



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

**APPENDIX VII: RESPONSE COVER SHEET**

**Organization name:** Community Counseling of Bristol County, Inc.

**Proposed catchment area name:** *Please submit individual proposals pertaining to each catchment area for which your agency is submitting a response:*

- Brockton
- Cape and Islands
- Fall River
- Taunton/Attleboro

**Contact person:** Philip Shea    **Title:** President/CEO

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**Proposed subcontractor(s), if any:** *(Please repeat this section if proposing more than one.)*

**Organization name:** \_\_\_\_\_

**Contact person:** \_\_\_\_\_                      **Title:** \_\_\_\_\_

**Mailing address:**  
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**Telephone number:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_                      **Fax number:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

**E-mail address:** \_\_\_\_\_

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

- \_\_\_ Child Mobile Crisis Intervention
- \_\_\_ Adult Mobile Crisis Intervention
- \_\_\_ Community-based location
- \_\_\_ Adult Community Crisis Stabilization (CCS)
- \_\_\_ Other: (specify) \_\_\_\_\_

**This cover sheet must be the first page of the bidder's response.**

**1. General qualifications and infrastructure:**

**1.1 Licensure:**

**1.1.1 Licensed as an outpatient mental health clinic by the Department of Public Health (DPH)**  Yes  No

**1.1.2 Licensed as a hospital**

1.1.2.1 by the DPH  Yes  No

1.1.2.2 by the Department of Mental Health (DMH)  Yes  No

**1.2 Accreditation:**

**1.2.1 Accredited by a national organization**  Yes  No

**1.2.2 If yes, please list accreditation(s).**N/A

**1.3 Currently contracted MassHealth provider or application in process:**  Yes  No

**1.4 At least three years' experience providing behavioral health services to a wide range of populations:**  Yes  No

**1.4.1 Number of years providing behavioral health services to children, adolescents, and families:** 45

**1.4.1.1 Number of youth served in CY14:** 3,000

**1.4.2 Number of years providing behavioral health services to adults:** 45

**1.4.2.1 Number of adults served in CY14:** 9,000

**1.4.3 Briefly describe the behavioral health services your organization has provided and the populations to which your organization has provided these services.**

Community Counseling of Bristol County (CCBC) is one of the largest community-based behavioral health providers in Southeastern Massachusetts and has been operating for over 45 years. CCBC has transformed itself from a traditional outpatient behavioral health provider delivering office-based treatment created from a medical-model to a strength-based recovery-oriented provider with a broad continuum of services for children, their families, adults, and elders.

Today CCBC serves over 12,000 clients each year, from children with serious emotional disturbance (SED) and their families, adults with serious and persistent mental illness (SPMI), to frail elders. In addition to office-based treatment, clients also receive services in their homes, schools, health centers, and other community settings. CCBC has also become the leader in developing peer supports for adults and for parents with a child with serious emotional disturbance. The agency employs 14 peer specialists, most of whom are "certified peer specialists" and 10 family partners. CCBC serves persons with serious and persistent mental illnesses in their outpatient clinics and under contract with the Department of Mental Health (DMH) for their Community-Based Flexible Supports (CBFS) and Program for Assertive Community Treatment (PACT) Programs. Both CBFS and PACT programs have developed strong collaborative relationships with local housing authorities and federal Department of Housing and Urban Development (HUD) to expand the supply of safe, stable, and affordable housing that is needed to support recovery. Additionally, the agency serves children with serious emotional disturbance with a full continuum of services under the Children's Behavioral Health Initiative (CBHI) and in our outpatient clinics.

Over the last twenty years CCBC has provided the 24-hour emergency psychiatric coverage to the Taunton/Attleboro Emergency Services Program operated by the DMH. For the past twelve years CCBC has provided this psychiatric coverage to the Brockton Emergency Services Program. CCBC also leases space and provides operational support for the Taunton/Attleboro Community Crisis Stabilization Program in Norton. Since 2013, CCBC has provided mobile crisis intervention services (MCI) to the DMH Emergency Services Programs (ESPs) in Brockton and Taunton.

**1.5 Presence in and knowledge of the catchment area for which your organization is applying for an ESP contract.**

CCBC has operated programs serving residents of the Brockton catchment area for over 15 years through the operation of three community-based programs: 1) The Community Support Program (CSP) for 15 years; 2) PACT for eight years; and 3) ESP Psychiatry for twelve years. Additionally, CCBC has provided MCI services for two years. The staff in all of these programs have developed working relationships with DMH case managers, local outpatient providers, hospital inpatient units, hospital emergency department staff at both Brockton and Good Samaritan Hospitals, and the current Emergency Services Program operated by DMH.

From their experience, CCBC has learned that there are many challenges in Brockton. The CCBC-contracted psychiatrists who have been part of the DMH ESP have also developed a great deal of knowledge about the catchment area. Brockton demographics represent an increasingly diverse population with significant populations of Latinos and Cape Verdeans, alongside poor and working class Whites in a struggling local economy.

**1.5.1**

**1.5.1.1** CCBC's CSP program has been operating in Brockton for 15 years. The psychiatrists serving the ESPs have been housed at the Brockton Multi-Service Center (BMSC) for ten years. The Brockton PACT program has been operating for eight years.

**1.5.1.2** The CCBC PACT and CSP programs have been operating at 4 Main Street since 2006 and recently moved to 56 Cherry Street in Brockton.

**1.5.1.3** CCBC has already begun to identify available space in the Brockton catchment area to establish the Community-Based Location (CBL) and the Community Crisis Stabilization program (CCS). We have found suitable space at 157 Main Street, Brockton, the former location of the Brockton Neighborhood Health Center. Upon award of the contract, CCBC will begin negotiations to secure a lease for both CBL and CCS space at this address. The negotiations will include a build-out to establish a six-bed CCS and CBL. The space is already handicapped accessible. The CCS design will parallel the model for the Taunton/Attleboro design, with the exception of one less bed. We will negotiate to have the build-out completed within three months of the contract award for the Brockton ESP program.

CCBC seeks to offer the Brockton area an expanded continuum for the services already being provided. The PACT program and the CSP program serve some of the highest risk clients in the area. The ESP will expand the capacity to coordinate care and build on CCBC's strong reputation as a consensus builder among community agencies to provide greater opportunities for recovery for children, adolescents and adults facing psychiatric crises.

**1.5.2** The Brockton catchment area has a full continuum of 24-hour and community-based diversionary behavioral health services, including: an inpatient psychiatric unit at Brockton Hospital; Detoxification services at High Point Brockton; and Community-Based Acute Treatment (CBAT) services through the McLean Hospital Brockton CBAT. Other services

include the DMH-operated Community Crisis Stabilization program, the CSP program operated by CCBC, the Brockton PACT operated by CCBC, the Brockton CBFS programs operated by DMH and BAMSI, and the full continuum of CBHI services operated by BAMSI. Brockton also has a high concentration of residential programs funded by state agencies: The Brockton YMCA has a boys and girls detention unit; DCF operates the Transitions Program for transitional-aged youth; and DPH funds the Castle Program, a residential program for adolescent substance abusers. The high concentration of these residential programs adds to the population of at-risk youth in the Brockton catchment area.

Brockton is one of the largest and most diverse cities in Massachusetts, with high concentrations of African-Americans, including Angolan refugees, Cape Verdeans and Latinos. There is a high rate of violence and poverty that puts additional stresses on limited city resources and adds to the roles of local social services, including behavioral health services and emergency room services.

The crisis continuum has several strengths including a well-known physical location at BMSC that has been in place for more than 20 years. Another strength is that the ESP is centrally located on property adjacent to Brockton Hospital. This physical location includes the 6-bed Community Crisis Stabilization program and Case Management offices of DMH, and DMH area office staff. In addition, all local behavioral health providers, law enforcement, and many community service providers are already familiar with BMSC.

The limitations of the crisis continuum include the capacity of the ESP staff to conduct mobile visits for both children and adults in psychiatric crisis beyond the Brockton Hospital and Good Samaritan Emergency Departments.

Another barrier in the current system is the difficulty in information exchange. For example, the current ESP solicits crisis plans and safety plans from community providers but does not have the capacity to integrate those plans into their electronic medical records (EMR) system or retrieve them or other data from the EMR from remote locations. There are also delays in communicating information to ESP clinicians in the field about a member's prior history with the ESP. When community CBFS, CSP, and PACT providers develop a crisis plan for a member at risk, the paper document is rarely accessed by the ESP staff.

Finally, there is the limitation in the capacity of the ESP to reduce the back up in the Brockton Hospital ED during periods when there is high ED volume.

**1.5.3** CCBC's CSP staff has developed strong working relationships with the full range of behavioral health and community resources in Brockton, including outpatient clinics, law enforcement, community health center, and social service agencies. This established credibility will allow CCBC to quickly pivot those relationships into an effective and responsive ESP; especially with the local hospital ED's and community service programs that often refer persons for crisis intervention.

Another strength is that the CCBC psychiatry program is currently contracted with the DMH ESP in Brockton. The CCBC-contracted psychiatrists will provide clinical continuity for that component of the ESP into the implementation of the CCBC ESP in Brockton.

The CCBC PACT in Brockton is another program that has established relationships with stakeholders in Brockton that include homeless shelters, Brockton Neighborhood Health Center, Signature Healthcare, and local law enforcement.

**1.5.4** CCBC holds the contract with DMH for psychiatric services in the DMH ESP that is currently operating. The psychiatrists have a key role in diverting clients from inpatient care

into the CCS program or back to their CBFS, PACT, or outpatient providers when the psychiatric emergency can be stabilized by ESP staff.

CCBC also holds a contract with DMH to provide MCI services that add capacity to the existing ESP. These staff are adept at working on a mobile basis through the Brockton catchment area, stabilizing family crises and providing follow-up visits in the home to maintain stability and extend community tenure during the course of a seven-day intervention and beyond.

The CCBC CSP program staff interfaces with a host of community providers and are very knowledgeable about the clinical baseline of persons with SPMI. CSP staff are skilled at working with outpatient providers, community health centers, and landlords to provide support that minimizes the current psychiatric episode, addresses the client's clinical triggers and provides additional support to maintain the member's stability.

The CCBC Brockton PACT is well-trained to work with the 80 clients in a community setting to provide additional resources in a psychiatric crisis and minimize referrals to the hospital ED and ESP for evaluation. CCBC is also the contractor in the Southeast area for the Runaway Assistance Program (RAP).

### **1.6 Continuum of care**

CCBC has evolved as an organization into a provider that has internalized a strength-based, recovery-oriented approach to the treatment of mental illness and addiction. CCBC management and clinical leadership have ensured that this approach is applied comprehensively and uniquely in each of the programs it operates: The Community Support Program has developed "retail" relationships with behavioral health and medical providers, including nurses in local emergency rooms. The ongoing collaboration has evolved into a credible relationship to make a case for diversions and community-based alternatives. CCBC's Community-Based Flexible Supports (CBFS) builds a full program around persons with SPMI that includes housing, daily supports, clinical treatment and coordination with primary care providers to prevent support recovery, manage co-morbid health conditions, and addresses any potential triggers to psychiatric crises that the clients identify. CCBC's Community Service Agency (CSA) has built a culture that is a family-focused and strength-based approach to strengthen the coping skills of families and their children to address crises in the home.

The psychiatrists assigned to the current DMH ESP Contract have developed a body of experience to support increased diversion and client stabilization for community providers and ESP clinicians to address and stabilize psychiatric crises.

In the MCI program, CCBC has a group of clinicians already providing MCI services within the DMH program. CCBC will provide additional value for the Children's system in operating the MCI by bringing its skills and experience in collaboration with the Brockton Systems of Care and actively participating with the other stakeholders to promote "family voice and choice" and a strength-based approach to resolving psychiatric crises for children with SED and their families.

### **1.7 Administrative infrastructure**

CCBC's organizational structure includes the following positions that will provide the administrative and fiscal oversight and management of the ESP contract: President/CEO; Chief Operating Officer; Medical Director; Chief Financial Officer; Director of Children's Services; Community Service Agency Director; Quality Management Director; and Information Technology Support

### **1.8 Medical and clinical infrastructure:**

The medical and clinical oversight and management will be the responsibility of the Chief Operating Officer; Medical Director; Emergency Services Program Director;

### **1.9 Quality Management (QM) infrastructure**

**1.9.1 Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of an ESP contract and service delivery system.** The Quality Management Director, and Utilization and Outcome Analyst will be responsible for the quality management and risk management elements of this contract.

**1.9.2 Required attachment: your organization's current Quality Management plan**  
**See Attachment 1.9.2**

**1.9.3 Quality Management and Performance Outcomes:** At CCBC, Quality Management is first and foremost defined by an organizational commitment to quality care and to a continuing process for improving that care. Supporting this commitment are organizational structures and processes designed to measure, monitor, and evaluate the care provided to clients in order to improve care. The components of this plan ensure the successful implementation of new services, such as the Brockton Emergency Services Program (ESP), as well as the ongoing operations of existing programs. Major components of this plan include:

- Risk Management Committee
- Utilization Management Plan
- Performance Improvement Committee
- Professional Services Review Committee
- Human Resources Management Committee
- Patient Care Assessment Committee

Upon a contract award, CCBC will develop a comprehensive evaluation plan for the Brockton ESP which will include:

- Development of specific tools to measure the Performance Indicators in the RFR;
- Establishment of specific performance targets utilizing a HIPAA compliant EMR; and
- Establishment of a data set to submit to CCBC Executive Management on a monthly basis.

**1.9.4 Provide specific examples how you shall use data and information, such as those identified in Section C.4 and C.5 below, to ensure and continuously improve the quality of ESP services and the performance of the ESP contract.**

CCBC has established a series of “*Dashboard*” reports that will be adapted for the ESP in Brockton to measure volume of activity. These reports will be updated to stratify crisis interventions by location: Community-Based Mobile Crisis Intervention, such as school, home, or CBFS program site; ESP-Community-Based Location, or Hospital ED. The volume will be tracked against the Performance Indicators in the RFR.

The Quality Management (QM) Director and staff will calculate compliance from the times marked on the ESP intake form with the 60-minute response time for face-to-face contact with the client requesting crisis intervention. Prior reviews of the data have led to improvements in staffing to reduce the response time.

The QM Director has access to a number of statistical programs to evaluate the data that is collected on outcomes, service delivery, and satisfaction. These include SPSS and SASS.

## 2. *ESP Core Competencies*

### 2.1 Crisis services

**2.1.1** CCBC has provided the coverage for Emergency Psychiatric Services to the current DMH ESP programs in Brockton since 2003 and in the Taunton/Attleboro area since 1993. The psychiatrists are Board Certified in Psychiatry by the American Board of Psychiatry and Neurology, have been credentialed and privileged by DMH, and meet MBHP's credentialing criteria. In their role they have developed competencies in crisis assessment, risk management, safety planning, and in effecting timely placements for complex clinical presentations. Their scope of duties includes medical oversight of clinical evaluations by ESP clinicians and clinical management of the Community Crisis Stabilization (CCS) programs in the Brockton and Taunton/Attleboro catchment areas. Under this contract CCBC also leases the property in Norton where the ESP is located.

Since 2013, CCBC has also provided the DMH ESP's in Brockton and Taunton/Attleboro with Mobile Crisis Intervention (MCI) services on a contracted basis.

**2.1.2** CCBC's psychiatric staff have responded to 24/7/365 requirements of the ESP for more than 20 years. The MCI contracted staff responds to requests for mobile visits within the 60-minute standard established for ESP programs. CCBC's In-Home Therapy staff has been trained to be flexible in addressing a family's changing needs, including increasing the timely response when the family is in crisis or at risk. CCBC operates many programs that require and receive a rapid response on a 24-hour basis, including: Community-Based Flexible Support (CBFS) Services; Program of Assertive Community Treatment (PACT); Community Support Program (CSP); Intensive Care Coordination (ICC); and In-Home Therapy (IHT).

**2.1.2.1 Experience.** The MCI staff under contract to DMH have been able to respond to requests for mobile visits within the required timeframe since the services were added to the contract. CCBC's clinical managers have provided clinical and administrative back-up for all of CCBC's adult and children's programs, with established protocols and support for staff to meet client needs and contractor requirements.

**Specific Strategies to Meet Response Time.** First, CCBC will have a "Central Telephone Triage Center" to deploy clinicians from the Brockton ESP to meet the one-hour response time, with back-up from relief staff in Brockton and relief staff in the proposed Taunton/Attleboro ESP. CCBC will use several additional strategies to meet the standard of a one-hour response time: 1) Posting clinicians at the Good Samaritan and Brockton Hospital Emergency Departments during later afternoons and evenings, historically periods of high demand; 2) mobilizing additional mobile clinicians to provide back-up to these assigned clinicians when unusual demand spikes in the EDs; 3) expanding the pool of available back up ESP staff in Brockton with on-call staff available from the Taunton/Attleboro ESP should CCBC be awarded both contracts; and 4) through recruitment of additional on-call clinicians from CCBC's roster of licensed clinicians.

**2.1.2.2** Within its current Emergency Psychiatry contract with DMH, CCBC provides 24/7/365 psychiatric back-up with consistent 15 minute or less telephone responsiveness and meets all response requirements for MCI back-up to DMH. CCBC has a lengthy track record of managing these resources. The reports that CCBC submits to DMH indicate full compliance with the timeliness and other key contractual requirements.

**Strategies.** CCBC's Brockton ESP will strengthen the capacity to address the fluctuating demand by creating a position called "hybrid" clinician. This will be a CCBC salaried employee with access to full employee benefits. They will be hired at a reduced salary and receive

additional fees for providing mobile ESP crisis interventions across the Brockton and Taunton/Attleboro catchment areas, should CCBC be awarded both contracts.

CCBC will also develop a “*Central Triage*” to coordinate the efficient and timely use of clinical resources in the Brockton and Taunton/Attleboro areas. Staff will be deployed in real time to where they are needed when fluctuations in demand require additional resources. An example of another strategy by CCBC to monitor timely access based on fluctuating demand will be the establishment of a “*Dashboard*.” The Dashboard will report data gathered from its ESP Electronic Health Record to review timely responses on a daily basis to ensure that all timeliness standards are being met. The chief operating officer, medical director and ESP program director will meet weekly to review responsiveness, identify barriers to access, and implement corrective actions as needed.

**2.1.2.3 Hiring Experience.** Throughout the more than 20 years of the contract with the DMH-operated ESP, CCBC has been successful in recruitment, hiring, and retention of the psychiatrists for the Emergency Psychiatric Services in the DMH programs in both Taunton/Attleboro and Brockton. CCBC has also had success in recruiting and retaining qualified staff for the MCI contracted program. CCBC’s Human Resources Department recruits a range of staff for CCBC’s other programs, many of which operate outside of the 9-5, Monday-Friday schedule.

**Strategies to hire ESP Staff.**

1. If awarded the contract, the executive staff at CCBC will outreach the existing staff of the Brockton ESP to offer qualified staff positions for the CCBC program.
2. If awarded the contract, CCBC would recruit candidates for ESP both internally posting ESP positions and externally through advertising and the engagement of a recruiting firm.
3. Through a contract with a national training organization, CCBC maintains a catalog of over six hundred online courses relevant to the needs of behavioral health care organizations. CCBC will add key training curricula on providing recovery-based crisis interventions for the ESP clinician and MCI clinician to be completed prior to their deployment.
4. Orientation and on-the-job mentoring to build skills in crisis intervention. As part of the orientation to ESP, the new hires will shadow an experienced ESP clinician during the course of crisis intervention on eight separate cases. Before each new clinician is allowed to make independent clinical decisions, they must pass an ESP clinician “*Competency Test*” on ESP capabilities.

**2.2 Mobile services**

**2.2.1** CCBC has provided mobile services in Brockton through their CSP Program for 15 years and their PACT program for eight years. The CSP serves over 500 clients per year in Brockton. These clients are MassHealth members at risk of psychiatric hospitalization or who typically have been recently discharged from 24-hour care. CSP case managers spend 90% of their working hours in community settings with these clients and work with them to prevent the need to utilize the ED and more restrictive 24-hour services. The CSP conducts these activities as mobile interventions throughout the Taunton/Attleboro or Brockton catchment area.

The Brockton and Taunton/Attleboro PACT programs serve DMH clients with serious and persistent mental illness in community settings. The PACT program is a mobile team that sees the clients in many different community settings, essentially bringing clinical staff – from peer support to psychiatrist – to the client. Based on DMH program evaluations, the CCBC PACT team meets the DMH standard of 90% client interactions occurring in a community setting.

The CCBC continuum of Children’s Behavioral Health Initiative (CBHI) services: Intensive Care Coordination, Family Support, In-Home Therapy, and Therapeutic Mentoring are all provided on a mobile basis to children with serious emotional disturbance (SED) and their families. CCBC has been operating CBHI services for six years.

**2.2.2** CCBC’s orientation towards recovery in both adult and children’s programs includes a foundation that most, if not all, services can be provided safely in the community. CCBC’s wide variety of interventions – CSP, PACT, and MCI staff in Brockton – and CSP, CBFS, PACT, CBHI, and Outpatient services in the Taunton/Attleboro area have resulted in a culture of community-based support for adults with SPMI and children with SED that promote client empowerment, a strength-based approach to the member, and partnership in developing a wide range of solution-focused interventions.

**Strategies.** Based on this foundation, CCBC will orient the ESP staff to the effectiveness of mobile services in promoting recovery and resiliency. The ESP program director will gather examples of mobile interventions to demonstrate how mobile services can be effective as a crisis prevention and intervention tool. The menu of case examples will be expanded as the ESP staff builds their own body of work through mobile outreach and intervention.

CCBC ESP staff will participate actively in the “*Citizen X*” community meeting that already involves CCBC’s Brockton PACT and CSP staff. This forum in Brockton involves local behavioral health providers, Brockton police, representatives from the hospital emergency departments, and Brockton Neighborhood Health Center. The purpose of the meeting is to develop community-based preventive strategies to divert high-risk members from the Emergency Room as an overall part of the 10-Year Plan to End Homelessness in Brockton.

As high volume referral sources are identified, the ESP program director will designate ESP staff as liaisons to these stakeholders, which may include group living environments, nursing homes, or local police. These “*ambassadors*” will personally carry the message of the belief in community mobile intervention.

**2.2.3** CCBC has conducted a preliminary assessment of the challenges in establishing a culture and practice of prioritizing mobile services listed below:

- The DMH-operated ESP does not prioritize mobile visits.
- Community stakeholders have limited experience with mobile ESP services.
- CCBC’s CSP and PACT staff work in many areas of Brockton and are aware of the potential risk, that have been addressed in CCBC’s Safety Committee, including the potential for physical harm or criminal victimhood in a few Brockton neighborhoods. Mobile ESP and MCI services can also pose a risk of exposure to physical harm or crime in a few Brockton neighborhoods. To address and mitigate the challenges above, CCBC proposes the following strategies:
  - CCBC will establish a Community-Based Location(CBL) in Brockton that is co-located with the Brockton CCS program;
  - CCBC will develop a social marketing campaign to educate the community stakeholders about the mobile capacity of the ESP in the Brockton area;
  - CCBC staff will establish orientation programs to the Brockton area neighborhoods and surrounding towns for ESP staff;
  - ESP staff will conduct introductory meetings with DMH and BAMSII CBFS providers, Caring Together Providers, DYS residential programs at the Brockton YMCA, homeless shelters, schools, and community health centers to build initial working relationships between ESP and sources of referrals for mobile visits;

- CCBC will engage the members of the Brockton Police Department who have participated in the Community Crisis Intervention Team (CCIT) program, to help as ambassadors to other law enforcement staff in the Brockton area in establishing a culture and practice for mobile services;
- CCBC will strengthen the “*Citizen X*” forum and provide working examples of successful mobile visits.

**2.2.4** CCBC is the CSA provider in the Taunton/Attleboro area. They have established the full continuum of CBHI services and a number of working collaborations with community stakeholders, including the DMH MCI program. The hiring, orientation, and ongoing support for staff includes providing comprehensive training, supervision, and ad hoc consultation for family partners and clinicians. CCBC has also developed a continuum of care with the DMH MCI program to support families in crisis during the seven-day crisis episode and also ensuring continuity of care with ICC and IHT services that will provide continued intervention for the family.

### **2.3 Diversion**

#### **2.3.1 ED diversion**

**2.3.1.1** CCBC’s clinical leadership that includes the medical director of the psychiatric services for the Brockton and Taunton/Attleboro ESP’s, has a broad range of experience in assessing clinical risk for clients, both in the ESP setting and in our community programs that include PACT, CBFS, CBHI services, and CSP. Similarly the CCBC Child MCI Team that are part of the existing DMH ESP have two years of experience providing community-based diversion as an alternative to hospital level of care.

We have worked collaboratively with clients to develop individual safety plans that establish a clear set of supports for care that can be delivered in the community as an upstream intervention prior to going to the ED or inpatient hospitalization. These safety plans incorporate client strengths, preferences, and natural supports that result in a consumer-directed plan. For families participating in the CBHI services, clinicians and family partners work with families and their children to develop a risk and safety plan to support families when the child is in a crisis based on the child and family’s strengths and preferences.

**2.3.1.2** CCBC can bring several important community resources to the Brockton catchment area to create and strengthen a culture of providing crisis services outside of the hospital ED. First, CCBC’s ESP staff will convene community stakeholders to reinforce their experience in working with high risk clients in community settings and emphasize the added value of the ESP to support these stakeholders. Second, the CCBC MCI staff will participate in the Brockton CSA Systems of Care meetings and share the capacity and competence of the MCI staff, as well as provide working examples of how children and families can be served in community settings by activating the Safety Plans. Finally, CCBC will build on the CCIT training already provided to law enforcement officials in Brockton to expand the visibility of the ESP and the CCIT skills to a larger law enforcement and human services audience.

The Brockton ESP will also develop the culture through rigorous data collection that aggregates the percentage of mobile visits versus ED visits and profiles ED visits that could have been seen in community settings. These data will provide concrete evidence to the stakeholders – ED staff, parents, referral sources, and ESP staff –of the merits and effectiveness of ESP evaluations outside of the ED.

Ultimately, CCBC will establish a Community-Based Location that is accessible and welcoming and will be attractive to clients and stakeholders alike.

**2.3.1.3** As part of the strategy to change the perception that all or most psychiatric crises must be sent to the local hospital ED, CCBC will familiarize key stakeholders with the value and utility of the Community Crisis Stabilization (CCS) programs, the Community-Based Location in Brockton, and the mobile crisis intervention capacity for adults and children that can provide ongoing support for up to seven days as part of the Mobile Crisis Intervention. The targeted populations include clients served by the local offices of DMH and DCF, persons referred by local police, other mental health and substance abuse providers, and persons referred through local advocacy organizations such as PAL and NAMI-Mass, and consumer groups. Specific points to be emphasized in this targeted outreach will include:

- Increase awareness of the mobile capacity of the ESP;
- The capacity of the CCS to provide a staff-secure setting that resembles an inpatient psychiatric unit in several ways;
- CCBC will address the law enforcement community by expanding the CCIT training to a larger audience of police officers in the Brockton catchment area. This model has been very successful in Taunton.

**2.3.1.4** CCBC is aware of a number of challenges to the pattern of reliance on Hospital Emergency Departments for behavioral health emergencies:

- CCBC will have to forge expanded relationships with the two hospitals in the Brockton Area – Good Samaritan Hospital and Brockton Hospital – at the administrative, clinical and programmatic level;
- The recent history of periods of high volume of mental health clients waiting in the Emergency Room for inpatient placement;
- The community stakeholders have only limited experience with mobile ESP visits from the DMH-operated teams;
- Mobile ESP and MCI services pose a risk of physical harm or criminal victimhood in some Brockton neighborhoods.

**Strategies.** With the social marketing campaign, CCBC will expand on the established relationships developed by the CCBC PACT and CSP programs with other community-based behavioral health providers and hospital systems, including their Emergency Departments. CCBC also has experience working with hospitals in preventing reliance on the ED for crisis interventions:

- CCBC’s ESP medical director will reach out to the ED medical directors at Brockton and Good Samaritan Hospitals to encourage their active participation in these forums to demonstrate the success of mobile visits and a willingness to set up a continuous quality improvement climate;
- The working relationship with the DMH Brockton area will provide a platform to work with the two hospitals and build trust and credibility.
- CCBC will eliminate the requirement for medical clearance for admission to the CCS, providing the admission is reviewed by a CCBC physician.

CCBC will work with MBHP and local outpatient providers to improve access to Urgent Care appointments as a timely resource for persons evaluated by the ESP and needing immediate outpatient follow-up.

### **2.3.2 ED-specific plans**

**2.3.2.1 See Attachment 2.3.2 for specific plans for Brockton and Good Samaritan Hospital EDs.**

*Note:* CCBC has recently begun outreach to the Brockton and Good Samaritan Hospital EDs with a goal of establishing a Memorandum of Understanding (MOU) on a hospital-specific plan to work with the ED staff. The attached plans represent the first step in the completion of the MOU. Discussion with two EDs has led to the EDs requesting consultation for patients that are boarding temporarily in EDs awaiting inpatient admission. CCBC will offer psychiatric consultation to ED physicians to assist them in managing patients while they remain in the ED; a practice that does not happen with any frequency at present.

### **2.3.3 Diversion from unnecessary psychiatric hospitalization and other out-of-home placement.**

**2.3.3.1 Brockton Diversion Experience.** CCBC has an established track record of delivering community-based services such as PACT, CBFS, CSP and CBHI services that divert hospital admissions for both adult and child populations. CCBC also has experience at training community stakeholders, including law enforcement personnel, in preventing crises from escalating into higher risk situations that will precipitate a psychiatric hospitalization.

CCBC psychiatrists, including the CCBC Medical Director, Paul Weiss, M.D., also have experience working directly with ESP clinicians, hospital ED staff, and community stakeholders in managing psychiatric emergencies and diverting potential hospitalizations to the Community Crisis Stabilization program and other community-based alternatives. The seasoned staff that are part of the MCI contracted service for the Brockton ESP are also experienced at diverting hospitalizations in their mobile visits throughout the Brockton catchment area.

As the MCI provider in Brockton, CCBC will work closely with the Brockton Systems of Care Committee to develop safety plans that are family-focused and strength-based, and designed to keep the child in his or her natural community setting.

**2.3.3.2 Creating a Culture inside CCBC to accept community-based alternatives.** CCBC begins with a strong foundation of experience with the effectiveness of strategies to divert clients from inpatient hospitalization. In addition to the emergency psychiatry and MCI service, this experience derives from the operations of the Partial Hospital, Day Treatment, CSP, CBFS, PACT and CBHI programs. With the ESP program, CCBC will build on that foundation by providing concrete examples to the ESP staff of the client-centered, strength-based approach to clients in crisis in community settings that result in effective diversions. CCBC will also orient the ESP staff with presentations from peer specialists and family partners about effective diversions that underscore the recovery orientation of the CCBC programs, even for clients whose baseline symptoms may, at first, appear to meet hospital level of care, and can provide timely relief to the triggers that are individualized to the client's needs and preferences.

**Creating a culture in the community and educating the community on alternatives.** CCBC will build on the social marketing of the ESP features that include mobility to community settings, availability of peers, partnership with police, and 24/7 availability. The social marketing campaign will be expanded to explain the clinical criteria for the Community Crisis Stabilization (CCS) program, the availability of the MCI to children and their families for up to seven days, and the commitment to member safety. The ESP will further build the culture by providing specific examples of diversion from hospitalization, involving both adults and children as the program gains experience in the Brockton catchment area.

### **2.3.3.3 Specific Strategies For Diversion from Unnecessary Psychiatric Hospitalization**

1. CCBC will strengthen three existing forums to create a culture, educate others, and increase working collaboration on effective and timely use of community-based

- alternatives. The first is the “*Citizen X*” meetings that CCBC will utilize to identify high-ED users, clients who are immediate risk, or clients who have a history of frequent non-compliance with community resources and often revert to the ED.
2. The second forum is the DMH Risk Meetings, which are convened to discuss crisis planning for PACT and CBFS clients in the Brockton area. ESP’s will build the capacity to share information on ESP evaluations with the community providers and, conversely, for the community providers to submit their crisis plans to the ESP, to be activated if the client presents for an ESP evaluation.
  3. The CCBC ESP will expand the working relationship between CCBC psychiatrists and ED physicians to be available to confer with ED physicians to offer consultation, including recommendations for medication management while the individual is in the ED.
  4. CCBC will become an advocate for the use of alternatives to inpatient hospitalization to the treatment community. The CSP and PACT programs are examples of the creative use of diversionary services in Brockton that promote recovery and client individual choice. CCBC will conduct follow-up meetings with referral sources to debrief on dispositions where the referral source disagreed with the outcome.
  5. The CCBC ESP will also act proactively with the higher volume referral sources such as the Castle Program, the DYS program at the Brockton YMCA, and DCF residential programs in the catchment area. CCBC will meet with them regularly to clarify hospital level of care and the many viable alternatives offered by CCBC and other community providers. CCBC will seek to expand the CCIT program for Law Enforcement personnel in the Brockton catchment area.

**2.3.3.4** CCBC does not expect to establish a “designated ED” model in the Brockton catchment area.

## **2.4 Recovery-oriented Services**

**2.4.1 Hiring Practices.** CCBC has demonstrated in all of its programs an ability to recruit, hire and retain staff epitomizing recovery values that match the organization’s mission. Its extensive outreach and community-based work guide a recruitment process that places a premium on finding the right candidates who understand and practice a recovery orientation. The agency attracts this type of staff person by virtue of the continuum of care it provides, the manner in which it provides these services, and the way the agency supports and promotes recovery resources, events, and initiatives.

**2.4.1.1** The agency has also been a regional leader in employing persons with lived experience as evidenced by the hiring of peer specialists in its adult programs for the past 12 years, including those in PACT, Day Treatment, and the Elder Mobile Outreach Team, and for the past six years in our two CBFS programs. These peer positions have proven to be critical in increasing each client’s level of engagement and receptiveness to that program’s service model. This agency-wide pledge to uphold and prioritize a Recovery Model has been reinforced by our partnering with the Department of Mental Health to provide access to Person-Centered Planning training that allows for direct translation of an individual’s goals and dreams into program objectives—further integrating the language of recovery into the work of all program staff.

CCBC is also the Community Service Agency (CSA) for the Taunton/Attleboro catchment area. In this model, all CSA staff are trained in the Wraparound model of recovery that focuses on “*family voice and choice*” and implementing a strength-based approach to engaging children with serious emotional disturbance (SED) and their families. In this CSA program, CCBC has

10 family partners—all of whom are parents of children with SED, who bring a strong and vocal vision of recovery to their work and provide a theme of authenticity for families struggling with complex and often acute behavioral healthcare situations.

**2.4.1.2** CCBC has demonstrated a strong commitment to recruiting individuals with an established Recovery-based practice skill set. First, CCBC has recruited and hired family partners who have been fully integrated into our CSA program. These employees come from families who have received services from the CSA, and have lived experience of raising children with SED. Second, our CBFS and PACT contracts include peer specialists and staff that have been recruited based on their willingness to speak personally about their own experiences with recovery, their ability to provide support based on their life experiences, and are trained to support clients to help them move forward in their own path to recovery. Our recruitment strategies have included promoting available positions with the local Recovery Learning Community and the Transformation Center, reaching out to persons in recovery who serve on CCBC advisory committees, and networking with people who are active on any one of the community-based task forces that CCBC participates in.

