

Written Statement of Services for Emergency Services Programs

I. Introduction

The Massachusetts Behavioral Health Partnership (MBHP) intends to secure a contract on behalf of MassHealth for the delivery and management of Emergency Services Programs (ESP) in the Southeast region. These services are currently provided by the Department of Mental Health (DMH).

In accordance with the June 2012 Guidelines for Implementing the Commonwealth's Privatization Law as required under Chapter 296 of the Acts of 1993, this document lays out the necessary services which are currently covered under DMH's ESP program in the Southeast region. This document also outlines all expected performance measures via the program's detailed specifications as well as quality measures that will be used to measure the effectiveness of the program following its transition.

A. Mission Statement

The mission of the Emergency Services Program (ESP) is to deliver high quality, culturally competent, clinically and cost-effective, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, rehabilitation, and recovery.

B. Guiding Values

The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters the ESP provides a core service of crisis assessment, resolution-focused treatment intervention, and stabilization. These encounters must also include crisis behavioral health assessments and offer short-term crisis counseling that includes active listening and support.

The ESP provides solution-focused and strengths-oriented crisis intervention (i.e. active listening, support, brief counseling) aimed at working with the individual and his/her family and/or other natural supports to bring relief to the crisis state, reduce symptoms, improve functioning, reduce harm, promote understanding of the current crisis, resolve ambivalence, identify solutions, and collaborate on decisions to access resources and services for comfort, support, assistance, and treatment.

As agreed upon, and after engaging the individual (and parent/guardian when applicable) in an informed, shared decision-making process, ESP arranges the behavioral health services that the individual selects to further treat his/her behavioral health condition based on assessments completed, declared readiness and preference, and the individual's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred

providers to share information (with appropriate consent) and makes recommendations for a treatment plan. The ESP also provides the individual and his/her family with resources and referrals for additional or alternate services and supports, such as recovery-oriented and consumer-operated resources in their community.

While it is expected that all ESP encounters include the basic components outlined in this document, these services also require flexibility in the focus and duration of many additional tasks associated with initial interventions, an individual's participation in treatment, and the number and type of follow-up services. ESP services are directly accessible to individuals who seek behavioral health services on their own and by those who may be referred to the program. ESP services are preferably community-based in order to bring treatment to individuals in crisis, allow for consumer choice, and offer medically necessary services, in the least restrictive environment, that are most conducive to stabilization and recovery.

C. Program Goals

The goals of the Emergency Services Program (ESP) are as follows:

Treatment Level of care: Local ESPs will operate as a discrete treatment level of care that delivers comprehensive crisis behavioral health services, including but not limited to crisis assessments, resolution-focused interventions, and stabilization services including CCS for adults as well as community-based stabilization for youth for a period of up to 7 days. The expectancy is that effective ESP treatment services will increase coping and functioning, decrease risk and thus diminish the need for a more restrictive level of care. This includes the capacity and competency to address the needs of special populations, including children and families. ESP is NOT a screening service that is limited to assessing eligibility for various levels of care.

Transformative: ESPs are not only committed to achieving established outcomes but also to serving as a local driver in transforming the way behavioral health crisis services are accessed and delivered across the community. This includes leading, supporting and contributing to initiatives, forums and collaboratives that increase the capacity and competency of community partners (community treatment providers, hospitals, schools, state agencies, law enforcements, courts, homelessness and housing services, local governments and businesses) in preventing and supporting individuals in crisis, assuring care continuity before, during and after an episode of crisis.

Timely: ESPs will respond to all requests for crisis assessment, intervention, and stabilization in a timely fashion, as required in Appendix II: ESP Performance Specifications and Appendix III: Quality Indicators. These performance specifications are intended to be responsive to the individual or their caretaker's sense of urgency and to prevent adverse impacts which treatment delays may have on individuals and families. Timeliness must be achieved through effective staffing, geographic location and dispatch strategies and not be compromising the

delivery of a quality, complete treatment service for one person in order to begin in a timely fashion with the next person.

Community-based: ESPs will provide crisis behavioral health services in the community, through Mobile Crisis Intervention services for youth/families and adults, accessible community-based locations, and adult Community Crisis Stabilization (CCS). These programs will ensure that ESP services reach those individuals in need, allow for consumer choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery.

Diversion: Through an array of initiatives and in ways that are experienced as beneficial to individuals in crisis, ESPs will shift utilization from more restrictive settings when that setting is not necessary, effective or desirable for the person in crisis, particularly hospital emergency departments (ED) and inpatient psychiatric care. ESPs will interrupt patterns of community over-reliance on hospital EDs to the extent permitted under applicable state and federal law. ESPs will focus on becoming the first point of contact in the event of a behavioral health crisis in an effort to shift volume away from hospital ED use. ESPs will also seek to maximize the use of community-based alternatives consistent with medical necessity criteria in lieu of admissions to inpatient psychiatric care. ESPs achieve this practice shift through effective engagement/collaboration and delivery of resolution-focused interventions that will lessen demand for higher levels of care, rather than by restricting access or imposing other plans.

Recovery-oriented: ESPs will support resiliency, rehabilitation, and recovery of all individuals by integrating mental health, substance use, and co-occurring recovery and rehabilitation principles and practices throughout the service delivery model to continually emphasize recover oriented care.

Clinical quality and consistency: ESPs will provide medically necessary and clinically appropriate behavioral health crisis assessment, intervention, and stabilization to all individuals they serve, consistent with their clinical presentation, culture, and special needs. This level of clinical care will be offered consistently across all ESPs statewide.

Cultural competence: ESPs will provide culturally and linguistically appropriate behavioral health services by ensuring that the content and process of the crisis assessment, intervention, and stabilization services are performed in culturally sensitive ways, recognizing among other things, an individual's preferred language and mode of communication.

Linkages: ESPs will be knowledgeable about community-based outpatient, diversionary, and inpatient mental health and substance use services, and will develop relationships with the providers of those services, ensuring effective consultation and referral processes and seamless transfer and coordination of care.

Information: MBHP will provide data to enable the local ESPs, MBHP, MassHealth, and DMH to manage the emergency behavioral health system effectively.

II. Statement of Services

The ESP provides crisis behavioral health services 24 hours per day, seven days per week, 365 days per year (24/7/365) to individuals who are experiencing a behavioral health crisis. The services provided by ESPs represent the hub of the behavioral health community safety net. The primary covered services included in the program are:

- Crisis screening (assessment)
- Short-term crisis counseling
- Crisis stabilization
- Medication evaluation

While this “core” set of ESP service is referred to throughout this document as “crisis assessment, intervention, and stabilization,” this term should be considered as inclusive of all services listed above.

A. Program Service Scope

The scope of the ESP is defined in terms of the services that are provided as well as the populations served by the program. The following parameters define the scope relative to each of these variables.

1. Population scope

- *In scope:*
 - Age:
 - ESP services are available to individuals of all ages.
 - Adult CCS, operated by the ESP, is available to individuals 18 years of age and older.
 - Diagnosis
 - ESP services are available to individuals who present mental health, substance use, and/or co-occurring conditions.
 - Adult CCS is available for individuals with mental health or co-occurring conditions.
 - Payer
 - ESP services, including adult CCS services, are available to all uninsured individuals as well as those enrolled in, or covered by, the following public payers: MassHealth plans, including the PCC Plan (MBHP), the MassHealth-contracted MCEs, MassHealth fee-for-service; DMH only; Medicare; Medicare/Medicaid; and One Care and Care Plus.
- *Out of scope:*
 - Diagnosis
 - Adult CCS services will not be available to individuals if the sole/primary focus of the crisis intervention is a substance use condition.
 - Payer
 - Payment will not be provided to ESPs for ESP or adult CCS services for individuals with commercial insurance. This contract does not mandate ESPs to provide ESP

and/or adult CCS services to this population, and any resulting contract with MBHP shall not require ESPs to provide ESP and/or adult CCS services to such populations. ESPs are encouraged to seek contracts with commercial payers for the provision of ESP and adult CCS services to their members.

2. Service scope

- *In scope:*
 - Community-based behavioral health services that provide a core service of behavioral health crisis assessment, intervention, and stabilization to all utilizers of ESP services, at all ESP locations and through all ESP services components, including but not limited to:
 - Mobile Crisis Intervention, for youth under age 21, as a component of the Children’s Behavioral Health Initiative (CBHI)
 - Adult Mobile Crisis Intervention services.
 - Adult Community Crisis Stabilization (CCS) services for ages 18 and older.

