharmacy 209		1,800				1,800						0	
29E Client Personal Allowances 211						0						0	
30E Provision Material Goods/Svs/Benefits 212						0						0	
31E Direct Client Wages 214						0						0	
32E Other Commercial Prod. & Svs. 214						0						0	
33E Program Supplies & Materials 215		11,000				6,000		3,750		1,250		0	
34E Non Charitable Expenses						0						0	
35E Other Expense						0						0	
36E Total Other Program Expense		147,294		0		42,124		9,203		3,068		92,900	
42E Other Professional Fees 410		21,500				0		0		0		21,500	
43E Leased Office/Program Office Equip.410,390						0		0		0		0	
44E Office Equipment Depreciation 410						0		0		0		0	
46E Program Support 216		28,800				18,204		7,947		2,649		0	
51E Total Direct Administrative Expense		50,300		0		18,204		7,947		2,649		21,500	
52E Admin (M&G) Reporting Center Allocation		226,647				79,820		61,117		31,645		54,065	
53E Total Reimbursable Expense		2,160,364		187,503		855,840		416,591		322,072		378,359	
54E Direct State/Federal Non-Reimbursable Exp.						0		0		0		0	
55E Allocation of State/Fed Non-Reimbursable Exp.						0		0		0		0	
56E TOTAL EXPENSE		2,160,364		187,503		855,840		416,591		322,072		378,359	

DMH Southeast Emergency Services Program Privatization Analysis

SUPPLEMENTAL EMERGENCY SERVICES PROGRAM SCHEDULE - Page 2

ORGANIZATION: FALL RIVER-ONE AREA

FY END: 2016

3. Service Statistics

	CBL	CCS	ADULT MOBILE	CHILD MOBILE
Number of Weeks Service was In Operation (e.g., 52):				
Defined Unit:				
Total Standard Unit Hours: 0				
Number of Defined Units Provided:				
Average Number of Clients in Group:	N/A	N/A	N/A	
Average Number of Staff in Group:	N/A	N/A	N/A	

4. Occupancy Space Utilization

TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE	
Square Ft.Used	Occupancy Total Exp.	Square Ft.Used	Allocated Expense	Allocated Expense %	Dollars	Allocated Expense %	Dollars	Allocated Expense %	Dollars
			0	0.0	0	0.0	0	0.0	0

5. SERVICE UTILIZATION AND REVENUE BY PAYER SOURCE

	TOTAL ESP		CBL		CCS		ADULT MOBILE		CHILD MOBILE		
	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	UNITS	DOLLARS	
Masshealth Only (non-MCE)	559.73	266,148			219.75	97,580	339.97	168,569			
Masshealth MCE MBHP	7,397.21	684,377			481.96	208,146	586.30	300,716	6,328.96	175,515	
Masshealth MCE Fallon	0.00	0			0.00	0	0.00	0			
Masshealth MCE NHP	703.78	65,410			77.94	23,903	94.81	27,990	531.03	13,517	
Masshealth MCE Tufts-Network Health	441.44	80,502			106.26	36,371	129.27	38,720	205.91	5,411	
Masshealth MCE BMC Health Net	2,547.96	212,631			235.23	74,512	288.16	82,745	2,026.57	55,375	
Masshealth MCE HNE	32.51	720			0.00	0	0.00	0	32.51	720	
DMH Only	0.00	0			0.00	0	0.00	0			
Medicare/Medicaid	848.26	392,661			451.78	202,578	396.48	190,082			
Medicare Only	0.00	0			0.00	0	0.00	0			
Uninsured	315.88	90,827			83.84	35,725	101.99	51,714	130.05	3,388	
Commonwealth Care Fallon	0.00	0			0.00	0	0.00	0			
Commonwealth Care NHP	0.00	0			0.00	0	0.00	0			
Commonwealth Care Tufts-Network Health	0.00	0			0.00	0	0.00	0			
Commonwealth Care BMC Health Net	0.00	0			0.00	0	0.00	0			
Commonwealth Care Cellcare/Compatico	0.00	0			0.00	0	0.00	0			
Health Safety Net	35.32	16,621			15.94	6,791	19.39	9,830			
Care Plus BMC	503.42	152,794			227.12	73,118	276.29	79,676			
Care Plus Fallon	1.97	558			0.89	312	1.08	246			
Care Plus NHP	143.18	44,728			64.60	22,022	78.58	22,706			
Care Plus HNE	21.72	7,602			9.80	3,430	11.92	4,172			
Care Plus Cellcare	111.84	22,091			31.79	10,699	80.05	11,392			
Care Plus Tufts-Network Health	175.65	56,000			79.25	27,124	96.40	28,876			
One Care CommCare Alliance	196.09	98,248			70.83	34,871	125.26	63,377			
One Care Fallon	0.00	0			0.00	0	0.00	0			
One Care Tufts-Network Health	17.30	5,515			7.80	2,671	9.49	2,844			
Commercial Insurer	0.00	0			0.00	0	0.00	0			
Commercial with MH TPL	0.00	0			0.00	0	0.00	0			
Other	0.00	35,476			0.00	0	0.00	0			
Total Service Utilization/Revenue	14,053.26	2,232,908	0.00	35,476	2,164.79	899,852	2,633.45	1,083,655	9,255.02	253,925	0.00