The agency's management and supervisory staff have received training and support in developing interviewing skills with candidates to identify individuals who share the agency's commitment and dedication to Recovery beliefs and to putting the skills into practice. This recruitment support has proven itself indispensable in identifying positive, likeminded candidates who have become loyal and committed program staff that support recovery and work in collaboration with staff with lived experience.

#### **2.4.2 Integration of Peers and Family Members**

**2.4.2.1** There are two members of CCBC's Board of Directors who are in recovery and one has a child with SED. Several enrollees in CCBC's PACT and CBFS programs also serve on CCBC's Human Rights Committee.

**2.4.2.2** CCBC employs 14 peer specialists in the CBFS program and in its adult programs. Ten family members with lived experience involving a child with SED are employed as family partners in the Community Service Agency. One senior family partner is also a member of the MCI contracted staff in the current contract with the DMH-operated ESP program in Brockton. CCBC intends to hire both peer specialists and family partners as part of the ESP program staffing model. In addition, CCBC would incorporate recovery-oriented training for all staff. This would include contracting for training with the Transformation Center and others recognized for their articulate voices on the subject of recovery from the perspective of someone with lived experience. North Suffolk Mental Health Association's Director of Recovery would provide this training.

Peers participate in a long standing local cable television program, "The Other Side," focusing on recovery and featuring local community resources and CCBC clients in recovery. CCBC has produced over 100 shows to date. Peer specialists will be deployed to run groups in the CCS and provide support to clients and families.

**2.4.2.2.1** CCBC's ESP program will have the benefit of the successful recruitment activities of CCBC's Human Resources Department to recruit, hire, and train peer specialists and family partners for the ESP. These strategies include outreach to the regional Recovery Learning Center, to parents who have completed involvement with the CSA program, word of mouth at local task forces and advisory groups that CCBC participates in, as well as traditional advertising in local and regional newspapers.

Both peer specialists and family partners who work in the ESP will have access to peer supervision as established in the CSA and CBFS programs. A senior family partner and a senior peer specialist will provide weekly supervision as well as ad hoc supervision as needed. Peer specialists and family partners will meet regularly with peer specialists and family partners in other programs to facilitate their learning and provide support.

### **2.4.3 Adherence to recovery principles**

#### **2.4.3.1 See Attachment 2.4.3.1**

**2.4.3.2** CCBC's existing CBFS, PACT, Day Treatment, Partial Hospital, and CBHI programs all practice the principles of recovery as described in Section II.B, including the reference to SAMHSA and Section II.C. The elements of a strength-based approach that empowers the individual to develop a holistic plan are contained in the team-based approach with members' active participation in each of these four programs. The practice of including peer supports on the treatment team and working with the client are wholly integrated in the Wraparound Planning process and in the PACT, Day Treatment, and CBFS programs. The approach to members is individualized and holistic because clients are encouraged to identify their own preferences, supports, and solutions to ongoing treatment *as well as* to help them respond to any triggers that may put them at risk of harm to self or others. These supports include friends, neighbors, other peers, and 12-step programs, including the Dual Recovery Anonymous program started in Massachusetts by CCBC.

CCBC is experienced in respecting clients' preferences; staff are trained to be open to many different pathways to recovery that include natural community supports, and are accepting of the non-linear nature of recovery from mental illness, substance use disorders, and serious emotional disturbance in children and adolescents.

These principles and practices will be integrated seamlessly into the ESP through training and orientation of ESP clinicians, the presence of peers specialists and family partners and sharing with the ESP the successful examples from CCBC's current practices. In sharing these successes with ESP staff, the community-based interventions centered on client preferences will become a model for ESP staff to establish creative interventions that address clients with escalating symptoms in a community setting, deploying a full range of safe and effective holistic interventions. The peers specialists, and family partners are active members of the treatment teams. Another practice of these programs that is critical to the successful implementation of the recovery principles is the recognition that recovery is individualized and non-linear. The ESP will have staff – clinicians, peer specialists, and family partners – that can be flexibly deployed to address members' individualized needs during the course of a crisis episode. CCBC recognizes that effective engagement is best accomplished by understanding the stages of change as outlined in the techniques of Motivational Interviewing. The community orientation of the ESP will encourage engagement with the client in a setting that is comfortable and safe, and this will provide the best opportunity to engage the client and partner with them in addressing the psychiatric crisis.

**2.4.3.3** CCBC recognizes that clients in psychiatric crisis present challenges to the recovery orientation in which dangerousness to self and others must be balanced with client choice and a strength-based approach. CCBC will address this challenge by training all ESP staff, including family partners and peer specialists, in the essential elements of client safety and dangerousness that relate to acute phases of mental illness and co-occurring mental health and substance use disorders. Within this frame, client choice and strength can still be activated and incorporated into the treatment plan, once the acute phase of the illness has been stabilized. The ESP will make a clear delineation to the clients at the outset of their right to refuse care to

promote client empowerment, but also be clear on the staff's obligation to make a judgment about client safety and risk of harm to others that will be balanced in the clinical disposition. CCBC has found that the clear delineation of these practices at the outset of the intervention assists in partnering with the clients.

ESP clinicians will also have access to timely clinical supervision and consultation with the ESP clinical supervisor, the ESP program director, and the ESP psychiatrists to address safety concerns and the soundness of diversion plans.

## **2.5 Culturally Competent Services**

### **2.5.1 Population and related experience**

**2.5.1.1** By virtue of providing PACT, CSP and MCI services in Brockton and the surrounding communities, CCBC is very familiar with the racial, cultural, and linguistic composition of the area and the importance of delivering culturally effective services to its clients. With respect to demographics, Brockton is home to more people of color than Whites, which comprise only 42.9% of the population, and where the largest racial group is Blacks/African-Americans at 31.2%. Hispanic/Latino of any race is 7.8% of the population. Brockton has the largest population of Cape Verdean ancestry in the United States, with 9.0% of its population reporting this ancestry, and also has one of the largest communities of Angolans in the United States. Brockton has been making strides to rebuild the inner city to address the opiate problem and gang violence. A housing initiative has been started with a focus on empty housing units to provide additional affordable housing for low income and homeless families. The unemployment rate is 6.8%, 2.1 percent higher than the state average of 4.7% in June 2015. The remaining communities have a much higher percentage of individuals with a Caucasian background.

**2.5.1.2** CCBC's current programs serve a diverse population linguistically and culturally: Latino, Hispanic, Portuguese, and Haitian cultures are represented in our client base, as are a number of languages in addition to English, including primarily Spanish, Portuguese, French, and Creole. CCBC strives to incorporate the Department of Public Health's Culturally and Linguistically Appropriate Services (CLAS) standards and guidelines with respect to trainings, staffing, brochures and staff languages, and to ensure that design, delivery, and monitoring of all services consider issues of race, ethnicity, culture, language, sexual orientation and gender.

The agency has a wealth of experience serving individuals from a variety of cultural and ethnic backgrounds. CCBC's local area includes a significant population of Portuguese and Spanish speaking residents. At present, CCBC has 27 staff persons who are bi/multi-lingual and available to do interpretation in languages that include Portuguese, Spanish, French, German, Danish, Somali, Arabic, Italian, Creole, and American Sign Language (ASL).

**2.5.1.3** CCBC operates many services that are tailored both culturally and linguistically to meet the needs of the clients served, as reflected in the staffing in both its Community Support Program and Program of Assertive Community Treatment in Brockton. CCBC's CSP, which is made up of case management staff providing services to all of the communities this proposed program will serve, has the ability to work with clients speaking Portuguese, Spanish, and French Creole. Likewise, the PACT Team in Brockton serves a very diverse clientele that mirrors the population statistics in the city, and the staff is also quite diverse, including staff who are African-American and those who speak French Creole.

**2.5.1.4** CCBC has been aware of the need to outreach the Asian community in all of our catchment areas as well as the French Creole population in Brockton. An effort to hire staff with cultural and ethnic backgrounds in this area and the ability to train other staff to understand the specific needs of these groups will be important to address any emergency

services or crises that may arise. CCBC will also make a concerted effort to engage leaders and resources in those communities to promote the availability of emergency services as well as other behavioral health services.

## **2.5.2 Organizational capacity**

### **2.5.2.1**

**2.5.2.1.1** The composition of the CCBC Board of Directors is currently made up of men and women who are Caucasian, with varying cultural backgrounds and linguistic capabilities, as well as those in recovery who bring critical perspectives to the agency. CCBC's senior management includes a team of vice presidents, program managers, and team leaders, as well as a clinical team that includes individuals in positions of critical importance to the agency who are Caucasian, African-American, Cape Verdean, and African. It is CCBC's plan to increase the number of board members, senior managers, as well as others in critical positions, particularly in the ESPs, who will represent the racial and ethnic population found in the Brockton service area that have experience providing culturally competent behavioral health services.

**2.5.2.1.2** CCBC's Board of Directors (BOD) has taken on the initiative to develop Advisory Boards for the agency to meet the needs of specific programs. One example of this includes The Consumer Advisory Board (CAB) which serves the Greater Taunton Area's HIV-positive Community. It monitors services provided and reviews programs to ensure they are living up to what they are contracted to do. The CAB seeks to have as diverse a membership as possible so that the perspective of all People Living With HIV/AIDS (PLWHA) in the Greater Taunton Area is represented. Currently one CAB member is hearing impaired, one is Hispanic, and one is African-American.

**2.5.2.1.3** CCBC seeks to ensure that staff members reflect the cultural and linguistic characteristics of the population served, and as such we are committed to providing services that acknowledge and enhance the dignity of all with a particular recognition and focus on the MassHealth-enrolled population. CCBC currently has 27 staff who are bi/multi-lingual and available as interpreters. Languages spoken include Portuguese, Spanish, French, Somali, Arabic, Italian, French, Haitian & CapeVerdian Creole, Romanian, and American Sign Language (ASL).

**2.5.2.1.4** CCBC uses its internal capacity for interpreters first as described above in 2.5.2.1.3, and if necessary employs the local interpreter services available through a service we have contracted with "Optimal Phone Interpreters" who provide instant interpretation in any language. The process is as follows: 1) *Call OPI*: Call 1-877-Ring-OPI (1-877-746-4674); 2) *Connect*: OPI asks what language and confirms your location 3) *Interpret*: Speak directly with an OPI interpreter. OPI also offers CCBC video remote interpretation for communicating with the deaf and CCBC also offers sign language interpreters through the Massachusetts Commission for the Deaf and Hard-of-Hearing, Deaf Inc., and other local providers that are available by developing a memorandum of understanding. At time of hire, all CCBC staff is asked to complete a form that lets HR know what language capability they have and their willingness to be involved in interpreter services for other agency programs, in addition to the program they are working in.

### **2.5.2.1.5 See Attachment 2.5.2.1.5.**

**2.5.2.2** CCBC's mission statement clearly addresses the need for culturally competent services as a priority for the agency:

***"To develop and deliver compassionate, responsive, culturally competent, and quality mental health and substance abuse services to meet the prevention, education, treatment, rehabilitation and recovery needs of those in our community. These services are based on***

*the latest evidence-based approaches to respond to the complex needs of children, adolescents, adults, elders and families as part of a locally integrated health-care delivery system linked to regional and statewide delivery systems.”*

CCBC has recently completed a total revision of our policy and procedure manual and our employee manual, both including a focus on cultural competency and the need to include definitions, values, and respect for the various cultures we serve as well as the staff that work for the agency.

**2.5.2.3** CCBC has developed training for all staff that will increase awareness, understanding, and cultural sensitivity of the diverse populations in the communities that CCBC serves. All of the strategies to ensure cultural and linguistic competency at CCBC are based on the following definition adopted by CCBC: *The knowledge and interpersonal skills that allow individuals to understand, appreciate, and work with, people from cultures other than their own.*

CCBC also incorporates the following expectations into our agency and staff practices regarding cultural competence:

- Cultural Awareness: Every culture holds distinct biases, values, beliefs, practices, lifestyles, and problem-solving techniques which can affect clients’ use of health services;
- Cultural Self-Awareness: Staff has awareness of our own biases, values, beliefs, practices, lifestyles and problem-solving techniques that may affect interactions with those they work with, from their own or other cultural groups;
- Cultural Respect: Treat all clients with dignity, consideration for, and understanding of the value they place on their beliefs;
- Cultural Knowledge: Staff have 1) in-depth knowledge of one or more cultures, including concepts of illness, family context, and other factors impacting health and health behavior; and 2) knowledge of illnesses and conditions more common among individuals of particular races and ethnic groups;
- Cultural Assessment: Staff assesses the extent to which clients’ beliefs are aligned with those typically associated with his/ her culture of origin;
- Cultural Adaptation: Staff reasonably adapts their approach to clients’ cultural values, beliefs, practices, lifestyles and problem-solving techniques.

**2.5.3** CCBC will build upon its already established strong working relationships with the local providers from minority, community-based, and mutual assistance organizations to emphasize the additional capacity to serve their members who are experiencing a psychiatric crisis. This expanded relationship will extend to a larger network of organizations in the Brockton catchment area. CCBC has developed partnerships with minority, community-based organizations, and other multi-service agencies for immigrants and refugees to meet the care and support needs of our clients. The partners include the Haitian Community Partners and the Cape Verdean Association of Brockton, who have worked closely with our CSP and PACT programs serving the Brockton area. One example of our collaboration with the Haitian Community Partners was that CCBC was able to address the cultural and linguistic barriers to the effective treatment of a Haitian immigrant who was suffering from both acute medical as well as psychiatric illnesses. The Cape Verdean Association offers individuals in CSP volunteer opportunities and English as a second language classes. Both of these organizations have provided assistance to individuals in navigating immigration-related issues.

## **2.6 Other special populations**

**2.6.1 Elders.** CCBC has a program dedicated to elders serving clients in the Taunton/Attleboro area funded by Title III funds of the older Americans Act, Bristol Elder

Services and Executive Office of Elder Affairs. This program, the “Elder Mobile Outreach Team” (EMOT) provides urgent care to elders with behavioral health care needs.

**2.6.2 Veterans.** CCBC serves Veterans who are homeless through CCBC’s Community Support and Housing Partnership programs (see 2.6.3 below). CCBC’s ESP will have access to case consultation to this program when a Veteran presents in psychiatric crisis.

**2.6.3 Persons who are homeless.** CCBC has developed a successful housing partnership in Taunton with property owners, city housing authority officials, DMH, and homeless shelters to provide clinical, social and housing supports to clients at risk for chronic homelessness. CCBC recently received a three year grant from the Substance Abuse and Mental Health Services Association (SAMHSA) to address the support needs of chronically homeless veterans and others in the community who require additional supports to gain and sustain adequate housing.

**2.6.4 Persons with substance use conditions.** CCBC’s outpatient clinics are licensed by BSAS as substance abuse clinics with accompanying expertise in treating substance use disorders. The orientation for ESP clinicians will include training in substance use disorders, including screening and motivational interviewing.

**2.6.5 Persons with co-occurring mental health and substance use conditions.** Between 50 and 75% of ESP clients in any given month present with a co-occurring disorder. CCBC’s clinical staff have established clinical protocols in the assessment, diagnosis, and treatment for persons with co-occurring conditions that addresses the functional barriers the client is facing. These protocols will be part of the ESP assessment.

**2.6.6 Persons who are deaf and hard of hearing.** CCBC will receive training on work with persons who are deaf and hard of hearing from North Suffolk Mental Health Services who has a specialized CBFS and community support services for this population. CCBC also has staff with competence in American Sign Language.

**2.6.7 Persons who are blind, deaf-blind, and visually impaired.** As necessary, CCBC utilizes the consultation of regional Mobility and Orientation Specialist Donna DiCorpo, M.Ed., who has worked for over 30 years for a vendor of the Massachusetts Commission for the Blind, as well as having a private consultation practice.

**2.6.8 Persons who are involved with the Department of Mental Health (DMH).** As the CBFS provider, CCBC is the leading provider of services to persons who are involved with the Department of Mental Health in the Taunton/Attleboro area. CCBC operates outpatient clinics in Taunton, and Attleboro and PACT teams in Taunton and Brockton. CCBC has well-established protocols for this population that include access to ESP’s and ESP interventions in community-based settings as part of the client’s Wellness Recovery Action Plan and the client’s Safety Plan.

**2.6.9 Youth and families involved with the Department of Children and Families (DCF).** About 50% of children presenting to the ESP are involved with DCF. CCBC works with the DCF Area Office in an Advisory Capacity. The CCBC CSA engages DCF to participate in the Taunton/Attleboro Systems of Care meetings that include the role of MCI as a part of the intervention and safety plan for the child and family.

**2.6.10 Youth and families involved with the Department of Youth Services (DYS) and/or the juvenile court system.** CCBC is the designated CSA for the Bristol County Juvenile Diversion Project that involves the Bristol County Juvenile Court, Probation Officers, the Court Clinic, and other Law enforcement officials.

**2.6.11 Youth who are on the Autism Spectrum.** Paul Donnelly, Ed.D., a consulting psychologist to CCBC, is experienced with this population. He will provide consultation and

training to the ESP staff on working with this population when they appear in crisis and with escalated behavioral presentations.

**2.6.12 Persons who are receiving services from Department of Developmental Disabilities (DDS).** Paul Donnelly, Ed.D., a consulting psychologist to CCBC with considerable experience with those with developmental disabilities will provide consultation and training to the ESP staff on working with this population when they appear in crisis and with escalated behavioral presentations that can often be managed more successfully in settings outside of an ED and an inpatient hospital.

## **2.7 Intersystem planning and affiliation**

**2.7.1** CCBC is well known in the Taunton/Attleboro area and throughout Bristol County for its organizational commitment to collaborating with other providers, payers, advocates, and clients to create integrated systems of care. CCBC has taken leadership in a number of community projects and CCBC is the conveyor of projects such as:

- The Continuum of Care for Greater Bristol County Attleboro/Taunton Coalition to End Homelessness, which includes the Mayors of Taunton and Attleboro, local housing authorities, Department of Mental Health, and human service providers and local businesses, and CCBC manages one million dollars in HUD funding annually on behalf of the Coalition;
- The Systems of Care meetings convened by the CCBC CSA comprising all local stakeholders involved with youth: DCF, DYS, local schools, day care providers, juvenile court, and after school programs;
- CCBC chairs the Taunton HIV Consumer Advisory Board (CAB) to reduce stigma and ensure access to services for persons with HIV/AIDS; and
- The Mayor's Opiate Task Force in Taunton is co-chaired by a CCBC senior manager, along with the city's director of human services.
- CCBC convened a local Committee to gather support for a SAMHSA grant to service homeless veterans. A three year contract has recently been awarded to CCBC, and this group will serve as the grant's Steering Committee and includes: DMH, BSAS, MBHP and others.
- CCBC convened a local coalition group of healthcare, behavioral healthcare, and public health professionals to develop a proposal to the Health and Wellness Trust Fund of DPH.

**2.7.2** CCBC will expand the culture of collaboration in the Taunton/Attleboro area into the operation of the ESP in the Brockton catchment area. CCBC will work closely with the key stakeholders and build new relationships to actively work towards the goals of timely response in a community setting.

CCBC recognizes that as a new ESP provider working with a very visible and high need population, that establishing credibility is the most important step. We will engage with stakeholders by establishing several principles that will guide the collaboration:

- A data-driven approach is the best method to solve problems;
- Each stakeholder deserves a timely, polite response that emphasizes the value of fully understanding the issue of the person(s) working with the ESP;
- Solutions are best developed in collaboration; and
- In psychiatric crisis, there will always be unusual clinical presentations that are best solved in a calm, accepting, and collaborative atmosphere.

First, CCBC will establish a working group to help CCBC ESP managers and staff implement the new program and provide a forum to review progress and address key issues in

the operation of the ESP. The working group will be co-led by the ESP program director and the ESP medical director. It will consist of representatives from all of the important stakeholders including, both hospital EDs, DMH, DCF, and DYS Area office staff, the Brockton CSA, the Brockton Community Health Center, and the local NAMI affiliate.

Second, CCBC will distribute information using multiple media about the operation of the ESP, that highlights 24/7 phone availability, access to the Community-Based Location, mobile capacity, and the seven-day model of MCI intervention. This will be followed up by face-to-face meetings by ESP staff.

Third, CCBC will develop measurement tools that will provide a data-driven approach to the success of the implementation. These reports will allow CCBC to be responsive to the priorities reported to them by the community stakeholders, including telephone responsiveness, responsiveness to the ED, and access to the CCS.

Fourth, CCBC will establish a subcommittee of the working group to form Critical Risk Teams to include peer specialists and family partners. The teams will develop safety plans with the clients to help the client and his/her family maximize their safety through the use of less restrictive alternatives. This group will be chaired by the clinical director of the ESP.

Finally, CCBC will undertake a Performance Improvement (PI) initiative to survey persons who come directly to the hospital EDs to determine their knowledge of the ESP, the pathway that resulted in directly coming to the ED, and their willingness and the willingness of the referral source to consider alternatives in similar circumstances. This PI effort will help the community stakeholders identify the **root causes** of reliance on the ED so that they target corrective actions in the most effective direction.

**2.8 Staff training, monitoring, and evaluation.** CCBC will enhance our current training, development, and evaluation of staff to include the goals of timeliness of response, diversion from the ED, increased mobile visits, and reduced reliance on inpatient hospitalization.

All CCBC staff positions have a set of core competencies that are established for the position. A set of required internet-based and in-house video trainings and live training sessions are established to align with the core competencies. Staff complete the required trainings, each of which includes a test that must be passed before credit for the course is given. Training also includes shadowing seasoned ESP clinicians. Once the clinician is conducting assessments independently, the clinician has to review the findings and recommendations with the CCBC Administrator-On-Call (AOC) in order to complete the intervention. Before the clinician attains complete autonomy, s/he must pass the ESP clinician "*Competency Test.*"

Competency will be maintained through monthly staff meetings, weekly supervision for Clinicians seeking licensure, and case-by-case supervision for all staff when needed. The AOC is available for case consultation at any time.

CCBC will also work with staff to improve the overall performance of the program through a number of Program Evaluation Indicators. One is the Consumer Satisfaction survey which is aggregated twice a year by CCBC's Quality Management Coordinator. Previous outpatient surveys have resulted in a performance improvement effort to address waiting time in outpatient services. The corrective action was the development of a "Rapid Access Project" that provides same day access to outpatient services.

The CCBC QM staff will also measure the performance of the ESP on key indicators related to the timeliness of telephone and face-to-face response, the percentage of mobile visits for children and adults, the percentage of community-based and ED face-to-face contacts, and the use of alternatives to inpatient hospitalization.

### **3. ESP service components: (100 points)**

#### **3.1 Emergency Services Program (ESP): overall program**

**3.1.1 Provide a brief program description that summarizes your overall ESP program model addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.**

**3.1.1** Since its inception as an organization Community Counseling of Bristol County, Inc. (CCBC) has tirelessly pursued the development of a comprehensive, recovery-focused integrated system of behavioral health in Bristol County and the Southeastern region of Massachusetts. We take pride in providing a broad array of innovative services to persons – adults and children – struggling with mental health and substance use disorders so that they and their families may live full and functional lives in their communities. CCBC views the Emergency Services Program (ESP) as a critical, distinct level of care in the behavioral health delivery system, sitting at the nexus of acute and sub-acute services for adults, children and adolescents.

In our experience, early and effective intervention is invaluable as a means of promoting resiliency and recovery, while also preventing potential crises from becoming more protracted, painful and costly episodes of care. Central to this effort is a team of capable clinicians, peer specialists, family partners, and psychiatrists who are experienced at engaging the client and family rapidly and respectfully. Our experience has demonstrated that the fullest participation of the client in the process leads to the best treatment outcomes. Our role is to respect the client's preferences in arriving at an appropriate disposition with a shared vision of long-term recovery. In summary, our philosophy is to provide timely intervention in a variety of community settings that promote the best opportunity for client engagement, participation, and recovery. CCBC is proposing to operate ESPs in two catchment areas in the Southeast: Brockton and Taunton/Attleboro, to enhance the resources of both sites with a larger pool of clinicians, peers, and family partners to meet the fluctuating demand in the Brockton area.

CCBC will establish an ESP that has ESP clinicians available 24/7/365 to respond to psychiatric crises in the Brockton catchment area. A clinician will be available from the initial phone call for triage, brief counseling, and face-to-face interventions, as well as evaluation and consultation with ED staff, family, other providers and referral sources such as DMH, DCF, schools and local law enforcement. Once the evaluation is completed, the ESP team will develop an intervention that begins in the community and includes a holistic plan with the member's strengths and preferences considered at each step. With an accessible community-based location, the ESP first point of contact will begin in the community and not in the ED.

Based on implementation of the ESP, CCBC proposes to strengthen the model in the Brockton catchment area with a higher percentage of mobile crisis interventions outside of the local hospital EDs. We are proposing a community-based site with 'walk-in' capacity at 157 Main Street, which will be built out to include a 6-bed Community Crisis Stabilization program.

**Flow of Services.** From the client's perspective, contact with emergency services will usually start with a phone call to the Brockton Community-Based Location (CBL). The community-based-sites in Brockton and Norton will also have mobile capacity. However the initial contact occurs, the first priority of the ESP team is to assure client safety and the safety of those around them. Some cases are able to be resolved over the phone; others may require face-to-face crisis counseling, and some may be appropriate for direct admission to the CCS. CCBC believes that it can successfully triage ESP encounters and divert them from the ED, decreasing the percentage of ESP assessments conducted in EDs to below the statewide average.

CCBC's intervention model includes not only immediate stabilization of clients in crisis, but also assurance that they are properly linked to appropriate and necessary follow-up supports and clinical services. For children and their families, the Mobile Crisis Intervention (MCI) will include support for the child and family in the seven-day window following the crisis, and transition to other supportive services, such as In-Home Therapy. Working with people at their most vulnerable, the philosophy of the ESP is that the clinician has the opportunity to support the client in a thorough and honest evaluation of their circumstances and to match their needs to a strength-based plan for recovery in a community setting, whenever clinically appropriate. That plan draws upon holistic resources, including a seven-day intervention with children and families and direct admission to the CCS for adults. Follow-up includes securing the necessary services for a safe and timely disposition, including the search for a 24-hour program, and follow-up with the referral sources and family to inform them of the outcome. CCBC has a long track record of working closely with the entire spectrum of healthcare, behavioral healthcare, housing, and human services providers in the Brockton and Taunton/Attleboro areas to assure that clients are able to access the care they need.

The staffing pattern for the ESP in the Brockton catchment area includes a 24-hour per day staffing of Master's level clinicians scheduled to respond in person within the required timeframes to the volume demands in the catchment area. All clinicians perform all of the core ESP services of crisis assessment, intervention, and stabilization services listed in the MBHP Performance Specifications, regardless of client location. These core clinical staff will be complemented with 1.5 FTE certified peer specialists and 1.7 FTE family partners. The entire ESP operation will be supported by a rotating group of psychiatrists totaling .8 FTE's and administrative staff to assist in scheduling and billing. The Brockton CCS will be staffed by a R.N. nurse manager, counselors during the day, and LPN's and a counselor on evenings, nights, and weekends.

All clinicians will be available for mobile visits. Eighty percent of the clinicians will be trained to be child/family competent at the time of implementation, and CCBC intends to train and credential the remaining clinicians to be both adult and child competent within three months of implementation.

Another key element of the philosophy of the program is high visibility with community stakeholders. CCBC will complement the delivery of ESP direct services with an active presence in the community through participation in forums sponsored by DMH, the Brockton CSA's Systems of Care, and the Good Samaritan and Brockton Hospital EDs. CCBC will also encourage, sponsor and participate in trainings for the law enforcement and public safety personnel in Brockton and surrounding communities built on the Community Crisis Intervention Training (CCIT) that has been so successful with the Taunton Police Department. The CCBC Brockton ESP will engage in joint planning with local hospitals on emergency services diversion. The current presence of CCBC's psychiatrists in the current ESP and the community visibility of CCBC's PACT Team and Community Support Program (CSP) will support a smooth implementation of the CCBC Brockton ESP and engagement with community stakeholders.

**How shall you change the perception which may exist in your organization and/or in your community that the ESPs function is to conduct "hospital screening"? What operational and cultural changes shall your organization make to ensure the delivery of ESP services**

**that consist of a comprehensive and discrete level of care, incorporating crisis assessment, resolution-focused intervention, and stabilization?**

CCBC will implement the ESP with the foundation that the community is the continuum of care for psychiatric interventions. The continuum includes telephone triage, open communication with the referral source as the evaluation is progressing and exploring community resources to match the member's needs. CCBC believes that this proposed model of operation of the Brockton ESP is congruent with the MBHP's description of the ESP service. The CCBC Brockton ESP will extend beyond a program that operates as a "hospital screening" program to include a continuum of care for both adults and children that offers a range of choices at each step of the crisis intervention, from telephone triage to final disposition. CCBC has established an internal culture of meeting clients in a range of community settings through our Brockton PACT, Brockton CSP and full continuum of CCBC programs in Taunton/Attleboro, that include CBHI services. We see a number of opportunities for improvement in establishing the Brockton ESP as a continuum of care based in the community:

- CCBC welcomes the opportunity to include the consumer voice in crisis intervention with the enhancement of the position of Certified Peer Specialist (CPS). Including a CPS as part of the team will provide an immediate, ongoing reminder of what it is like to be on the receiving end of behavioral health services and provide an additional resource to clients in psychiatric crisis that extends beyond hospital screening and increases options for diversion. CCBC has had success with CPS and FPs by incorporating them directly into CBFS and CBHI program operations.
- CCBC also looks forward to creating a distinct child/adolescent mobile crisis intervention team, complete with Family Partners. We have relevant experience with children in crisis through our Taunton/Attleboro CSA, which convenes Systems of Care meetings to develop and coordinate Safety Plans for families that involve the MCI. CCBC also provides staff as MCI contracted services for the current ESPs in Brockton and Taunton/Attleboro. The Brockton ESP will collaborate closely with the BAMSI Community Services Agency (CSA) that covers the Brockton catchment area.

Based on relationships already established in the Brockton catchment area, CCBC will change the perception of the ESP in the community through continuing outreach to police, schools, mental health providers, health centers, homeless shelters, and the hospital EDs on the utility of mobile crisis outreach. New and improved visibility of the ESP to these stakeholders will provide a foundation to shift the reliance for emergency intervention *away* from the ED to other community settings. Demonstrated ESP capacity in community settings such as Community Health Centers will also result in less inconvenience for their members.

CCBC will initiate a sustained social marketing campaign to educate clients, families, providers and other referral sources and stakeholders on the expanded hours and capabilities of the community-based sites and will also highlight the value of mobile crisis interventions for adults and children and their families in other community settings.

CCBC's strategy will include community meetings with key stakeholders at which concrete examples of the value of mobile crisis intervention will be shared. We will also survey the referral sources on an ongoing basis to identify the root causes of the current patterns of referral and incorporate those findings into the social marketing strategy to emphasize the capacity of the ESP to provide crisis interventions in community settings outside of the ED.

CCBC will provide training for the telephone triage staff to complete a standardized set of questions with the referral source to complete an assessment, resolution-focused intervention and disposition of the psychiatric crisis. CCBC will also work with the local ED staff to gather the same information. The triage staff will explore the reasons for the call, the feasibility of a mobile visit, and the source of the referral to the ESP. CCBC will use the findings to provide ongoing discussion with all ESP staff and the referral sources about the patterns of the calls and the viability of mobile visits. The ESP managers will brainstorm methods to address the obstacles that emerge from the findings.

Finally, CCBC will provide community stakeholders with tools to effect community-based evaluations, including Wellness Recovery Action Plans (WRAPs) used for adults in the DMH service system, Safety Plans for Children with SED and their families, and other outlines designed to inform stakeholders of steps to take to keep the client in a community setting. Another tool is the Community Crisis Intervention Training that CCBC has overseen successfully through the CCIT and the Taunton Police Department. CCBC will seek to replicate that training in Brockton. Useful experience with these tools will provide an alternative to the default reaction of dialing 911 in a psychiatric emergency.

**3.1.3 Describe how you shall realize the vision and manage your ESP program, inclusive of all service components, as one integrated continuum of emergency services responsible for meeting the emergency behavioral health needs throughout the proposed catchment areas.**

CCBC welcomes this RFR as an opportunity to establish a regional ESP with accompanying efficiencies in service delivery, a team of Certified Peer Specialists (CPSs) and Family Partners (FPs), and a larger pool of ESP clinicians who can provide timely crisis interventions in all of the communities in the Brockton and Taunton/Attleboro catchment areas. CCBC will realize the vision of the ESP that follows from our established culture of community-based care for persons with mental illness, substance use disorders, and serious emotional disturbance. CCBC operates that model with key components that parallel the ESP requirements: flexible deployment of staff to meet fluctuating demand; skill and competency at providing an individualized intervention based on the clients' strengths, needs and least restrictive pathway to stability and recovery; capacity to deploy a team-based approach with CPSs and FPs as full participants; and knowledge and familiarity with the communities in the Brockton catchment area to conduct safe and effective crisis interventions.

The integrated continuum of services will be enhanced with a combined Community Based Location (CBL) and the Community Crisis Stabilization (CCS) program that will include nursing staff that will be available around the clock to check vital signs. ESP triage staff will be available to assist CCS staff in managing behavioral crises on the unit and assisting with the treatment program involving group, individual and family counseling. All master's level clinicians regardless of their assigned location will function as mobile clinicians, responding to all community requests for mobile crisis intervention.

The Child Mobile Crisis Intervention (MCI) Team will have full access and back up of the entire CBL and its functions, since 80% of the ESP clinicians will be child-trained at the time of implementation. Within three months of implementation all ESP clinicians will be available to conduct Child Mobile Crisis Interventions.

In short, CCBC views the ESP as the emergency room without walls, handling the full range of psychiatric interventions: telephone triage, mobile crisis visits, next day follow-up, linkage to ongoing treatment in the community, initiation to treatment, or disposition to more intensive 24-

hour level of treatment when indicated. The model will be enhanced with the additional support available to adults and children through the CPS and FP as resources for the clients and their families that can contain the crises in home and community settings. This model will provide the best opportunity for a strength-based, individualized approach to clients in crisis with a greater frequency of community-based mobile interventions outside of the ED. CCBC will realize this vision by increasing the percentage of mobile visits and strengthening links with other providers to reduce the existing practices among many referral sources of sending persons in crisis directly to the ED.

On the occasions when members are admitted to the EDs at either Brockton Hospital or Good Samaritan Hospital, CCBC will have clinicians on-site during peak demand periods to provide more responsive interventions and to build working partnerships with the ED staff.

The ESP program director will work with the CCBC Quality Management staff to identify key measures related to the percentage of mobile visits and timeliness of response to actively manage the pursuit of the vision. CCBC has established a strong foundation to engage in performance improvement initiatives across the agency.

**3.1.4 Describe how your ESP program shall operate in a fashion that ensures fluidity among its service components, including how you shall use your staff resources in an integrated and flexible manner, while accommodating fluctuations in volume, location of services, etc. Please include your strategy to address seasonal variations in volume as well as variability among shifts.**

As mentioned in 3.1.3 above, ESP staff will be cross-trained to provide interventions to both children and adults and to cover both catchment areas as needed based on fluctuating demand. Any staff member can offer real time assistance and fulfill the functions of the various components on an as-needed basis. CCBC is also proposing to create “*hybrid*” positions that cover all seven days of the week and that can be shared at both sites. These hybrid staff will be hired at reduced level salaried positions with full time benefits and will receive additional payment for each evaluation completed. CCBC retains these staff by paying them a case rate in addition to their base salary, giving them an incentive for efficient responsiveness, while at the same time containing costs. They can respond to peaks in volume for children or adults in both catchment areas when there are staff shortages, high client volume, or combinations of both.