B. Core Competencies

All ESP services

ESP providers demonstrate the capability to meet the following competencies:

Crisis services

The fast-pace and unpredictable demand for 24/7/365 crisis services requires that selected ESP providers pay very close and ongoing attention to service flow and staffing patterns. Core competencies include:

- Ability to deliver services requiring crisis response on demand
- Success in meeting response requirements in a crisis environment and ability to comply with response-time requirements mandated in Appendix II: ESP Performance Specifications and in Appendix III: Quality Indicators
- Success in managing resources to respond quickly to fluctuations in demand in a crisis environment (through use of strategies such as cross-training, use of on-call staffing, and non-traditional scheduling)
- Efficiency in the dispatching of individuals or teams, managing on-site crisis service and crisis stabilization capacity and referral processes
- Ability to hire, develop, and retain staff who are competent at mobile crisis response, are skilled at risk management, and are able to operate in an independent and self-directed fashion
- Use of electronic, telephonic, and other technological tools that optimize efficiency, reduce risk, and/or otherwise support achievement of results

Upstream intervention

As is the case with most healthcare interventions, early identification and treatment of symptoms can often prevent a full-blown crisis episode. Therefore all ESP programs must contain the following core competencies:

- A commitment to intervention at the earliest possible point in the crisis episode in a cost effective manner that contributes to the prevention of adverse outcomes, such as arrest, filing for an emergency petition, loss of housing, family stress, or injury to self or others
- Commitment to facilitating rapid access to a range of urgent treatment services
- Commitment to collaborating with other systems in managing behavioral health crises when risk of out-of-home placement is high

Recovery-oriented treatment

To achieve optimal results, it is essential that ESP providers move fully from a deficit/disability construct to one that is strengths-based and client-driven. In order to effectively accomplish this, ESP programs must deliver services in a manner that is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) consensus statement on mental health recovery, which is provided in Section F, Recovery-Oriented Services.

Cultural and linguistic competence

The Substance Abuse Mental Health Services Administration (SAMHSA) defines cultural competence as “an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.” The potential consequences of inadequate attention to and insufficient attainment of, cultural and linguistic competency are particularly great for ESPs given the high-risk nature of the work and relative lack of alternatives for seeking crisis intervention. Therefore all ESP providers must:

- Provide services in a culturally and linguistically competent manner, including access to informal and formal supports reflecting the family's cultural and linguistic preferences, including bilingual professionals, materials and interpreters.
- Hire, develop, and retain culturally and linguistically competent staff
- Commit to continuous learning in the area of cultural competence, reflected in training curricula, supervision, and performance evaluation at all levels of the organization
- Commit to continuous evaluation of the service environment, written materials, communications, facilities, and appearance of staff from a cross-cultural perspective in an effort to promote an open, welcoming, and accepting environment

Mobile (non-hospital) response: *the preferred service delivery model*

The preferred environment for the delivery of crisis services is in the home or other natural community setting, which is intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs), lessen the expectancy of and reduce the likelihood of use of restrictive dispositions such as psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner.

Therefore ESP providers must:

- Be able to implement a service delivery model that achieves the provision of the majority of ESP services for adults and all MCI services for youth in the home or other natural

community setting. (Crisis assessments for youth only occur in a hospital emergency department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuses required consent for service in home or alternative community settings; or if request for Mobile Crisis Intervention originates from a hospital ED.)

- Support the development of procedures and decision-making tools that promote delivery of ESP services in the community and outline when use of ED/911 is indicated.
- Arrange for services to be alternatively delivered in the ESP's community based location or other setting consistent with consumer/family preferences, time of day, or clinical considerations.
- Tailor crisis behavioral health services in a home/community environment.

Least restrictive treatment

As is the case elsewhere in the nation, there is heavy statewide reliance on EDs as the providers of first contact in the event of a behavioral health crisis. Persons who receive behavioral health crisis services in the ED are more likely to be hospitalized than those treated in the community. While EDs are an important component of the crisis continuum, most behavioral health crises can be more effectively addressed in the community. Doing so adheres to the principle of least-restrictive treatment, while ensuring the provision of medically necessary services, and will increase the likelihood of referral to appropriate, timely, and least-restrictive ongoing medically necessary services, consistent with individual and community safety as follow-up to the crisis service. Therefore all ESP providers must:

- Commit to care that is voluntary and consumer-directed and is delivered in, or as close to, home as possible
- Deliver care that is minimally disruptive
- Create a service pathway that screens for the need to refer up to, rather than step-down from, hospital-based emergency care

Effective use of treatment resources

Effective utilization management increases the likelihood that treatment options are available when needed. Without a broad continuum of services and resources, the likelihood increases that scarce resources will be misappropriated just to ensure that some service is provided. Community Crisis Stabilization services are beneficial only to the degree that there are regular openings, and that they remain true to their intended purpose. Programs that seek to grow and effectively utilize resources, such as reserved appointment slots for rapid urgent referrals (in or outside of own agency), broaden the continuum of resources that they can offer to the persons they serve, increase the likelihood of a discharge home, and increase consumer satisfaction. Because of the volume and variety of needs of those served, ESPs are well-positioned to identify persons in need of specialized services such as Enhanced Acute Treatment Services (E-ATS),

Intensive Care Coordination (ICC), In-Home Therapy, or Program of Assertive Community Treatment (PACT), and should develop referral relationships and processes that will fast-track linkage. Therefore all ESP providers must have:

- A commitment to ensuring medically necessary services and the right level of care for the right length of time
- The ability to measure supply of services and demand for those services, and implement strategies, in collaboration with MBHP, to ensure access
- An assurance to efficient and timely discharges from the ESP's community-based location and CCS to maximize service capacity
- 24/7/365 ESP access to capacity information at CCS and other outpatient and diversionary levels of care
- 24/7/365 ESP linkage capability with CCS and other outpatient and diversionary levels of care

Intersystem knowledge, planning, and affiliation

While ESPs might be the most visible provider of crisis behavioral health services, a community is not well-served if ESPs bear the full burden of providing an effective safety net. The bulk of crisis work should be focused on prevention and very early identification of symptoms by those entities that are serving persons/families in an ongoing capacity. Cross-system education will increase competency in effective use of ESP services. For example, advances in mental health system collaboration with, and training of, law enforcement officers have led to very exciting programs and outcomes in this state and elsewhere. Therefore ESPs must

- Demonstrate broad knowledge of the community behavioral health system via:
 - Excellent collaborative skills – uses collateral information effectively
 - Knows what services are provided in the community, how they are funded, and how clients access them; develops professional relationships with peers in these agencies
 - Able to use system resources in order to complete work in an efficient fashion and to facilitate access to services by clients
- Knowledge of referral streams into the crisis system
- Identification and amelioration of barriers to early, upstream intervention
- Strategic initiatives to strengthen collaboration with key partners in crisis prevention, early intervention, hospital and jail diversion, and placement disruption. Partners include, but are not limited to:
 - Law enforcement entities
 - State agencies including child and elder protective services and juvenile justice
 - Schools
 - Residential treatment facilities
 - Hospitals
 - Primary care clinicians and health centers

Commitment to Continuous Quality Improvement

Though ESPs are the primary provider of community-based behavioral health crisis services, adopted strategic goals should reflect both agency-specific and systemic outcomes, indicators, and measures. The success of the ESP in meeting its service-specific and agency-specific goals, and contributing to the achievement of systemic outcomes in its communities, depends greatly on the degree to which the ESP has effectively engaged the broader system in supporting and

strengthening the community crisis continuum and the service/referral pipelines both into and out of crisis services. ESP providers must therefore:

- Use continuous quality improvement processes, including outcomes measures and satisfaction surveys, to measure and improve quality of care and service delivered to persons served, including youth and their families, and services to special populations
- Routinely track overall and discipline-specific service volume and type by day and by shift so that staffing and service patterns are optimally efficient
- Routinely analyze trends in referral-in/referral-out patterns, and develop specific measures aimed at reducing overuse of hospital EDs
- Evaluate service penetration patterns by race, age, culture, geography, and other variables for indicators that services may not be viewed as being accessible
- Plan to impact and track strategic objectives to achieve or contribute to the achievement of:
 - Increased ED diversions
 - Reduced use of inpatient psychiatric treatment
 - Reduced commitments
 - Increased criminal justice diversion for youth and adults, to the extent resulting from the youth/adult's behavioral health condition
 - Increased diversion from out-of-home placement
 - Increased volume of risk management/safety plans and WRAP plans filed with ESP
 - Achievement of linkage timeframe targets in areas such as:
 - Urgent psychiatric appointments
 - ICC linkages
 - Admission to diversionary services, including CCS, CBAT, In-Home Therapy, EATS, and ATS
- Establish/strengthen affiliations and collaborations as measured by
 - Impact of partnership on achieving strategic objectives
 - Adoption of shared outcomes