Note: CCS: 1 unit = 1 bed day; Adult Mobile: 1 unit = 1 encounter; Child Mobile: 1 encounter = 10 units

ATTACHMENT 7: PRIVATIZATION LAW ASSURANCES

Appendix X: Organizational Commitments Pursuant to Massachusetts Privatization Law

Under Massachusetts' Privatization Law (M.G.L. c. 7 §§ 52, 53, 54, and 55), a successful bidder must:

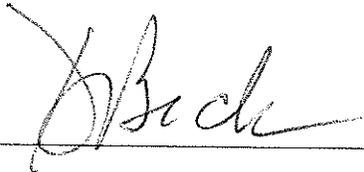
- (i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:
 - 1. provided ESP services; and
 - 2. were terminated as a result of DMH ceasing to provide such ESP services;
- (ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees; the Commonwealth currently contributes 80% of the cost of health insurance DMH employees.
- (iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate as determined by the state pursuant to M.G.L. c. 7 §54 (2) for those positions for which the duties are substantially similar to the duties performed by regular agency employees;
- (iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons; and
- (v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

In addition, a successful bidder must certify in writing to the state that both the organization and its supervisory employees, while in the employ of the successful bidder, have "no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest."

Name of Organization: Boston Medical Center

I hereby acknowledge that if the organization listed above is chosen to provide ESP services in the Southeast region of Massachusetts, the organization must implement the relevant provisions of the state's Privatization Law referenced above.

Signature: _____



Name and Title (please type or print): David Beck, Vice President & General Counsel & Clerk

Date: September 3, 2015

Letters of Support

August 11, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

Justice Resource Institute (JRI) is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

JRI has multiple residential and community-based services throughout the Southeastern region of Massachusetts. These include adolescent therapeutic residential schools (Swansea Wood School & Meadowridge Academy), outpatient clinics in Taunton and Attleboro, a STARR program, the Lindencroft group home for girls, a CBAT, the DCF/DMH Caring Together Continuum, and the Cape and Islands CSA (the CBHI network) that provides extensive community-based services serving hundreds of families. We have worked for many years with the DMH ESPs in the area, and have developed strong relationships with them.

The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs while integrating the “know how” gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC proposes the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center
- 24/7 access to board-certified BMC adult and child psychiatrists
- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth

- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Southeast Region.

Sincerely,



Andy Pond, LICSW
President and CEO



GROWTHWAYS, INC.