From consultations with other ESPs who have developed this model, the effect of such positions will have a positive impact on the ESP operation in the Brockton catchment area. First, the client will benefit from a quick response. Second, the hybrid staff member will be employed with a full benefit structure. Third, the teams as a whole will be less stressed by inevitable staff vacancies and spikes in client volume which, without such a “safety net,” have the potential to exact a toll on staff morale and productivity. This “*fire-house*” model will allow CCBC to be responsive within the expected timeframes on a day-to-day basis, and will add stability and continuity to the program and strengthen CCBC’s capacity to provide high quality, consistent service. An effective crisis clinician needs to have their basic hierarchical needs of safety, predictability, and security met, so they can meet the needs of the population in the Brockton catchment area requiring crisis intervention.

CCBC will also employ a “*courtesy*” evaluation strategy for peaks in volume. This is a system wherein the agency will have a protocol to tap into our existing staff roster by calling ESP staff who are off duty, but who may be available and interested in responding to a case or two for an established case-rate of pay. Similarly, CCBC has an extensive roster of appropriately trained adult and child clinical staff on which it can draw to augment the ESP clinical staff on

nights, weekends and during periods of unusual heavy demand. These mechanisms will allow us to be creatively responsive to client needs.

The CPS can facilitate skill building in systems navigation and development of coping skills for CCS clients in group counseling sessions and also engage in peer counseling and support for walk-ins to the community-based location. CCBC has established training, orientation, supervision and other supports for peer specialists in their PACT, CBFS, and Day Treatment programs that will include the ESP as part of the implementation.

Our strategy for addressing seasonal fluctuations in Brockton involves several elements: First, CCBC's Human Resources Department and the ESP program director will add on-call and relief staff during the October to mid-December and mid-January to May time periods when volume tends to escalate the most. Second, the Brockton ESP program director will proactively meet with high volume referral sources to identify any preventive steps that can be taken with ESP staff, including peer specialists, to keep the client safe and stable in his/her home environment and reduce the need to refer the client to either Brockton or Good Samaritan Hospital ED. Finally, the ESP clinicians will notify the ESP program director and ESP medical director when any high-profile, high-risk, or complex cases are first evaluated so that the Managed Care Entity to whom the member has been assigned, state agency representatives from DCF, DYS, DDS and DMH, MassHealth, and other key stakeholders can be brought into a clinical discussion around disposition before the client has experienced an extended stay in the ED. Examples of these types of cases include persons with serious mental illness who have recently been released from prison, children with developmental disabilities and co-occurring serious emotional disturbance; and juveniles committed to DYS for violent offenses presenting with suicidal or homicidal ideation.

**3.1.5 Describe how your ESPs 800number and triage function shall operate, noting any variance by time of day or day of week.**

CCBC will establish a centralized triage function based on other innovative models in current ESPs. An ESP clinician will be available to answer the phone to initiate telephone triage 24 hours per day, seven days per week, 365 days per year. We propose to manage calls during normal business hours at the Brockton CBL from 8am–8pm, Monday–Friday. Initial triage during the day shift will be handled by an experienced BA-level staff, with immediate back-up from on-site ESP licensed clinicians. During evenings, there will be one ESP clinician at the CBL and one clinician at one of the Hospital EDs. After hours all calls are answered by a licensed clinician as part of the Brockton ESP. If all three clinicians are involved in a face-to-face evaluation, the calls will be automatically routed to the Taunton/Attleboro ESP and are answered by an on-call licensed clinician. As noted in the previous section, there is at least one licensed clinician available to receive calls 24 hours each day, 7 days per week, year round.

Clinicians staffing CCBC's ESP will have 24/7/365 access to the ESP program director, the ESP clinical supervisor, and psychiatrist through an on-call system. These staff will respond to all pages within 15 minutes per the MBHP performance specifications. The CCBC psychiatrists also work in other CCBC programs, including PACT, Day Treatment, CBFS, and outpatient settings and are familiar with the CCBC client population. The Brockton ESP will operate an "Administrator-On-Call" rotation with supervisory back-up 24/7/365 for ad hoc clinical supervision from a clinical manager on call and a psychiatrist to help with resolution of "systems issues" and complex clinical presentations. This Central Triage will cover both the Brockton and Taunton/Attleboro catchment areas to ensure timely access to an expanded pool of clinicians and

centralizing critical information in one agency. MBHP will gain efficiencies and consistency in operations with a regional approach.

**3.1.6 Geographic coverage; Does your organization have resources such as various locations you can leverage, as part of your strategy?**

CCBC has an office site in Brockton and numerous staff who already work in the Brockton PACT and CSP programs. Some of these staff can function as ESP relief clinicians to supplement ESP staff. In addition, CCBC is proposing a single administrative structure to the ESPs in Brockton and Taunton/Attleboro to provide additional resources and administrative efficiencies to the Brockton catchment area.

The CCBC ESP Community-Based Location will share a co-location with the Brockton CCS program. The communities in the Brockton catchment area do not require long travel times from the Brockton Community-Based Location (CBL).

**3.1.6.1** The strategic location of the CBL at 157 Main Street in downtown Brockton will ensure that all mobile visits in the catchment area available within a 30-minute drive.

CCBC will develop creative staffing strategies involving hybrid clinicians described in section 3.1.4 and placement of clinicians at the Brockton and Good Samaritan Hospital EDs during certain weekday evening shifts to address the fluctuations in volume as the need arises. CCBC will have the capacity to respond to any “hot spots” in the Brockton catchment area, such as the Brockton Hospital ED, with an expanded roster of ESP clinicians from two catchment areas that will meet or exceed the response time standards established in this RFR. As noted above, CCBC has a roster of dozens of clinicians with the necessary training, including supervisory staff, to back up dedicated ESP staff to assure timely response and exceed MBHP performance standards, particularly during peak demand and during any start-up period.

**3.1.7** The regional approach proposed by CCBC will assure MBHP of a consistent approach for the Brockton and Taunton/Attleboro catchment areas.

CCBC will also address the high volume demand at the two hospitals in the Brockton Area—Brockton Hospital and Good Samaritan Hospital, with a clinician available to be posted at each Hospital ED from 3-11pm and 11pm–7am for up to five days per week, Monday through Friday, and available to be on-site as needed during peak demand times on weekends and holidays. These clinicians can be deployed elsewhere in the catchment area to provide mobile crisis interventions upon request from the triage clinician.

**3.1.8 Location of services:**

**3.1.8.1 Please provide general information about the planned location(s) of ESP functions and services as well as hours of operation:**

Service Component	Address(es) where Service will be Delivered or Dispatched From	Days/Hours of Operation		Other Services at this Location
		Of the Service Component	Of the Physical site	
ESP Management Function	<u>Executive Management:</u> CCBC Taunton Main Office 1 Washington Street, Taunton <u>Program Management:</u> 157 Main Street, Brockton	8:30am – 5pm, M–F	8am–8pm	CBFS, CBHI, PACT Outpatient, PHP
800 number and	Brockton CBL – 157 Main	24/7/365	24/7/365	CCS

triage	Street, Brockton			
Community-Based Location	Brockton CBL – address TBD	8am – 8pm, M–F	24/7/365 8am–8pm, M–F	CCS
Youth Mobile Crisis Intervention	Brockton CBL – 157 Main Street, Brockton and from CCBC Main office as needed for back up volume	24/7/365 24/7/365	24/7/365 8am–8pm, M–F	CCS, Outpatient
Adult Mobile Crisis Intervention	Brockton CBL – 157 Main Street, Brockton and from CCBC Main office as needed for back up volume	24/7/365 24/7/365	24/7/365 8am–8pm, M–F	See above
Adult CCS	Brockton CBL – 157 Main Street, Brockton	24/7/365	24/7/365	ESP, CRS, ACT, QM
Run Away Program (RAP)	Brockton CBL - 157 Main Street, Brockton	4:30pm – 8am; 24 hours, weekends and holidays	8:30am–8pm, M–F	CCS

**3.1.8.2** CCBC is currently considering available space at 157 Main Street, Brockton for the co-location of the CBL and the CCS. Upon award of the contract, CCBC will move to complete the lease and build out the space to comply with contract requirements.

**3.1.9 ESP management**

**3.1.9.1** Please attach resumes, or if not yet hired, please describe hiring qualifications of the following positions:

- 3.1.9.1.1** ESP Program Director – See Attachment 3.1.9.1.1
- 3.1.9.1.2** Quality/Risk Management Director – See Attachment 3.1.9.1.2
- 3.1.9.1.3** Medical Director – See Attachment 3.1.9.1.3

**3.1.9.2** Attach an organization chart that indicates where these and other key ESP staff shall sit within the organization at an administrative and supervisory level.  
See Attachment 3.1.9.2

**3.1.10 Psychiatry: Describe your plan for psychiatry staffing and ensuring that all performance specifications related to access to adult and child psychiatric consultation and direct services, in all ESP service components, are met 24/7/365.**

CCBC will appoint Paul Weiss, MD as ESP Medical Director to oversee the rotation of on-call psychiatrists in Brockton and also in Taunton/Attleboro. Dr. Weiss is currently serving as the contracted Emergency Services Medical Director to the Brockton and Taunton/Attleboro ESPs operated by DMH. In the CCBC ESP for the Brockton catchment area, he will provide clinical supervision to the on-call psychiatrists, the nurse manager in the CCS, the ESP program director and the program manager for MCI. He will also sit in on weekly clinical rounds at the ESPs and CCS in the Brockton catchment area one morning per week. Other duties include acting as the clinical liaison to ED physicians and community primary care physicians and participation with the ED director in the regular meetings with the ED administrators.

CCBC has a rotating on-call system of psychiatrists who work for CCBC community-based programs, including the DMH-Operated ESPs. Each rotation lasts seven days. The doctors are required to respond to all calls from the ESP within 15 minutes, but CCBC expects them to respond within 60 seconds, almost 100% of the time. CCBC believes that the model of having a single doctor on-call in both catchment areas for case consultation will be a better use of limited resources across the two catchment areas. We believe that a consistent clinical approach across the two catchment areas will add value to the ESP program model that CCBC is proposing. As ESP medical director, Dr. Weiss will provide back up to the on-call rotation for both adults and children.

In an effort to increase the frequency of community-based mobile crisis interventions and use of alternatives to inpatient hospitalization, the medical director will chair a team to review and update the clinical criteria for diversion from the ED and from inpatient hospitalization. He will work with the Brockton and Good Samaritan Hospital staff to formalize a protocol for urgent psychopharmacology consultation for clients in the ED. The medical director will also be available for review of mobile requests.

The medical director will serve as the primary contact person in the ESP to provide a clinical resolution for clients who have remained in the ER or on a medical floor for more than 24 hours. An inherent strength of the CCBC system is the presence of psychiatric staff in various programs. The Board-certified child psychiatrist on-call function will be fulfilled by existing CCBC child psychiatrists. All psychiatrists meet MBHP credentialing criteria.

### **3.1.11 Strategies to Assess Risk**

CCBC ESP staff will all be trained in completing core elements of a risk assessment, from the initial telephone contact to the completion of the intervention. Often the telephone contact comes from a family member or provider. The triage clinician asks critical questions about severity of symptoms, presence of weapons, recent use of alcohol or drugs, history of violence, and any immediate injuries or threats of injuries to the client or those in the immediate vicinity.

CCBC will develop a “*decision tree*” that their telephone triage and front-office staff will deploy to provide an initial risk assessment. This decision tree covers: signs of intoxication; any external reports of danger posed by the client to others or to him/herself; the current level of ideation of self-harm; the willingness of the client to engage with ESP staff on discussing his/her mental state; and to contract for safety and to transport him/herself safely to the location where the evaluation will be completed. The CCBC protocol also includes questions on the client’s strengths and preferences.

In person, the ESP clinicians complete a standardized risk assessment form that covers the following: the client’s current mental status; the treatment history; current collateral contacts; the CCBC clinical history and medical record review; the nature and seriousness of the presenting problems; and current stressors. For children, CCBC conducts a joint interview and separate interviews with the child and guardian based on the age of the child and the nature of the problem.

At each stage of the interview process, the CCBC clinician re-confirms the client’s consent for treatment and their goals for the crisis intervention.

CCBC triage will go beyond the requirements of the RFR to consider with the client the possibility of the ESP clinician conducting the assessment in the client’s community setting, even when the client is not willing. The ESP medical director will oversee the established protocols to work with local police and families to decide on a case-by-case basis if a mobile

visit is safe and warranted on a non-voluntary basis. The ESP will have the capacity to assign additional staff in these cases.

CCBC will continue to refine and centralize policies and procedures to guide the triage staff and ESP clinicians in decision-making on mobile crisis interventions that address the key risk and safety issues for community-based ESP services. The consistent application of these practices across the Southeast region will minimize risk for the clients and their families.

### **Strategies to Mitigate Risk**

CCBC will deploy a host of strategies to mitigate risk during the course of a crisis intervention at the CBL. Most importantly, ESP staff, along with all other CCBC staff who work in the community, will carry electronic safety devices that alert supervisors, colleagues, and emergency responders, if necessary, if the employee is in any type of danger or requires back up or consultation. Currently CCBC has distributed over 250 of these devices (5 Star by Great Call) to CSP, CBFS, CBHI, and PACT staff.

There are three steps to mitigate safety risks in the ESP evaluation process: First, the ESP clinician will clarify the client's consent for treatment at each stage so that there is open and ongoing communication, even when the clinician determines that an involuntary intervention is required for safety reasons.

Second, when the clinical staff believe that the physical presence of the safety staff will provide stability and calm for an agitated client in a CBL, CCBC will deploy additional staff, including CPSs and FPs.

Third, in limited circumstances the hospital ED will be used due to the availability of security staff or local police may be asked to accompany clinical staff.

Finally, the ESP medical director or his designee will review all cases that are diverted from 24-hour care back to a community setting to ensure client safety as well as the safety of others.

## **3.2 Community-based location**

### **3.2.1 Describe your ESPs proposed community-based location(s) including:**

#### **3.2.1.1 General description of the physical plant, include parking, signage, entryway, waiting areas, treatment areas, meeting space, and staff work areas.**

The site is located at 157 Main Street, Brockton, on the corner of West Elm Street and Main Street, approximately two blocks west of City Hall. This central, downtown location is easily accessible to clients, families, and staff. This building previously housed the Brockton Neighborhood Health Center making it an ideal location for a behavioral health service. The offices are in close proximity to the District and Superior Courts, the Police Department, Brockton Hospital, and the new location of the Brockton Neighborhood Health Center.

The facility at 157 Main Street will be built out to include a reception area, three treatment offices for ESP evaluations, a conference room for group meetings of up to 10 participants, and three executive offices for the ESP program director, MCI program manager, and the ESP clinical supervisor. There is an adjacent parking lot for easy access of clients and collateral parties. The office will be accessible directly from the street with clear signage indicating the "Emergency Services Program of Community Counseling of Bristol County."

**3.2.1.2** One Hundred Fifty Seven (157) Main Street is centrally located in downtown Brockton in close proximity to other mental health services, social services, the Mainspring Homeless shelter, the Brockton Neighborhood Health Center, and within 2 miles driving distance from Brockton Hospital.

**3.2.1.3** One Hundred Fifty Seven (157) Main Street is located in the downtown Brockton community and thus qualifies as "being in the community."

### **3.2.1.3.1 Optional attachment: letters of support endorsing the selected location**

**3.2.1.4** The office is directly on the BAT Bus Line with a Brockton commuter rail stop nearby. It is a short drive for staff deployed to Good Samaritan Hospital.

**3.2.1.5** CCBC will have warm and calming colors on the walls with recovery-oriented and strength-based posters complementing any artwork hanging on the walls. The message of the posters will communicate hope.

All staff will be trained in motivational interviewing, client engagement, and customer service skills to make sure the clients, their families, collateral providers and other parties are treated with respect, dignity, and the right to determine the course of their care and recovery to the maximum extent possible. Staff will repeatedly ensure that all persons who come to the ESP are oriented to the specific features of the program, beginning with initial contact. Staff will explain the steps to be taken during the ESP episode: initial information gathering, clinical assessment, plan of action developed with the client, and placement or discharge with identification of the necessary resources. The staff person will also provide an initial estimate for the length of time for each step of the ESP process. The client will also be made aware of the resources of the ESP, including an offer of support from a peer specialist or family partner to provide further explanation of the ESP process.

Staff will underscore the member's right to confidentiality and, while emphasizing the importance of talking to collateral providers, acknowledge the member's right to refuse the ESP to contact other parties and that only written permission will suffice once verbal permission is obtained.

**3.2.1.6** CCBC staff will ensure that any client or family member coming to the Community-based location is fully oriented to the nature and purpose of the ESP and will repeat such clarifications as needed during the member's visit.

CCBC recognizes that emergency services staff will usually be encountering clients at moments of heightened vulnerability. To be effective, staff must rapidly engage the client, and develop rapport. A potential problem arises if the client decides that their ESP clinician is the only one that can help them. Staff will be very clear that their role is to support the client in achieving equilibrium and staff will communicate openness to the client's individual needs and preferences to address any acute psychiatric symptoms. On some occasions staff will need to set firm, but caring limits, particularly with that sub-set of clients that use the service and want ongoing support. A key in such situations is to use the techniques of motivational interviewing to align with clients on follow-up with community-based services. Indeed, linking the client to the appropriate community-based services is the primary goal of the ESP post-stabilization.

All staff will be trained to follow a standard protocol that results in a consistent message to the client: the ESP is for crisis intervention, stabilization and follow-up to the services that match the client's needs; that the client will be informed and have choice about that service; staff will keep lines of communication open to the client, his/her family as appropriate and for adults, when consent is given by the client, regarding next steps and available support for the client; and finally, that the client has access to a clinician, a peer specialist or family partner for the parent of a child, and that staff have access to consultation from a clinical supervisor, nurse and psychiatrist on-call if the need arises.

**3.2.2 Describe how you shall utilize your community-based location(s) to achieve the goals of ESP and this procurement, including:**

**3.2.2.1 How the selected community-based location shall support the goal of diverting behavioral health utilization from the hospital EDs in the proposed catchment area**

The CBL will be located in an accessible section of Brockton and will be open from 8:00 a.m. 8:00 p.m. Monday through Friday. The community-based location at 157 Main Street Brockton is located near public transportation and is accessible to the Brockton Hospital ED by walking or a short drive to promote diversions from the ED.

**3.2.3 Staffing**

**3.2.3.1 Describe how the staffing in your community-based location shall be used flexibly to meet the needs on a daily basis, including integration with the adult CCS.**

The CCBC Brockton ESP program will develop a model of flexible deployment of staff in the Brockton catchment area. CCBC is planning the features and benefits to assist MBHP in reducing reliance on the two EDs in Brockton, increasing mobile crisis interventions in the community and accessing a wider range of community-based alternatives to hospitalization. There are several highlights to the operation of this design that maximize flexibility and promote responsiveness to referral sources for crisis interventions:

- The co-location of the Brockton Community-Based Location (CBL) with the CCS at 157 Main Street, Brockton, will allow for staff from the CCS to assist staff assigned to the CBL during high call volume and demand for crisis interventions, staff shortages or acute client episodes within the community-based location. Similarly, staff in the CBL can assist staff in the CCS when there is higher than normal acuity or when clients' symptoms become more acute or disruptive in the CCS setting.
- Staff who are placed on site at either the Brockton or Good Samaritan hospital ED during evening shifts are not precluded from being re-assigned by the triage clinician to another site or to a mobile crisis intervention.
- The "hybrid" clinician position ensures additional staff during high volume periods of late afternoon early evening with a staff person who is available outside of the normal staff complement.
- CCS staff may be used for phone coverage, transportation to and from sites, and safety for office-based visits as part of de-escalation interventions.
- The peer specialists and family partners are available to accompany ESP clinicians for mobile visits.
- The administrative staff at both CBLs will be skilled at completing the administrative tasks that are often time-consuming in completing a crisis intervention. Their ability to communicate client status, verify insurance, respond to calls regarding a hospital search, and connect with collateral providers and family members, enables the ESP clinician to spend more face-to-face time with the client and the family completing the assessment and de-escalating the crisis.
- Eighty percent of the ESP clinicians will be cross-trained to work with children and families at the time of implementation. Within three months, 100% of ESP staff will be able to support the Youth Mobile Crisis Team.
- CCBC will draw upon its roster of experienced adult and child clinicians throughout the organization to assist in providing a rapid response during periods of unanticipated heavy demand.

**3.2.3.2 Describe how you shall utilize Certified Peer Specialist staff in your ESP community-based location(s).**

The CCBC ESP will work closely with the CPS to define and refine their role with the ESP. At the outset, however, we envision some key functions for the CPS:

- The CPS can provide peer support for clients who are especially withdrawn or perhaps somewhat agitated to assist the clinician in engagement and to provide reassurance during the period that the ESP and the client are awaiting a resolution to the intervention.
- The CPS can assist in the interview to help the clinician in understanding the client's symptoms and answers if the client is especially agitated. Sometimes an informal approach by the CPS may yield better results, and the client may share more if they know that the peer may have gone through similar struggles.
- The CPS can provide same day or next day follow-up to the client in assisting them with intake appointments, securing of basic necessities, applying for benefits, or attending local self-help programs.
- The CPS can accompany the ESP clinician on mobile crisis interventions as a "safety" staff person and to help in gathering information from family members or the referring provider.
- The CPS will run peer support groups in the CCS for interested clients to help them build coping skills and help them learn to access community resources, including 12-step recovery programs, housing, entitlements, and social supports.

### **3.3 Adult Mobile Crisis Intervention**

**3.3.1 Provide a brief program description that summarizes your planned Adult Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.**

**3.3.1** CCBC's proposed model of operating the Brockton ESP will ensure a consistent application of MBHP performance specifications. This approach will enhance timely telephone triage, responsive program management, comprehensive clinical supervision, and access to risk management and quality improvement resources that will result in a higher quality of care, more efficient use of resources, and more timely achievement of MBHP goals. This structure will ensure a higher rate of mobile visits, higher rate of diversion from inpatient hospitalization and more timely responses to requests for ESP interventions.

**Program Philosophy and Culture.** The philosophy of CCBC's Brockton ESP is that rapid response to urgent care situations increases community-based interventions that lead to greater rates of diversionary disposition. Therefore ESP staff will quickly determine at the initial phone triage, the feasibility of an adult mobile crisis intervention through a telephone assessment by the experienced triage staff. They will work with the referral source to assess the utility of a mobile crisis intervention based on the client's willingness, the current risk and safety issues, the availability of family, friends or providers to assist, the need for police assistance, and any outstanding medical issues that would contraindicate a mobile visit. Other factors include CCBC's working familiarity with the referral source and the client's involvement with CCBC services including the client's prior ESP episodes both of which will be available to the Triage clinician through the CCBC Electronic Health Record (EHR) system. The ESP will also have access to any standing crisis plan with current providers, such as the CCBC Risk Management Team.

**Service Delivery Model.** When the telephone triage clinician decides on a mobile visit, s/he can immediately dispatch one of the available clinicians to the location. There will be a "white board" in the office that specifies the location and activity of all ESP clinicians on duty. The

triage clinician also has a roster of the hybrid clinicians and the other ESP relief clinicians who can be contacted if all of the clinicians on duty are involved in other crisis interventions. All master's level clinicians are available for mobile crisis interventions. With an adaptation of CCBC's EHR, CCBC will incorporate a computer tracking and scheduling system to monitor requests and response times throughout the two catchment areas.

**Flow of Services.** CCBC ESP managers and supervisors on-call will determine the support for the ESP clinician in the mobile setting. A mobile visit to a private home is likely to often involve two ESP staff. Visits to group homes, schools, local jails, and nursing homes will usually require only the ESP clinician, unless the client or family requests a CPS or FP.

**3.3.2 Describe how you shall utilize bachelor's level staff and/or Certified Peer Specialists to support the adults utilizing these services and to assist the master's level clinicians in providing ESP services to adults in a mobile capacity.**

**3.3.2** The use of the BA and CPS staff for Mobile Crisis Interventions will follow the same protocol as the determination of mobile visit from the outset. For example, some clients prefer the presence of a CPS in their self-determined crisis plan. Other clients may prefer to have a person, who has similar experiences as the client in a crisis, accompany the clinician. CCBC also knows from experience that the BA-level or CPS can be a stabilizing influence on the client by taking time to explain to the client or sit with the client while a follow-up service is being located. The addition of these staff may also be preferred by the family member or referral source. The triage clinician will consider all of these factors in assigning a BA staff person or CPS to accompany the ESP clinician in a mobile crisis intervention. It is CCBC's goal to have the CPS fill the BA-level staff positions as well as the CPS positions. CPS staff can also be useful in keeping the family informed about the status of the assessment and answering their questions.

### **3.4 Adult Community Crisis Stabilization (CCS)**

**3.4.1** The goal of CCBC's CCS program is to stabilize clients experiencing a behavioral health crisis that might otherwise deteriorate to the point of needing hospitalization. The program shares several features with an inpatient setting: a multi-disciplinary team approach, a staff secure setting with around-the-clock presence of nursing and counseling staff, low client/staff ratios, a separate living environment that affords a respite from daily life, and the capacity to prescribe and monitor psychotropic medication.

Clients admitted to the CCS will participate in an organized program of individual and group counseling, peer support, medication management, education, and case management. The goal of the client's participation in the program is to enhance their existing strengths, stabilize their psychiatric symptoms, coordinate with existing supports in the community, and prepare the client for a timely return to their community setting. All clients will receive an initial bio-psychosocial assessment that includes an evaluation of current medications. Each day the assessment will be updated throughout the client's stay in CCS.

At the outset of the ESP intervention, the program philosophy will be to rule in all adults for admission to the CCS when the client requires a safe placement. This includes persons with active substance use issues and persons who present some risk to themselves or others. CCBC triage staff will then rule out admission to the CCS if the client's mental health requires the presence of skilled clinical staff around the clock, if a locked setting is required to prevent the client from harming him/herself or others, or if there are other medical conditions, including detoxification, that require monitoring by skilled medical staff around the clock.

CCBC will provide 24/7 awake staffing of the CCS with a minimum of one LPN and one BA counselor or safety worker on-site for all shifts. During the day and evening shifts, the clients will participate in structured activities, including medication education groups, self-help groups on building coping skills (facilitated by the CPS), discharge planning groups, and recreational activities. Staff will also provide case management activities with clients to assist them on making arrangements for follow-up care and other necessary resources such as housing, entitlements, court appearances, medical appointments, and accessing natural community supports.

Each client will have an assigned counselor who will oversee their participation in the program and work with the client on discharge planning, crisis planning, contacting current providers, arranging for intake appointments with new providers, and helping the client to identify and follow-up with holistic resources and natural community supports identified to be a part of the client's continued recovery.

The ESP psychiatrist will review and approve all admissions in consultation with the nurse manager and participate in medication evaluations as needed. The ESP psychiatrist will approve all CCS discharges.

### **3.4.2 Physical plant**

#### **3.4.2.1 General description of the adult CCS's space, including treatment areas, living space, meeting space, staff work areas, and parking**

CCBC proposes to co-locate its ESP community location and CCS at 157 Main Street in Brockton. The site is located on the corner of West Elm Street and Main Street, approximately two blocks west of City Hall. This central, downtown location is easily accessible to clients, families, and staff. This building previously housed the Brockton Neighborhood Health Center, making it an ideal location for a behavioral health service.

The second floor space of this location, currently unoccupied, has up to 5,300 square feet available to fit the needs of the ESP and CCS. This space has a dedicated handicapped accessible entryway as well as elevator access from the street level. The parking lot leading to the primary entryway has 20 vehicle spaces, as well as additional street parking if necessary. The office suite meets all fire and safety code requirements. Every door and entryway meets ADA requirements and there are two handicapped bathrooms.

While this space will require some remodeling and build-out for the CCS component, there is more than adequate existing space for treatment areas, meeting space, and staff working areas. The current layout is conducive to all elements of the ESP and a modest redesign for the CCS. Directly upon entering the suite, there is a waiting room with a reception area for the program assistant to serve both the ESP and CCS. Given its previous use as a health center, there is plumbing available throughout the suite. The space is large enough to accommodate single bedrooms for the CCS, with potential expansion of capacity going forward.

The CCS will have six single-room occupancy bedrooms to accommodate six clients. There will be a communal living room for leisure and social group activities and all community meetings. There will also be two small counseling offices for individual meetings and one larger room for group meetings involving clients, families, and other providers to attend. The full-service kitchen will accommodate all residents.

#### **3.4.2.2 How you shall establish a physical environment and interpersonal climate that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support**

The CCS will have warm, calming colors on the walls with posters that provide hope, encouragement, and examples of recovery for the residents. The rules of the program, client

rights, and daily schedule will also be prominently displayed so that clients are fully aware of their responsibilities and obligations in the program.

Staff will be trained in motivational interviewing, clarity of communication, and in holistic approaches to psychiatric interventions. The peer specialists will be part of the orientation for staff and will also be available to clients who seek informal communication to share any concerns about the program.

**3.4.3 State your plan related to co-location of the adult CCS with the ESP community-based location**

CCBC is actively engaged in discussing a lease arrangement with the owner of the property at 157 Main Street, Brockton to include a Community Crisis Stabilization program with six beds. The general floor is for street level entry with a greeting area. The main entrance is handicapped accessible and with over 5,000 square feet of buildable space has sufficient space for staff offices, interview rooms, medical records, and waiting area. The living space includes a kitchen, and bathrooms with shower. CCBC is negotiating a lease that will become effective upon notice of award with the schedule to permit necessary renovations before implementation date.

**3.4.3.1 Describe the co-located or shared space relative to proximity, flow, and any space that shall be shared for functions of both the ESP and adult CCS.**

The proposed CBL/CCS described above has a space configuration that provides ready access between the CCS and the CBL for maximum flexibility in staff deployment. The layout allows for both separation of the CBL and CCS, but also easy access between each service component. with the ESP component has a reception area, counseling rooms, administrative offices, and a conference room. The CCS area will have space for six beds, bathrooms, kitchen, living room, conference room, counseling rooms, and several offices for CCS staff.

CCBC will negotiate the lease at 157 Main Street, Brockton that will become effective upon notice of award, with the schedule to permit necessary renovations before implementation date.

**3.4.3.2** The lease for co-location of the ESP will be in place at the time of the implementation of the contract.

**3.4.3.3** N/A

**3.4.4 Changes in CCS Capacity**

CCBC proposes no changes to the capacity of the CCS in the Brockton catchment area.

**3.4.5 What is your proposed communication plan between your adult CCS and your other ESP service components, particularly your ESP community-based location, for example, staffing, sharing resources, transfers, sharing clinical knowledge, risk management/safety planning, joint rounds, joint staff meetings, etc.?**

**3.4.5** CCBC is proposing to locate the telephone triage and community-based location for the Brockton catchment area in the same building as the CCS. The location of all staff on duty is listed on a white board. Triage clinicians have authority to call in additional clinicians and BA level staff when the need arises.

The ESP medical director and the nurse manager of the CCS will work collaboratively with other ESP staff in reviewing client records daily on all CCS clients. The nurse manager will conduct daily rounds for CCS clients. All CCS staff can follow-up with ESP clinicians who completed the initial ESP assessment if there are any questions. Psychiatrists will review each CCS client with the psychiatrist taking the next shift, as a warm clinical hand off.

At weekly staff meetings of all ESP staff, case presentations will be discussed to determine the appropriateness of members referred to CCS in line with risk management criteria around

safety. A portion of the staff meeting will include joint rounds to identify problem cases when a CCS admission could not be managed in the CCS and successful cases where CCS was an appropriate diversion.

On a monthly basis, the ESP program director will invite representatives from the Brockton Hospital and Good Samaritan EDs to participate in case reviews that involve members referred from EDs to CCS.

**3.4.6 Describe your planned approach to utilize the full clinical potential of the adult CCS outlined in this RFR and the performance specifications. Address how shall you educate stakeholders of the capacity and acuity level of the adult CCS and how shall you make consumers, families, and other stakeholders feel comfortable using the adult CCS to treat those who present with a higher level of acuity.**

**3.4.6** Based on the experience of the CCBC-contracted psychiatrists providing clinical oversight to the DMH-operated CCS programs, CCBC will continue to build the culture within the ESP that the CCS can manage an increasingly challenging client. The CCBC psychiatrists who are contracted to work with the DMH-operated CCS's in Brockton and Taunton/Attleboro have developed a close working relationship with the nurse manager in charge of each CCS. Together they have developed a philosophical commitment to serving those most in need, and a track record of eliminating barriers to access. The first objective will be to review the clinical criteria and admission process to identify any obstacles to timely access. Among these are required medical clearances that may or may not be necessary. The second objective is to train all staff, including staff in the CBL, on the admission criteria, admission process and approval of admissions.

As a new provider for ESP and CCS services in the Brockton catchment area, CCBC recognizes that much work with stakeholders will be necessary to build an acceptance of the full capacity of the CCS, especially one that is located in the community setting of downtown Brockton. There are several steps that CCBC will take to demonstrate the capacity of the CCS: First, the admission criteria and steps to admission process will be distributed to all clinical referral sources, including hospital EDs, Brockton Neighborhood Health Center, mental health centers, CBFS and PACT providers in Brockton, DMH case management staff, and local ambulance companies as well as law enforcement officials. The second step will be face-to-face meetings with examples of recent referrals that were admitted to the CCS to provide a context for the referral sources as well as examples of clients. The other step will be to host a series of open houses at the CCS to encourage stakeholders to view the physical setting and meet the direct care staff.

Once the CCS has begun operating, the ESP program director will assign staff to work as ESP clinician “ambassadors” to community programs such as nursing homes, group residences, shelters, and community support programs whose clientele can most benefit from the CCS as an alternative to hospitalization. CCBC’s social marketing efforts will tout the benefits and the capacity of the CCS to other providers as well as to ED medical staff and police. The ESP will also hold informal “open houses” for community stakeholders to visit both the Central Triage and the CCS.

### 3.5 Mobile Crisis Intervention (MCI) Response Section

**(Note: An incomplete or unsatisfactory response to this element could exclude a bidder's proposal from consideration.)**

#### 3.5.1 Statement of intention:

- X The bidder intends to directly operate the Mobile Crisis Intervention component of the ESP and shall demonstrate competency in the section that follows.
- N/A 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.