C. Clinical competencies

ESP providers must also possess significant clinical competencies in order to effectively deliver core and ancillary services which fall under the ESP program. All ESP Programs therefore must possess satisfactory levels of clinical competency in the following areas:

Clinical assessment

All ESPs must demonstrate an ability to perform a focused and comprehensive assessment of persons in crisis due to a mental health and/or substance use condition that includes:

- Understanding of the presenting problem as defined by the person in crisis, family, referral source, and/or other stakeholders
- Mental Status Exam, including assessment of previous and current risk of harm to self or others

- Assessment of current or past use of substances and indications for arranging immediate medical treatment or medical follow-up, including the capacity to screen for intoxication or withdrawal
- Assessment of other medical conditions and indications for immediate medical treatment and medical follow-up
- Multi-axial diagnosis (DSMV)
- Specific identification of biological, psychological, and all social domain stressors and strengths (that either increase or decrease risk)
- Multi-system involvement or needs (i.e., educational system, child/adult/elder protective services, juvenile justice, criminal justice, primary care, military/veteran, or homelessness services)
- Assessment of strengths, resources, capacities, past successes, and natural supports
- Level-of-care assessment

ESPs should also have a developed protocol for multi-disciplinary evaluations, based on the comprehensive assessment of multiple contexts including:

- Comprehension of normal child, adolescent, and adult development
- Comprehension of grief and trauma

Diagnostic accuracy

- Comprehension of, and ability to use, the Diagnostic and Statistical Manual
- Knowledge of diagnostic, medical, substance-related, developmental, and environmental differentials that must be considered
- Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults

Client engagement and de-escalation skills

- Able to engage client in a manner that is both professional and calming
- Able to identify cues that might indicate the best means of communicating with the client
- Able to identify, consider, and respect cultural/lifestyle differences and the impact on treatment
- Able to work with clients in their natural environment
- Ability to modify engagement techniques to meet the individualized needs of the client
- Skilled in verbal and non-verbal de-escalation techniques

Risk assessment and management skills

ESP services are widely accessible, and persons seek these services due to crises that are self-defined. Clinical presentation varies dramatically as it relates to the apparent significance and impact of stressors; the coping ability of the person/family in crisis; the nature and degree of risk; the co-morbid presence of a medical condition or disability; the degree to which care is being sought voluntarily; the age, culture, and life experience of the recipient and family; and the concurrent involvement in other systems. Competent crisis providers are in every way respectful of the perspective of the service recipient, family, and other stakeholders in

assessing risk and identifying resources and solutions. Crisis assessments, though focused in nature, must address a broad array of risks, including those present in the daily living environment. Therefore ESP providers must:

- Establish a culture that “risk management is everybody’s job”
- Be able to identify potential risks to client or others, and to develop and implement a plan of action to reduce those risks
- Recognize lethality risk in special populations
- Use problem-solving skills by considering various options and potential outcomes in a creative yet timely manner
- Identify the need for, seeks, and utilizes supervision/consultation
- Seek consensus-driven dispositions

Recovery-promoting treatment approach

Recovery-promoting treatment approaches are those that instill hope; capitalize upon the strengths of the person and his or her family/support system; are self-directed; are aimed at enhancing problem-solving, coping, and other competencies; and are highly individualized and collaborative. Recovery-oriented processes recognize and respect that change occurs in nonlinear stages, and effective providers assess the level of change-readiness and pair stage-effective intervention techniques accordingly. Therefore ESP providers must:

- Use interventions that are compatible with rehabilitation and recovery principles and likely to promote self-help, including techniques found in:
 - Developing authentic relationships
 - Risk management that includes dignity of risk concepts
 - Collaboration in assessment and disposition planning
 - Wraparound care planning
 - Solution-Focused Therapy
 - Cognitive Behavioral Therapies
 - Stages of Change
 - Motivational Interviewing
 - Shared Decision-Making
 - Illness Management and Recovery
 - Peer-to-Peer Support
- Refer to recovery-oriented programs, including peer-led services
- Preserve the right to refuse treatment when at all possible.
- Strive to achieve a consensus disposition.

Capacity and competency to treat specific populations

Unique competencies are required to assess and intervene with specific populations. Well-developed policies and procedures, combined with effective training and supervision and appropriate referral pathways for special populations will improve treatment outcomes, increase individual satisfaction, and decrease risk. Therefore ESP providers must be capable of providing services to these special populations.

D. Mobile Crisis Intervention

- In order to qualify to provide the Mobile Crisis Intervention component of ESP services, ESP services need to demonstrate compliance with the core competencies articulated above for all aspects of ESP service delivery, as they apply to providing crisis behavioral health services to youth and their families, particularly the following:
- Comprehension of grief and trauma in children and adolescents
- Diagnostic accuracy in the assessment of children and adolescents
- Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults
- Risk assessment and management skills in working with children, adolescents, and families
- Client engagement and de-escalation skills with children, adolescents, and their families
- Competency in crisis theory and in the use of interventions with children, adolescents, and families that are compatible with principles of resiliency and recovery and likely to stimulate self-help including techniques utilized in:
 - Solution-Focused Therapy
 - Cognitive Behavioral Therapy
 - Stages of Change
 - Motivational Interviewing
 - Shared Decision-making
- Demonstrated broad knowledge of the community behavioral health system for children, adolescents, and families including Child Behavioral Health Initiative (CBHI) services.
- Demonstrate strategic initiatives to strengthen collaboration with local CBHI providers.
- Coordinate all behavioral health crisis response with the youth's existing providers, including Intensive Care Coordination (ICC), In-Home Therapy (IHT) and outpatient providers, other care management programs and primary care provider (PCP/PCC).

Additionally, with regards to providing Mobile Crisis Intervention component of ESP services, ESP programs need to demonstrate the ability to adhere to and demonstrate the following core competencies:

Agency/programmatic competencies

- Documented understanding of Crisis Theory, Recovery-Oriented Care, Wraparound planning process, and Systems of Care principles and philosophy at all levels of the organization's management, and preferably experience in the implementation of these approaches
- 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
- Documented experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services;

administrative infrastructure that supports the delivery of Mobile Crisis Intervention 24/7/365, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist

- Ability to integrate youth and family voice in organization governance
- Solicits and values the youth's view of the crisis situation and possible solutions
- Competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services
- Articulation and adherence to a program philosophy that:
 - Values a young person's return to natural environment
 - Expects client's return to higher level of functioning
 - Instills client/family with hope for the future
 - Expects improvement by the end of intervention
- Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families
- Relationships with child- and family-focused community resources in the service area, including but not limited to, child-serving state agencies and social service providers, schools, residential programs, family and youth organizations, pediatric primary care providers, and ability to coordinate care and treatment across providers and service agencies
- Membership in child advocacy and/or child-focused trade organizations

Clinical competencies

- Comprehension of family dynamics and ability to engage caregivers as partners in finding solutions
- Comprehension of normal child development
 - Developmental milestones
 - Cognitive development
 - Identity development
 - Physical development
- Adherence to Wraparound philosophies¹
 - Family voice and choice
 - Team-based (includes child and family)
 - Use of natural supports
 - Collaboration
 - Community-based
 - Culturally competent
 - Individualized
 - Strengths-based

¹ Source: Eric J. Bruns, Janet S. Walker, Jane Adams, Pat Miles, Trina Osher, Jim Rast, and John VanDenBerg, (2004). *The Ten Principles of Wraparound*

- Persistence
- Outcomes-based

Providers are expected to demonstrate a commitment to best practice principles as outline in the documents below:

MCI Practice Guidelines are located <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/cbhi-resources-for-providers.html>

Crisis planning tool companion guide is located <http://www.masspartnership.com/provider/CrisisPlanning.aspx>

III. ESP Structure

The structure of the Emergency Services Program system includes locally based ESPs supported by statewide functions that contribute to programmatic improvements and system efficiencies.

A. Local ESP Structure

Each locally based ESP shall be a comprehensive, integrated program of crisis behavioral health services, including services delivered through the ESP's mobile crisis intervention services for adults and children, in the ESP's accessible community-based location, and in the ESP's adult Community Crisis Stabilization (CCS) program. Each of these service components are described further in the section below. The selected ESP providers shall be expected to envision their programs, inclusive of all these service components, as one integrated emergency services program. They shall be expected to use their staffing resources in an integrated and flexible manner, using all available resources to respond to the needs of individuals who require their services on a daily basis, with fluctuations in volume, location of services, etc. The ESP structure includes staffing infrastructure to provide ESP specific management, clinical supervision, and direct services in proportion to the projected volume beginning in FY16 for each catchment area.