Community Supports for People with Developmental Disabilities

41 North Pearl Street, Brockton, MA 02301 (508) 941-6505 fax 583-7651

August 19, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802

Dear Dr. Buczek:

Growthways, Inc. is pleased to support the proposal of Boston Medical Center Psychiatry, along with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

Growthways, Inc. is a non-profit organization that provides education, training, advocacy, and support services to people with intellectual/developmental disabilities and their families in the Greater Brockton Area. We provide a variety of services which include: residential and independent living programs as well as placement services. We currently provide residential services to 80 individuals. Our organization is dedicated to providing quality services where individuals are supported and empowered to be valued, contributing members of their community.

We are familiar with the programs operated by the team submitting this proposal. The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs, while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC is proposing the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center
- 24/7 access to board-certified BMC adult and child psychiatrists

- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth
- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Greater Brockton Area.

Sincerely,



Marty Berliner
President & CEO



141 Park Street
Attleboro, MA 02703
T 508 226-1445
F 508 226-1476
www.arcnbc.org

August 19, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center/ BUSM
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

The Arc of Bristol County, Inc. is pleased to support the proposal of Boston Medical Center Psychiatry, with partners Bay Cove Human Services, Inc. and Vinfen, to operate the four Southeast Region Emergency Services Programs currently operated by the Department of Mental Health.

The Arc of Bristol County began in 1959 as a grassroots organization of parents whose children had mental retardation. Families who once believed they were alone found support and fellowship among other families facing the same challenges. It is an organization with a track record of 52 years, helping people with intellectual and developmental disabilities to gain many of the rights afforded by citizenship. They work, they own homes, and they contribute to the rich diversity of their community. The Arc's advocacy, research, programming and outreach have played a pivotal role in these advances. Today, The Arc of Bristol County provides a wide array of supportive services to over 2,000 children and adults with intellectual and developmental disabilities, and their families, helping them to maximize their talents and abilities, develop independent living skills, and participate as contributing citizens of their communities.

The team led by BMC brings many combined years of experience providing high quality, community-based, and recovery-oriented crisis services to the diverse populations and neighborhoods of Metro Boston, including Vinfen's active crisis services on Cape Cod.

Building on the current strengths of the DMH-operated programs while integrating the "know how" gleaned from operating the Commonwealth's largest ESP, Boston Emergency Service Team (BEST), BMC proposes the following model:

- Centralized 24/7 800# staffed by master's level clinicians, folded into BMC's current call center

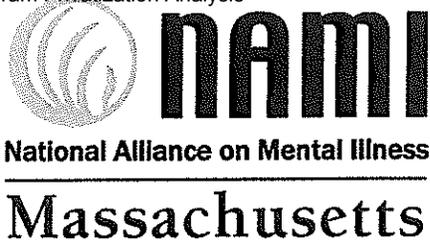
- 24/7 access to board-certified BMC adult and child psychiatrists
- An Urgent Care Center and Mobile teams for each catchment area operated by Bay Cove Human Services, with each focused on mobile community response for adults as well as youth
- A 7-bed Community Crisis Stabilization (CCS) for each SE ESP, operated by Vinfen for continuity and maximizing efficiencies and co-located with each ESP's mobile team headquarters
- BMC providing daily psychiatry services to the four CCS programs, including psychiatric nurse practitioners and psychiatrists
- Onsite clinical response fine-tuned to meet the unique challenges of serving Martha's Vineyard and Nantucket
- BMC's existing web-based ESP electronic medical record for all teams
- Centralized billing and financial management through BMC's existing structures
- Centralized oversight by an expert leadership team of BMC, BayCove and Vinfen managers, highly experienced in providing Emergency Service Programs.

We look forward to collaborating with the BMC team in providing responsive and effective services to the residents of the Southeast Region.

Sincerely,



Michael Andrade
President and CEO



September 9, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center
85 E. Newton Street
8th Floor, Room 802
Boston, MA 02118

Dear Dr. Buczek:

On behalf of NAMI Massachusetts, I am pleased to write this letter offering my strong support of your proposal to provide emergency services in four catchment areas in the Southeast Region of Boston.