**3.5.2** CCBC believes that we are well positioned to exceed the MBHP Performance Specifications of the MCI Program in the Brockton catchment area because of the following:

1. CCBC has two years of experience as the contractor for MCI services to the DMH-operated MCI Team.
2. CCBC has 12 years of experience as the contractor for Emergency Psychiatric Services with the DMH-operated ESP Team in Brockton.
3. CCBC has established leadership as the CSA provider for other children's behavioral health providers and other children's stakeholders in the Taunton/Attleboro area. This foundation of leadership, collaboration, and skill at establishing the Wraparound model of care with a variety of stakeholders in the Taunton/Attleboro catchment area will be implemented in the Brockton area in collaboration with the Brockton CSA and other CBHI providers and children's stakeholders in that area. CCBC's letter of support from the CSA provider, Brockton Area Multi-Services, Inc. (BAMSI) confirms CCBC's qualifications in Brockton. CCBC is best positioned to deliver MCI with the highest fidelity to the wraparound model of care.
4. CCBC's Taunton/Attleboro CSA is the lead behavioral health provider for Bristol County's Juvenile Justice Behavioral Health Alternative Path Program (JJ-BHAPP).
5. The operation of the CSA and other CBHI services is continuously being improved through a robust quality improvement process based on feedback from families and standardized measures of wraparound fidelity. This Continuous Quality Improvement (CQI) process will include the Brockton MCI program.
6. CCBC has a solid foundation in Taunton/Attleboro as a provider of Child Outpatient mental health services, CBHI services such as In-Home Therapy and Therapeutic Mentoring, as well as the established Community Service Agency (CSA) for the Taunton/Attleboro area.
7. CCBC is the Runaway Assistance Program (RAP) lead for all of the Southeastern Area for DCF that includes the Brockton area.
8. CCBC has a community orientation in the Brockton catchment area through our PACT and CSP programs.

**3.5.3 Further demonstrate your organization's readiness to provide Mobile Crisis Intervention by attaching the following documents (as many as are available and applicable to your organization) in order to demonstrate meeting the criteria delineated in Section V.B. of this RFR:**

**3.5.3.1** Below are examples of CCBC's experience with key measures of competence for an MCI Program:

- CCBC serves 3,000 children annually in our outpatient mental health clinics.
- CCBC serves 900 children annually in our full spectrum of CBHI Services: Intensive Care Coordination, Family Support and Training, In-Home Therapy and Therapeutic Mentoring.
- CCBC employs 10 family partners in its CBHI programs. One of these family partners also works for the DMH-operated ESPs as one of the family partners.
- CCBC's CSA is fully compliant with MassHealth CBHI performance specifications in the use of the Strength-Needs-Cultural Discovery Assessment Form, in developing Crisis Management Plans with families, scoring on the Wraparound Fidelity Index (WFI) and Team Observation Measure (TOM) measures, and Family Satisfaction survey results on families being included in service planning.
- CCBC's CSA meets twice a year with the MCE network managers, a proxy for compliance with existing standards of care related to access, quality, and outcome.

**3.5.3.2** CCBC is fully compliant in training all staff on the Principles of Wraparound Systems of Care. Staff receive ongoing coaching and training to maintain and improve skills.

**See Attachment 3.5.3.2 for evidence from the Wraparound manual indicating CCBH's compliance.**

**3.5.3.3 Evidence of working with Family and Youth.**

**See Attachment 3.5.3.3 on FY 2014 Report on Family Satisfaction Survey and key findings from FY 2015 survey.**

**3.5.3.4 Policies and Procedures and/or Clinical Protocols.**

**See Attachment 3.5.3.4**

**3.5.3.5 Outcomes Data:** CCBC's CSA participates in the measurement of the WFI, and the TOM with other CSA's.

**See the WFI and TOM Reports in Attachment 3.5.3.5.**

The scores are tallied annually and CCBC uses the findings to design program improvements to better serve children and families.

**See Attachment 3.5.3.5 on FY 2014 Report on Family Satisfaction Survey and key findings from FY 2015 survey.**

**3.5.3.6 Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels in providing behavioral health services to children, adolescents, and their families. Evidence may include accreditation reports that speak to your work with youth and families and in-service training schedules or curriculums addressing the assessment and treatment of youth and families.**

CCBC's CSA provides a credentialing report to the MCE's on the staff hired as intensive care coordinators and family partners.

The agency operates three licensed outpatient sites licensed by DPH that serve children and families.

**See Attachment 3.5.3.6 for the Wraparound Facilitator Checklist.**

**3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention**

**3.5.3.7.1 See Attachment 3.5.3.7.1**

**3.5.3.7.2 See Attachment 3.5.3.7.2**

**Job descriptions of any identified staff members who would be staffing the Mobile Crisis Intervention service in any capacity, including the Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians, paraprofessionals and/or family partners.**

**3.5.3.8 Experience of integrating youth and family voice in organization governance. Evidence may include names and length of service of those currently on advisory boards.**

One member of CCBC's Board of Directors has a child with serious emotional disturbance bringing that experience and voice to organizational governance. Also, the CCBC CSA's Systems of Care Committee convenes monthly meetings that are open to all children's advocates and stakeholders in the Taunton/Attleboro catchment area. CCBC's family partners and CSA and IHT family members in care attend the monthly statewide PPAL meetings.

The CSA director is a member of the DCF Children and Family Area Board for Children. The goal of the meeting is to provide support to DCF foster parents, help children graduating from Foster Care into independent living and support DCF's mission overall. The CSA director is also on the board of Associates for Human Services' Early Intervention Transition Committee for children transitioning from Early Intervention to public school. CSA has also conducted focus groups comprised of parents and guardians of children enrolled in the CSA to solicit their input into program development.

**3.5.3.9** The CCBC CSA has worked with the DYS, DCF and DMH residential providers when members from their CSA are receiving 24-hour care in one of these programs. The CSA has also accepted referrals of children and families from the Brockton catchment area when there is a temporary backlog in the Brockton CSA. When doing so the CSA has worked along with the Brockton School Department, local IHT, and In Home Behavioral services.

**3.5.3.10 Membership in child advocacy and/or child-focused trade organizations**

CCBC is a member of the following local and statewide child advocacy and trade organizations:

- Parent Professional Advocacy League (PPAL);
- The Department of Children and Families' Area Advisory Committee;
- The Association for Behavioral Health (ABH)'s CBHI committee and ABH's Child Policy Committee;
- CCBC attends Statewide CSA Meetings, Southeast CSA meetings and the CSA statewide Coaching meetings; and
- Language Access Committee in Taunton/Attleboro Area, facilitated by Associates for Human Services

### **3.5.4 Mobile Crisis Intervention**

**3.5.4.1 Provide a brief program description that summarizes your planned Mobile Crisis Intervention service addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services.**

**Describe how you will provide a bi-disciplinary (clinician and family partner) intervention to engage and address the treatment needs of the child while also engaging, and supporting the experiences of the parent(s) whose child is in crisis.**

**Program Description.** CCBC will implement the Mobile Crisis Intervention program in the Brockton catchment area to be fully compliant with the ESP Performance Specifications and consistent with the Principles of the Wraparound model of care. CCBC's program philosophy underlying MCI services are embodied in the Principles of Wraparound Services. CCBC will be committed to providing 70% of the services at a minimum in the community-based settings, such as schools, homes, day care programs, after-school programs, and group homes and shelters. All clients presenting for Mobile Crisis Intervention will be evaluated by the clinician who is child-competent and experienced with children and families.

MCI staff will be fully trained in the Wraparound model of care to provide a strength-based approach to children with SED and to their families. Their approach to family engagement and empowerment and the child's resiliency will increase the use of the full continuum of community-based alternatives in the Brockton catchment area to which families and children can receive support as diversions and safe alternatives to 24-hour care. The MCI clinician will work in partnership with family partners to engage the whole family, complete a thorough biopsychosocial assessment that includes family preferences, resources, and natural supports, and work in partnership with the family to determine the next steps for supportive services. The CCBC MCI will have the capacity to support the family throughout the crisis up to seven days of mobile crisis intervention as needed by the family to stabilize the presenting crisis and facilitate a smooth transition to other CBHI services, as needed.

All staff will be capable of providing MCI in community settings throughout the Brockton catchment area.

The MCI staff will have access to two board-certified child psychiatrists, Diane Press, M.D. and Gabriella Velcea, M.D. to discuss clinical dispositions and to resolve complex clinical issues, especially as they arise with children in DCF or DYS custody. The goal of the intervention is to assure the safety and comprehensive clinical management of children in crisis.

A key component of MCI is the initial and ongoing support for the family, provided by both the ESP clinician and the family partner. Families will receive ongoing support as the disposition is being implemented. The team approach can be especially valuable when families are waiting in the Hospital Emergency Department where the atmosphere can be chaotic and stressful.

CCBC recognizes that the resolution of the presenting problem is only one part of the full crisis intervention. The Wraparound approach includes assistance to the family in identifying natural community supports and resources to give the family additional strengths to support the child in crisis. The support for the child and family also includes a seamless transition to other CBHI services on a timely basis.

**3.5.4.2** The CCBC MCI program manager will have a full complement of full-time, part-time and on-call clinical and family partner staff for the Brockton ESP. In addition, there will be a Centralized Triage and clinician assignment capacity that will afford the Brockton MCI program additional resources from the Taunton/Attleboro catchment area to address

fluctuating demand in the Brockton area, especially at Brockton Hospital which has been one of the higher volume EDs in the state in recent years. CCBC can draw upon the current roster of MCI staff that are contracted with DMH as well as the family partners who work in CCBC's CBHI programs. CCBC also has a full complement of outpatient clinicians who are child competent.

In addition, CCBC will train all ESP clinicians to be competent in completing child clinical evaluations. The additional capacity will help CCBC to address fluctuating demand for children's evaluations. CCBC has had success with hiring parents of children with SED as family partners once the parent has completed their involvement with the CSA.

**3.5.4.3** CCBC has learned from our experience in the Wraparound Model of care that the needs of children with SED can vary from hour to hour and day to day. The Wraparound Model provides a foundation to work with the family to assess their needs, mobilize their strengths, and provide ongoing support as needed during the crisis. Such an approach will be smoothly adapted to the MCI model of intervention with families up, to seven days as needed.

There are several steps to take during the initial intervention to assure access to the seven-day intervention. First the MCI clinician will assess the child's safety and mental status to insure that the symptoms of the serious emotional disturbance can be managed in a home setting. This assessment will be reviewed with the clinical supervisor, ESP program director or consulting child psychiatrist. Second, the family partner will orient the caretaker to the nature of the MCI visit and outline options for them that include placement outside the home, referral to community-based services and ongoing support from the MCI Team that includes both clinical staff and family partners to help stabilize the child. Third, when the clinical assessment is completed, the MCI Team will work with the caretaker to outline the options and help the caretaker to choose the best option up to and including a seven-day intervention. Finally, the MCI Team will work with the child and family to identify the follow-up services needed post stabilization and identify the steps the family needs to take to secure those resources.

During this time, CCBC will engage other CBHI providers including In-Home Therapy as a transition from the crisis intervention episode to ongoing treatment. The culture in CCBC's CBHI service array involves ongoing flexibility to meet family needs and recognition of the non-linear nature of serious emotional disturbance and family resiliency in crisis.

If CBHI services are already in place for the family, MCI can be accessed to meet additional needs identified in the mobile crisis intervention that fall outside the hours that the CSA and In-Home Therapy are being provided. CCBC has a demonstrated track record to meeting access standards for CSA's without a waiting list. This practice will be extended to the operation of the MCI's ongoing reporting to CCBC's senior leadership.

During the course of the intervention the MCI Team will review the child and family's status with CCBC's ESP clinical leadership to ensure that client safety is being maintained and that progress is being made to stability and follow-up supports.

**3.5.5** CCBC has established a culture of linkage to CBHI services through its experience convening Systems of Care meetings in the Taunton/Attleboro catchment area. In Brockton, CCBC MCI staff will actively seek out Brockton Area Multi Services, Inc. (BAMSI), the CSA provider in Brockton, to participate in their Systems of Care meeting. The CCBC MCI will also convene smaller meetings of CBHI providers and other stakeholders to develop safety plans for children at risk of, or following a crisis intervention. CCBC will utilize these linkages to enhance family voice and choice in the establishment of these safety plans that are designed to keep the child at home, support the family, and engage them in the supportive care of their child.

Our CSA has already established working relationships with residential programs operated by DCF, DYS, BSAS and DMH in the Brockton catchment area. The CSA program director has a working relationship with the DCF Area Office that oversees both the Brockton and Taunton/Attleboro areas.

Another strategy to ensure linkages with other CBHI providers is to enlist the support of the Managed Care Entities who can help the MCI staff access CBHI service providers, outpatient providers and specialty providers to support the family. CCBC recognizes the MCE responsibility to ensure timely access for their members, especially members who are in crisis.

### **3.6 Runaway Assistance Program (RAP)**

CCBC is the designated Runaway Assistance Program (RAP) for the four state operated Emergency Services teams in the Southeast Region, as one component of its Emergency Services contract with DMH. This service provides assistance to police officers who are dealing with runaways during the hours the juvenile courts in the Southeast region of DCF are closed. The service operates Monday thru Friday 4:30pm to 8:30am and weekends from Friday 4:30pm–Monday 8:30 am, the times that the courts are not open to respond to these situations. CCBC on-call staff are prepared to respond to conduct a face-to-face assessment of any child age 17 and under who is brought to the ESP community site within one hour of notification.

#### **3.6.1. Describe your experience in collaborating with local police departments, court clinics and DCF relative to youth served by your agency.**

CCBC has a long history of collaboration with local police departments, court clinics and DCF youth. CCBC was a leading partner in the design and delivery of the Community Crisis Intervention Training program through a contract with the Taunton Police Department. When a CSA or IHT client is involved or potentially involved with the police, the staff will request that the police assign an officer who has been through the CCIT program to provide a more sensitive approach to the child and family. CCBC has also shared crisis safety plans with the police to prevent escalation of crisis situations when law enforcement is involved. The police are invited to the CCBC Systems of Care meetings in the Taunton/Attleboro area. The CCBC CSA Systems of Care has regular collaboration and attendance from the court clinics, DYS, DMH, DCF and Juvenile Justice Partners.

CCBC has been designated as the first CSA to participate in the Juvenile Justice Diversion Program in Bristol County, set to begin in the fall, 2015. Court Clinic personnel are invited to attend the Systems of Care meetings hosted by the CCBC CSA.

As stated above, CCBC serves on DCF’s Advisory Committee for the Taunton/Attleboro catchment area and invites DCF personnel to attend the monthly CSA Systems of Care meeting.

## **4. Additional response requirements, if applicable to bidder (considered but not scored)**

### **4.1 Hospitals as bidders**

#### **4.1.1 N/A**

### **4.2 Bidders submitting responses for multiple catchment areas**

**4.2.1** Community Counseling of Bristol County is pleased to submit a proposal for a regional approach covering both the Brockton and Taunton/Attleboro catchment areas to operate the Emergency Services Program for MBHP. We believe that this model offers superior value to clients, their families, MBHP and the important stakeholders through the creation of a regional network, which provides a more efficient, flexible, effective, uniform, and integrated ESP program of the highest quality.

The regional ESP system will be overseen by a program manager who will supervise both the Brockton ESP program director and the Taunton/Attleboro ESP program director. The two combined ESP sites will also benefit from the expertise of a medical director who has been associated with the two ESPs for 5 years. One psychiatrist will be on-call for both sites, substantially reducing the cost of on-call psychiatry. The expanded roster of ESP staff will be available in both catchment areas through CCBC's Centralized Triage, providing greater flexibility to respond to fluctuations in demand. The regional staffing will include a large enough pool of workers for CCBC to recruit specialist staff for the following populations: Hispanics, Cape Verdeans, and persons with developmental disabilities. In addition this model will allow for a team of certified peer specialists and family partners to become integrated into the ESP model and offer greater support to one another. Similarly, continuous quality improvement, risk management and billing functions and cost would be spread over a longer base, reducing total cost.

**4.2.2.** As the operator of two ESPs in the Southeast region, CCBC will bring a number of strengths that will enhance the goals of the ESP in both operation and in better matching services to the needs of the members. First, CCBC will be able to extend the culture of community-based recovery and collaboration with other stakeholders to Brockton, where CCBC already provides care in its CSP, PACT and psychiatric emergency services. Second, CCBC will have a wider pool of ESP clinicians, peer specialists and family partners to draw upon for the Brockton catchment area. As the largest behavioral health provider in the Taunton area, CCBC has refined the skill at recruitment and retention of both clinicians and non-clinical staff. Third, CCBC's community orientation towards strength-based, solution-focused, and client-centered interventions will reduce the volume of clients going to EDs in both areas and will access untapped community resources for clients to access to prevent exacerbation of the mental health conditions. Finally, the administrative efficiencies of a combined oversight will reduce the financial exposure at the startup of the program.

While CCBC believes certain efficiencies are achieved with an ESP serving the combined Taunton/Attleboro and Brockton areas this proposal is not contingent upon a combined service area. This proposal for the Brockton ESP may be considered a stand-alone proposal.

## **1.9.2 Quality Management Plan**

**ESP RFR Attachment 1.9.2**

Community Counseling of Bristol County, Inc.

**Policy and Procedure**

Title: Quality Management Plan

Policy Number: VII-01

Effective Date: August 5, 2005

Page: 1 of 7

Reviewed/Revised Dates:

8/2/05, 2/20/14, 5/19/14, 2/10/15, 3/3/15, 3/10/15, 3/18/15, 4/2/15, 6/2/15, 8/26/15

**GOVERNANCE AND STRUCTURE**

**STATEMENT OF POLICY:**

**In order to fulfill the mission of the Agency, Community Counseling of Bristol County, Inc. is committed to a comprehensive quality management, which includes continuous quality improvement and regular program evaluation.**

The purpose of this plan is to ensure that reliable and valid data are gathered, reviewed, analyzed, and utilized in correcting problems, enhancing the quality of the Agency's services, and obtaining and properly managing the human, financial, physical, and community resources, so that the services provided to individuals and families served meets the highest standards of ethics, quality, and cost effectiveness. All services and administrative operations of the Agency are included.

The Agency's Quality Management processes include data collection, review, and management actions that are sufficiently frequent for timely corrections or improvements. The processes are inclusive, involving individuals served, staff, and community and Board representatives. The processes are functionally integrated in ongoing management activities – identifying strengths, weaknesses, and areas for development, and tracking the implementation and success of management actions designed to improve program outcomes, solve problems, and enhance the quality of services.

Quality management includes three essential components. The first, and most important, is an organizational commitment to quality care and to the continuous improvement of that care. Beyond this commitment, the two additional essential components, organizational structures and processes, are required to continuously monitor, measure, and evaluate the care provided. The following describes the organizational structures and processes in place at Community Counseling of Bristol County, Inc. (CCBC) designed to carry out the quality management with respect to the Agency's management and programmatic performance.

- 1. CCBC has a governing body, which functions with overall responsibility for the Agency's operations.**

CCBC's Board of Directors is the governing body for the Agency, with overall responsibility for the Agency's operation. The Board meets on a bi-monthly basis. Committees of the Board, Finance Committee, meet monthly or with greater frequency as needed. CCBC's President has regular contact with the Chair of the Board of Directors to update him on Agency services, finances, personnel and related issues. The Agency's President is an ex-officio, non-voting member of the Board of Directors attending all meetings of

## **ESP RFR Attachment 1.9.2**

the Board of Directors. Other management staff attends meetings of the Board of Directors as requested. At each meeting of the Board of Directors, the President reports to the Board on the organization's finances, services, human resources, regulatory issues and other matters of importance to the Corporation.

At least one member of the Board of Directors participates as a member of the Patient Care Assessment Committee (PCA) and reports to the Board on a quarterly basis. The Patient Care Assessment Committee is a primary mechanism by which the Board of Directors monitors and evaluates the services of the organization. The Agency's PCA Plan is approved by the Massachusetts Board of Registration in Medicine. The PCA Committee is comprised of the Chief Operations Officer, the Medical Director, the Vice President of Integrated Care, the Vice President of Adult Outpatient Services, the Vice President of Child & Family Services, the Vice President of Community Treatment and Rehabilitation, the Vice President of Housing and Special Initiatives, Quality Management and Compliance Coordinator, and other staff as assigned.

The PCA Committee regularly reviews the activities of the Risk Management Committee (RMC), the Safety Committee, and the Human Rights Committee. The Committee also reviews the results of any and all external reviews, including: all investigations, contract performance reviews, compliance reviews and licensing reviews. The Committee also reviews the results of any internal audits and regularly reviews client outcome data and client satisfaction surveys.

The Agency maintains an ongoing program to assure that processes are in place to assess and maintain compliance with regulatory requirements and contractual obligations provides mechanisms for staff reporting and regularly performs tests of compliance in areas identified as critical or difficult from a regulatory compliance perspective or when prior compliance has been a problem.

### **2. CCBC maintains up-to-date written descriptions of the administrative structure and lines of authority of the Agency.**

CCBC maintains an up to date Table of Organization. The Board of Directors is the appointing authority for the positions of President and Medical Director. The President appoints all other staff. The organizational chart is reviewed at a minimum of once a year, but also at each occasion as a new program or service is added to the Agency's continuum of care.

The Leadership Team for the Agency meets on a weekly basis, and is comprised of the President, the Chief Financial Officer, Chief Operating Officer, Vice President of Adult Outpatient Services, Vice President of Child and Family Services, Vice President of Community Treatment and Rehabilitation Vice President of Integrated Care, Vice President of Housing and Special Initiatives, Facilities Manager, and Human Resources Coordinator. Other management staff, including Program Directors, meets with the Leadership Team on a monthly basis. The purpose of this meeting is to assure good communication, disseminate information, and develop and review organizational policies and procedures. Program Coordinators and others are invited for specific projects and discussions. Minutes are kept of each meeting. The Leadership Team is charged with responsibility for all aspects of management of the Agency, including, but not limited to developing and monitoring program budgets, meeting licensing requirements, human resource management, identifying operational problems and solutions, reviewing consumer access and service issues and participating in quality management activities.

### **3. Assessment of Program Quality and Performance.**

**The Quality Management Plan is designed to insure that sufficient monitoring and evaluation procedures are in place to assess program quality, measure program performance against stated goals and improve client outcomes and overall program quality.**

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Components of the Quality Management Plan include:

### 1. Standards and Performance Evaluation:

- (a) **Evidence Based and Evidence Informed Practices:** The organization is committed to meeting or exceeding the expectations of our stakeholders. Stakeholders include clients, purchasers, staff, regulatory agents, and community members. Meeting or exceeding the expectation of stakeholders is closely associated with providing care and treatment based upon the best science and treatment approaches available. In behavioral health care the best science available is incorporated into what is known as evidenced-based or evidence informed practices. Whenever possible the organization embraces evidenced based practices in the delivery of care and treatment. Current evidence based practices include Dialectical Behavior Therapy in Day Treatment and CBFS, Motivational Interviewing in Outpatient, and Illness Management and Recovery (IMR) in Day Treatment and CBFS. The PACT and CSA programs are also held to tight industry fidelity standards.
- (b) **Client Outcome Data:** On no less than an annual basis, all programs establish appropriate methods for assessing and measuring client outcomes both on a client specific basis and on an overall program basis. These data will serve as a critical component of program evaluation and the basis for initiatives to improve client outcomes.
- (c) **Risk Management Data:** All agency incidents, as described later in this document, are recorded, categorized and aggregated in order to analyze trends and inform performance improvement.
- (d) **Continuous Quality Improvement:** Each year opportunities for quality improvement are identified. With input from its constituencies, objectives are set for major programs. Each program also identifies responsible parties, resources, processes, and timetables needed for implementing the plan. In establishing goals and objectives for quality improvement, the Agency obtains input from, and considers the interests of clients and their families, referral and funding sources, other community representatives, staff, and the governing body.

Objectives are generally derived from the following categories:

- 1. Service outcomes, indicating effectiveness and/or cost-effectiveness of services. Examples: independence, as measured by decreases in required personal assistance and supervision for clients living in group living environment.
- 2. Service progress, indicating the progress of clients served in their course of program activities. Examples: the percentage of individual service plan objectives achieved vs. set for clients with severe and persistent mental illness.
- 3. Service processes, indicating the amounts, utilization, timeliness, appropriateness, and quality of services, and their documentation, as measured by routine service and/or management data systems, and by special audit processes. Special systems to monitor the protection of client rights and client choice are also measured. Examples; the average time between referral and evaluation by a prescribing clinician; the percent of individual service plans updated as specified by timeliness standards; the number of serious human rights complaints filed in a given time period.

## ESP RFR Attachment 1.9.2

4. Management of human, financial, physical, and community resources. Examples: the percentage of staff turnover in a given time period; the average time required to complete a repair or maintenance task.
  5. Stakeholder surveys for all areas of operation, including service outcomes, progress, and processes, and surveys of staff, referral source, funder, and customer/community satisfaction with program services and management. Example: customer satisfaction ratings on several dimensions of access, service, and outcome.
  6. Client Satisfaction Surveys are conducted regularly in all programs providing an important information and direction from agency clients regarding the appropriateness and effectiveness of the programs and services and ideas on how to improve the quality of the service.
- (e) A common approach for guiding quality efforts is the *PDCA* Model, referring to the stages of *Plan, Do, Check, Act* as described below.

*Plan:* Identify the area of focus, process, or element that will be concentrated upon. Having past data will be important here for more longitudinal efforts. Develop measurement standards, quality measures to be employed, and indicators used in the *Do* stage. Current baseline data will be required for comparison in the *Check* stage.

*Do:* Implement the designs created in the *Plan* stage. Collect data as designed.

*Check:* Examine the data collected. Assess the data's accuracy, validity, and reliability. Is the information meaningful and informative? Was the goal(s) achieved? From a *PDCA* stand point, what worked well and what could be improved upon for future cycles?

*Act:* Take action on the information. Make adjustments for future planning. Start the *PDCA* cycle over again.

## 2. Human Resource Management

- (a) **Credentialing and Privileging:** A system of credentialing and privileging for staff licensed at the independent level is in place and is reviewed and updated by the Professional Services Review Committee (PSRC). The PSRC is comprised of the President, Chief Operating Officer, Medical Director, and Vice Presidents. Credentialing includes verification of academic degrees, licensure, and previous employment experience. References are required and documented. Staff are privileged by the Board of Directors subsequent to credentialing and review by the PSRC.
- (b) **Training:** All clinical and direct care staff positions will have an identified set of core competencies described as part of the job description. The job description will also indicate how the core competencies are to be evaluated. In most instances, there will be a specific set of training requirements which must be complete in order to satisfy that these core competencies have been evaluated and achieved. Each program manager will be responsible for establishing these training requirements and documenting that they have been fulfilled. All professional

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licenses are updated periodically, generally every two years. All licensed staff is required to have a current license on file with the Human Resources office.

- (c) **Supervision:** All direct care and clinical staff will receive regular supervision. Individual clinical supervision for staff providing outpatient services occurs on a regularly scheduled basis in accordance with Department of Public Health regulations. Clinical supervision is documented by the supervisor. The focus of supervision is to review the quality and clinical appropriateness of care.
- (d) **Staff Evaluation:** Newly hired employees will receive an evaluation at the end of three months. This review will be documented. Subsequent to the first three months of employment, employee evaluations will be conducted each year. Staff who exhibit performance difficulties, may receive an evaluation and/or performance improvement plan at any time during his/her employment. New staff may be evaluated prior to their one year anniversary. Also, any staff person who is on some disciplinary status will have an evaluation at a timeline indicated in the written notice.
- (e) **Continuing Education:** The Agency has an organized training initiative in which managers, supervisors and line staff from the continuum of services participates. The Agency offers a staff training and education program that focuses upon incorporating evidenced-based practices into the Agency's practices at all levels. Managers and supervisors review the professional literature to identify evidenced based practices and to design relevant training curriculum, which is required of CCBC employees.
- (f) CCBC has an online learning system that has the capacity to support, advance, and track agency and programmatic training initiatives. The system includes over 600 offerings and can be used to create program-specific courses and individual specific curricula.
- (g) The Agency offers staff training opportunities to access workshops offered outside CCBC. When resources permit, financial assistance towards the cost of the workshop is provided.

**All staff are expected to maintain any and all relevant licenses for which they are eligible and secure all necessary continuing education credits to do so.**

### 3. Risk Management and Safety

- (a) **Risk Management Committee** was developed to address the needs of CCBC consumers, staff and the community at large with respect to insuring the operation of the Agency's program in a manner that promotes the safety, well-being and dignity. This Committee is chaired by the President and includes the Vice President of Adult Outpatient Services, Chief Operations Officer, the Vice President of Community Rehabilitation Services Vice President of Community Treatment and Rehabilitation, Vice President of Housing and Special Initiatives, Medical Director, Vice President of Integrated Care, the Vice President of Child and Family Services, and the Quality Management and Compliance Coordinator..

The responsibility of the Risk Management Committee is to provide timely and ongoing review of those incidents, events and situations that present the potential for significant risk to the safety or wellbeing of clients, staff or others and to make recommendations as to clinical, supervisory and administrative procedures and protocols to the governing body, Patient Care Assessment Committee, Leadership Committee, and other committees as appropriate. A file of all incidents

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is maintained. All incidents are reviewed and action taken as appropriate. All action taken by the Committee is documented in writing.

The Risk Management Committee reviews the following:

#### **Major Incidents As Defined By the Board of Registration in Medicine 243 CMR 3.08:**

1. Maternal deaths that are related to delivery.
2. Death in the course of, or resulting from, elective ambulatory procedures.
3. Any invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity or body part.
4. All deaths or major or permanent impairments of bodily functions (other than those reported above) that are not ordinarily expected as a result of the patient's condition on presentation).

**Critical Incidents:** With respect to all clients deemed eligible and receiving services under contract between CCBC and the Department of Mental Health, any events defined as a Critical Incident by DMH Critical Incident Reporting Protocol effective October 1, 2012 and any subsequent reviews.

#### **Serious Incidents (Department Of Public Health):**

Serious Incidents as defined by the Department of Public Health (105 CMR 140.307) which includes any of the following which occur **on the Agency's premises**:

1. Fire,
2. Suicide,
3. Serious criminal acts; or
4. Pending or actual strike action by employees.

#### **Risk Management Screening and Monitoring Events:**

Such other events and situations determined by the CCBC RISK COMMITTEE not limited to but including:

1. Any situation which a supervisor or a clinician requests a risk assessment or review.
2. All client deaths including, but not restricted to, medical/legal deaths.
3. All incidents of any suicide attempt that results in medical treatment or results in significant injury, or could have resulted in significant injury or impairment.
4. All requests for commitment under the provision of Section 12E of M-G-L CH 123, issued by any member of our clinical staff (psychiatrists, psychologists and clinical nurse specialists).
5. Any alleged sexual assault by a client or upon a client at any agency facility.
6. Any injury to a client or to a staff member at an Agency facility.
7. Any injury to a staff member while on duty.
8. Any violence by a client directed toward another client or staff. This includes threats and acts of intimidation.
9. Situation which gives rise to a "duty to warn" third parties of the likelihood or threat of aggression by a client or if a client utters any threat to staff, clients or others.
10. Any mandated reporting required of providers under Massachusetts General Laws pertaining to the neglect of children (51A), the abuse or neglect of disabled persons per the Disabled Person's Protection Commission, or the abuse or neglect of elderly persons.
11. Any reported or alleged human rights complaint.

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12. Any written complaint filed by a client, parent or guardian of a client with regard to their care or the care of their child for whom they have custody, or the individual for whom they are guardian, or any complaint that the Committee chooses to review.
  13. Any medication occurrence.
  14. Any act of violence against a staff member of the agency, including assault, assault and battery, threats, intimidation or coercion that occurs during the course of their service.
  15. Any act of violence against a client of the agency in the course of their receiving care provided by the agency.
1. **Safety Committee:** The organization maintains a Safety Committee for the purpose of ensuring that services are provided in a manner that promotes safety for clients, staff, and the community. The Safety Committee reviews its activities with the Board of Directors on a regular basis and makes recommendations to the Board and management with respect to the safety of clients and staff. The Safety Committee reviews the Workplace Violence Prevention Plan at least annually and makes recommendations to management as to changes in the Plan.

### 2. Human Rights and Consumer Involvement

- (a) **Human Rights Committee:** CCBC has a Human Rights Committee with several agency clients serving on the Committee. The Organization's Human Rights Officer attends committee meetings and serves as liaison between the Committee and the Management Team, and the governing Board. The Human Rights Committee follows DMH guidelines 104 CMR 15.03(13) (a-f) and 15.03(5) (I) for Community Programs.

The responsibilities of the Committee include, but are not limited to:

- Review of Human Rights complaints.
- Review proposed Agency policies, which may have an impact on human rights.
- Review and monitor any research projects of the Agency which involve consumers.
- Annual visits and inspections of Agency sites, with recommendations reported to the Management Team.

- (b) **Consumer Involvement includes a variety of activities to facilitate consumer participation in the development and review of their service plan and in the review and evaluation of the Agency's programs and services.**

These processes include:

- A commitment to person-centered care and treatment where the consumers' needs and preferences are incorporated into all aspects of the service plan.
- Inclusion of those with lived experience in all of the organization's major programs. Those with lived experience play a critical role in ensuring that programs and services are person-centered and sensitive to the needs, preferences and goals of those receiving care. Those with lived experience bring a particular sensitivity to the attitudes, processes and approaches that facilitate a recovery oriented treatment system. Those with lived experience can also serve as role models for those in early stages of recovery and can serve to illustrate that recovery is possible and achievable;
- Program specific satisfaction surveys that gather data with respect to consumer perception of service delivery.

**2.3.2.1 Specific plan on how our organization shall collaborate with hospital to achieve goals related to ED diversion and ensure timely response**

**ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area**

**2.3.2 ED-specific plans related to ED diversion and timely response**

**2.3.2.1 Hospital Diversion Plans**

**2.3.2.1.1 Please describe how you shall work with Morton Hospital Emergency Department in an ongoing, collaborative, and integrated fashion.**

CCBC will establish a working relationship with the Morton Hospital ED at a number of levels:

<b>CCBC Contact</b>	<b>Hospital ED Contact</b>	<b>Scope of Collaboration</b>
CEO	CEO	Negotiate Memorandum of Understanding
ESP Medical Director	ED Medical Director	Establish working protocols on medical and psychiatric issues and develop criteria on level of care for inpatient, CCS and community alternatives. Act as final arbiters of clinical presentations and dispositions; approval of clinical policies on ESP activity. Participate in monthly community stakeholder meetings
Psychiatrist On- Call	ED Physician	CCBC psychiatrist provides consultation on acute cases, including recommendations for psychopharmacology to stabilize acute patients who have experienced extended stays in the ED
ESP Program Director	ED Nurse Manager	Review monthly statistics; identify cases for monthly review; resolve logistical issues on timeliness and ESP staffing; ensure ongoing communication during ED back-ups; Implement MOU

CCBC will assign one ESP clinician to the Morton Hospital Emergency Department. They will be available to provide mobile crisis interventions at the hospital ED from 4 p.m. to midnight Monday through Friday. Additional staff can be deployed from the Norton community based location on weekends.

The CCBC clinician will work closely with the triage nurse and the ED physician in charge to provide timely assessments and joint treatment planning. The ESP clinician will have access to a telephone.

The ESP program director will schedule regular meetings every other month to discuss the working arrangement. The goal is to improve communication, validate response times, assure CCBC accountability to ED staff, and resolve any hospital issues with the appropriate ED managers. The ESP program director and the ESP medical director will attend the meeting. **With a regional approach CCBC ESP will combine these meetings with the regular meetings with Sturdy Memorial Hospital. This arrangement will result in more efficient dissemination of information on methods of reducing utilization of both ED's.**

**2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital, and the community serviced by that hospital--for how**

### **ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area**

**you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP’s alternative community-based settings and services.**

The population served by Morton Hospital ED represents the diverse cultures of the city of Taunton with a higher concentration of Medicaid and uninsured than the demographics, including a higher concentration of Portuguese-speaking client, including children. The CCBC ESP will be able to meet the needs of these clients based on its successful staffing and support for other CCBC programs in the Taunton-Attleboro catchment area. In addition to recruiting bilingual/bicultural front office staff, CCBC will actively recruit clinicians who speak Portuguese, Spanish and other languages.