It is also expected that ESP programs shall have resources to support the management and delivery of ESP services, such as administrative and financial oversight, medical leadership, and technology infrastructure. Please reference Appendix IV for an example staffing pattern for an average size ESP.

B. Catchment Areas

Appendix I: ESP Catchment Areas lists the cities and towns to be included in each of the four Southeast ESP catchment areas as of July 1, 2015. A total of five local ESPs shall deliver ESP services in the Southeast region of the Commonwealth. Four of the five ESPs (formerly DMH operated) are included in this RFR and listed in Appendix I. One local ESP shall cover each of 4 catchment areas that were formerly DMH operated (The fifth ESP is currently managed by MBHP).

C. System Level Structure

1. Contract management

MBHP is responsible for contract management, financial management, and claims payment, as well as the consistency and quality of ESP services. Integral to ensuring consistency and quality of care, MBHP works with providers to develop statewide universal competencies for all ESP programs and ESP clinicians, which are to be integrated into the ongoing evaluation of each ESP.

Performance measurement

MBHP measures the performance of ESP contracts through a variety of quantitative and qualitative indicators. In collaboration with the Department of Mental Health (DMH) and MassHealth Office of Behavioral Health, MBHP has established Quality Indicators to measure the ESP provider requirements delineated in the General Performance Specifications, the ESP Performance Specifications, the Mobile Crisis Intervention Performance Specifications, and the Adult Community Crisis Stabilization Performance Specifications, all of which are included in the Appendices to this document. Please reference Appendix II for ESP Performance Specifications and Appendix III for a breakdown of ESP/MCI Quality Indicators.

The **Quality Indicators** include:

- Intervention Location
- Disposition
- Response Time in Minutes
- Response Time Percent within 60 minutes

Additional quality measures may include but are not limited to:

- Delivery of a comprehensive crisis service that minimally includes crisis assessment, intervention, and stabilization
- Clinical appropriateness of disposition, including use of diversionary services when clinically indicated
- Compliance with standards of care
- Satisfaction survey data
- Identifying and implementing quality improvement initiatives

MBHP will monitor and manage the performance of ESP services across all ESPs utilizing data on the following levels: provider, regional, and statewide. MBHP will monitor and manage the performance of each ESP through regular reporting requirements and in-person network management meetings.

ESPs shall be expected to comply with all reporting requirements of MBHP, as well as those of MassHealth.

Accountability to MassHealth-contracted Managed Care Entities (MCEs)

It is important to note that ESPs will also be accountable to other payers with whom they contract, including the MassHealth MCEs. This accountability will include, but not be limited to, the clinical care of their members, compliance with authorization procedures, and all other applicable requirements of the MCE, including information reporting requirements.

2. Statewide function

The local ESPs are further supported by the following statewide function. The ESPs are expected to use this resource in their daily service to individuals and families statewide, as required in Appendix II: ESP Performance Specifications.

- *Massachusetts Behavioral Health Access (MABHA) website*: ESPs shall use MABHA to enable ESP clinicians to locate potential openings in mental health and substance use services for the purpose of referring individuals to those available services.
- The ESP is required to update the MABHA website a minimum of once per 8 hour shift, every day with current Community Crisis Stabilization bed availability.

3. Staff Compensation

For each position in which a private contractor will employ any person where the duties of the position are substantially similar to the duties currently performed by a regular DMH employee, the private contractor must pay at least a minimum wage rate equal to the lesser of:

- 1) Step one of the grade or classification under which the comparable regular agency employee is paid, or
- 2) The average private sector wage rate for said position as determined by the executive office for administration and finance from data collected by the division of employment and training and the division of purchased services.

The minimum wage rates associated with ESP Core Staffing positions that are substantially similar to duties currently performed by DMH employees are summarized in Appendix V.

D. Program Model Overview

1. Emergency Services Program (ESP)

Description

MBHP will contract with one locally based provider to administer the ESP for each catchment area. Each ESP shall be a comprehensive, integrated program of crisis behavioral health services, including services delivered in the community through the ESP's mobile crisis intervention services for adults and youth, in the ESP's accessible community-based location, and in the ESP's adult CCS. The ESP shall provide crisis behavioral health services including but not limited to, the core clinical services of a behavioral health crisis assessment, intervention, and stabilization to all individuals, within the defined population scope, who access ESP services through any and all of these service components. Each of these service components are described below. The consistent availability of these service components across all ESPs statewide is necessary in order to ensure consistency in the type and quality of these services in all catchment areas and to serve as the basis for educating the public about the availability of these services and facilitating access to them.

Local variation

While every ESP across the Commonwealth shall offer all of these service components, there will be some variation among ESPs, so as to be responsive to differences in local needs and resources. For example, while access to crisis behavioral health services shall be provided on a 24/7/365 basis in all catchment areas through one or more service components, the operating hours of the ESPs' community-based locations may vary, in part as dictated by volume in a particular catchment area. Additionally, the ESPs' responses to the needs of special populations may vary, based on local population characteristics and related community resources. Finally,

there may be variance in the service components that the ESP provider will operate directly and those that the ESP provider may subcontract to another provider.

Access

All ESP services in a given catchment area shall be accessed through a toll free number operated by the contracted ESP provider 24/7/365. The ESP shall triage calls to its most appropriate ESP service component, the one that shall provide crisis behavioral health services to the individual in the least restrictive setting, ensuring safety and responsiveness to consumer and family choice.

Integration

ESP providers shall be expected to envision and manage their programs, inclusive of all service components, as one integrated emergency services program responsible for meeting the crisis behavioral health needs of the populations identified in this document, throughout their catchment areas, 24 hours per day, 7 days per week, 365 days per year. The overall ESP program should operate in a fashion that ensures fluidity among its service components and minimizes transitions and inconvenience to individuals in crisis. With the use of flexible, cross-trained staff and cross-scheduling, programs should demonstrate the ability to respond to varying levels of demand in ESP site-based crisis intervention services, mobile crisis intervention services, and CCS services.

It is important to note that the ESP's adult CCS shall be required to be co-located with the ESP community-based location, preferably upon initiation of the ESP contract, or within three months. co-locating ESP services with other services that may be helpful to individuals who utilize ESP services, such as outpatient and diversionary services, operated by their organizations and/or other provider agencies is also encouraged, but not mandatory.

Management functions

The contracted ESP provider shall conduct all clinical, medical, quality, administrative, and financial oversight functions across all the services provided by the ESP and all locations in which these services are provided, including any ESP services provided by subcontractors. More specifically, management functions shall include:

- Staff recruitment, hiring, training, supervision, and evaluation
- Triage
- Clinical and medical oversight
- Quality management/risk management
- Information technology, data management, and reporting
- Claims and encounter form submission
- Oversight of subcontracts
- Interface with payers including the MassHealth-contracted Managed Care Entities (MCEs)
- Interface with MBHP for contract management purposes
- Member and Stakeholder Satisfaction Surveys

Safety

Safety is integral to all ESP services, functions, and operations. Assessing and mitigating risk for individuals who participate in ESP services, as well as for staff who provide them, is a priority. In fact, safety in the workplace is both a need and responsibility of employers in any profession or work setting, for their employees, their customers, visitors, and others who enter that workplace. The ESP model includes various resources and strategies toward this end. Offering various venues for services is one tool, as well as acknowledging that some individuals will continue to require the medical services of a hospital ED setting. Technology resources, including cell phones with GPS and laptops, have been included as operating expenses in the ESP rates. Staffing infrastructure, including bachelor's level staff, Certified Peer Specialists, and Family Partners have been included in the staffing pattern to provide support and comfort to consumers and families, as well as to be available to provide a two-person response, along with a master's level clinician, to many requests for mobile crisis intervention services. Additionally, specific "safety" staffing has been included in the staffing pattern for the ESP community-based locations, to be utilized by ESPs in a manner that helps to promote a calm and safe environment, mitigate risk, and facilitate safety in these settings. ESPs may choose to use these positions in a variety of ways that contributes to a safe environment. In part, this staffing will enable providers to ensure that at least two staff members are present in their community-based locations during at least high-volume operating hours. Finally, various training for all staff will be important to mitigating and managing risk, and sound triage protocols are important in enabling ESPs to make clinical decisions about the services each individual needs, the venue in which they are provided, and the staffing that can best provide them in both a clinically appropriate and safe manner.

Staffing

The ESP structure includes staffing infrastructure to provide ESP-specific management, clinical supervision, and direct services beginning in FY16 for each catchment area. ESPs shall be expected to use their staffing resources in an integrated and flexible manner, utilizing all available resources to respond to the needs of individuals who require their services on a daily basis, while accommodating the specific needs of individuals and families, fluctuations in volume, location of services, etc.