NAMI Mass is a nonprofit agency dedicated to supporting both people with mental illnesses and their families. As Executive Director, I am well aware of our longstanding affiliation with BMC. We have partnered together on many initiatives, including the Boston Emergency Services Program, the Cambridge/Somerville Emergency Services Program, the Metro Boston Recovery Learning Community and the Southeast Recovery Learning Community Program. For the current proposal, I understand that you hope to include NAMI Mass members on your advisory committees, as well as work with them directly to provide crisis services to families and individuals in the Southeast area. I believe that our organization is well positioned to assist in these roles; our membership is comprised of individuals living with mental illness, their families and friends, mental health professionals and others who care about people with mental illness.

I am very pleased to lend our organization's support to this project, and look forward to collaborating with BMC on yet another important initiative. I wish you the best of luck during the review process.

Sincerely,

A handwritten signature in black ink that reads "Laurie Martinelli".

Laurie Martinelli
Executive Director

BOARD OF DIRECTORS 2015

President

Robert Rousseau

Vice Presidents

Harold Sletzinger
Jacqueline Martinez

Clerk

Katie Zachary

Treasurer

Paula Fisher

Boston

Tim Peace
Jacqueline Martinez

Metro-Suburban

Don Maloney
Erin McCarthy

Northeast

Patrick Connolly
Jamie Loud

Western

Jessica Bloom

Southeast

Ron Grillo
Frances Sokkoll

Central

Jennifer O'Connor
Paula Fisher

At Large

Marco Gonzalez
Vivian Nunez
Harold Sletzinger
Katie Zachary



August 31, 2015

Joanna Buczek, MD
Vice Chair, Clinical Psychiatry
Boston Medical Center
85 E. Newton Street, Room 802
Boston, MA 02118

Dear Dr. Buczek:

On behalf of the Transformation Center, I support your bid(s) to lead the Cape and the Islands, Taunton/Attleboro, Fall River, and Brockton Emergency Services Program(s).

As you know, The Transformation Center is one of the first mental health and trauma recovery-oriented organizations in Massachusetts and is recognized as a national leader in trauma informed peer support and training. Our organizational mission is that people –with all our vulnerabilities and strengths, live in communities where people help each other with mutual respect and compassion to overcome the challenges in life. We promote the growth and voices of people with lived experience of mental health, substance use and trauma so that they may find their unique paths to healing and recovery, and so that they may impact and transform policy and practice.

Your proposed emergency services program(s) will meet critical service needs for members of the Cape and the Islands, Taunton/Attleboro, Fall River, and Brockton communities. The mobile crisis intervention and community crisis stabilization services that you propose are integral in supporting the recovery of children, families and adults. We are particularly pleased that there will be significant involvement of peer specialists in your Emergency Service Programs.

Please let me know if there is anything else we can do in support of your bids.

Sincerely,

Deborah Delman
Executive Director

Phone: (617) 442-4111
Toll free: (877) 769-7693
VP: (617) 606-7512
FAX: (617) 442-4005

100 Magazine Street
Roxbury, MA 02119
Website: www.transformation-center.org
Email: info@transformation-center.org



First, we listen...

488 West Center Street Suite #2

West Bridgewater, MA 02379

Phone: (508)297-0015

Fax: (508)297-1821

www.compassioncounselingservices.com

8/13/15

RE: Letter of support

To Whom It May Concern:

I am writing on behalf Compassion Counseling Services, PC in support of Boston Medical Center Psychiatry, with partners Bay Cove Human Services and Vinfen's proposal for the four Southeast region emergency service program contracts up for bid. I have direct experience working for and with the BayCove UCC/Mobile Crisis Team. I can't imagine a more competent group of experienced and clinically sound professionals taking on these contracts. They continue to bring consistent, high quality, community-based crisis services to the diverse populations in the areas they serve. I have no question they are the best candidate for the job and will be able to effectively use their model to meet the needs of the community and save lives of the individuals in the most need of services. If you have any questions or concerns, you can contact me at (508)297-0015 ext 2

Sincerely,

A handwritten signature in black ink that reads "Erin Bell, LMHC". The signature is written in a cursive, flowing style.

Erin Bell, LMHC

Psychotherapist/Owner