CCBC will deploy three strategies to divert behavioral health clients from the ED:

- First, CCBC will work in the community with referral sources about the increased mobile capacity of the ESP and the availability of peer specialists and family partners.
- Second, CCBC and the ED staff will conduct a survey of ED clients who present for behavioral health assessment. The survey will ask whether the client or referral sources called CCBC before, whether they considered a mobile visit or a visit to the ESP community site before coming to the ER, and whether their health care provider had counseled them about alternatives to the ED. CCBC will use the results of this survey to identify the best target for follow up information and social marketing in the community.
- Third, CCBC will work with ED staff to triage follow up in the community-based ESP and at the CCBC clinic site in Taunton to try to minimize the pattern of clients returning to the ED by habit even in non-crisis situations.

CCBC will set up meetings with the ED administrators at Morton Hospital to identify cohorts, or sub-populations familiar to them who may be considered “convenience” users of ED services. The ESP will follow up with these providers who are identified from these cohorts to develop alternative response plans, informing them that the CCBC Triage and Mobile Crisis Intervention are viable alternatives to the ED as first point of contact.

CCBC will also have a standing offer from the ESP Medical Director to the ED program director to convene an ad hoc meeting when a complex presentation cannot be immediately resolved. The ESP will take the responsibility to convene interested parties, including the Managed Care Entity, state agencies who are involved with the member, primary care providers, and other behavioral health providers.

**2.3.2.1.3 Describe how you will minimize the need for ED “boarding” and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.**

CCBC recognizes that ED boarding is a serious problem across the Commonwealth. Both Sturdy Memorial and Morton Hospitals have had unusual spikes in volume that can precipitate

### **ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area**

ED Boarding for days. There are several ways to minimize the spikes and to quickly address the high volume cases:

- CCBC will establish an electronic method of developing and storing Safety Plans, Crisis Plans and other upstream plans that can provide structured interventions before clients at high risk are referred to the ED.
- CCBC's ESP psychiatrist will also be available 24/7 to consult with the treating ED physician on appropriate medication regimen for members with extended stays in the ED and for members who are highly agitated and at acute risk of harm to self or others. Some of these interventions are likely to stabilize clients and enable referrals to CCS as a diversion from inpatient hospitalization, thus reducing the volume in the ED's.
- The ESP staff can track bed availability using the MABHS "Bedfinder" to alert staff, ED managers, and community stakeholders of limited availability and prioritize timely hospitalizations.
- ESP and ED staff will develop criteria to flag complex cases such as adults with histories of violence, children and adolescents with SED and Autism or PDD, and adolescents with recent histories of violence. When the clinician completes an assessment with this type of presentation, the ESP program director will inform the MCE immediately to request assistance with placement and plan to convene the appropriate community stakeholders to plans for disposition.

**2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. What volume do you anticipate initially, and what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis? Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED?**

CCBC will monitor compliance within the time frames based on a daily review of the ESP case records from the previous day by the program director and a monthly review of aggregated data by the Program Director and the hospital ED staff. This information will be discussed at the regular meetings. Real time accountability will be assured by the availability by pager of all CCBC-ESP supervisory and managerial personnel, up to and including the Program Director.

CCBC estimates that there will be about 70 requests for crisis intervention each month in the Morton ED. When the demand for ESP evaluations creates delays in timely access in the ED, CCBC will provide additional back-up from the "all-around" clinician available through the Norton community-based location who can be dispatched by the Triage staff. CCBC expects to reduce that amount to 60 per month in the FY 2017.

A contract with Morton Hospital will be signed before January 1, 2016.

**ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area****2.3.2 ED-specific plans related to ED diversion and timely response****2.3.2.1 Hospital Diversion Plans****2.3.2.1.1 Please describe how you shall work with Sturdy Memorial Hospital Emergency Department in an ongoing, collaborative, and integrated fashion.**

CCBC will establish a working relationship with the Sturdy Memorial Hospital ED at a number of levels:

<b>CCBC Contact</b>	<b>Hospital ED Contact</b>	<b>Scope of Collaboration</b>
CEO	CEO	Negotiate Memorandum of Understanding
ESP Medical Director	ED Medical Director	Establish working protocols on medical and psychiatric issues and develop criteria on level of care for inpatient, CCS and community alternatives. Act as final arbiters of clinical presentations and dispositions; approval of clinical policies on ESP activity. Participate in monthly community stakeholder meetings.
Psychiatrist On- Call	ED Physician	CCBC psychiatrist provides consultation on acute cases, including recommendations for psychopharmacology to stabilize acute patients who have experienced extended stays in the ED.
ESP Program Director	ED Nurse Manager	Review monthly statistics; identify cases for monthly review; resolve logistical issues on timeliness and ESP staffing; ensure ongoing communication during ED back-ups; Implement MOU.

CCBC will assign one ESP clinician to the Sturdy Memorial Hospital Emergency Department. They will be available to be on site from 4 p.m. to midnight five days per week. The CCBC clinician will work closely with the triage nurse and the ED physician in charge to provide timely assessments and joint treatment planning. The ESP clinician will have access to a telephone in the ED.

The ESP program director and the ESP medical director will schedule monthly meetings at the outset to discuss the working arrangement. The goal is to improve communication, validate response times, assure CCBC accountability to ED staff, and resolve any hospital issues with the appropriate ED managers.

**2.3.2.1.2 Delineate strategies that are specific to the hospital, the populations served by that hospital - for how you shall work with the hospital and other stakeholders to divert behavioral health utilization from their EDs to the ESP's alternative community-based settings and services.**

The clients served by the Sturdy Memorial ED represent the demographics of the surrounding communities in the Taunton-Attleboro catchment area. In addition, clients from local DMH group homes and nursing homes also present at the Sturdy Memorial ED. CCBC's

### **ESP RFR Attachment 2.3.2 -- Taunton/Attleboro Catchment Area**

ESP clinicians have the skills and experience to conduct thorough crisis interventions with clients from these populations.

#### CCBC will deploy three strategies to divert behavioral health clients from the ED:

- First, CCBC will work in the community with referral sources about the increased mobile capacity of the ESP and the availability of peer specialists and family partners.
- Second, CCBC and the Sturdy Memorial ED staff will conduct a survey of ED clients who present for behavioral health assessment. The survey will ask whether the client or referral sources called CCBC before, whether they considered a mobile visit or a visit to the ESP community site before coming to the ER, and whether their health care provider had counseled them about alternatives to the ED. CCBC will use the results of this survey to identify the best target for follow up information and social marketing in the community.
- Third, CCBC will work with ED staff to triage follow-up in the Community-Based Location nearby the hospital ED for urgent psychopharmacology and at nearby clinic sites in the area to minimize the pattern of clients returning to the ED by habit even in non-crisis situations.

CCBC will have meetings at Sturdy Memorial Hospital where the ED administrators identify cohorts, or sub-populations familiar to them who may be considered “convenience” users of ED services. The ESP will follow-up with providers identified in the Sturdy Memorial survey to develop alternative response plans, informing them that the CCBC Triage and Mobile Crisis Intervention are viable alternatives to the ED as first point of contact.

CCBC will also have a standing offer from the ESP medical director to the ED program director to convene an ad hoc meeting when a complex presentation cannot be immediately resolved. The ESP will take the responsibility to convene interested parties, including the Managed Care Entity, state agencies who are involved with the member, primary care providers, and other behavioral health providers.

**2.3.2.1.3 Describe how you will minimize the need for ED “boarding” and how you collaborate with the ED to deliver intervention services aimed at crisis resolution and recovery to individuals throughout any period of wait for a higher level of care.**

CCBC recognizes that ED boarding is a serious problem across the Commonwealth. Both Sturdy Memorial and Morton Hospitals have had unusual spikes in volume that can precipitate ED Boarding for days. There are several ways to minimize the spikes and to quickly address the high volume cases:

- CCBC will establish an electronic method of developing and storing Safety Plans, Crisis Plans and other upstream plans that can provide structured interventions before clients at high risk are referred to the ED.

### **ESP RFR Attachment 2.3.2 – Taunton/Attleboro Catchment Area**

- CCBC’s ESP psychiatrist will also be available 24/7 to consult with the treating ED physician on appropriate medication regimen for members with extended stays in the ED and for members who are highly agitated and at acute risk of harm to self or others. Some of these interventions are likely to stabilize clients and enable referrals to CCS as a diversion from inpatient hospitalization, thus reducing the volume in the ED’s.
- The ESP staff can track bed availability using the MABHS “Bedfinder” to alert staff, ED managers, and community stakeholders of limited availability and prioritize timely hospitalizations.
- ESP and ED staff will develop criteria to flag complex cases such as adults with histories of violence, children and adolescents with SED and Autism or PDD, and adolescents with recent histories of violence. When the clinician completes an assessment with this type of presentation, the ESP program director will inform the MCE immediately to request assistance with placement and plan to convene the appropriate community stakeholders to plans for disposition.

**2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. What volume do you anticipate initially, and what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis? Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED?**

In addition to the ESP clinician assigned to Sturdy Memorial Hospital ED on weekday evenings, CCBC will provide back-up and triage from the centralized CCBC ESP Team at the Community-Based Location in Norton. Real time accountability will be assured by the availability by pager of all CCBC ESP supervisory and managerial personnel, up to and including the program director. CCBC ESP expects to complete on average about 71 crisis interventions monthly in the Sturdy Memorial ED, but will reduce it to 60 per month in FY 2017 with creative strategies to increase mobile crisis interventions outside of the ED.

CCBC monitors compliance within the timeframes based on a daily review of the responsiveness from the ESP case records from the previous day and a monthly review of aggregated data by the program director and the hospital ED staff. This information is discussed at meetings that are held every month. **The CCBC regional approach will allow for a full-time ESP quality/risk manager to develop, distribute, collect and analyze the response time data, the survey data and the results of the corrective actions to achieve MBHP goals and in both the Brockton and Taunton-Attleboro catchment areas.**

The contract with Sturdy Memorial Hospital will be operational by January 1, 2016.

**2.4.3.1 Professional development activities and trainings that our organization has provided staff related to resilience, rehabilitation, and recovery within the last two years**

**ESP RFR Attachment 2.4.3.1**

**List of Trainings and Professional Development Activities  
Related to Resiliency, Rehabilitation and Recovery in the Past Two Years**

- 2013 Mass Psychiatric Rehabilitation Association (PRA) Conference: Connections for Life: Recovery and Community Partnerships
- 2014 Mass PRA Conference-Supporting the Recovery Workforce Toward Lifelong Learning
- Training taken on-line by CCBC staff from CCBC's On-Line Training Resource - *Relias*:
  - WRAP (Wellness Recovery and Action Plan) Values and Ethics;
  - Mental Health Recovery and WRAP (Wellness Recovery Action Plan);
  - Intentional Peer Support-A Different Kind of Relationship;
  - Mental Health Recovery and WRAP (Wellness Recovery Action Plan);
  - Key Recovery Concepts;
  - Peer Support: Supporting One Another in Recovery;
  - A Culture-Centered Approach to Recovery.
- "Illness Management and Recovery" - a three day training by the Bridge of Central Massachusetts
- CCBC staff also participated in an online webinar, "Peers as Crisis Service Providers II" sponsored by SAMHSA

**2.5.2.1.5 Professional development activities and trainings  
that our organization has provided for staff relative to  
cultural competence with the last two years**

**ESP RFR Attachment 2.5.2.1.5**

**List of Trainings and Professional Development Activities  
Related to Cultural Competence in the Past Two Years**

CCBC utilizes the Relias Training System to provide and track all staff training since September 2014. Training provided in cultural competence is included in the core competency curriculum for many CCBC programs, including Community Based Flexible Support, DBT, and PACT Services.

**Training over the past two years included:**

- A Culture Centered Approach to Recovery
- Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence
- Cultural Issues in Mental health Treatment
- Cultural Issues in Treatment for Paraprofessionals
- Cultural Diversity

**In Person Trainings attended:**

- BSAS training on implementing the CLAS Principles
- Military Culture, In-person BSAS training by Ben Cluff
- Mass-PRA Conference-2013: Allies in Recovery: Learning to Engage Racially and Culturally Diverse Adults with Psychiatric Conditions
- Mass-PRA Conference 2014: Courageous Conversations: Unpacking the Construct of Race
- DPH Ounce of Prevention conferences: 2015: Adewale Troutman, MD, who spoke on "Creating a Health Equity Movement."
- NACCHO conference 2015-" Cultivating a Culture of Health Equity"

### **3.1.9.1.1 – 3.1.9.1.3**

## **Job description of ESP Program Director and Resumes of Quality Management Coordinator and Medical Director**

### ESP RFR Attachment 3.1.9.1.1

Community Counseling of Bristol County, Inc.

#### Job Description

Position (UFR):       **102 Program Director**  
Position Title:       Program Director  
Program Name:       Emergency Services Program  
Service Type:        Emergency Services  
Accountability:      Vice President of Emergency and Diversionary Services

#### Summary of Position:

The Program Director (PD) is responsible for the overall operations of the ESP, including the supervision of all ESP staff and the clinical effectiveness of the program. The PD's primary function is to:

- Share responsibility with the ESP Medical Director for the clinical oversight and quality of care across ESP services.
- Responsible for the administrative and financial oversight of the ESP contract.
- Serve as primary point of accountability to MBHP and MCEs for the ESP.
- Ensure compliance with all requirements and performance specifications, including standard assessment tools, electronic encounter forms, and other data collection mechanisms.

#### Education/Training:

- Master's degree in Social Work or related mental health field or doctoral level.
- Must be independently licensed (LICSW, LMHC, PhD).
- Must have at least five (5) years post-graduate experience providing behavioral health services to children, families, and adults.
- Must have at least three (3) years of supervisory and/or management experience.

#### Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, potential safety issues, etc.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.

### **ESP RFR Attachment 3.1.9.1.1**

- Must be able to articulate and promote a recovery-orientation that is resolution-focused, strengths-based, and culturally competent.
- Ability to manage resources, including the hiring and retention of culturally competent staff.
- Possess knowledge and practice skills regarding Continuous Quality Improvement (CQI).
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties, as well as the written skills required to manage an electronic health record system.

#### Responsibilities:

- Administer the recruiting and hiring process for all ESP employees.
- Develop and maintain community connections with key stakeholders
- Develop and maintain programmatic policies and procedures to support a high fidelity ESP.
- Develop and maintain the training process and protocols for all new staff.
- Provide weekly individual and group supervision to staff and conduct regular performance reviews.
- Supervise program staff, which includes providing clinical support and oversight.
- Provide monthly trainings to all program staff to ensure compliance with all agency and managed care entities mandates.
- Oversee and ensure that all managed care entities' performance specifications and medical necessity criteria are being maintained by program.
- Collaborate with community resources, local and state agencies, schools, therapists and vocational programs.
- Facilitate monthly meetings and maintain collaborative partnerships with managed care entities and various states agencies including DMH, MCI and DCF.
- Provide oversight and support to all staff in ensuring they are completing all mandated responsibilities. This includes various quality management tasks and managing any staff disciplinary issues/performance improvement efforts.
- Manages various reports needed within the program to meet Mass Health requirements
- Provides on-going support to all team members as needed.
- Provides clinical oversight to all program matters and cases.
- Assist in the development of fiscal budgets and maintain program operations within allotted budget.

#### List Other Job Requirements:

All staff must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.

All staff must maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren). All staff must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

**ESP RFR Attachment 3.1.9.1.1**

Physical Requirements:

All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance. All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

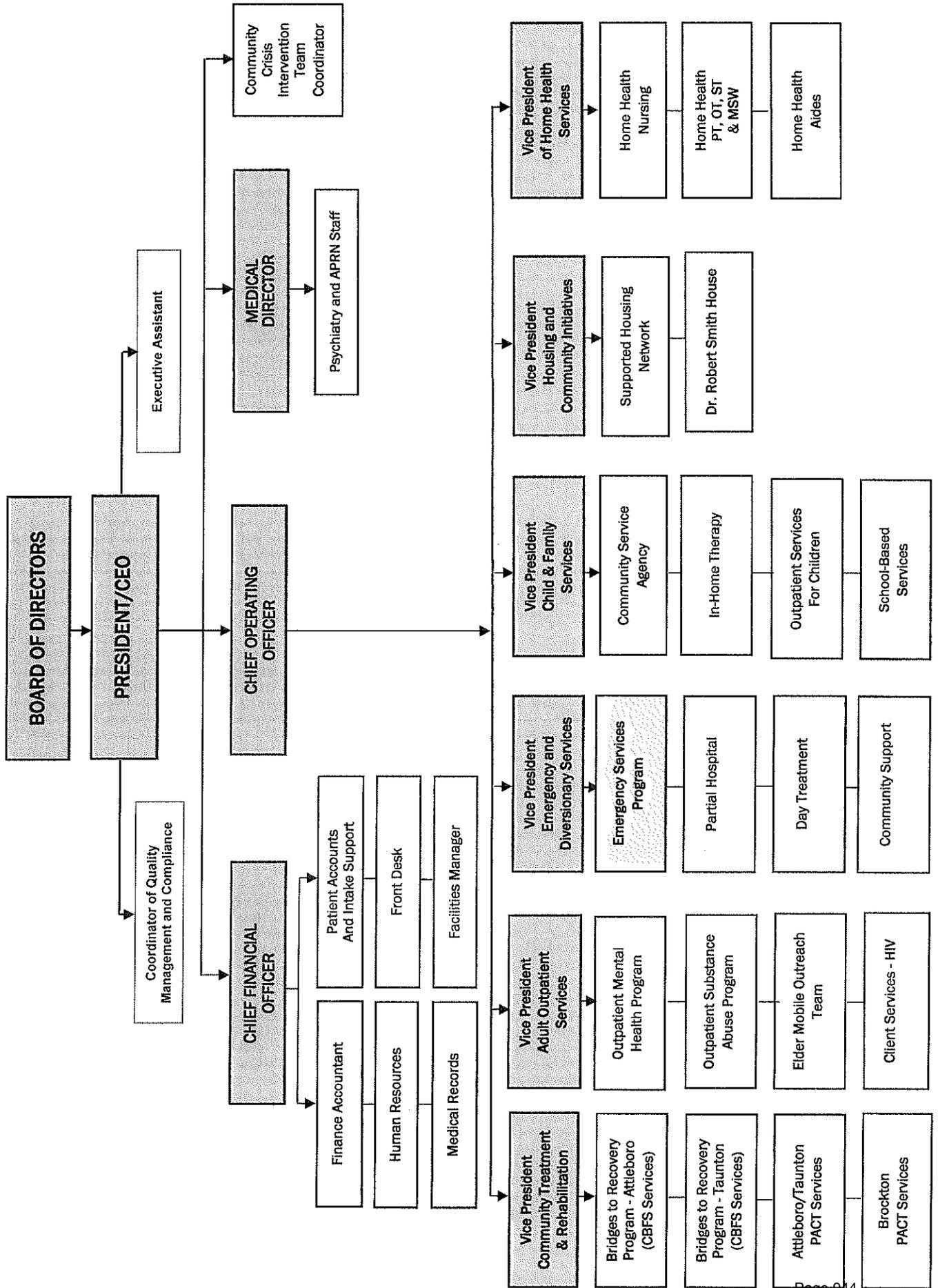
This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

\_\_\_\_\_  
Signature

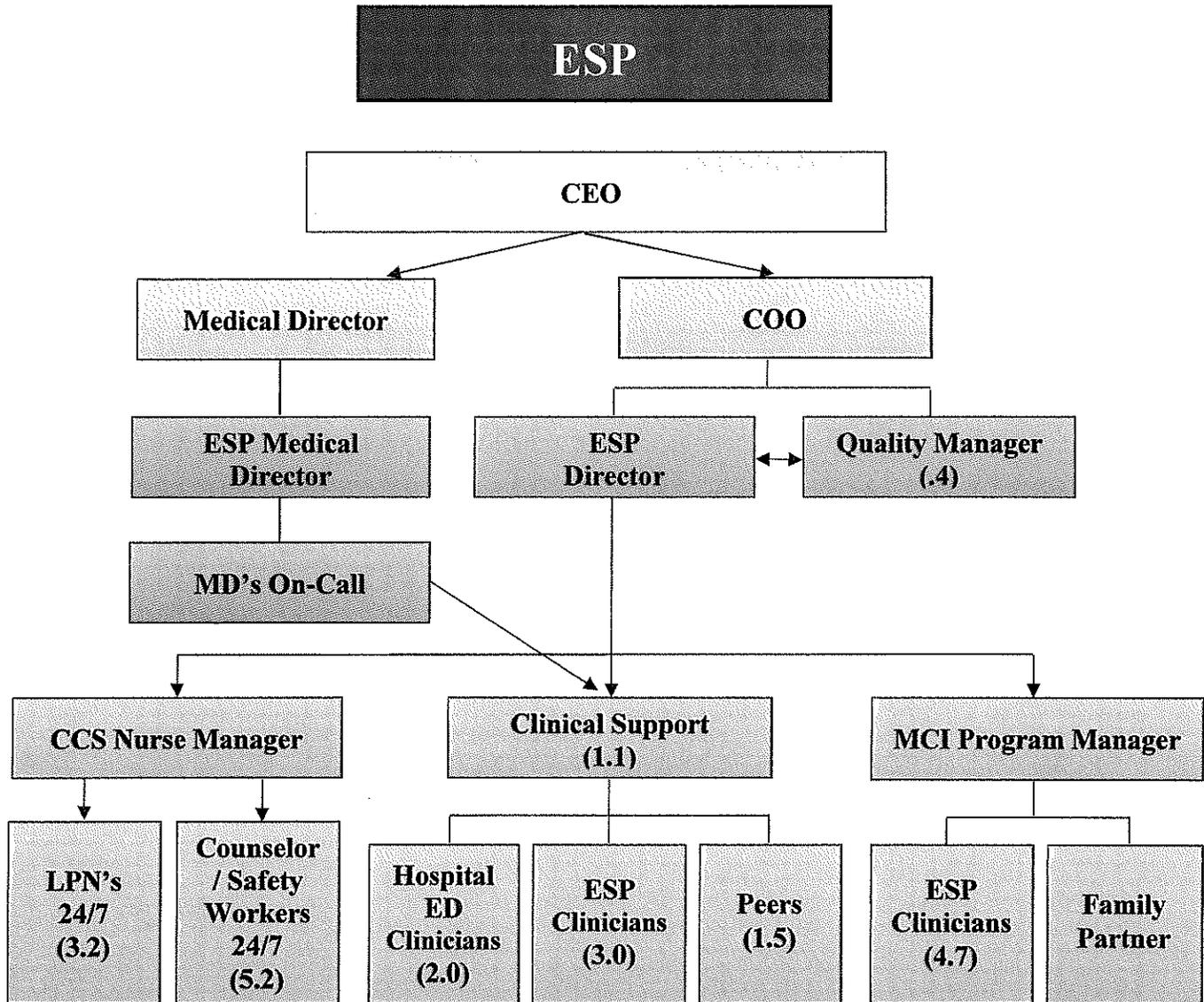
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Date

**3.1.9.2 Organization chart that indicates where ESP key staff shall sit within the organization at an administrative and supervisory level**

TABLE OF ORGANIZATION



ESP RFR Narrative Response – Attachment 3.1.9.2



## CCBC Central Triage and Liaison Role with ESP Sites

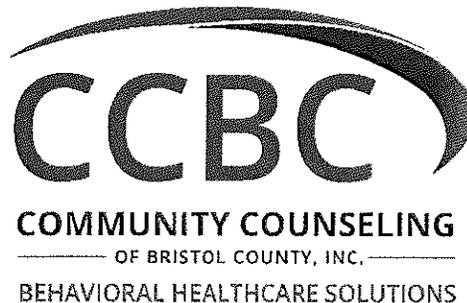
### **Brockton Site Unique Toll Free Number:**

- Direct line from ED's, DCF, DMH, DYS, CBFS, and PACT.
- Open line 8 am – 8 pm.

### **Taunton-Attleboro Site Unique Toll Free Number:**

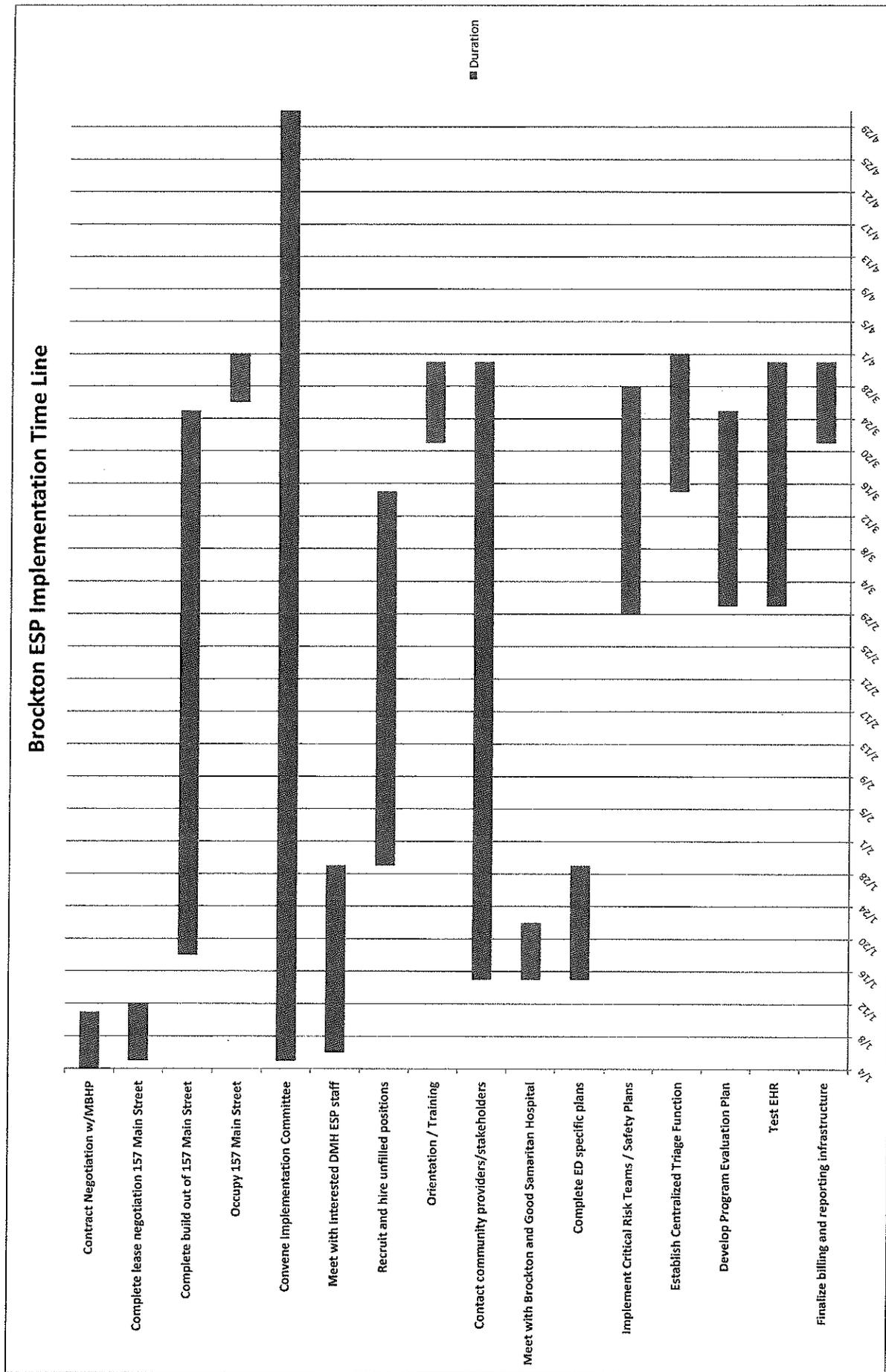
- Direct line from ED's, DMH, DYS, CBFS, PACT, and Police.
- Open line 8 am – 8 pm.

- CCBC Central Triage 8 pm – 8 am.
- Roster of on-call clinicians and assigned clinicians to each site.
- Central triage rotates between Brockton and Taunton/Attleboro Sites.
- After 8 pm toll free lines merge.
- Central triage keeps rolling roster of clinicians on site, clinicians doing evaluations, clinicians on-call, doctors on-call, and relief staff on-call (Peers, FP's, Safety staff, CCS staff).
- CCS census at each site.



**3.4.3.3 Implementation plan outlining how and when co-location shall be achieved within three months of the initiation of contract**

ESP RFR Attachment 3.4.3.3 - Brockton Catchment Area



### **3.5.3.3 – 3.5.3.6**

**Evidence of competence working in partnership with youth, parents, and caregivers of youth with mental health needs**

**Policies, procedures, and protocols developed for provision of behavioral health services to youth and families**

**Outcome data, quality improvement processes and satisfaction survey results focused on youth and families**

**Training, licensing certification and verification of expertise in providing behavioral health services to youth and families**

### Family Support Partner—Tier One Certification Checklist

Exercise	Date Verified
1	Pre Reading and Preparation for Training Exercise
2	Tier One and Tier Two Certification
3	The Principles of Wraparound
4	The Phases and Activities
5	The Theory of Change
6	Staff Roles
7	The VVDB Action Steps
8	Challenges to Engaging Families
9	Trust Building, Voice and Choice, and Self Efficacy
10	Develop your own Family Scenario
11	Behavioral Rehearsal of Engagement
12	Initial Meeting with the Family (continues)
13	Crisis Stabilization
14	Your Personal Natural Supports
15	Natural Supports in your Scenario Family
16	Impact and Explaining the SNCD
17	Life Domains
18	Learning more about Wraparound & Spirituality Boundaries
19	Long Range Vision and Prioritized Needs
20	Family Culture
21	Practicing the SNCD
22	Explaining Wraparound to Custodial Agency Staff
23	Preparing the Family and Team
24	Recruiting a Reluctant Team Member
25	Supporting Families towards Independence
26	Completing the first SNCD
27	Debriefing the SNCD Assignment
28	Ensuring that SNCD drift does not occur
29	Choose the Right Sequence for Planning
30	Using the DVD family (Mariam) building “AJs plan, add strengths and set ground rules
31	Adding to the Team Mission
32	Prioritized Needs
33	Developing Goals, Objectives and Measurement Strategies

## ESP RFR Attachment 3.5.3.4

<b>Exercise</b>		<b>Date Verified</b>
34	Options and Action Steps	
35	The Terms of Functional Assessment	
36	Functional assessment	
37	Crisis plan	
38	Progress Tracking Measures	
39	Needs and Services	
40	Individualization of Transition	
41	Story Board Brainstorming	
42	Team Cohesion: Dealing with Team Fragmentation	
43	Recruitment of Surrogate Supports	
44	Family Culture in Area of Celebration of Milestones	
45	Building Self Efficacy for a Family	
<b>Shadowing Activities</b>		<b>Date Verified</b>
1	a. Observe engaging a family.	
	b. An additional observation of engaging a family.	
2	a. Observe preparing a family for the SNCD.	
	b. An additional observation of preparing a family for the SNCD.	
3	a. Observe a sample of gathering information.	
	b. An additional observation of gathering information.	
4	a. Observe identifying and building natural supports	
	b. An additional observation of identifying and building natural supports	
5	a. Observe preparing a family for a meeting.	
	b. An additional observation of preparing a family for a meeting.	
6	a. Observe recruiting team members.	
	b. An additional observation of recruiting team members.	
7	a. Observe planning meetings.	
	b. An additional observation of planning meetings.	
<b>Supplemental Exercises</b>		<b>Date Verified</b>
1	Layout the roles of Wraparound Staff in agency	
2	Behavioral rehearsal: Engaging families	
3	Behavioral rehearsal: Sharing your experience to prepare for SNCD	
4	Behavioral rehearsal: Gathering information	
5	Behavioral rehearsal: Identifying and building natural supports	
6	Behavioral rehearsal: Preparing a family for the initial WA meeting	
7	Behavioral rehearsal: Recruiting team members	

**Coaching Debriefing Comments:**

## Wraparound Facilitator—Tier One Certification Checklist

Exercise		Date Verified
1	Pre Reading and Preparation for Training Exercise	
2	Tier One and Tier Two Certification	
3	The Principles of Wraparound	
4	The Phases and Activities	
5	The Theory of Change	
6	Staff Roles	
7	The VVDB Action Steps	
8	Challenges to Engaging Families	
9	Trust Building, Voice and Choice, and Self Efficacy	
10	Develop your own Family Scenario	
11	Behavioral Rehearsal of Engagement	
12	Initial Meeting with the Family (continues)	
13	Crisis Stabilization	
14	Your Personal Natural Supports	
15	Natural Supports in your Scenario Family	
16	Impact and Explaining the SNCD	
17	Life Domains	
18	Learning more about Wraparound & Spirituality Boundaries	
19	Long Range Vision and Prioritized Needs	
20	Family Culture	
21	Practicing the SNCD	
22	Explaining Wraparound to Custodial Agency Staff	
23	Preparing the Family and Team	
24	Recruiting a Reluctant Team Member	
25	Supporting Families towards Independence	
26	Completing the first SNCD	
27	Debriefing the SNCD Assignment	
28	Ensuring that SNCD drift does not occur	
29	Choose the Right Sequence for Planning	
30	Using the DVD family (Mariam) building “AJs plan, add strengths and set ground rules	
31	Adding to the Team Mission	
32	Prioritized Needs	

## ESP RFR Attachment 3.5.3.4

<b>Exercise (Continued)</b>		<b>Date Verified</b>
33	Developing goals, objectives and measurement strategies	
34	Options and action steps	
35	The terms of functional assessment	
36	Functional assessment	
37	Crisis plan	
38	Progress tracking measures	
39	Needs and services	
40	Individualization of transition	
41	Story board brainstorming	
42	Team cohesion: Dealing with team fragmentation	
43	Recruitment of surrogate supports	
44	Family culture in area of celebration of milestones	
45	Building self efficacy for a family	
<b>Shadowing Activities</b>		<b>Date Verified</b>
1	a. Engaging families in a meeting	
	b. An additional experience engaging families in a meeting	
2	a. Strengths, Needs, and Culture Discovery with a family	
	b. An additional experience with SNCD	
3	a. Preparing a family for a meeting	
	b. An additional experience preparing a family for a meeting	
4	a. Recruiting team members	
	b. An additional experience recruiting team members	
5	a. First team meeting	
	b. An additional experience of the first team meeting	
6	a. Functional assessments	
	b. An additional experience with functional assessments	
7	a. Crisis team meetings	
	b. An additional experience with crisis team meetings	
<b>Supplemental Exercises</b>		<b>Date Verified</b>
1	Layout the roles of Wraparound Staff in agency	
2	Behavioral rehearsal: Engaging families	
3	Behavioral rehearsal: The SNCD	
4	Behavioral rehearsal: Preparing the family for a team meeting	
5	Behavioral rehearsal: The first team meeting	
6	Behavioral rehearsal: Doing a functional assessment	
7	Behavioral rehearsal: Crisis planning meeting	

ESP RFR Attachment 3.5.3.5  
 FY 2014 Annual Member Satisfaction Survey Data Results

Q#	QUESTION	Response Distribution						TOTAL RESPONSES
		STRONGLY AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NOT ANSWERED	
1	Does your care coordinator help you to understand the Community Service Agency and Wraparound?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	31	1	0	1	1	0	34
		91%	3%	0%	3%	3%	0%	
2	Is involvement in community-based activities reflected in the care planning process?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	23	5	3	0	1	2	34
		68%	15%	9%	0%	3%	6%	
3	Are there on-going and persistent efforts to engage natural supports?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	27	4	1	2	0	0	34
		79%	12%	3%	6%	0%	0%	
4	Will natural supports continue to be involved with your family when CSA Wraparound is finished?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	26	1	5	2	0	0	34
		76%	3%	15%	6%	0%	0%	
5	Does your care coordinator help you to identify and help you to work on the needs that are most important to your family?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	28	5	0	0	1	0	34
		82%	15%	0%	0%	3%	0%	
6	Has your care coordinator improved your confidence and ability to get your family's needs met?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	29	1	3	0	1	0	34
		85%	3%	9%	0%	3%	0%	
7	Does your care coordinator use your family's voice and choice in the problem solving process?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	29	2	2	0	1	0	34
		85%	6%	6%	0%	3%	0%	
8	Does your care coordinator provide opportunities to celebrate and mark your accomplishments?  STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =	26	4	2	0	0	2	34
		76%	12%	6%	0%	0%	6%	
		94%						

ESP RFR Attachment 3.5.3.5  
 FY 2014 Annual Member Satisfaction Survey Data Results

Q#	QUESTION	STRONGLY AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE	NOT ANSWERED	TOTAL RESPONSES
9	Does your care coordinator provide you with information about community, advocacy resources, and ways to connect with others?	28 82%	0 0%	3 9%	2 6%	1 3%	0 0%	34
STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =		91%						
10	Does your care coordinator pay attention and demonstrate sensitivity to your preferences and culture?	29 85%	2 6%	2 6%	1 3%	0 0%	0 0%	34
STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =		97%						
11	Are natural supports engaged in the planning and the implementation process of Wraparound efforts?	21 62%	4 12%	7 21%	1 3%	1 3%	0 0%	34
STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =		94%						
12	Are community-based ideas brainstormed, prioritized, and utilized in care planning meetings?	26 76%	2 6%	4 12%	0 0%	1 3%	1 3%	34
STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =		94%						
13	Is your family confident that in the occurrence of a crisis, the team can keep your child in the community?	27 79%	3 9%	3 9%	1 3%	0 0%	0 0%	34
STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =		97%						
14	Does your care coordinator help create a team of people to work on your family-driven plan based upon your vision?	29 85%	1 3%	1 3%	3 9%	0 0%	0 0%	34
STRONGLY AGREE + SOMEWHAT AGREE + NEUTRAL =		91%						
Families that received surveys		220						
Families declined to participate.		201						
Family submitted a blank survey.		0						
Families who submitted written comments.		24						
Families who submitted surveys without written comments.		10						

## **Family Support Partner (FSP) Skill Sets, Functions, and Roles**

### **Functions of the Family Support Partner**

1. Partner with the Wraparound Staff (Wraparound Facilitator, Youth Support Partner and Wraparound Coach) to ensure that the wraparound process is provided with high fidelity and is successful for families.
2. Provide direct support to parents and child and family team members to carry out action steps from the wraparound plan.
3. Connect families to other families to strengthen natural supports and provide system level family voice and choice.