It is also expected that providers shall have resources to bring to bear on the management and delivery of ESP services, such as administrative and financial oversight, medical leadership, and technology infrastructure, and support for such overhead and has been included in the rate. Staffing of each Emergency Services Program shall include the positions listed in Appendix II, Emergency Services Program – Staffing.

2. ESP Community-based Location

Description

The ESP's community-based location is the 24/7/365 "hub" of the emergency services program in each catchment area. The primary purposes of the ESP's community-based location are to:

- Coordinate the operation of, and access to, all the service components of the ESP
- Directly deliver its core service of crisis assessment, intervention, and stabilization at the ESP
- Provide a Community-based location as an alternative to hospital emergency departments (EDs) for individuals seeking behavioral health services when use of the ED may be avoided, such as when there is not a physical condition requiring medical assessment and intervention.

ESPs with contracts in more than one catchment area, might realize operational efficiencies such as centralized call/triage centers, training tools etc.

The ESP community-based location is thereby a primary venue, in addition to mobile crisis intervention services, through which the ESP provides community-based access to crisis behavioral health services. Ensuring that every ESP has a robust community-based location for these stated purposes represents a significant system enhancement. ESPs must have protocols to guide the decision making process regarding the location of intervention.

Expected outcomes from the ESP community-based location include the diversion of unnecessary volume from hospital EDs and increased consumer, family, and community satisfaction with access to crisis services in this less restrictive, community-based setting. ESPs encourage early crisis intervention in order to prevent the development of symptoms that may require hospital-based interventions. The ESP community-based location shall provide a setting that is more conducive than a busy hospital ED to the ESPs utilizing their focused expertise, rapid service initiation, skill in crisis intervention, knowledge of community resources, ability to access ongoing treatment and to offer brief follow-up treatment, and ability to offer flexibility in service duration. ESPs offer a front door into crisis services with the opportunity to be referred up to hospital-based care when indicated.

The ESP shall perform the following functions at, or dispatched from, their community-based location. Any variance will need to be justified by the provider based on local needs and resources.

- Operate a toll free number on a 24/7/365 basis that shall:
 - Triage all requests for crisis services
 - Dispatch adult and Mobile Crisis Intervention services and maintain communication with individuals, families, and such other referral sources as hospital EDs to keep them informed of the expected arrival time of these services
 - Access MABHA when seeking available resources for CBHI or 24 hour levels of care. to MABHA,
 - Provide ESP services on-site at the community-based location for a minimum of 12 hours per day on weekdays and eight (8) hours per day on weekends. Recommended minimum hours are 7 a.m. to 11 p.m. weekdays and 11 a.m. to 7 p.m. weekends. (Note that ESPs shall operate Child and Adult Mobile Crisis Intervention services and the adult CCS 24/7/365, with the latter being co-located with the ESP community-based location at the initiation of the ESP contract or within six months thereof.)

The ESP community-based location shall offer an environment that encourages individuals and families to seek crisis services in this less restrictive, community-based setting. The physical environment and interpersonal climate shall be one that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support. Concurrently, the environment needs to communicate that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization.

The ESP provider must directly operate the ESP's community-based location. The ESP's community-based location must be an easy-to-find, centrally located physical site in a population center within the catchment area in which the provider is bidding. The site must be accessible to persons relying on public transportation. .

Also included in the ESP program model and rates are some operating expenses that will facilitate successful delivery of clinical services at the community-based location and support consumers' ability to remain in the community while receiving medically necessary services. As reported by numerous stakeholders, it is often seemingly small details such as food and transportation that can make the difference in the attempt to support consumers through the ESP process and enable them to remain in the community. Modest levels of operating expenses that have been built into the ESP rates include food that will allow the ESP to provide comfort and nourishment to consumers and family members while receiving services; pharmacy, given that ESPs are often faced with needing to spend a small amount of money on a pharmacy co-pay to help a consumer obtain his/her medication and successfully participate in a community-based level of care; and transportation for situations in which the ESP may need to facilitate transportation for a consumer to a pharmacy to obtain medications or to a community-based disposition, such as an outpatient appointment. Thus, these operating expenses are meant to facilitate access to care and increase the feasibility of diversions and community-based services.

Concurrently, ESPs shall be expected to access other resources available to them and the individuals they serve, such as assisting them to arrange MassHealth transportation benefits, to provide or pay for these resources whenever possible.

3. Mobile Crisis Intervention Services (MCI)

Description

MCI shall be integrated into the ESP's infrastructure, services, policies and procedures, staff supervision and training, and community linkages. All ESP services for MassHealth-enrolled and uninsured children and adolescents shall be provided through the ESP's Mobile Crisis Intervention services and staff

Mobile crisis intervention services are an integral part of a comprehensive behavioral health crisis services continuum and a key strategy in reducing the use of unnecessary hospital emergency department (ED) and inpatient psychiatric services.

For children and adolescents, the best practice for delivering crisis services is via discreet and minimally disruptive mobile response to a natural setting such as the child's home or school, or a neutral community-based site. The delivery of strengths-based and solution-focused intervention is aimed at resolution of the crisis, mobilization of natural supports, and rapid linkage to the right level of care. Mobile Crisis Intervention delivers services that are consultative and collaborative, placing a high value on achieving a least restrictive, consensus disposition while ensuring access to medically necessary services

The services are provided in the home, school, or other community-based location and are consensual in nature. Delivery of services in the home or school allows the service provider to take into consideration observations about the environment, gain understanding of culture, interact with family members or other supports, and identify risks. The expectation by service recipients, family members, and care providers – including those in residential facilities, schools, nursing homes, group homes, and shelters – that hospitalization or other placement will result from the intervention is lowered. When mobile crisis intervention services are delivered in schools, residential facilities, nursing homes, group homes, and shelters, mobile crisis professionals have the opportunity to interact with, and educate colleagues about, the system, commitment guidelines, risk management/safety planning, and risk assessment and reduction – interactions that can have positive impact well-beyond the immediate situation.. Mobile crisis intervention professionals are well poised to serve as advocates, educators, system ambassadors and mediators, consultants, and coordinators of care. While mobile care is generally the optimal service delivery option, mobile crisis professionals and teams, guided by ESP developed policies and procedures, retain discretion in choosing whether to begin or continue a mobile intervention based on identified risk factors. Safety of service providers (whether delivering mobile or site-based services) is a first priority, and this factor should be integrated in all aspects of operating a mobile crisis team, including but not limited to, guidelines in driving, navigating, use of maps, cell phones, GPS devices, environmental scanning, ensuring personal safety, identifying exceptions to mobile response, and involving law enforcement agencies. Though not acceptable as a standard method of response, there are times when first response by law enforcement, or co-response by law enforcement and the mobile crisis professional/team, are indicated, and ESPs are strongly encouraged to affiliate with law enforcement agencies to develop these response protocols.

Mobile Crisis Intervention services provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, seven days a week, 365 days a year. The service includes an intervention that may be up to seven (7) days duration encompassing:

- A crisis assessment, including:
 - Conducting a mental status exam
 - Assessing crisis precipitants, including psychiatric, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current

crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication)

- Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior
- Assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the youth's behavioral health needs
- Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care
- Assessing medication compliance and/or past medication trials
- Assessing safety/risk issues for the youth and parent/guardian/caregiver(s)
- Taking a medical history/screening for medical issues
- Assessing current functioning at home, school, and in the community
- Identifying current providers, including state agency involvement
- Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parent/guardian/caregiver(s)
- Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support
- Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone from an on-call child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist

Introduction of Crisis Planning Tools, and assistance in the developing a plan if the youth/family does not already have one, including the elements delineated in the Mobile Crisis Intervention Performance Specifications located in Appendix II. Also see: Crisis Planning Tools: Companion Guide for Providers located at <http://www.masspartnership.com/provider/CrisisPlanning.aspx>

- Crisis intervention, including
 - Solution-focused crisis counseling
 - Brief interventions that address behavior and safety
- Continued delivery of crisis treatment, stabilization and support services for a period of up to 7 days from the initiation of the crisis service, during which time the ESP shall provide follow up services as indicated, including on-site face-to-face therapeutic services, psychiatric consultation, urgent psychopharmacology intervention, and/or collateral consultation
- Referrals and linkages to family's preferred, chosen and medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care and the Children's Behavioral Health Initiative (CBHI) services.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff shall coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also shall coordinate with the youth's primary care physician, any

other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

The primary objectives of Mobile Crisis Intervention services are as follows:

- Early intervention in behavioral health crises with family preservation and community-tenure serving as highly valued priorities
- Delivery of a comprehensive crisis service focused on the child and family that includes a crisis assessment, a course of intervention, stabilization of crisis, creation of a risk management/safety plan, and linkage as needed to other services
- Referral to least restrictive and least intensive treatment services consistent with medical necessity and personal and community safety, that serve to divert unnecessary deep-end services or interventions such as inpatient hospitalization, as well as residential treatment services or detention to the extent that utilization results from the youth's behavioral health condition
- Connection and coordination of care for children and their families who qualify for CBHI services
- Ensuring family connection with the services, which are chosen with the family to meet the child's and family's needs, that will promote recovery, family skill-building, and natural family and community support
- Provision of a brief period (up to 7 days) of follow-up treatment services and supports to ensure crisis resolution and effective connection to ongoing, medically necessary services

Effective Mobile Crisis Intervention shall produce the following outcomes:

- Increased confidence by child and family in crisis self-management
- Increased use of natural supports
- Timely and increased connections to community services
- Timely follow-up with child's treatment service
- Decreased use of hospital emergency departments (EDs)
- Reduced use of inpatient psychiatric services

Effective Mobile Crisis Intervention may also contribute to the following additional outcomes, to the extent the use of these resources may result from a youth's behavioral health condition:

- Reduced referrals into residential treatment
- Juvenile court/DCF diversions
- Fewer days out of the home

ESP services for children and adolescents shall be provided by the ESP's Mobile Crisis Intervention services in the community as described above unless the child, parent, or caretaker prefers to receive these services in another setting such as the community-based location. Or, the

ESP may assess that there is a clinical or safety need that contraindicates providing services in the home and indicates the need to use the ESP's community-based location or other setting for a given child or adolescent. Crisis assessments for youth only occur in a hospital emergency

department (ED) if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuse required consent for service in the home or alternative community settings; or if the request for Mobile Crisis Intervention services originates from a hospital ED. In those instances in which a youth is brought or sent to a hospital ED before the ESP is called or as determined by the ESP during the triage call, or because the parent or child chooses to go to the ED at any time they believe that the child requires services to treat an Emergency Medical Condition, the Mobile Crisis Intervention staff mobilizes to the ED. The number of hospital-based interventions will be closely monitored to ensure that mobile crisis intervention services are delivered primarily in community settings.

Staffing

Mobile Crisis Intervention service shall be overseen and supported by the ESP staff who relate to all ESP service components. Please reference Appendix II, Mobile Crisis Intervention- Staffing for a list of required staff and credentials.

“Emergency Services Program: Staffing.” This service component shall be further supported by a dedicated program manager who shall be responsible for managing the Mobile Crisis Intervention service in compliance the MCI Performance Specifications. This service shall be further staffed by child-trained clinicians and paraprofessionals who will work in a braided fashion to ensure crisis resolution and successful linkage. Paraprofessionals who are part of the teamed response to youth and families are shall generally meet the definition of and be trained as Family Partners, who have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. ESPs shall be expected to ensure that at least one of their Bachelor’s level staff members are in fact Family Partners. Regardless, the role of the second person on the team is to pay attention to and support the specific experience of the parent(s) whose child is in the midst of a serious health event.

4. Runaway Assistance Program

Description

As a component of the Mobile Crisis Intervention program, providers shall be responsible for the provision of Runaway Assistance in the community 24/7/365 to youth between the ages of 6 to 18. The ESP/MCI Provider shall establish a Mobile Crisis Intervention/Runaway Assistance Program (“MCI/RAP”) to provide a temporary and safe place for youth to stay on a voluntary basis, until such youth is transferred to another appropriate service provider.

The primary tasks of the RAP Provider are as follows:

- Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.
- Maintain an MCI/RAP site where police can bring youth during non-court hours.
- Greet police officers and youth who come to the MCRI/RAP site during non-court hours;
- Supervision at least a one-to-one basis until the youth:
 - Is transferred to a hospital level of care
 - Is transferred to the care of ALP staff, or

- Voluntarily leaves the site
- If a youth who is brought to the MCI/RAP site chooses to voluntarily leave:
 - Immediately notify the police department of the city or town where the MCI/RAP site is located and the DCF (if the youth is known to be in DCF custody);
 - Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123 §12, and, if determined appropriate, apply for hospitalization, and
 - Submit a critical incident report form to MBHP
- Designate a manager to oversee the MCI/RAP

The MCI/RAP manager designated by the ESP/MCI shall oversee the MCI/RAP and shall also:

- Ensure the MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court hours and be available to MCI/RAP staff for consultation
- Provide back-up coverage for on-call MCI/RAP staff
- Train program staff regarding MCI/RAP procedures
- Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP, and
- On the business day following the arrival or transfer of a youth, follow up with the police department, and follow-up with any ALP to which the youth was transferred

The ESP/MCI shall provide quarterly and annual reports to MBHP in a form designated by MBHP on outcomes and outputs related to the MCI/RAP, including, but not limited to:

- The number of youth who receive a crisis intervention assessment
- Demographics related to youth served including, but not limited to, age, gender, ethnicity and city/town of residence
- The number of youth unable to be maintained safely at the MCI/RAP site and who require further assessment in the secure environment of the emergency department
- The number of youth transferred to the care of ALP staff, and
- The number of youth who voluntarily leave the MCI/RAP site

5. Adult Mobile Crisis Intervention

Description

The Emergency Services Program (ESP) provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year (24/7/365) to Members of all ages who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows a Member to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with a Member in crisis, the ESP provides a core service including crisis assessment, intervention, and stabilization. In doing so, the ESP conducts a crisis behavioral health assessment and offers short-term crisis counseling that includes active listening and support. The ESP provides solution-focused and strengths-oriented crisis intervention aimed at working with the Member and his/her family and/or other natural supports to understand the current

crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment. The ESP arranges the behavioral health services that the Member selects to further treat his/her behavioral health condition based on the assessment completed and the Member's demonstrated medical need. The ESP coordinates with other involved service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. The ESP also provides the Member and his/her family with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community. While it is expected that all ESP encounters minimally include the three basic components of crisis assessment, intervention, and stabilization, crisis services require flexibility in the focus and duration of the initial intervention, the Member's participation in the treatment, and the number and type of follow-up services.

ESP services are directly accessible to Members who seek behavioral health services on their own and/or who may be referred by any other individual or resource, such as family members, guardians, community-based agencies, service providers, primary care physicians, residential programs, schools, state agency personnel, law enforcement, courts, etc. ESP services are community-based in order to bring treatment to Members in crisis, allow for Member choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery. Local ESPs provide crisis behavioral health services in the community, through mobile crisis intervention services, accessible community-based locations, and Community Crisis Stabilization (CCS) programs.

All ESPs shall provide Adult Mobile Crisis Intervention services to any community-based location, including private homes, from 7 a.m. to 8 p.m. Outside of those hours, Adult Mobile Crisis Intervention services shall be provided in residential programs and hospital EDs. ESP performance will be measured against established targets for the percentage of services that are provided on a "mobile" basis, exclusive of hospital EDs.

6. Adult Community Crisis Stabilization (CCS)

Description

The adult (ages 18 and over) Community Crisis Stabilization (CCS) program provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18-20 under the Children's Behavioral Health Initiative (CBHI). CCS provides a distinct level of care where primary objectives of active multi-disciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the Member, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized crisis prevention plan and/or safety plan, as part of the Crisis Planning Tools for youth; and linkage to ongoing, medically necessary treatment and support services. CCS staff provides continuous observation of, and support to, Members with mental health or co-occurring mental health/substance use

disorder conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include: crisis stabilization; initial and continuing bio-psychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support and/or other recovery-oriented services; and mobilization of family and natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. CCS staff provides psycho-education, including information about recovery, wellness, crisis self-management, and how to access wellness and recovery services available in the Member's specific community. Guided by the treatment preferences of the Member, CCS staff actively involves family and other natural supports at a frequency based on Member needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. For young adults who are involved with, or who are referred for, CBHI services – including Intensive Care Coordination (ICC) – with Member consent CCS staff provides treatment recommendations and participates in team meetings, as appropriate.

CCS shall be primarily used as a diversion from an inpatient level of care; however, the service may be used secondarily as a transition from inpatient services, if there is enough service capacity and the admission criteria are met. Admissions to the CCS shall occur 24/7/365 based on determinations made by mobile and site-based ESP staff. Discharges from the CCS shall occur 24/7/365, and discharge processes shall include efficiencies that maximize service capacity. Readiness for discharge shall be minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Minimum Capacity

The allocations of CCS capacity identified in Appendix I: ESP Catchment Areas, should be considered a minimum number that can be adequately supported by the core staffing pattern reflected and described under “staffing” below. Each catchment area must have a minimum number of CCS beds available as follows:

Brockton – 6
Cape and Islands – 6
Fall River – 5
Taunton/Attleboro – 7

Adult CCS program utilization will be monitored by MBHP to ensure adherence to the performance specifications for this service (Appendix II), the goals of the ESP system, and relevant performance indicators including but not limited to daily reporting of CCS capacity on Massachusetts Behavioral Health Access (MABHA) website at least once per shift, (3x daily) every day.

Location of adult CCS

The ESP's adult CCS is required to be co-located with the ESP community-based location. Preferably upon initiation of the ESP contract, or within the first three months thereof. If a provider is awarded a contract with this contingency and fails to meet the full set of criteria within three months, the provider may be at risk of termination of the contract.

Collaboration between ESP and adult CCS

The co-location of the adult CCS and the ESP's community-based location shall enhance service continuity and increase administrative efficiency to benefit those served. The overall ESP program shall operate in a fashion that ensures fluidity among ESP mobile services, site-based crisis services at the ESP community-based location and the CCS and minimizes inconvenience to individuals in crisis. With the use of fluidly trained staff and cross-scheduling, ESPs shall demonstrate the ability to respond to varying levels of demand in these three service components. All staff members are expected to share expertise in terms of clinical knowledge, service delivery (as appropriate for each discipline), and discharge planning.

Staffing

Community Crisis Stabilization (CCS) service shall be overseen and supported by the ESP staff who relate to all ESP service components, as listed in Appendix II, Emergency Services Program-Staffing. The CCS is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year. CCS provides awake staffing 24/7/365. CCS utilizes a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use disorder conditions in adults. The ESP/MCI ensures that all staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with MBHP's credentialing criteria. For CPSs and Family Partners, this supervision includes peer supervision.

Please reference Appendix II, Adult Community Crisis Stabilization – Staffing, for additional staffing requirements.

E. Linkages

The ESP has a clear command of the local community crisis continuum - the strengths and limitations, resources, barriers, and practice patterns – and, in collaboration with MBHP, initiates strategies aimed at strengthening service pathways and the safety net of resources. ESP staff is knowledgeable of available community mental health and substance use disorder services within their ESP catchment area and statewide as needed, including the MBHP levels of care and their admission criteria, as well as relevant laws and regulations. They also have knowledge of other medical, legal, emergency, and community services available to the Member and their families, including recovery-oriented and consumer-operated resources and resources.

The ESP also communicates, consults, collaborates, refers to, and ensures continuity of care with many other resources involved with utilizers of ESP services including, but not limited to, the following:

- Primary care services and hospitals
- State agencies
- Schools
- Residential programs
- Law enforcement entities

The ESP develops and maintains close working relationships with recovery-oriented and consumer-operated resources in its local community, including but not limited to Recovery Learning Communities (RLCs), Clubhouses, and AA/NA. The ESP develops specific linkages with the RLCs relative to warmline services, if offered by their local RLC. These working relationships are expected to be with recovery-oriented and consumer-operated organizations that support not only adults but youth and families as well.

With Member consent, the ESP collaborates with the Member's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.

The ESP develops and maintains relationships with the hospitals in its catchment areas characterized by ongoing and consistent communication, problem solving, planning and innovation. The ESP works with the ED to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for Members who present for services in both the ED and ESP settings. The ESP negotiates roles with the ED, develops contingency plans for fluctuations in utilization, and creatively uses hospital and community resources to meet the needs of its communities. The ESPs/MCIs are required to collaborate with the ED to ensure that proper documentation of any intervention within the ED is appropriately shared with that facility.

Other linkages with behavioral health continuum for youth:

The ESP develops and maintains linkages relevant to services for children, adolescents, and families, as required in the MCI performance specifications. This knowledge includes ESP staff being fully aware of, and knowing how to access, CBHI services.

When serving a youth (up to age 21) who is receiving ICC or In-Home Therapy Services, ESP staff shall work closely with the youth's care coordinator or therapist throughout the delivery of the service.

- ESP staff shall readily identify youth up to the age of 21 with MassHealth Standard or CommonHealth who are involved in multiple services systems or otherwise appear to demonstrate a medical need for one or more CBHI services.

- ESP staff, with informed consent, shall connect children and families to mutually agreed-upon CBHI services. If it appears that more than one service may be useful to the family, ESP staff shall connect the family to the CSA so that a plan of service can be developed.
 - ESP staff shall support linkages with the family’s natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g., Parental Stress Line, AA, PAL, etc.).

Other linkages

ESPs shall disseminate information about community resources that will aid in the amelioration of stressors, including those that offer food, clothing, shelter, utility assistance, homelessness support, supported housing, supported employment, landlord mediation, legal aid, educational resources, parenting resources and supports, etc.

F. Recovery-Oriented Services

Background

ESPs shall deliver services in a manner that is consistent with the Substance Abuse and Mental Health Services Administration’s (SAMHSA) consensus statement on mental health recovery,² which states:

“Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the ‘single most important goal’ for the mental health service delivery system.”

“To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over expert panelists participated, including mental health consumers, family members, providers, advocates researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels.”

The following consensus statement was derived from expert panelist deliberations on the findings:

² U.S. Department Of Health And Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services, www.samhsa.gov

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

The 10 Fundamental Components of Recovery

SAMHSA’s consensus statement on mental health recovery identified the following fundamental components of recovery that ESP providers are expected to integrate into their service delivery. It is reproduced here from that document.

Self-direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and person-centered: There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end-result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner,

caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive, trust- based relationships.

Peer support: Mutual support – including the sharing of experiential knowledge and skills and social learning – plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers – including protecting their rights and eliminating discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Description

Recovery-oriented values, principles, practices, and services have been integrated into the program model described in this document. To summarize, ESPs shall support resiliency, rehabilitation, and recovery of all individuals to whom they provide emergency behavioral health services, by integrating mental health, substance use, and co-occurring rehabilitation and recovery principles and practices throughout the service delivery model and implementing specific recovery-oriented services, including peer specialist and family support services. All program policies and procedures are designed to promote acceptance of Members into their contracted services within an atmosphere of trust at all levels of motivation and readiness and with any reasonable personal preferences.

All ESPs shall be required to employ one or more Certified Peer Specialists (CPS) to work in the ESPs’ community-based locations. Additionally, there is bachelor’s level staff in the staffing patterns for the ESPs’ Adult Mobile Crisis Intervention services and adult Community Crisis Stabilization programs (CCSs), and ESPs will be encouraged to hire those who are also credentialed as a CPS. As described above, Certified Peer Specialists shall provide support and information to consumers while they are receiving services at the ESP community-based

locations and may assist ESP clinicians in arranging the services needed for individuals after the ESP intervention. In the Adult Mobile Crisis Intervention services, the bachelor's level staff, some of whom shall also be CPSs, shall accompany the master's level clinician on mobile visits. Similarly, the staffing pattern for Mobile Crisis Intervention includes paraprofessional staff, many of whom shall also be Family Partners. ESPs shall be specifically required to hire at least one Family Partner in their Mobile Crisis Intervention program. Family Partners have lived experience as a primary caretaker of a child with Serious Emotional Disturbance. These staff shall provide support to youth during their involvement in the Mobile Crisis Intervention services.

The ESPs shall also develop and maintain close working relationships with local programs that and will complement and integrate their services with the following formal and informal resources and programs:

- a. Recovery-oriented and peer-operated services and supports;
- b. Wellness programs that promote skill-building, vocational assistance, supported employment, and full competitive employment;
- c. Natural community supports for Members and their families;
- d. Self-help including Anonymous recovery programs (e.g., 12-step programs) for Members and their families; and
- e. Consumer/family/advocacy organizations that provide support, education, and/or advocacy services, such as Parent/Professional Advocacy League (PPAL), the Federation of Children with Special Needs, Recovery Learning Communities (RLCs), Clubhouses, the National Alliance on Mental Illness (NAMI), etc.

G. Services for Special Populations

Background

ESP services must be relevant to the age, level of development, culture, values, beliefs, and norms of all individuals who seek services and their families. Both the content of the assessment and intervention, as well as the manner in which these services are delivered, must be informed by knowledge, respect for, and sensitivity to the individual's clinical and cultural context and provided in his/her preferred language and mode of communication. Ensuring that ESP services are relevant to all populations is a great challenge given the broad range of populations who utilize these services, and doing so involves strategies at both the local and statewide levels of the ESP system.

The ESP ensures that service delivery facilitates communication, access, and an informed clinical approach with special populations including but not limited to:

- Intellectual and developmental disabilities
- Deaf and hard of hearing
- Blind, deaf-blind, and visually impaired
- Culturally and linguistically diverse populations
- Elders
- Veterans

- Homeless
- Gay, lesbian, bisexual, transgendered

The needs of specific or “special” populations may be characterized relative to one of the following, which are not intended to be mutually exclusive:

Communication: Individuals with communication needs will be able to benefit from the core ESP service, but require the facilitation of communication, such as through language interpreters, American Sign Language interpreters, TTD, or Braille materials.