### **Family Support Partner Roles**

- The FSP role models effective personal interactions and behavior.
- The FSP advocates for and supports families to identify their own strengths, needs, culture and vision and get these needs met.
- The FSP shares their own experiences to build relationships with and help families be successful with wraparound.
- The FSP mentors families to improve their confidence and ability to advocate for and effectively manage the services and supports for their own family.
- The FSP supports development, reconnection and strengthening of natural supports for families.
- The FSP partners with the wraparound staff (e.g., wraparound facilitator, youth support partner, and wraparound coach) to provide a high fidelity wraparound process.
- The FSP supports development of Family to Family Supports. .

### **Family Support Partner Skill Sets for Roles**

#### Models Effective Interactions

1. The FSP encourages and models commitment to the family and encourages the family to believe in their future and to stick with the process.
2. The FSP honors the culture of the family by keeping their own views in check.
3. The FSP aligns themselves with the family to support the family's choices.
4. The FSP engages in strategic and mutually respectful partnerships with the facilitator, youth support partner and other team members.
5. The FSP role models strengths-based interactions by not blaming or shaming others in the presence of the family or other team members.
6. The FSP models protection of confidentiality by never talking about wraparound families outside of the appropriate work setting, without the families' permission and input.
7. The FSP checks in with the family during and at the end of interactions and activities to determine family satisfaction with the process.

Advocates for and Supports Families Needs

8. The FSP help the family understand that support can take on many different forms and that the family will determine what the support will look like for them.
9. The FSP actively listens to the family and takes notes about support needs, clarifying points with the family and facilitator.
10. The FSP shares experiences with families to help them understand how wraparound can help families meet positively framed needs.
11. The FSP educates and supports family members to use their own voice to express their needs and preferences (e.g., “do for, do with, and cheer on”).
12. The FSP supports self advocacy by providing the least amount of support that will be successful with planned fading of support (do for, do with and then cheer on).
13. The FSP recognizes and values the differences among families, discovering the unique culture of each family and using this information to determine how they can best advocate for their family.
14. The FSP helps family members understand and to explain their culture and strengths to get their plan to match their family culture.
15. The FSP understands family needs, culture, strengths and preferences and supports families to advocate for them.
16. The FSP helps the family understand the mandates and perspective of other team members, while keeping family perspective at the forefront of team discussions.

Sharing Your Experience

17. The FSP shares their own experiences to develop a shared sense of understanding and relationship with families.
18. The FSP may share their own experience with wraparound to give the family an understanding of how the process can be an opportunity for them.
19. The FSP may share their own experience with the different activities of the wraparound process to give the family an understanding of how the process can affect them.
20. The FSP may prepare the family for the strengths, needs, and culture discovery conversations through sharing personal and other family experiences.
21. The FSP may give personal examples to help clarify questions.
22. The FSP share their own experience of how being honest and open helped them to get better support.

Mentors Families to Improve Self Efficacy (Confidence they can be successful)

23. The FSP observes and interacts with the family to help the family understand and celebrate strengths.
24. FSP knows available resources within a community and helps the families in choosing and accessing those that address their needs.
25. The FSP educates and supports the family in the importance of maintaining and using documentation to advocate and control the process of service and support.
26. The FSP helps families to understand how to store and use documentation to support services for their children.
27. The FSP helps and encourages families to find and develop effective self advocacy skills.

### Supports Development, Reconnection and Strengthening of Natural Supports for Families

28. The FSP may share personal experiences and reasons why natural supports can be important for families.
29. The FSP helps families identify reciprocal relationships (what each person gets from the relationship) that define and sustain natural supports.
30. When families do not easily identify natural supports an FSP may be enlisted to do more in depth work with the family to identify potential supports.
31. The FSP may work with the family to plan for contacting potential natural support team members and orienting them to the process.
32. The FSP may meet with natural supports to get them ready for initial or follow-up wraparound meetings.
33. The FSP helps families to plan and reconnect with extended family and natural supports based on family voice and choice.
34. The FSP helps families and natural supports work through barriers to partnership.

Supports Implementation of the Phases and Activities of Wraparound. (The FSP partners with the wraparound facilitator and youth support partner to complete the activities of the wraparound process).

#### *Wraparound Phase One: Engagement*

35. The FSP may assist the wraparound facilitator by doing one on one orientation, sharing their own experience with wraparound, and helping the family to understand how wraparound might be a positive opportunity for them.
36. The FSP helps the family understand what is different about wraparound by explaining wraparound from a family's perspective.
37. The FSP may provide written materials and other resources to help families understand wraparound, review these materials with the family and answer questions.
38. The FSP explains their role including what they may do and limits on the role.
39. The FSP may assist the wraparound facilitator in explaining confidentiality and client rights and responsibilities, and as needed, help ease these fears and answer questions from a family perspective.
40. The FSP may assist in the development of crisis stabilization plans to make sure the plans are individualized, based on voice and choice and are realistic for the family.
41. If a family member is very distrustful of systems and does not want to sign consent and release forms, the FSP may need to do some one on one time with the family member to help them understand why sharing could benefit their family.
42. The FSP may help the family prepare for the SNCD by helping the family identify their strengths, needs, culture and vision from a family perspective.
43. The FSP may help the family prepare for the SNCD by understanding why wraparound works better when focused on positive needs and reframing negative concerns into positive needs.
44. The FSP may help the family to gather and organize information that they will need to advocate for their child.

**ESP RFR Attachment 3.5.3.6**

45. The FSP observes the SNCD conversations to ensure that the family does not answer questions in the way they think the wraparound facilitator wants them to answer, and is the truth teller or negotiator of this issue should it arise.
46. The FSP may take the completed summary document to the family and sit with them and go over it to make sure it is correct and to add to the document as needed.
47. The FSP may be able to help the family find natural supports within the community to help with the planning process.
48. The FSP may spend additional time with the family to prepare them for the initial wraparound meetings making sure they understand each of the parts of the agenda and are prepared to use their voice and choice.
49. If the family wants the FSP at planning meetings the FSP works with the family to decide the role the FSP will play in advance of the meeting.
50. The FSP works with the wraparound facilitator and youth support partner to make sure family needs are met in the scheduling, location and agenda for the wraparound planning meetings .
51. The FSP may contact team members who will need support to get to the meeting and to participate in the meeting.

*Wraparound Phase Two: Planning*

52. The FSP helps other team members to understand the importance of and feel comfortable with family voice and choice.
53. The FSP encourages thinking beyond the usual services and supports.
54. The FSP is determined to ensure family voice and choice during needs selection. Ideally, the FSP comes to the meeting with an understanding of family wishes in this area (and on goals and objectives).
55. The FSP agrees to take on action steps that are compatible with their role and that they have the time and resources to complete them.
56. The FSP is careful to ensure that the family understands the reason for the crisis plan and why it is being done.
57. The FSP explains the functional assessment process and shares how this process has helped other families and the importance of in-depth accurate information.
58. The FSP checks in with the family to ensure they feel they were heard and that the developed plan is individualized to who they are and is realistic.

*Wraparound Phase Three: Implementation*

59. The FSP reviews the written plan with the family to make sure they understand it, agree with it and have any resources or supports needed to implement it.
60. The FSP encourages the family in completing action steps, through motivation, support, reminders.
61. The FSP works with the family to determine if the plan is working and to decide when they need to ask for changes in the plan.
62. The FSP checks with the family on emerging needs and if the needs should be brought to the team and if new strategies are needed.
63. The FSP may help the family to update their various documents and information used to advocate for their child and family, helps the family to identify the strengths of their

natural support systems and communities and helps them identify ongoing needs to be more connected as needed.

64. The FSP constantly checks with the family on their feeling of support from the team, and if they are beginning to feel a lack of support, too much support, or if the family is not content with the team for any reason.
65. The FSP can be used to spend additional time with the family to prepare them for follow-up wraparound meetings.
66. The FSP works creatively with the family and their team to make sure that progress does not stop when barriers and challenges occur.
67. The FSP models positive collaboration with all team members to build team cohesion (togetherness).
68. The FSP documents their work with the family through progress notes that meet the criteria set by the participating agencies.

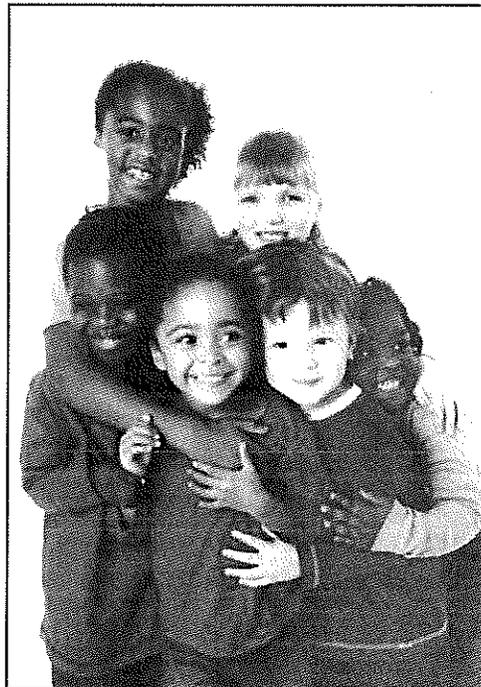
#### *Wraparound Phase Four: Transition*

69. The FSP supports the family to identify the needs that will continue to need attention after formal wraparound ends.
70. The FSP helps the family to identify the successes they have had and the lessons they have learned through the wraparound process.
71. The FSP checks in with the family to ensure that the modification to the wraparound process is understood and is culturally competent to the family.
72. The FSP checks with the family to see how and if they would like to celebrate success in a culturally competent manner.
73. Ideally the FSP should be committed to remaining with the family as long (and no longer) than the family needs / desires. The FSP supports the family through self-advocacy. Phasing out the FSP should be a gradual process as families expand their role.

#### Supports Development of Family to Family Supports

74. The FSP may link the family up with other graduates of the process who can be team members and natural supports.
75. The FSP gives families opportunities to become part of the larger circle of families where they can find support from other parents and caregivers with similar experiences.
76. FSPs connect families to local family groups and organizations.

**Massachusetts Wraparound Fidelity Assessment System**  
Wraparound Provider Practice Analysis  
**Community Counseling of Bristol County- Attleboro**



**Fifth Edition: September 2014**

Developed by MBHP in Collaboration with the Wraparound Evaluation and Research Team  
Department of Psychiatry, University of Washington  
Public Behavioral Health and Justice Policy



**LIST OF ACRONYMS**

CANS	Child and Adolescent Needs and Strengths
CBHI	Children’s Behavioral Health Initiative
CPT	Care Planning Team
CSA	Community Service Agency
FS&T	Family Support and Training
ICC	Intensive Care Coordination
ICM	Intensive Clinical Manager
IHBS	In-Home Behavioral Services
IHT	In-Home Therapy
PCC	Primary Care Clinician
SED	Severe Emotional Disturbance
TM	Therapeutic Mentoring

**BACKGROUND**

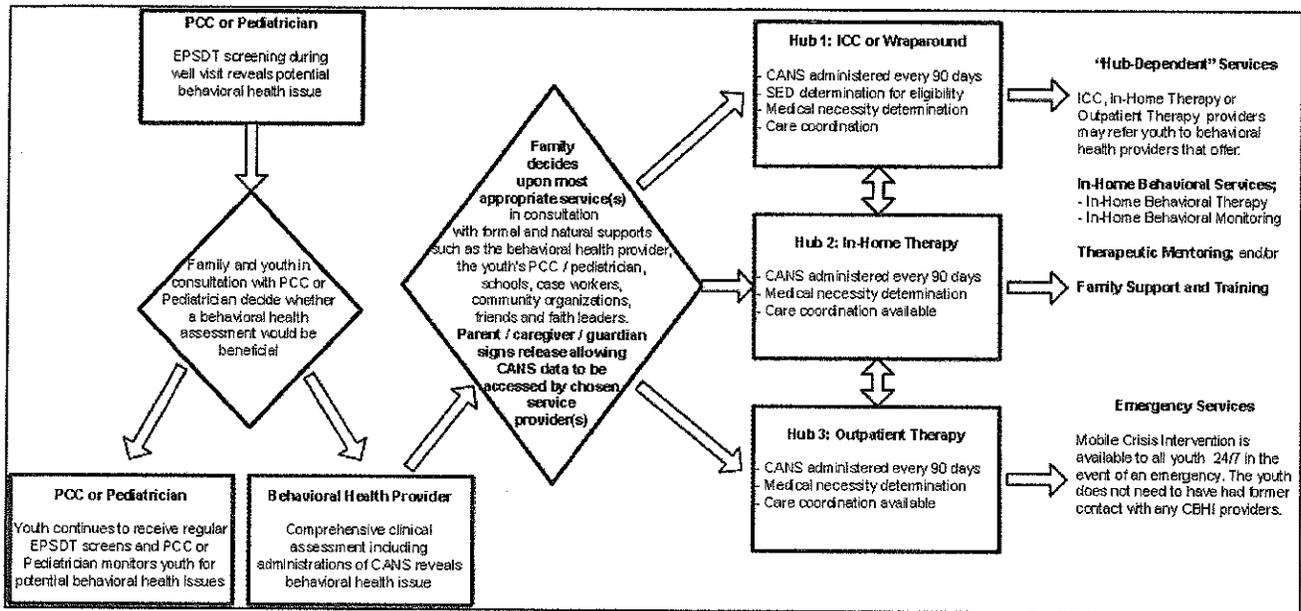
When the district court ruled in *Rosie D. v. Romney* that youth in Massachusetts were not receiving adequate behavioral health screenings, community-based care, or service coordination, work was begun to develop a remedial plan. The result is the CBHI, established as a means of strengthening, expanding and integrating state services into a comprehensive, community-based system of care for youth and families. The initiative is a collaborative effort of health care providers, consumers, advocacy groups, state agencies, managed care entities and other stakeholders.

Among the key components of the CBHI is the provision of *wraparound* care coordination for youth living with a serious emotional disturbance. During *wraparound*, a care coordinator affiliated with one of the state’s 32 community service agencies works with the youth’s family to convene a care planning team. Using the results of a comprehensive clinical assessment inclusive of the MA CANS, the team works together to develop an individual care plan and safety plan (and other Crisis Planning Tools chosen by the family) tailored to meet the youth’s needs.

**CBHI Mission**

Strengthen, expand and integrate Massachusetts services into a comprehensive, community-based system of care so that families and their children with significant behavioral, emotional or mental health needs can obtain the services necessary for success in home, school and community.

*Wraparound* is not a form of treatment, but rather a process for coordinating service delivery for youth with complex needs. Intensive home and community-based services offered to youth and families engaged in *wraparound* include in-home therapy, in-home behavioral services, therapeutic mentoring, family support and training, and mobile crisis intervention.



**Figure 1:** This diagram shows how youth access Wraparound services, from the initial behavioral health assessment (left), to an encounter with the “hub” service (middle), to referral for additional services (right).

Seven experimental and six quasi-experimental studies have compared outcomes of traditional interventions for youth to outcomes from interventions that incorporate *wraparound*. Two findings of particular importance to providers are that to be successful, *wraparound* programs must display *fidelity* and be targeted to youth who meet medical necessity.<sup>1</sup>

Typically we define *fidelity* as the degree to which a program is implemented as intended by its developers. Since *wraparound* wasn’t developed by an individual or team – but rather through a collaborative process spearheaded by the National Wraparound Initiative ([www.nwi.pdx.edu](http://www.nwi.pdx.edu)) – the definition of *wraparound fidelity* has been shaped by multiple individuals and organizations. In this analysis, *wraparound fidelity* is defined as the degree to which providers (a) adhere to the principles of quality wraparound and (b) carry out the basic activities of facilitating a wraparound process.

This document was developed as a tool for providers to gauge the degree to which their CSAs exhibit *wraparound fidelity* and to identify strengths and areas for improvement. The following pages summarize findings from the Massachusetts Wraparound Fidelity Assessment System (WFAS). This system encompasses the Wraparound Fidelity Assessment, Version 4 (MA WFI-4) and the Team Observation Measure (MA TOM).

<sup>1</sup> Bruns E, Leverentz-Brady K, Suter J. 2008. Is it Wraparound Yet? Setting Quality Standards for Implementation of the Wraparound Process. *Journal of Behavioral Health Services & Research* 35(3): 240-252.

## HOW TO USE THIS PROVIDER PRACTICE ANALYSIS

The Massachusetts Fidelity Assessment System was developed as a means for providers to monitor the fidelity of their Community Service Agencies to the principles and activities of Wraparound. Research shows that the attainment of high fidelity scores at the care team and program levels is associated with positive youth and family outcomes.<sup>2</sup> Fidelity monitoring also lays the groundwork for measuring the outcomes and efficiency of the Children's Behavioral Health Initiative over time.

This Wraparound Provider Practice Analysis is organized into four sections:

**Section 1: Massachusetts Team Observation Measure Results** (pp. 6 – 17)

**Section 2: Massachusetts Wraparound Fidelity Index Results** (pp. 18 – 24)

**Section 3: Relative Strengths and Areas for Improvement** (pp. 25 – 27)

Sections 1, 2 and 3 present customized results of the MA TOM and MA WFI-4 for **Community Counseling of Bristol County- Attleboro**. Each section begins with a summary of the methods by which the measure is administered and the items are scored. Findings are then presented in three ways, starting with broad summaries and then moving to more detailed analyses:

1. **Total Fidelity scores** are presented alongside the average Fidelity score for all CSAs (“state mean”) and the average Fidelity score for all states that have participated in the TOM or WFI (“national mean”);
2. **Principle scores** are presented for each of the 10 principles of Wraparound. These scores are presented alongside the average Principle score for all CSAs (“state mean”) and the average Principle score for all states that have participated in the TOM or WFI (“national mean”); and
3. **Item scores** are presented for each of the items corresponding to the 10 principles of quality Wraparound. These scores are presented alongside the average Item scores for all CSAs (“state mean”) and the average Item scores for all states that have participated in the TOM or WFI (“national mean.”)

Until recently, CSA scores would have been difficult to interpret due to a lack of external criteria or norms against which to compare them. To overcome this barrier, the Wraparound Evaluation and Research Team compiled a national database of TOM and WFI data. This is what allows us to compare your CSA's scores to the national mean. National means were calculated by averaging scores across all TOMs and WFI-4 caregiver interviews completed outside of Massachusetts. The means were updated in FY 2012 to include observations and interviews completed between July 2009 and June 2012.

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<sup>2</sup> Suter J, Bruns E. 2009. Effectiveness of the Wraparound Process for Children with Emotional and Behavioral Disorders: A Meta-Analysis. *Clinical Child and Family Psychology Review* 12(4): 336-351.

The final section of the Wraparound Provider Practice Analysis contains a summary of the results from the MA TOM and MA WFI-4, including a listing of strengths and areas for improvement.

To read more about measuring wraparound fidelity, consider visiting the National Wraparound Initiative homepage and clicking on “assessment/fidelity”:  
<http://www.nwi.pdx.edu>

To read more about psychometrics, reliability and validity of the WFI, go to <http://depts.washington.edu/wrapeval/docs> and download the document entitled “Psychometrics...” A study of the psychometrics, reliability and validity of the TOM is expected to be published in FY2013 and will be posted on the National Wraparound Initiative Web site.

### Ten Principles of Wraparound

1. Family Voice and Choice
2. Team-Based
3. Natural Supports
4. Collaboration
5. Community-Based
6. Culturally Competent
7. Individualized
8. Strengths-Based
9. Unconditional
10. Outcome-based

For detailed information on the *Principles of Wraparound*, please see **Appendix A**.

### CBHI Vision

A behavioral health care system where policies, financing, management and delivery of publicly-funded behavioral health services are integrated to make it easier for families to find and access appropriate services, and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

### CBHI Values

- **Strengths-based:** Services are built on the strengths of family and their community.
- **Family-Driven, Youth-Guided:** Services are driven by the needs and preferences of the child and family, and are developed in partnership with and are accountable to families.
- **Culturally Responsive:** Services are responsive to the family’s values, beliefs, norms, and to socioeconomic and cultural context.
- **Continuous Improvement:** Service improvements reflect a culture of continuous learning, and are informed by data, family feedback, evidence and best practice.
- **Collaborative and Integrate:** Services are integrated across child-serving agencies and programs.

## SECTION 1: MASSACHUSETTS TEAM OBSERVATION MEASURE (MA TOM)

### Background from the NWI Resource Guide to Wraparound

*The Massachusetts Team Observation Measure (MA TOM) assesses adherence to standards of high-quality wraparound during team meeting sessions. It was originally developed to be used by external evaluators, but has also been used by supervisors to help support coaching and supervision of wraparound staff. The MA TOM consists of 20 items, with two items dedicated to each of the 10 principles of wraparound. Each item consists of up to 4 indicators of high-quality wraparound practice as expressed during a child and family team meeting. Trained raters indicate whether or not each indicator was in evidence during the wraparound team meeting session. These ratings are translated into a score for each item as well as a total fidelity score for the session overall.*

### Interpreting MA TOM Scores

Your CSA's FY2010, FY2011, FY2012, FY2013, and FY2014 total fidelity, principle and item/indicator scores are displayed on the following pages with comparisons to the state and national averages. To arrive at a principle score, the two item scores corresponding to each principle were summed, resulting in a score ranging from 0 (low fidelity) to 8 (high fidelity). Principle scores were then expressed as a percent of total possible fidelity. A principle score of 7 out of 8, for example, would be expressed as 87.4% fidelity.

MA TOM items are comprised of up to 4 indicators (denoted by letters a through d) that the observer assigns a "yes" or a "no." For each TOM, item scores were calculated using the following logic model, which takes into account the fact that each item is made up of a different number of indicators. Overall item scores represent the average of item scores across all TOMs completed by your CSA:

Number of Indicators	Number of Indicators Scored 'Yes'	Item Score
4	4	4
	3	3
	2	2
	1	1
	0	0
3	3	4
	2	3
	1	1
	0	0
2	2	4
	1	2
	0	0
1	1	4
	0	0

Indicators corresponding to each item are displayed as a percent, interpreted as the percent of time the indicator was assigned a 'yes.'

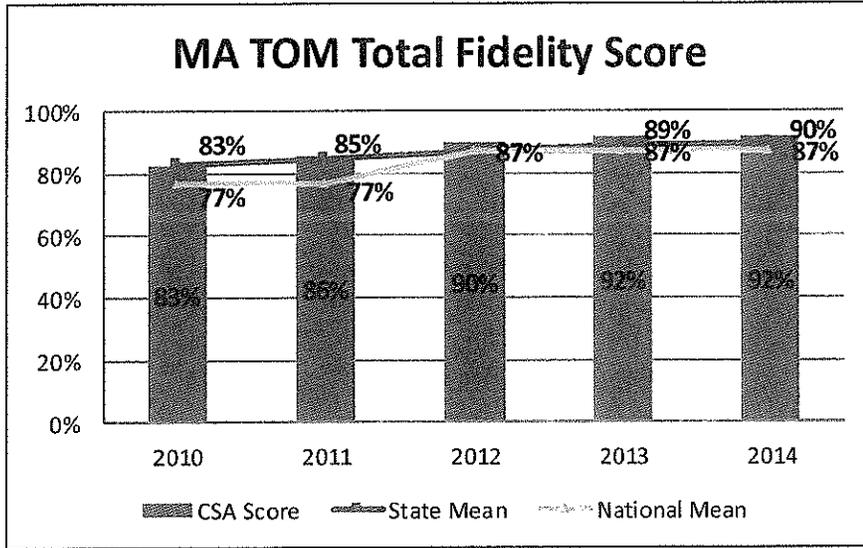
- 0 None of the indicators for this item were evident during the team meeting (i.e. none were scored 'yes')
- 1 Some, but fewer than half of the indicators for this item were scored 'yes'
- 2 About half of the indicators for this item were scored 'yes'
- 3 More than half, but not all, of the indicators for this item were scored 'yes'
- 4 All of the indicators for this item were evident during observation (i.e. all were scored 'yes')

### Methods

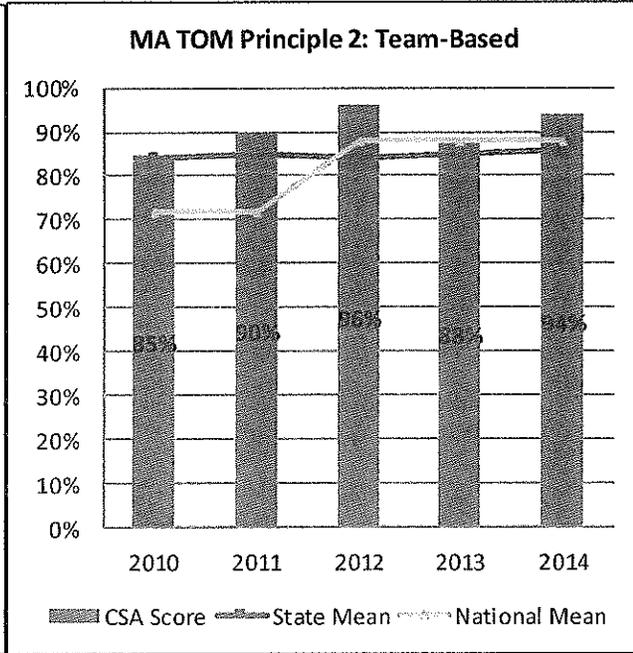
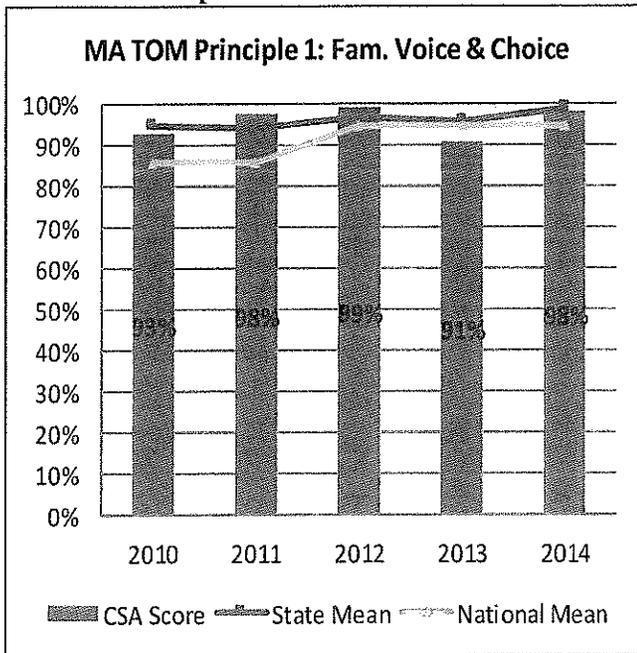
The MA TOM is one of two tools being used to monitor and evaluate (1) adherence to the principles of Wraparound, and (2) whether the basic activities of facilitating Wraparound are occurring. From July 1, 2013 through May 30, 2014, the MA TOM was administered by program supervisors during care team sessions led by intensive care coordinators (ICCs) carrying a caseload for four or more months. For existing ICCs, the requirement is that two TOMs be completed per year. For new ICCs, the requirement is that two TOMs be completed within months four and six from their date of hire. There were 717 TOM assessments completed and entered into WrapTrack in FY2014. This number includes 23 assessments from **Community Counseling of Bristol County- Attleboro**.

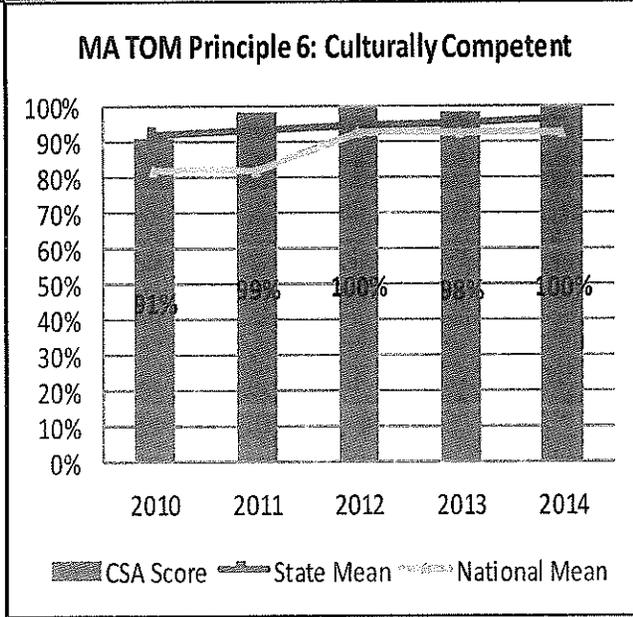
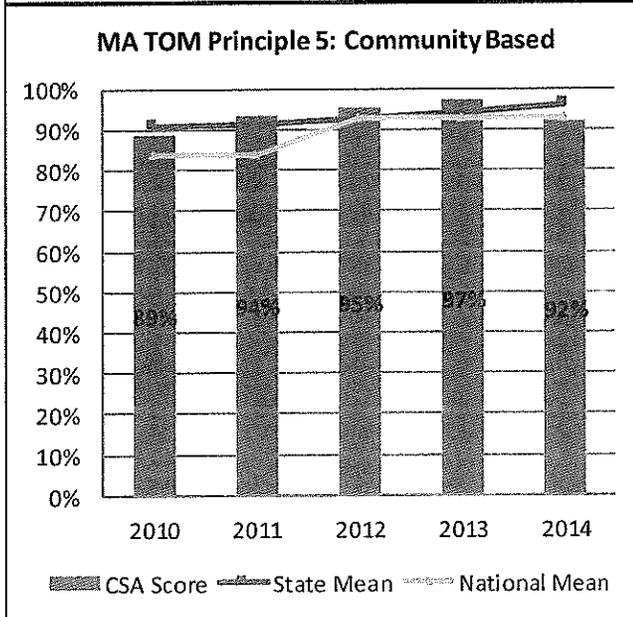
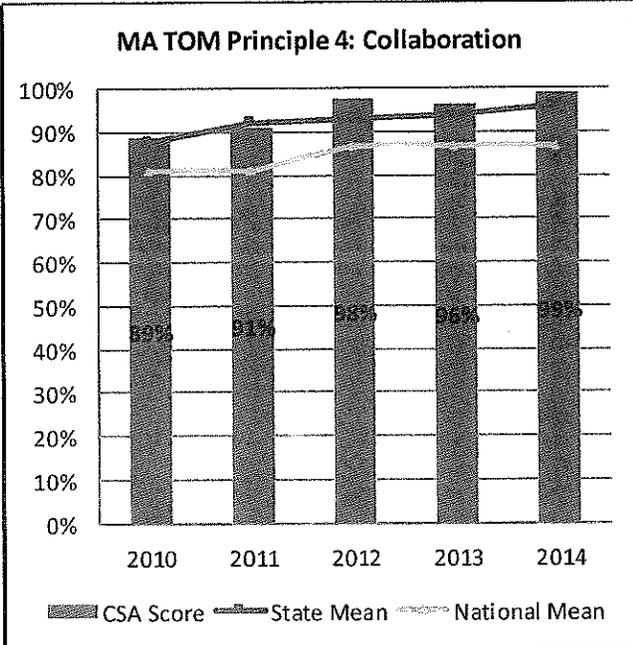
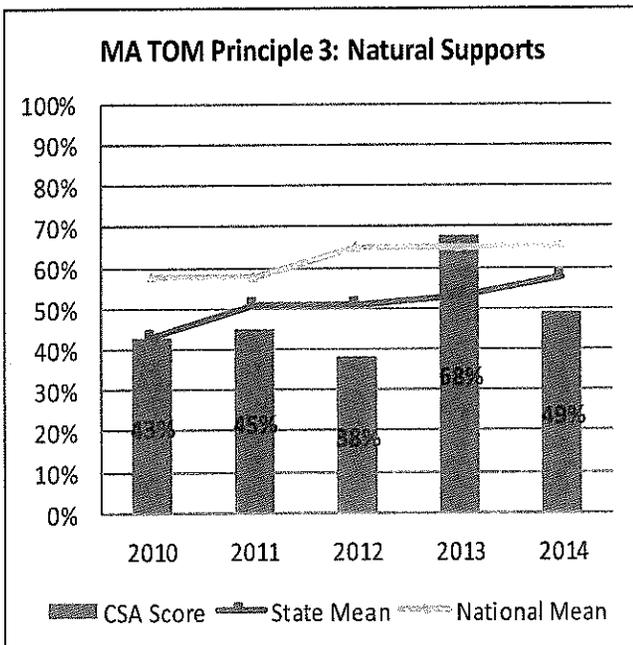
### Results: FY2014 Total Fidelity and Item Scores

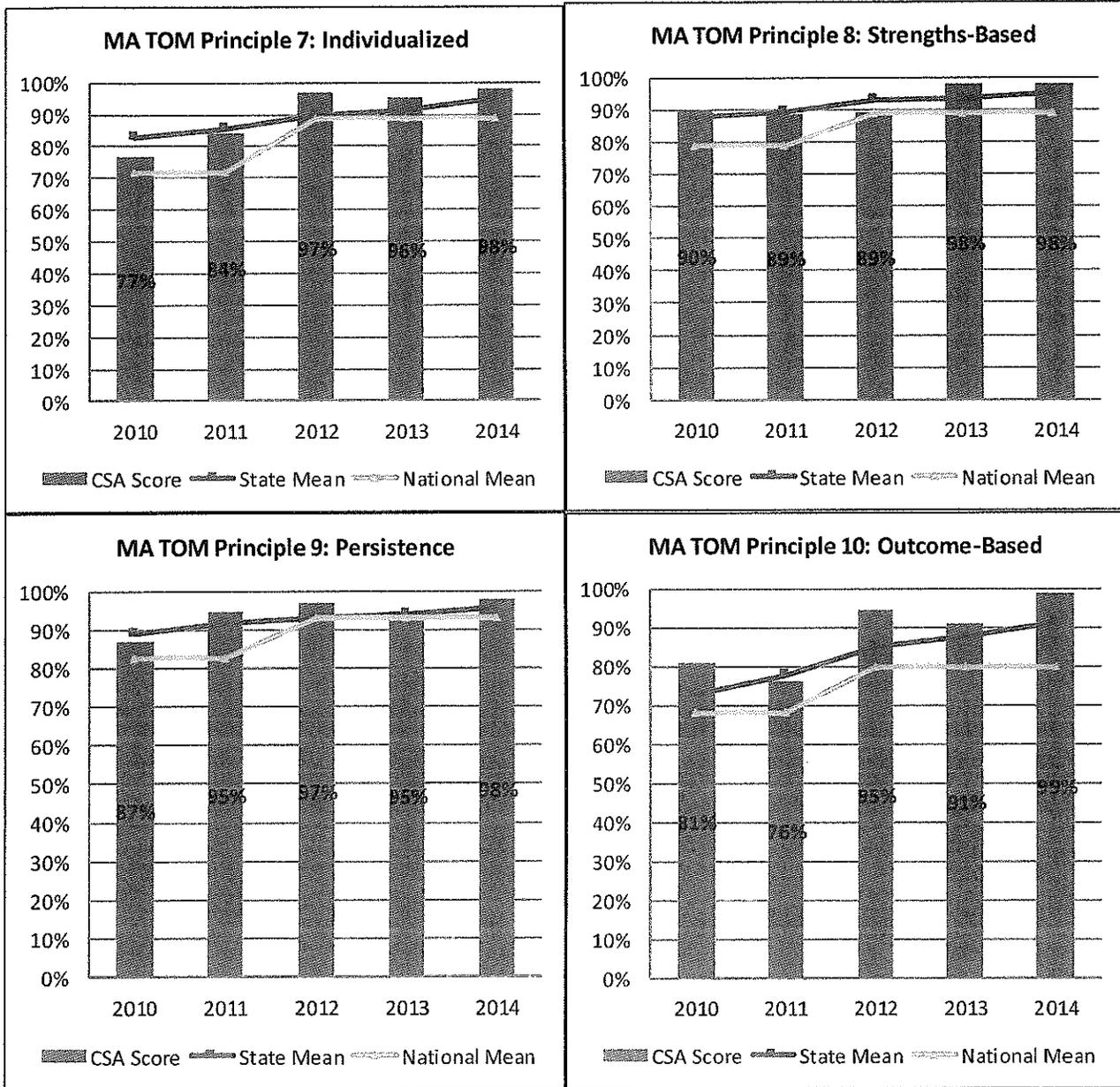
Item	CSA Score	State Mean	National Mean
1 Team Membership and Attendance	88%	76%	86%
2 Effective Team Process	100%	97%	91%
3 Facilitator Preparation	99%	95%	82%
4 Effective Decision Making	100%	97%	92%
5 Creative Brainstorming and Options	100%	94%	84%
6 Individualized Process	96%	97%	94%
7 Natural and Community Supports	38%	43%	47%
8 Natural Support Plans	60%	74%	83%
9 Team Mission and Plans	97%	94%	91%
10 Shared Responsibility	100%	98%	95%
11 Facilitation Skills	100%	96%	90%
12 Cultural and Linguistic Competence	100%	99%	96%
13 Outcomes-Based Practice	100%	91%	80%
14 Evaluating Process and Success	98%	92%	81%
15 Youth and Family Voice	99%	99%	98%
16 Youth and Family Choice	98%	98%	93%
17 Focus on Strengths	99%	95%	87%
18 Positive Team Culture	98%	97%	91%
18 Community Focus	85%	94%	89%
20 Least Restrictive Environment	99%	98%	98%
<b>Total Fidelity Score: Average Fidelity score across TOMs (for CSAs and National Mean) or CSAs (for State Mean)</b>	92%	90%	87%



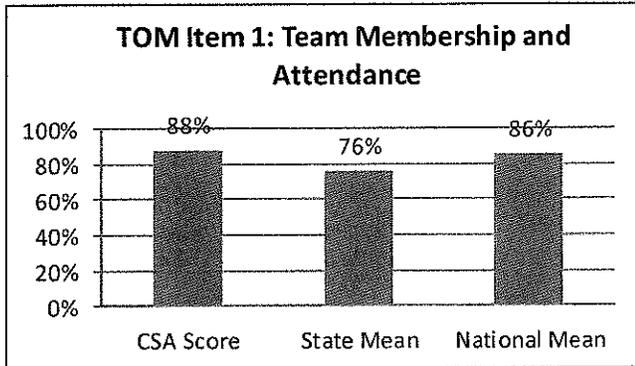
**Results: Principle Scores**



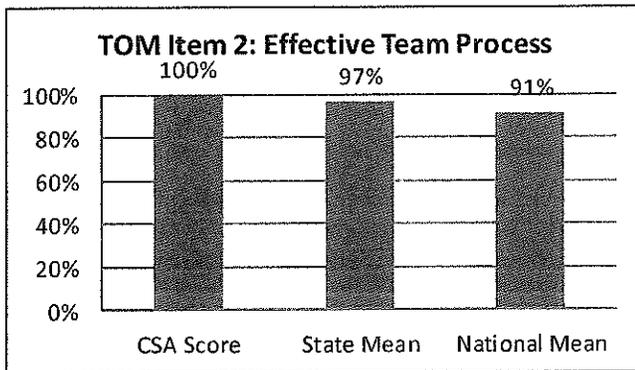




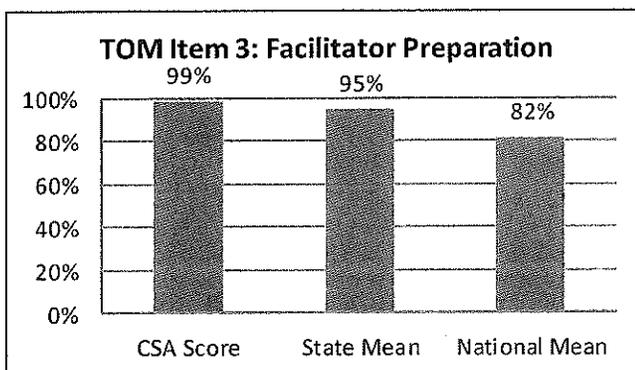
**Results: FY2014 Item Scores**



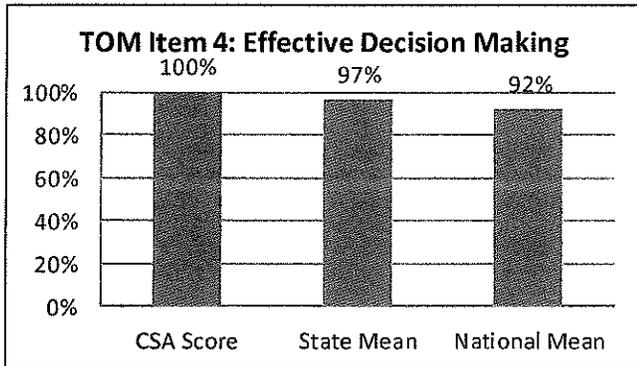
Team Membership and Attendance		Mean score
		3.52
a	Parent/caregiver is a team member and present at meeting	100%
b	Youth (over age 9) is a team member and present at the meeting	77%
c	Key school and/or other public stakeholder agency representatives are present.	67%



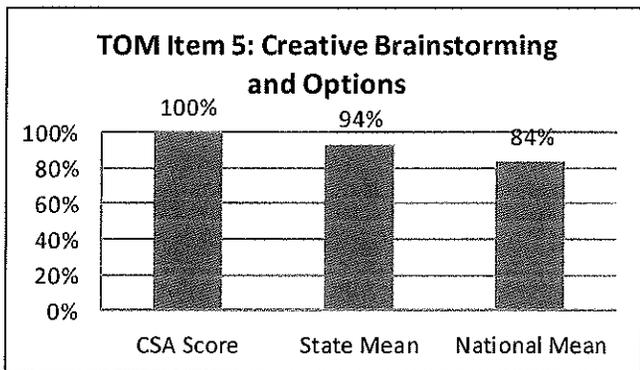
Effective Team Process		Mean score
		4.00
a	Team meeting attendees are orientated to the wraparound process and understand the purpose of meeting	100%
b	The facilitator assists the team to review and prioritize family and youth needs	100%
c	Tasks and strategies are explicitly linked to goals	100%
d	Potential barriers to the nominated strategy or option are discussed and problem-solved	100%



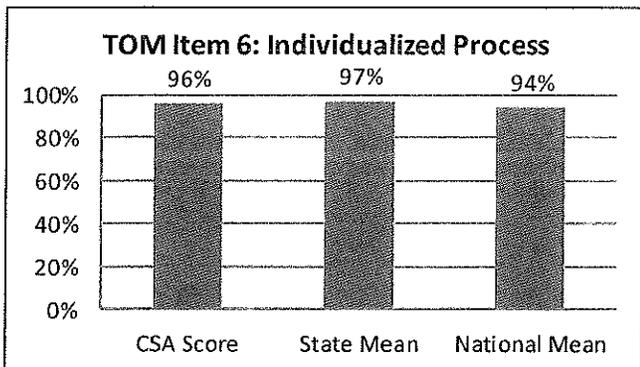
Facilitator Preparation		Mean score
		3.96
a	There is a clear agenda or outline for the meeting, which provides an understanding of the overall purpose of meeting	100%
b	The meeting follows an agenda or outline such that team members know the purpose of their activities at a given time	100%
c	The facilitator has prepared needed documents and materials prior to the meeting	100%
d	A plan for the next meeting is presented, including time and date	95%



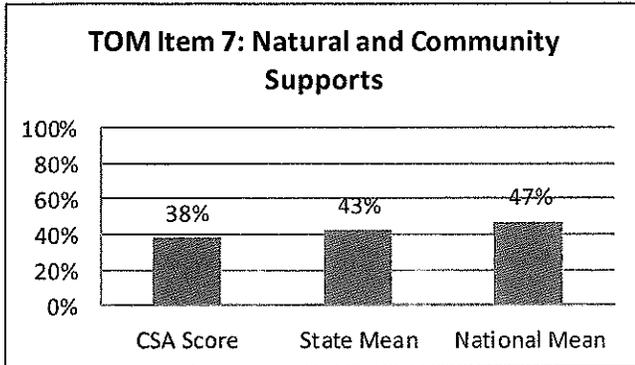
		Mean score
<b>Effective decision making</b>		<b>4.00</b>
<b>a</b>	Team members demonstrate consistent willingness to compromise or explore further options when there is a disagreement	100%
<b>b</b>	Team members reach shared agreement after having solicited info from several members or having generated several ideas	100%
<b>c</b>	The plan of care is agreed upon by all present at the meeting	100%
<b>d</b>	The facilitator summarizes the content of the meeting at the end of the meeting, including next steps and responsibilities	100%



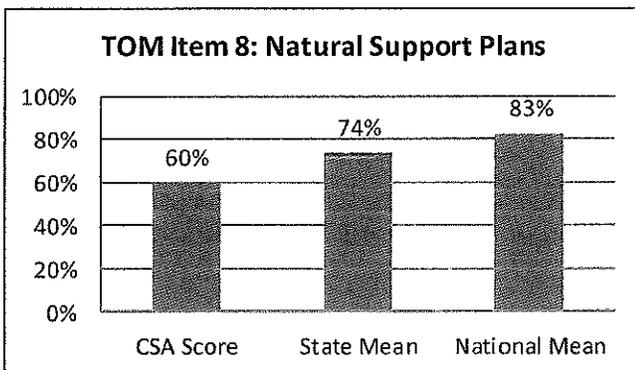
		Mean score
<b>Creative Brainstorming and Options</b>		<b>4.00</b>
<b>a</b>	The team considers several different strategies for meeting each need and achieving each goal that is discussed	100%
<b>b</b>	The team considers multiple options for tasks or action steps.	100%
<b>c</b>	The facilitator leads a robust brainstorming process to develop multiple options to meet priority needs.	100%



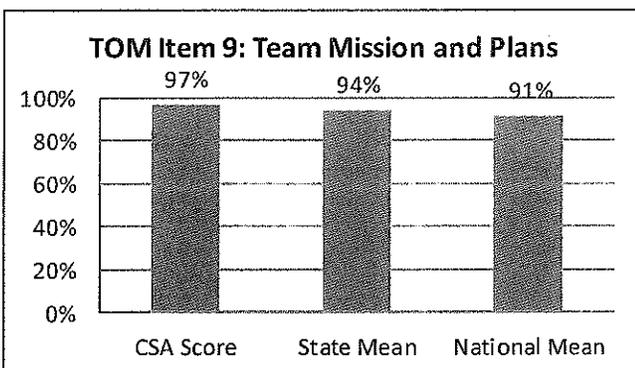
		Mean score
<b>Individualized process</b>		<b>3.83</b>
<b>a</b>	Planning includes action steps or goals for other family members, not just identified child	91%
<b>b</b>	Facilitator and team members draw from knowledge about the community to generate strategies and action steps based on unique community supports	100%
<b>c</b>	Team facilitates the creation of individualized supports or services to meet the unique needs of child and/or family	96%
<b>d</b>	Youth, caregiver, and family members give their opinions about potential services, supports or strategies; including describing what has or has not worked in past	96%



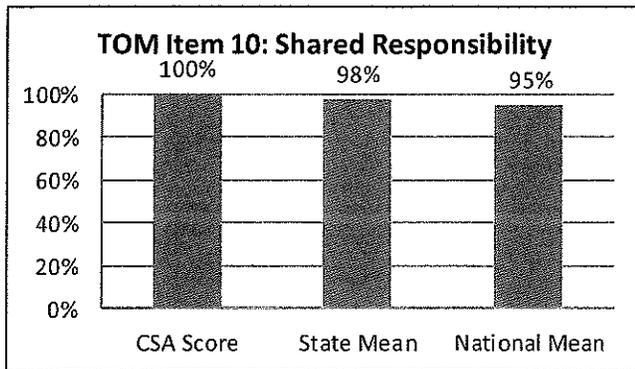
Natural and community supports		Mean score
		1.52
<b>a</b>	Natural supports for the family are team members and present	26%
<b>b</b>	Team provides multiple opportunities for natural supports to participate in significant areas of discussion	69%
<b>c</b>	Community team members and natural supports participate in decision-making	42%
<b>d</b>	Community team members and natural supports have a clear role on the team	73%



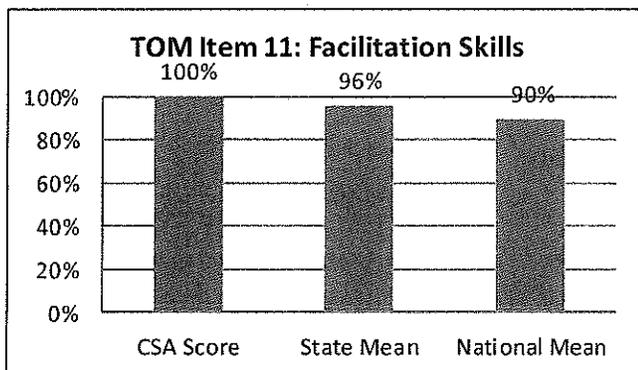
Natural support plans		Mean score
		2.39
<b>a</b>	Brainstorming of options and strategies includes strategies to be implemented by natural and community supports	86%
<b>b</b>	The plan of care represents a balance between formal services and informal supports	43%
<b>c</b>	There is flexible funding available to the team to allow for creative services, supports and strategies	38%



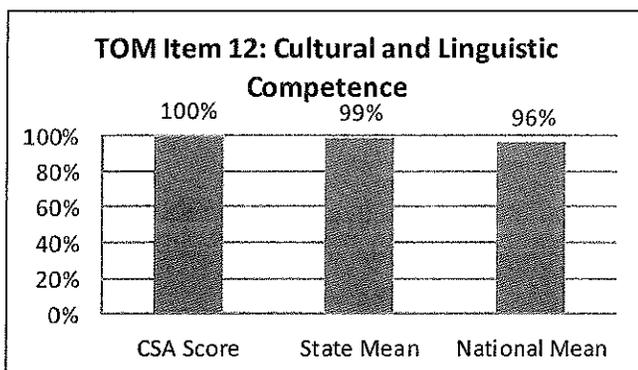
Team mission and plans		Mean score
		3.87
<b>a</b>	The team discusses or has produced a mission/vision statement.	100%
<b>b</b>	The team creates or references a plan that guides its work	100%
<b>c</b>	The team has confirmed or is creating a crisis plan	87%
<b>d</b>	The team plan contains specific goals that are linked to strategies and action steps	100%



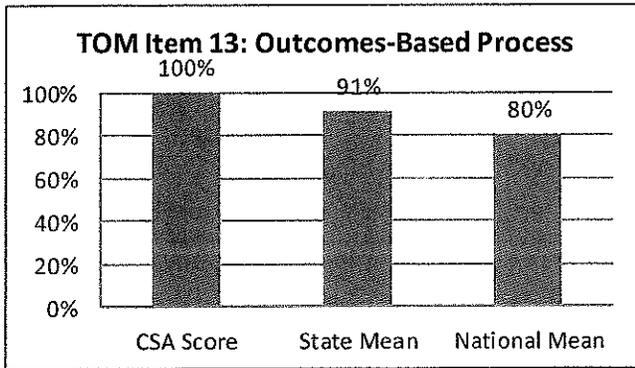
<b>Shared Responsibility</b>		Mean score
		4.00
<b>a</b>	The team explicitly assigns responsibility for action steps that define who will do what, when and how often	100%
<b>b</b>	There is a clear understanding of who is responsible for action steps and follow up on strategies in the plan	100%
<b>c</b>	Providers and agency representatives at the meeting demonstrate that they are working for the family and not there to represent a different agenda or set of interests	100%



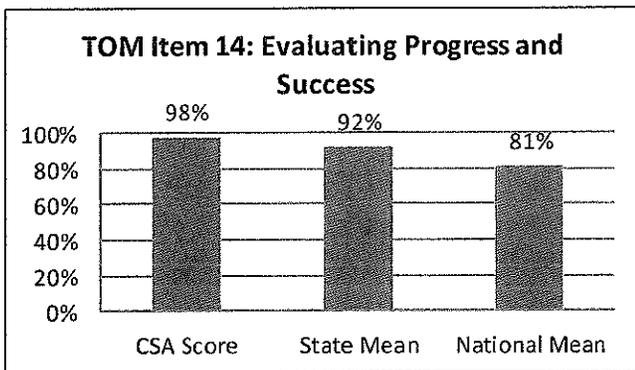
<b>Facilitation skills</b>		Mean score
		4.00
<b>a</b>	Facilitator is able to impart understanding about what the wraparound process is, how it will work for this family, and how individual team members will participate	100%
<b>b</b>	Facilitator reflects, summarizes, and makes process-orientated comments	100%
<b>c</b>	Facilitator is able to manage disagreement and conflict and elicit underlying interests, needs, and motivations of team members	100%
<b>d</b>	Talk is well distributed across team members and each team member makes an extended or important contribution	100%



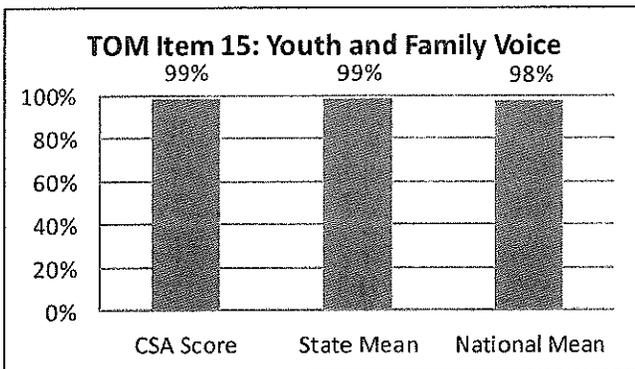
<b>Cultural and Linguistic Competence</b>		Mean score
		4.00
<b>a</b>	The youth, caregiver, and family members are given time to talk about the family's values, beliefs, and traditions	100%
<b>b</b>	The team demonstrates a clear and strong sense of respect for the family's values, beliefs, and traditions	100%
<b>c</b>	Meetings and meeting materials are provided in the language the family is most comfortable with	100%
<b>d</b>	Members of the team use language the family can understand (i.e. no professional jargon or acronyms)	100%



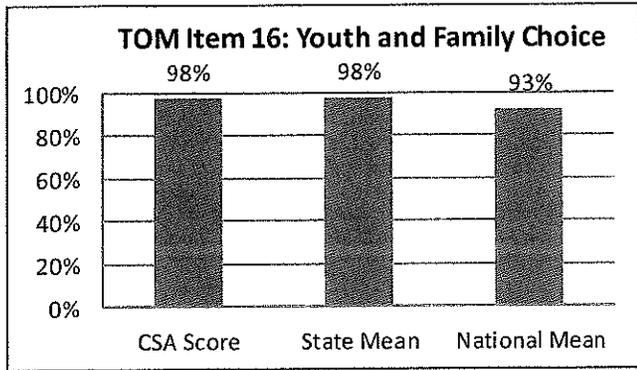
Outcomes Based Process		Mean score
		4.00
a	The team uses objective measurement strategies	100%
b	The team assesses goals/strategies using measures of progress	100%
c	The team revises the plan if progress toward goals is not evident.	100%



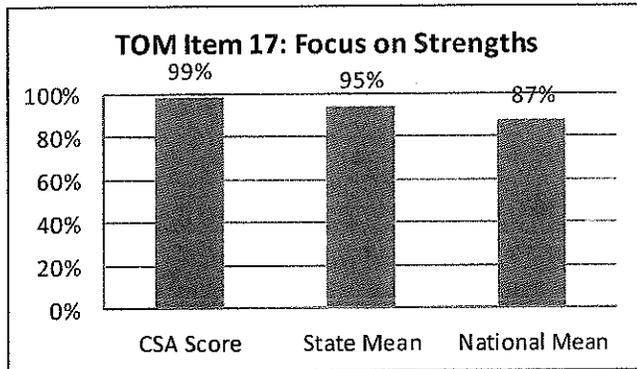
Evaluating Progress and Success		Mean score
		3.91
a	The team conduces a systematic review of members' progress on assigned action steps	100%
b	The facilitator checks in with the team members about their comfort and satisfaction with the team process,	95%
c	Objective or verifiable data is used as evidence of success, progress, or lack thereof.	95%



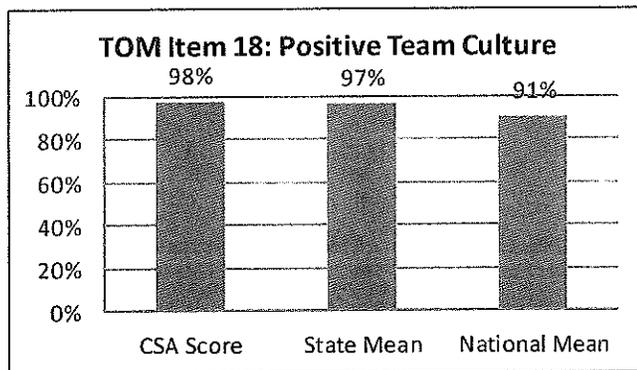
Youth and Family Voice		Mean score
		3.96
a	The team provides extra opportunity for caregivers to speak and offer opinions, especially during decision making	100%
b	The team provides extra opportunity for the youth to speak and offer opinions, especially during decision making	100%
c	Caregivers, parents, and family members are afforded opportunities to speak in an open-ended way about current and past experiences and/or about hopes for the future	100%
d	The youth is invited to speak in an open-ended way about current and past experiences and/or about hopes for the future	92%



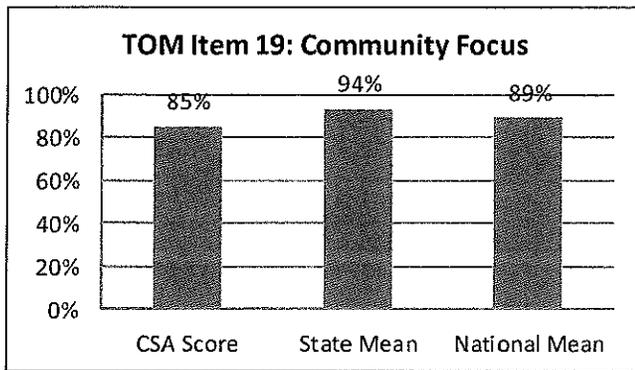
Youth and Family Choice		Mean score
		3.91
<b>a</b>	The youth prioritizes life domains, goals, or needs on which she or he would like the team to work	92%
<b>b</b>	The caregiver or parent prioritizes life domains goals, or needs on which he or she would like the team to work.	100%
<b>c</b>	The family and youth have highest priority in decision making	96%



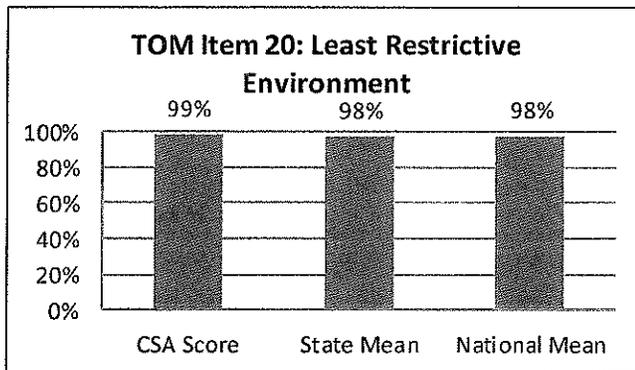
Focus on Strengths		Mean score
		3.96
<b>a</b>	Team members acknowledge or list caregiver/youth strengths	100%
<b>b</b>	Team builds an understanding of how youth strengths contribute to the success of team missions or goals	100%
<b>c</b>	In designing strategies, team members consider and build on strengths of the youth and family	100%
<b>d</b>	Facilitator and team members analyze youth and family member perspectives and stories to identify functional strengths	96%



Positive Team Culture		Mean score
		3.91
<b>a</b>	The team focuses on improvements or accomplishments throughout the meeting	100%
<b>b</b>	The facilitator directs a process that prevents blame or excessive focus on or discussion of negative events	96%
<b>c</b>	The facilitator encourages team culture by celebrating successes since the last meeting	100%
<b>d</b>	There is a sense of openness and trust among team members	96%



Community Focus		Mean score
		3.41
<b>a</b>	The team is actively brainstorming and facilitating community activities for the youth and family	90%
<b>b</b>	The team prioritizes services that are community-based	77%
<b>c</b>	The team prioritizes access to services that are easily accessible to the youth and family	90%



Least Restrictive Environment		Mean score
		3.96
<b>a</b>	The team's mission and/or identified needs support the youth's integration into the least restrictive residential and educational environments possible	100%
<b>b</b>	When residential placements are discussed, team chooses community placements for the child or youth rather than out-of-community placements, wherever possible.	80%
<b>c</b>	Serious challenges are discussed in terms of finding solutions, not placement in more restrictive residential or educational environments	100%

## SECTION 2: MASSACHUSETTS WRAPAROUND FIDELITY INDEX, VERSION 4

### Background from the NWI Resource Guide to Wraparound

*The Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4) is an interview that measures the nature of the wraparound process that an individual family received. The MA WFI-4 is completed through brief, confidential telephone interviews administered by staff of the consumer-led non-profit Consumer Quality Initiatives to caregivers of youth participating in Wraparound who have signed release of information forms. A demographic form is also part of the WFI-4. The WFI-4 interviews are organized by the four phases of the wraparound process. In addition, the 40 items of the WFI interview are keyed to the 10 principles of the wraparound process, with 4 items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess adherence to the basic wraparound practice model, as well as fidelity to the principles of wraparound. WFI data can be used to assess the overall fidelity of an organization or wraparound initiative. Data can also be analyzed by phase, principle or item to help a program or supervisor make mid-course corrections.*

### Interpreting WFI Scores

Your CSA's FY2010, FY2011, FY2012, FY2013, and FY2014 total fidelity scores, principle and item scores are displayed on the following pages with comparisons to the state and national averages. To arrive at a total Principle score, the four item scores for each Principle were summed, resulting in a score ranging from 0 (low fidelity) to 8 (high fidelity). Principle scores were then expressed as a percent of total possible fidelity; a Principle score of 7 out of 8, for example, would be expressed as 87.4% fidelity.

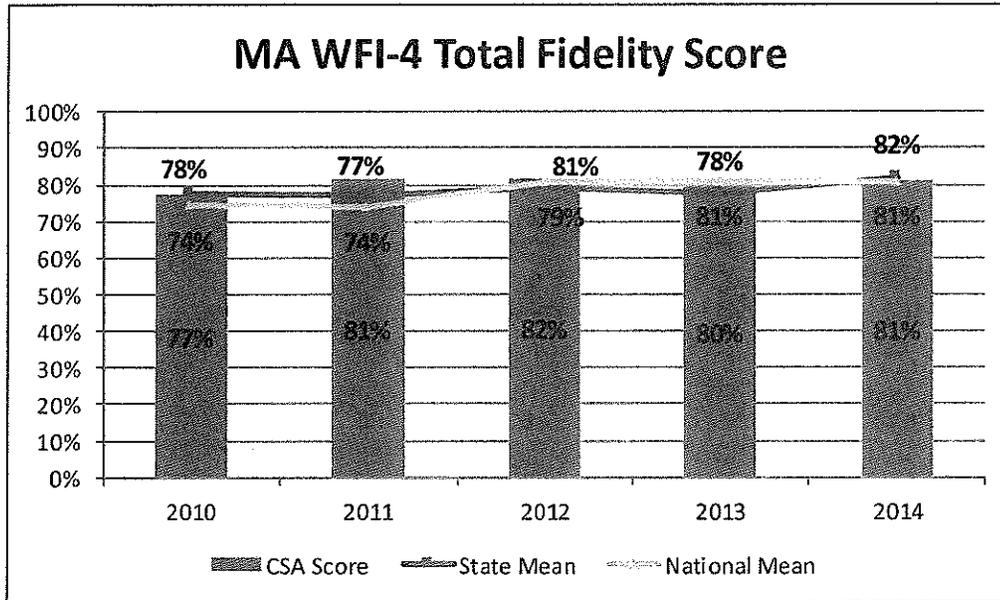
MA WFI-4 respondent forms include 40 items, corresponding to four items per Wraparound principle. For each item, caregivers' answers from the WFI interview were coded as "yes" (high fidelity), "somewhat or sometimes" (partial fidelity) or "no" (low fidelity). Item responses, which are presented on pp. 22-24, were then scored by the interviewer on a scale from 0 (low fidelity) to 2 (high fidelity).

When scoring the WFI, interviewers from CQI had to keep in mind that items are reverse-coded. For example, a "yes" response on a standard item (e.g., "Before your first team meeting, did your wraparound facilitator fully explain how the wraparound process would work?") would be scored a 2, indicating good Wraparound fidelity. However, a "yes" response to a reverse-coded item (e.g., "Is it difficult to get team members to attend team meetings when they are needed?") would receive a 0.