Access: Some individuals require support, accommodations, assistance, and/or service delivery in a particular venue to gain access to ESP services. Once accessed, these individuals are able to benefit from the core ESP service. Access needs may include specific education and outreach, the availability of mobile evaluations for populations who are unable or reluctant to seek services in the community, transportation, an environment that is welcoming and inclusive, etc. For example, many elders require mobile crisis intervention services provided in their homes, due to their medical conditions and/or difficulty leaving their homes and/or reluctance to use behavioral services, particularly in traditional settings.

Informed clinical approach: For some individuals, an informed clinical approach is needed in the implementation of the core ESP service. ESP clinicians must have understanding and sensitivity to both the unique clinical and cultural context of these populations in conducting the core ESP services of assessment, crisis intervention, and stabilization. This sensitivity means, for example, that in addition to utilizing appropriate means of communication with an individual who is deaf, it is equally important to understand deaf culture and assess the individual in that context.

Unique clinical service: Services to individuals may require the use of specialized assessment tools or techniques that vary substantively from those normally used in providing core ESP services. Examples may include a different approach to clinical engagement, different means of gathering information, and collection of different than usual content that must be included in the assessment to inform the diagnosis and disposition, such as for individuals with intellectual disabilities.

Please note that the following are not identified as “special populations” because these populations represent the majority of individuals who utilize ESP services, and their needs are addressed throughout the program model described in this document. ESPs shall ensure that all ESP clinicians and other staff receive training and meet core clinical competencies in serving the following populations:

- Children, adolescents, and their families
- Adults
- Persons with mental health conditions

- Persons with substance use condition
- Persons with co-occurring mental health and substance use condition

Local ESP response to special populations

The responses to the needs of special populations at a local ESP level shall therefore include:

- *Access:* Each ESP shall be required to articulate and implement specific outreach and other strategies to ensure access to ESP services for each identified special population.
- *Core clinical competency:* In order to provide an informed clinical approach in the crisis assessment and intervention with individuals in each identified special population, each ESP shall be required to ensure that ESP clinicians receive training and meet specified core clinical competencies relative to each.
- *Special services:* All ESPs shall ensure staff training and other mechanisms for providing an ESP service appropriate to individuals with intellectual and developmental disabilities. Some ESPs shall also offer specific services to some other special populations, based on the needs of their local communities and the prevalence of given populations therein. For example, an ESP may develop a mobile crisis intervention team to respond to a certain high incidence culturally or linguistically diverse population in a given area.

Statewide support from state agencies

In order to support ESPs in responding to special populations, DMH, MassHealth, and MBHP will work with state agencies to identify central office and local contacts that can be available to consult with each ESP on available resources and systems issues relative to their constituents. Some state agency staff may also be resources for clinical consultations regarding the populations they serve.

H. Hospital/Medical Interface

ESP working relationships with hospital emergency departments (EDs) in their catchment areas

The working relationship between an ESP and the hospitals in their catchment area, particularly their EDs, is critical to meeting the behavioral health needs in the communities they both serve. ESP relationships with the hospitals in their catchment areas should include ongoing and consistent communication, problem solving, and planning. ESPs and EDs must work together to evaluate ED and inpatient service utilization patterns, identify strategies to reduce unnecessary hospitalization, and plan how to divert utilization from the ED setting to the ESP's alternative community-based services, as well as how to best care for individuals who present for services in both the ED and the ESP settings. ESPs and EDs should negotiate roles, develop contingency plans for fluctuations in utilization, and creatively use hospital and community resources to meet the needs of their communities.

Please see Appendix I: ESP Catchment Areas, which identifies the hospital EDs located in each catchment area. Providers are expected to articulate specific strategies for collaborating with each ED to achieve the goals related to hospital utilization articulated in the section below.

ESPs shall cooperate with hospitals that require ESP clinicians to be credentialed in order to provide crisis behavioral health services in the hospital ED, in compliance with MBHP Network Alert #19 *General Hospitals Credentialing ESPs*.

ESP goals related to hospital utilization

Emergency department (ED) diversion

Subject to applicable state and federal regulations that entitle MassHealth members to seek emergency services for an Emergency Medical Condition, a priority goal of the ESP model is to interrupt patterns of over-reliance on hospital EDs as the first point of contact in the event of a behavioral health crisis. While EDs are an important component of the crisis continuum, most behavioral health crises can be readily and more effectively addressed in the community. Every ESP must be organized around the diversion of behavioral health utilization from those settings when there is not a physical condition or level of acuity that requires medical assessment and intervention, while understanding that MassHealth Members are entitled to seek emergency services in an ED if they believe they have an Emergency Medical Condition. ESPs are expected to develop and implement specific strategies to change referral and utilization patterns in their communities and shift volume from hospital EDs to their community-based services, specifically their child/adolescent and Adult Mobile Crisis Intervention services, their community-based locations, and their adult CCSs. ESPs shall create a service pathway that screens for the need to refer up to a hospital ED rather than step-down from hospital-based emergency care.

Timely response

Another priority goal of the ESP system is to respond to all requests for crisis assessment, intervention, and stabilization in a timely fashion, in order to be responsive to the individual's and/or caretakers' sense of urgency, intervene in behavioral health crises early, and prevent the adverse impact that treatment delay may have on individuals, families, and settings in which those individuals await these services. This goal is particularly important relative to those who await ESP services in the hospital ED setting. Although the ESPs will be working toward the goal of decreasing behavioral health utilization in the ED setting, some individuals are expected to continue to present at EDs if they believe they have an Emergency Medical Condition. It is critical for ESPs to respond quickly to requests for their services in the hospitals EDs in their catchment areas, in order to minimize the duration of individuals' time in this more restrictive setting, thereby contributing to efforts to reduce ED overcrowding and boarding. ESPs shall begin all crisis assessments requested for individuals, within the ESP scope defined in the ESP Performance Specifications, no later than one hour from the time of readiness. Please refer to Appendix II: ESP Performance Specifications and Appendix III: Quality Indicators for more information regarding response time requirements.

ESPs shall be expected to develop specific strategies with EDs in their catchment area to ensure timely access to ESP services for individuals who present in the ED seeking behavioral health

services. ESPs shall negotiate arrangements with each ED, which may include, but not be limited to, ESP clinicians traveling to the ED to provide ESP services within required timeframes; the ESP outposting clinicians at the ED during specified high-volume hours; the ESP subcontracting to the ED for the hospital to directly provide the emergency behavioral health service; and/or other arrangements as identified by the ESP and negotiated with the ED. ESPs shall also educate EDs about other behavioral health services to which individuals may be triaged, such as ATS or urgent outpatient services. When ESPs respond to individuals who have presented in an ED, the ESP shall be required to meet a response time requirement of no longer than one hour, and they shall be responsible for providing the core ESP service of crisis assessment, intervention, and stabilization.

Inpatient diversion

Strategies that reduce unnecessary psychiatric hospitalization help to preserve the availability of this vital community resource in instances when it is needed. Persons who receive behavioral health crisis services in a hospital ED are more likely to be hospitalized than those treated in the community. Providing ESP services in alternative community-based locations will increase the likelihood of referral to appropriate, timely, and least-restrictive ongoing services in lieu of an inpatient psychiatric admission. In addition, ESPs shall be expected to work with EDs to identify and implement additional specific strategies to maximize utilization of community-based diversionary services (including rapid linkage to treatment) in a manner that is consistent with medical necessity criteria. Please refer to Appendix III: Quality Indicators for more information regarding disposition goals.

Medical evaluation

During a behavioral health crisis, a small percentage of individuals require medical evaluation to assess and/or treat a medical condition that may or may not be contributing to their behavioral health condition. Most individuals do not require general medical evaluation, beyond screening, as part of a crisis assessment and intervention. Given that the majority of ESP services shall be provided in the community rather than in hospital EDs, ESPs will be expected to develop protocols and strategies to support ESP staff in screening individuals for the need for medical evaluation, based on the *Medical Clearance Guidelines for Emergency Service Programs (ESP) & Acute Inpatient Facilities: A Consensus Statement* developed by task force members of the Massachusetts College of Emergency Physicians and the Massachusetts Psychiatric Society. ESPs shall refer differentially to hospital EDs and primary care clinicians, within a timeframe that is based on the urgency of that need. It will be important for ESPs to develop and maintain protocols with their local EDs in order to ensure access to medical evaluation for individuals who require this service and have come to the ESP's attention in their community-based location or through their mobile crisis intervention services.