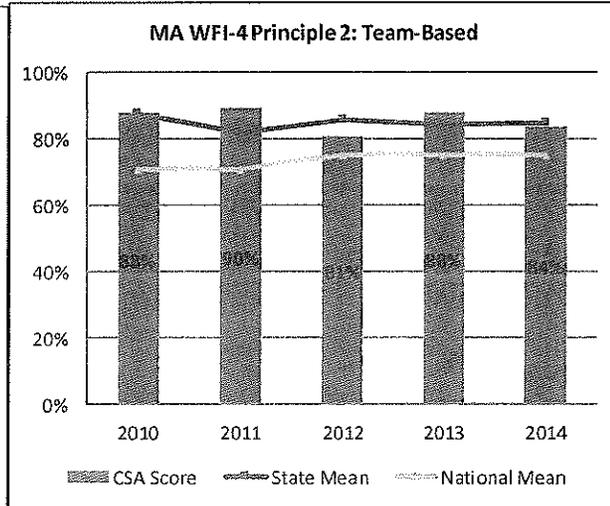
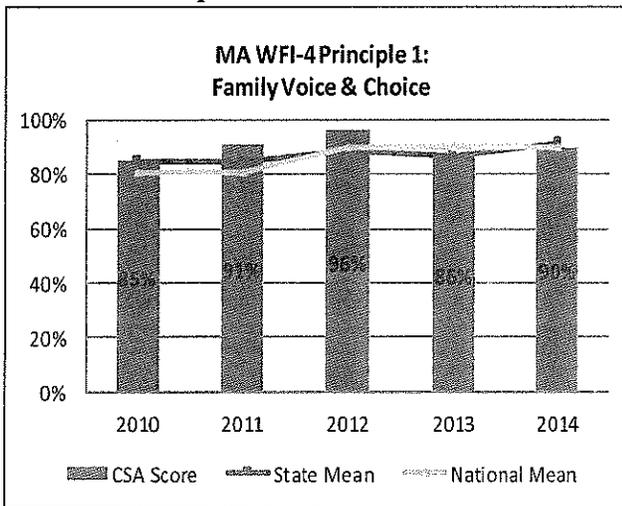
### Methods

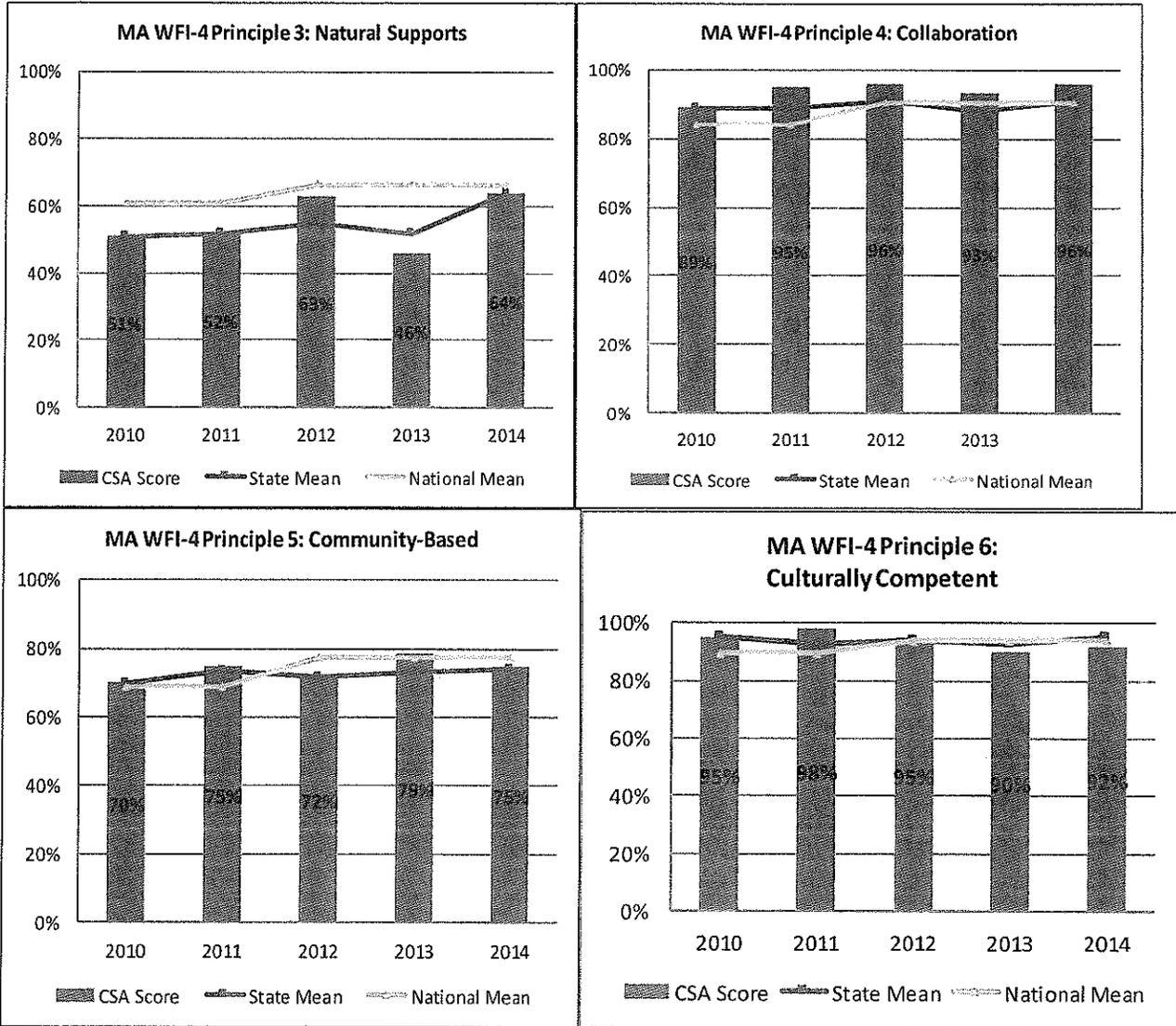
The Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4) is one of two tools being used to monitor and evaluate (1) adherence to the principles of Wraparound, and (2) whether the basic activities of facilitating Wraparound are occurring. The MA WFI-4 was administered by staff of Consumer Quality Initiatives (CQI) from September 2013 through June 2014. During this time CQI interviewed caregivers of youth who enrolled in wraparound from January through December 2013, and who signed release of information forms. (Note that no caregivers interviewed for the MA WFI-4 FY2013 were re-interviewed). The requirement was that 20 WFI interviews be completed for each CSA – provided there were enough youth enrolled and, consequently, an adequate number of release forms. On June 30, the end of the data collection period, 629 MA WFI-4 assessments had been completed and entered into the online data and reporting system, WrapTrack. This number includes 20 interviews with caregivers of youth participating in Wraparound at **Community Counseling of Bristol County- Attleboro**.

**Results: Total Fidelity Score**

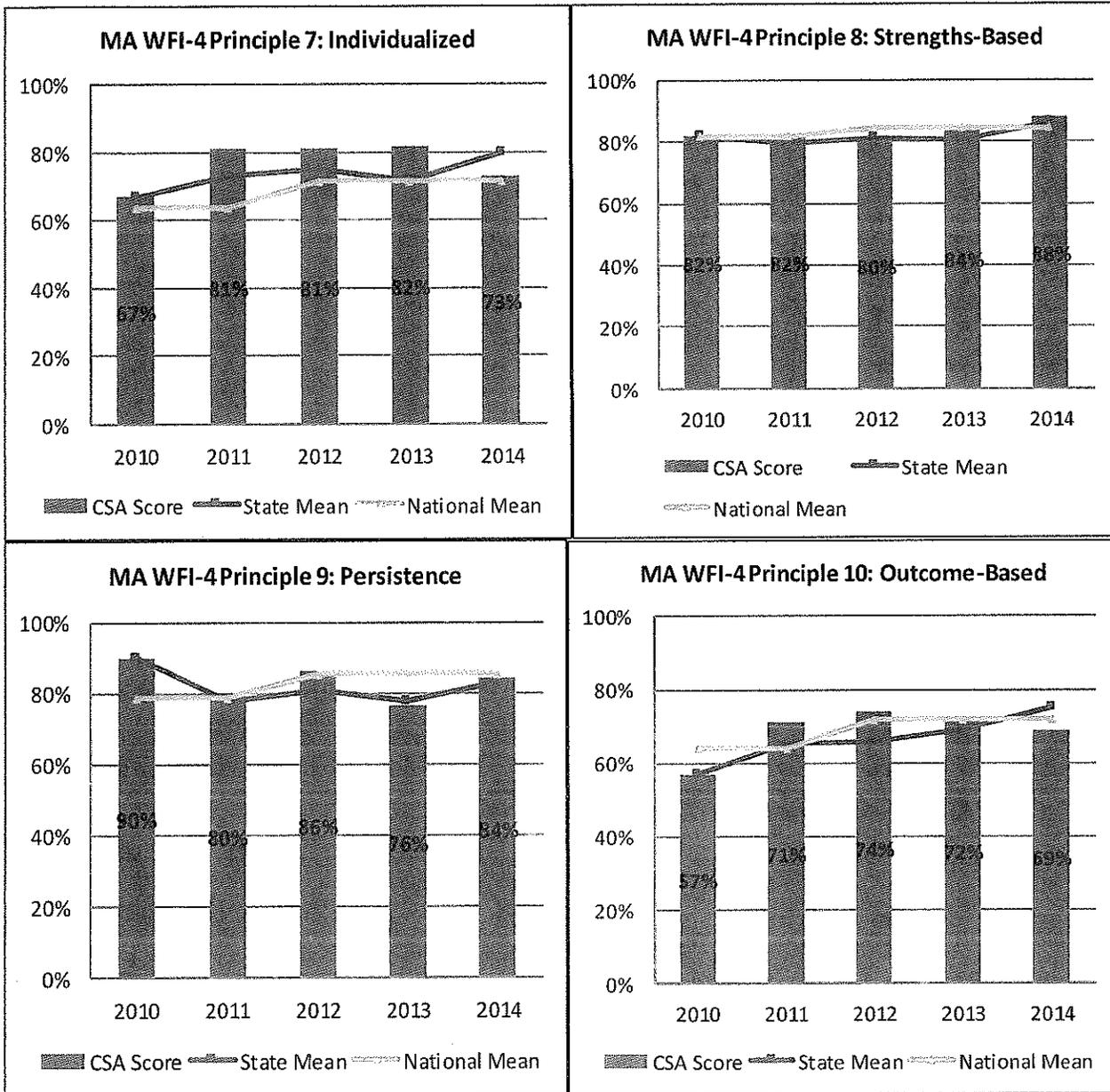


**Results: Principle Scores**





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**Results: FY 2014 Item Scores**

WFI Item	CSA Score	National Mean	National SD	State Mean	State SD
1.1 (CC) When you first met with the family, were they given ample time to talk about their strengths, beliefs, and traditions?	1.68	1.82	0.50	1.85	0.10
1.2 (FVC) Before the first team meeting, did you fully explain the wraparound process and the choices the family could make?	1.84	1.83	0.51	1.92	0.07
1.3 (SB) At the beginning of the wraparound process, was the family given an opportunity to tell you what things have worked in the past for the child and family?	1.95	1.81	0.53	1.91	0.08
1.4 (TB) Did the family members select the people who would be on their wraparound team?	1.45	0.93	0.95	1.40	0.26
1.5 (TB) Is it difficult to get team members to attend team meetings when they are needed?	1.85	1.64	0.66	1.74	0.14
1.6 (OB) Before the first wraparound team meeting, did you go through a process of identifying what leads to crises or dangerous situations for the child and family?	1.63	1.76	0.61	1.91	0.10
2.1 (Col) Did the family plan and its team create a written plan of care (or wraparound plan, child and family plan) that describes how the team will meet the child's and family's needs?	2.00	1.78	0.53	1.93	0.08
2.2 (TB) Did the team develop any kind of written statement about what the future will look like for the child and family, or what the team will achieve for the child and family?	1.60	1.63	0.69	1.78	0.16
2.3 (Ind) Can you summarize the services, supports, and strategies that are in the family's wraparound plan?	0.80	0.74	0.84	1.25	0.26
2.4 (SB) Are the supports and services in the wraparound plan connected to the strengths and abilities of the child and family?	1.95	1.85	0.45	1.85	0.10
2.5 (CB) Does the wraparound plan include strategies for helping the child get involved with activities in her or his community?	1.35	1.27	0.83	1.39	0.20
2.6 (Col) Are there members of the wraparound team who do not have a role in implementing the plan?	1.80	1.78	0.57	1.78	0.14

[22]

2.7 (Col)	Does the team brainstorm many strategies to address the family's needs before selecting one?	1.85	1.84	0.49	1.83	0.14
2.8 (Ind)	Is there a crisis or safety plan that specifies what everyone must do to respond to a crisis?	1.72	1.67	0.68	1.75	0.13
2.9 (CB)	Do you feel confident that, in the event of a major crisis, the team can keep the child or youth in the community?	1.58	1.74	0.60	1.71	0.15
2.10 (FVC)	Would you say that people other than the family have higher priority than the family in designing their wraparound plan?	1.85	1.71	0.66	1.87	0.12
2.11 (CC)	During the planning process, did the team take enough time to understand the family's values and beliefs?	1.74	1.85	0.45	1.85	0.12
3.1 (FVC)	Are important decisions ever made about the child or family when they are not there?	1.70	1.77	0.58	1.88	0.10
3.2 (Ind)	When the wraparound team has a good idea for a support or service for the child, can it find the resources or figure out some way to make it happen?	1.80	1.82	0.49	1.76	0.14
3.3 (SB)	Does the wraparound team get the child involved with activities she or he likes and does well?	1.25	1.18	0.86	1.25	0.24
3.4 (NS)	Does the team find ways to increase the support the family gets from its friends and family members?	1.53	1.43	0.83	1.49	0.21
3.5 (Col)	Do the members of the team hold each another responsible for doing their part of the wraparound plan?	2.00	1.84	0.48	1.80	0.13
3.6 (NS)	Is there a friend or advocate of the child or family who actively participates on the wraparound team?	1.00	0.96	0.96	0.93	0.22
3.7 (Per)	Does the team come up with new ideas for the wraparound plan whenever the family's needs change?	1.90	1.85	0.46	1.82	0.12
3.8 (CB)	Are the services and supports in the wraparound plan difficult for the family to access?	1.84	1.72	0.61	1.64	0.12
3.9 (OB)	Does the team assign specific tasks to all team members at the end of each meeting?	1.55	1.73	0.62	1.77	0.23
3.10 (CC)	Do members of the team always use language the family can understand?	2.00	1.93	0.31	1.96	0.10

3.11 (SB)	Does the team create a positive atmosphere around successes and accomplishments at each team meeting?	1.95	1.92	0.33	1.92	0.09
3.12 (TB)	Does the team go out of its way to make sure that all team members – including friends, family, and natural supports – present ideas and participate in decision making?	1.80	1.85	0.46	1.88	0.10
3.13 (Per)	Do you think the wraparound process could be discontinued before the family is ready for it to end?	1.42	1.54	0.76	1.36	0.16
3.14 (CC)	Do all the members of the team demonstrate respect for the family?	1.90	1.94	0.30	1.90	0.09
3.15 (FVC)	Does the child or youth have the opportunity to communicate his or her own ideas when the time comes to make decisions?	1.84	1.91	0.34	1.60	0.18
4.1 (OB)	Has the team discussed a plan for how the wraparound process will end?	1.05	0.80	0.88	1.01	0.23
4.2 (NS)	Has the wraparound process helped the child develop friendships with other youth who will have a positive influence on him or her?	1.11	1.27	0.86	1.22	0.29
4.3 (OB)	Has the wraparound process helped the child to solve her or his own problems?	1.25	1.46	0.71	1.31	0.18
4.4 (Ind)	Has the team helped the child or youth prepare for major transitions?	1.60	1.50	0.78	1.64	0.22
4.5 (Per)	After formal wraparound has ended, do you think that the process will be able to be "re-started" if the youth or family needs it?	1.89	1.76	0.59	1.86	0.11
4.6 (NS)	Has the wraparound process helped the family to develop or strengthen relationships that will support them when wraparound is finished?	1.45	1.65	0.66	1.48	0.18
4.7 (CB)	Do you feel like the child and family will be able to succeed without the formal wraparound process?	1.21	1.49	0.77	1.22	0.27
4.8 (Per)	Will some members of the team be there to support the family when formal wraparound is finished?	1.47	1.68	0.65	1.62	0.19

**SECTION 3: RELATIVE STRENGTHS AND AREAS FOR IMPROVEMENT**

**TOM and WFI Items: Relative Strengths**

**TOM and WFI Items: Areas for Improvement**

**Two Strongest Principles Overall (TOM and WFI)\***

<b>Principle:</b>		
<b>CSA Score:</b>	<b>State Mean:</b>	<b>National Mean:</b>
Description:		

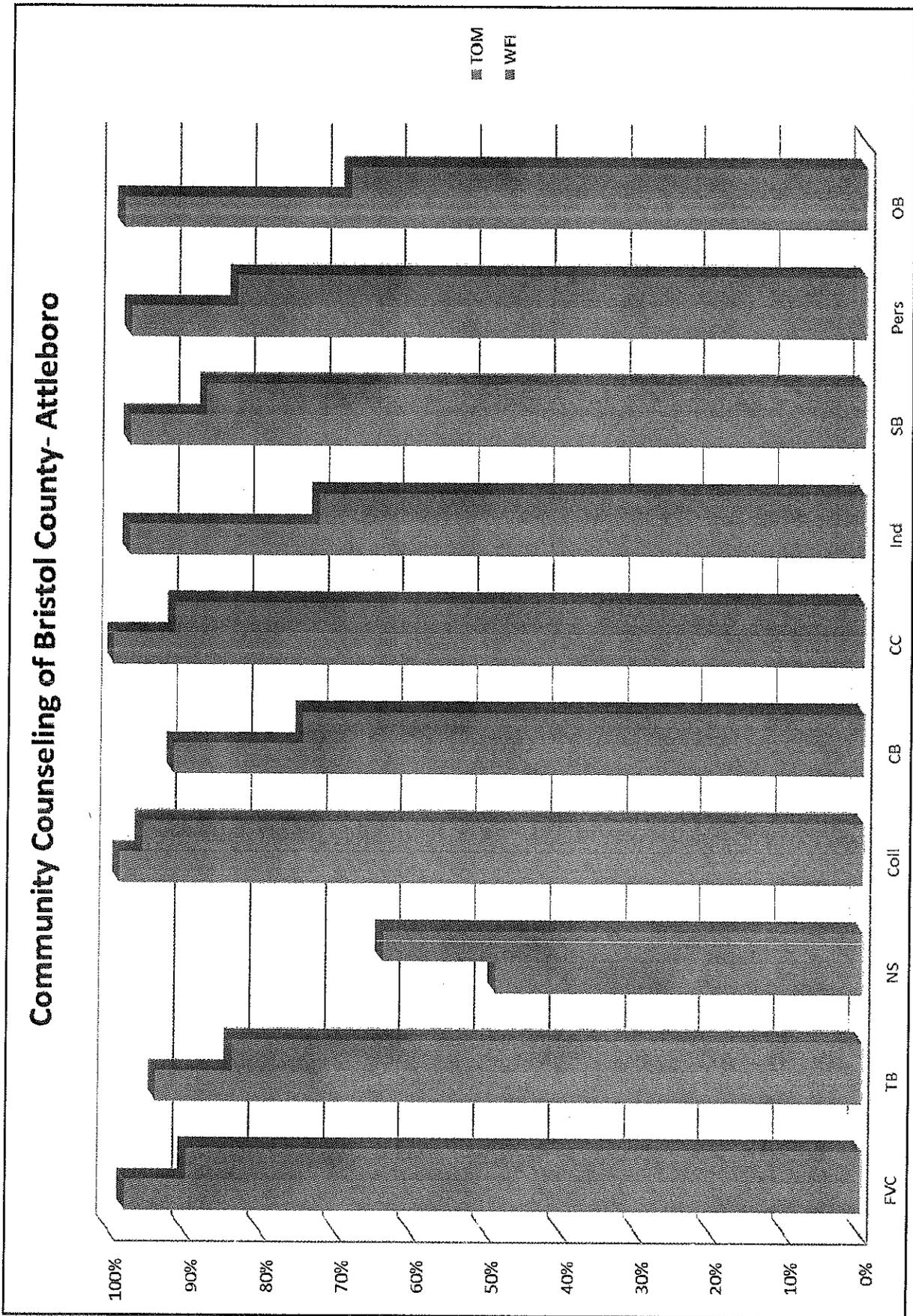
<b>Principle:</b>		
<b>CSA Score:</b>	<b>State Mean:</b>	<b>National Mean:</b>
Description:		

**Two Weakest Principles Overall (TOM and WFI)\***

<b>Principle:</b>		
<b>CSA Score:</b>	<b>State Mean:</b>	<b>National Mean:</b>
Description:		

<b>Principle:</b>		
<b>CSA Score:</b>	<b>State Mean:</b>	<b>National Mean:</b>
Description:		

\* For descriptions of each principle, please see the attached *Ten Principles of the Wraparound Process* published by the NWI, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.



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**TOM and WFI: Linking Principles to Items**

<b>Principle</b>	<b>Corresponding Items on TOM</b>	<b>Corresponding Items on WFI</b>
1: Family Voice & Choice	15, 16	1.2, 2.10, 3.1, 3.15
2: Team-Based	1, 2	1.4, 1.5, 2.2, 3.12
3: Natural Supports	7, 8	3.4, 3.6, 4.2, 4.6
4: Collaboration	3, 4	2.1, 2.6, 2.7, 3.5
5: Community-Based	19, 20	2.5, 2.9, 3.8, 4.7
6: Culturally Competent	11, 12	1.1, 2.11, 3.10, 3.14
7: Individualized	5, 6	2.3, 2.8, 3.2, 4.4
8: Strengths-Based	17, 18	1.3, 2.4, 3.3, 3.11
9: Unconditional	9, 10	3.7, 3.13, 4.5, 4.8
10: Outcome-Based	13, 14	1.6, 3.9, 4.1, 4.3

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### **3.5.3.7.1 – 3.5.3.7.2**

**Resumes from staff at director-level positions that have 5+ years of experience providing behavioral health services to youth and families and would be involved in MCI**

**Job descriptions of identified staff members who would be staffing MCI in any capacity**

### ESP RFR Attachment 3.5.3.7.2

#### Community Counseling of Bristol County, Inc.

#### Job Description

Position (UFR):       **104 Supervising Professional**

Position Title:       MCI Program Manager

Program Name:        Mobile Crisis Intervention

Service Type:         Emergency Services

Accountability:      ESP Program Director

#### Summary of Position:

The MCI Program Manager is responsible for the overall supervision of the Clinician/Mobile Crisis Intervention Specialists and Family Partners. The MCI Program Manager maintains oversight of the program, including, but not limited, to crisis evaluation calls, evaluations, evaluation dispositions, seven-day intervention periods for youth remaining in the community, clinical appropriateness of brief solution-focused interventions, and program collaboration with collateral contacts. Data streams will include time from call to community response and location of service.

#### Education/Training:

- Must have at least five (5) years post-graduate experience providing behavioral health services to youth and families.
- Independently Licensed Master's Level Clinician.
- Must have at least three (3) years of supervisory and/or management experience.
- Excellent assessment and differential diagnostic skills.

#### Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, and potential safety issues.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.
- Must be able to articulate and promote a recovery orientation that is resolution focused, strengths-based, and culturally competent.
- Ability to manage resources including the hiring and retention of culturally competent staff.

### **ESP RFR Attachment 3.5.3.7.2**

- Possess knowledge and practice skills regarding Continuous Quality Improvement.
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties as well as the written skills required to manage an electronic health record system.

#### Responsibilities:

- Weekly 1 hour supervision with Intake Supervisor and Clinical Supervisors.
- Triage consultation/supervision as needed to staff.
- Formal written tracking of supervisory sessions.
- Participation in quarterly meetings with MCEs.
- Hire and orient new staff.
- Create and maintain on-call schedule.
- Maintain ongoing relationships with MCEs and referral sources.
- Track weekly productivity of all staff and update deficits monthly.
- Track financial and referral data and provide updates to administration as requested.
- Supervise and implement disciplinary actions as needed.
- Plan annual trainings in accordance with identified core competencies and MCE training requirements.
- Supervise billing administrator and provide back-up for billing functions as needed.
- Facilitate weekly staff meeting.
- Facilitate Clinicians peer supervision meetings.
- Input all new clients and update authorizations into database system and manage error reports.
- Complete staff employee evaluations annually.

#### List Other Job Requirements:

Knowledge of Core-Competencies as identified by the employee's assigned department. Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

#### Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

The noise level in the office / facility is usually quiet, but can be loud due to client participation and groups. The work environment is primarily within an indoor facility with occasional exposure to outdoor weather when traveling to outreach or meeting sites, or when participating in special program activities.

**ESP RFR Attachment 3.5.3.7.2**

Disclaimer:

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks, and duties. The responsibilities, tasks, and duties of the jobholder might differ from those outlined in the job description and that other duties, as assigned, might be part of the job.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ESP RFR Attachment 3.5.3.7.2**

Community Counseling of Bristol County, Inc.

**Job Description**

Position (UFR):       **104 Supervising Professional**  
Position Title:       MCI Clinical Supervisor  
Program Name:       Emergency Services Program  
Service Type:        Emergency Services  
Accountability:      MCI Program Manager

Summary of Position:

Provide clinical supervision to staff, and also provide clinical services to children, adolescents, and their families.

Education/Training:

- Master's degree in a human services related discipline.
- Licensed as an LICSW, LMFT, or LMHC by the Commonwealth of Massachusetts.

Qualifications/Experience Requirements:

- Five (5) or more years of experience (post-licensure) in a human service position with at least two years of child-services-related supervisory experience.
- Must possess good organizational skills, effective written and verbal skills, and have experience with an electronic health record (EHR).
- Must possess clinical core competencies and experience regarding crisis assessment, intervention and stabilization strategies for children, adolescents, and families.
- Experience providing mobile crisis intervention services.

Responsibilities:

- Meet with individual clinicians for one-on-one supervision on a weekly basis.
- Provide impromptu supervision to clinicians in order to manage risk and client safety issues.
- Provide training/orientation for new clinicians.
- Monitor completion of client documentation and sign-off on comprehensive assessments and individualized action plans in the electronic health record.
- Review client documentation to insure that medical necessity is indicated.
- Participate in program development.
- Address clinicians' performance issues: develop performance improvement plans and manage HR issues as needed.
- Attend all required trainings.

**ESP RFR Attachment 3.5.3.7.2**

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance.

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Signature

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Date

**ESP RFR Attachment 3.5.3.7.2**

Community Counseling of Bristol County, Inc.

**Job Description**

Position (UFR): **135 Direct Care/Program Staff II**

Position Title: Family Partner

Program Name: Emergency Services Program

Service Type: Emergency Services

Accountability: MCI Program Manager

Education/Training:

- Bachelor's degree in human services field from an accredited university and one (1) year of experience working with the target population; **or**
- Associate's degree in a human service field from an accredited university and one (1) year of experience working with children/adolescents/transitional aged youth; **or**
- High school diploma or GED and a minimum of two (2) years working with children/adolescents/transitional aged youth.

Qualifications/Experience Requirements:

- Experience as a caregiver of a youth with serious emotional disturbance.
- Experience navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems.
- Willingness to provide mobile emergency services interventions/follow-up.

Responsibilities:

- Utilize personal and professional life experience to provide peer support to parents and caregivers served by the ESP.
- Learn the family's story, culture, strengths, and concerns.
- As requested, participate in Care Planning Team (CPT) meetings to ensure access, voice and choice within the wraparound process and to support the parent/caregiver's connection to the CPT members, as necessary.
- Serve as a bridge to ensure that family and providers understand each other's perspective and information.
- Provide a consistent source of encouragement and hope.
- Provide non-judgmental, unconditional support to parents and caregivers.
- Model effective coping techniques for parents and caregivers.
- Engage parent/caregiver in activities in the home and community.
- Assist the parent/caregiver with meeting the needs of the youth and meet one or more of the following purposes: Educating, supporting, coaching, modeling, and guiding.
- Promote parent/caregiver empowerment by including linkages to peer/parent support and self-help groups in the community.

**ESP RFR Attachment 3.5.3.7.2**

- Teach the parent/caregiver how to identify formal and community-based resources (e.g., after-school programs, food assistance, housing resources, etc.)
- Meet weekly with an independently licensed clinician for supervision.
- Comply with all CCBC personnel policies and procedures related to employment.

List Other Job Requirements:

- Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.
- Maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren).
- Must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

Physical Requirements:

The ESP family partner provides home-based services and thus job responsibilities are often carried out in client's homes and in the community. All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

Disclaimer:

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### ESP RFR Attachment 3.5.3.7.2

Community Counseling of Bristol County, Inc.

#### Job Description

Position (UFR):           **102 Program Director**  
Position Title:        Program Director  
Program Name:        Emergency Services Program  
Service Type:         Emergency Services  
Accountability:       Vice President of Emergency and Diversionary Services

#### Summary of Position:

The Program Director (PD) is responsible for the overall operations of the ESP, including the supervision of all ESP staff and the clinical effectiveness of the program. The PD's primary function is to:

- Share responsibility with the ESP Medical Director for the clinical oversight and quality of care across ESP services.
- Responsible for the administrative and financial oversight of the ESP contract.
- Serve as primary point of accountability to MBHP and MCEs for the ESP.
- Ensure compliance with all requirements and performance specifications, including standard assessment tools, electronic encounter forms, and other data collection mechanisms.

#### Education/Training:

- Master's degree in Social Work or related mental health field or doctoral level.
- Must be independently licensed (LICSW, LMHC, PhD).
- Must have at least five (5) years post-graduate experience providing behavioral health services to children, families, and adults.
- Must have at least three (3) years of supervisory and/or management experience.

#### Qualifications/Experience Requirements:

- Must possess clinical core competencies and experience regarding crisis assessment, intervention, and stabilization strategies for children, adolescents, adults and elders.
- Experience managing mobile, remote teams, i.e. managing quick response time, potential safety issues, etc.
- Experience with short term counseling.
- Practice skills relevant to grief, trauma, and substance use.
- Supporting referrals to other behavioral health resources and services.
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and behavioral health outpatient facilities.
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers.

### **ESP RFR Attachment 3.5.3.7.2**

- Must be able to articulate and promote a recovery-orientation that is resolution-focused, strengths-based, and culturally competent.
- Ability to manage resources, including the hiring and retention of culturally competent staff.
- Possess knowledge and practice skills regarding Continuous Quality Improvement (CQI).
- Must have strong communication skills, demonstrating an ability to communicate critical issues to relevant parties, as well as the written skills required to manage an electronic health record system.

#### Responsibilities:

- Administer the recruiting and hiring process for all ESP employees.
- Develop and maintain community connections with key stakeholders
- Develop and maintain programmatic policies and procedures to support a high fidelity ESP.
- Develop and maintain the training process and protocols for all new staff.
- Provide weekly individual and group supervision to staff and conduct regular performance reviews.
- Supervise program staff, which includes providing clinical support and oversight.
- Provide monthly trainings to all program staff to ensure compliance with all agency and managed care entities mandates.
- Oversee and ensure that all managed care entities' performance specifications and medical necessity criteria are being maintained by program.
- Collaborate with community resources, local and state agencies, schools, therapists and vocational programs.
- Facilitate monthly meetings and maintain collaborative partnerships with managed care entities and various states agencies including DMH, MCI and DCF.
- Provide oversight and support to all staff in ensuring they are completing all mandated responsibilities. This includes various quality management tasks and managing any staff disciplinary issues/performance improvement efforts.
- Manages various reports needed within the program to meet Mass Health requirements
- Provides on-going support to all team members as needed.
- Provides clinical oversight to all program matters and cases.
- Assist in the development of fiscal budgets and maintain program operations within allotted budget.

#### List Other Job Requirements:

All staff must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president.

All staff must maintain proper motor vehicle insurance coverage and all safety inspections for vehicle used for employment and possible transport of enrolled parent/caregiver and their child (ren). All staff must complete and pass MA and ADP Criminal Offense Record Information (CORI) process.

**ESP RFR Attachment 3.5.3.7.2**

Physical Requirements:

All staff members must be able to manage various style home settings (ex. able to walk up multiple flights of stairs). The employee must occasionally lift and / or move up to 40 pounds. Specific vision abilities required by this job include vision, color vision, and ability to focus. The employee is expected to drive a personal vehicle and maintain proper vehicle insurance. All staff must be able to manage operating a motor vehicle for multiple hours a day (this can range from 1-2 hours a day up to 8 hours for the day).

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Signature

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Date

**ESP RFR Attachment 3.5.3.7.2**

Community Counseling of Bristol County, Inc.

**Job Description**

Position (UFR):           **104 Supervising Professional**  
Position Title:        Children's Outpatient Clinical Supervisor  
Program Name:        Children's Outpatient Program  
Service Type:         Outpatient  
Accountability:       Reports directly to the Vice President of Children's Services

Education/Training:

- Master's degree in a human services related discipline.
- Licensed as an LICSW, LMFT, or LMHC by the Commonwealth of Massachusetts.

Experience Requirements:

Five or more years of experience (post-licensure) in a human service position. One – two years of supervisory experience. Must possess good organizational skills, effective written, verbal, and computer skills.

Summary of Position:

Provide clinical supervision to staff, and also provide clinical services to children, adolescents, and their families. Provide administrative support to the Vice President of Children's Outpatient Services.

Responsibilities:

- Meet with individual clinicians for one-on-one supervision on a weekly basis.
- Provide impromptu supervision to clinicians in order to manage risk and client safety issues.
- Provide training/orientation for new clinicians.
- Monitor completion of client documentation and sign-off on comprehensive assessments and individualized action plans in the electronic health record.
- Mandatory attendance at Supervisors' and Children's Team Meetings. Participate in facilitating these meetings.
- Attendance at the Monthly Management Meeting.
- Review client documentation to insure that medical necessity is indicated.
- Provide Emergency Responder coverage.
- Participate in program development.
- Provide outpatient therapy to a designated number of clients per week.
- Address clinicians' performance issues: develop performance improvement plans and manage HR issues as needed.
- Attend all required trainings.

**ESP RFR Attachment 3.5.3.7.2**

List Other Job Requirements:

Knowledge of Core-Competencies as identified by the employee's assigned department. Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

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Signature

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Date

**ESP RFR Attachment 3.5.3.7.2**

Community Counseling of Bristol County, Inc.

**Job Description**

Position (UFR):       **105 Physician (Psychiatrist)**

Position Title:       Child Psychiatry Professional

Program Name:       Emergency Services Program

Service Type:        Emergency Services

Accountability:     ESP Medical Director

Education/Training:

- An MD or DO with Board certification in psychiatry or Board Eligible; or Advanced Practicing Nurse.

Experience Requirements:

- At least five years of experience in a community crisis intervention or behavioral healthcare setting.

Responsibilities:

- Provide clinical consultation to the ESP team in assessment and crisis interventions.
- Conduct psychiatric assessments and emergency consultations.
- Consultation to hospital medical/clinical staff as required.
- Provide after hours on-call consultation and support.
- Consultation to community providers as required.
- Educate consumers and their families regarding medications / symptoms / illness / side effects.
- Provide on-site crisis assessment and management and collaborate with acute and long-term inpatient providers.
- Collaborate with other service providers as necessary (i.e., inpatient psychiatrists, primary care physicians).

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

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**ESP RFR Attachment 3.5.3.7.2**

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**ESP RFR Attachment 3.5.3.7.2**

Community Counseling of Bristol County, Inc.

**Job Description**

Position (UFR):           **123 Clinician (1.0 FTE)**  
Position Title:        Clinician / Mobile Crisis Intervention Specialist  
Program Name:         Mobile Crisis Intervention  
Service Type:         Mobile Crisis Intervention (MCI)  
Accountability:        MCI Clinical Supervisor

Education/Training:

- Master's degree in human services discipline.
- Licensed as a LMHC, LCSW, or LICSW in Massachusetts.

Qualifications/Experience Requirements:

- Ability to work a flexible schedule, including nights and weekends.
- At least one year of experience working with youth and their families in a clinical role within a mobile delivery system
- Knowledge of and experience with utilizing CBHI services and the Wraparound process.
- Able to provide clinical care and support to youth and their families to prevent hospitalization and stabilize youth in the community.
- Possess a valid driver's license and reliable transportation.
- Experience with computers, specifically Electronic Health Records (EHR) systems.

Responsibilities:

- Provide brief solution-focused interventions and reassess current level of need with youth waiting for higher level of care treatment.
- Post-crisis evaluation over the course of a seven day intervention period for youth deemed appropriate to return to the community.
- Provide brief solution-focused interventions.
- Work collaboratively with family partners to provide resources/referrals, support, and psychoeducation to families.
- Attend community-based meetings in conjunction with youth, their families, and providers to assist with advocacy and addressing safety concerns.
- Complete collateral contacts with a youth's providers.
- Assist with safety planning over the course of the seven day intervention period and outside the evaluation/intervention period
- Conduct comprehensive mental health status exam for youth and adults utilizing an admissions/screening instrument which includes providing a diagnosis in accordance with the DSM V and ICB-10.

**ESP RFR Attachment 3.5.3.7.2**

- Understanding of different treatment modalities that can be applied to stabilize clients in their home and prevent hospitalization.
- Consult with clinic director/administrator on-call and or consulting psychiatrist prior to disposition plan to include outpatient services, hospitalization, or hospital diversion.
- Participate in regularly scheduled clinical supervision, staff meetings, staff development, and training curriculum.

List Other Job Requirements:

Must have a valid driver's license in the state of residence and submit a copy of satisfactory record of driving from the state of residence of registry of motor vehicles, as determined by the department vice president. Must complete MA and ADP Criminal Offense Record Information (CORI) process. Must have computer literacy as related to the requirements of the position.

Physical Requirements:

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**D. 1.1 Proposed Program Budget**  
**Appendix VIII ESP Cost Report**

