EMERGENCY SERVICES PROGRAM AGREEMENT

This Emergency Services Program Agreement (the "Agreement") is made this ____ day of ____, 20__, by and between the Massachusetts Behavioral Health Partnership, a Massachusetts general partnership with principal offices at 1000 Washington Street, Suite 310, Boston, Massachusetts ("MBHP") and _____, a Massachusetts _____ with its principal place of business at _____ ("Provider") (collectively referred to herein as the "parties" or individually referred to as a "party").

R E C I T A L S

WHEREAS, employees of the Commonwealth of Massachusetts Department of Mental Health ("DMH") currently provide services related to the Emergency Services Program ("ESP) in the southeastern region of the state;

WHEREAS, the Massachusetts Executive Office of Health and Human Services ("EOHHS") desires to privatize ESP services in southeastern Massachusetts pursuant to the state's Privatization Law by contracting with an appropriate and qualified third party to provide ESP services for the southeastern of the state;

WHEREAS, MBHP has entered into a contract with EOHHS to arrange for the provision of certain behavioral health services to individuals in Massachusetts and which requires MBHP to administer certain emergency service programs (the "PCC Plan Contract");

WHEREAS, EOHHS amended the PCC Plan Contract to authorize MBHP to issue a Request for Response dated July 6, 2015 ("RFR") relating to the procurement of ESP services in southeastern Massachusetts;

WHEREAS, MBHP selected Provider as the successful bidder to provide ESP Services based on Provider's response to the RFR (the "RFR Submission"); and

WHEREAS, Provider is qualified and willing to perform its duties as set out in this Agreement.

NOW, THEREFORE, in consideration of the promises, mutual covenants, agreements and other good and valuable consideration herein contained, receipt and sufficiency of which is hereby acknowledged, MBHP and Provider mutually agree as follows:

SECTION 1 DEFINITIONS

1.1 Definitions.

"Catchment Area" shall mean the catchment area identified on MBHP's ESP Directory as posted on the MBHP web site at http://www.masspartnership.com.

"Eligible Individual" means any individual of any age who is in need of ESP Services within the Catchment Area, including individuals up to age twenty-one (21) in need of Mobile Crisis Intervention, and individuals aged twenty-one (21) and over in need of Adult Mobile Crisis Intervention, and individuals aged eighteen (18) and over in need of Community Crisis Stabilization.

"Encounter" means the provision by the Provider of any single service or combination of services as described in the General Performance Specifications as well as the Performance Specifications for the Emergency Services Program, Adult Community Crisis Stabilization, and Mobile Crisis Intervention, all of which are part of the MBHP Provider Manual which is an extension of this Agreement. "Encounter" also includes any single service or combination of services as described in the program service list for the Mobile Crisis Intervention/Runaway Assistance Program, attached as Exhibit A.

"ESP Services" means emergency behavioral health crisis assessment, intervention and stabilization, including all services required by an individual until an acute behavioral health crisis has been stabilized or until the individual can be safely referred or transferred to another appropriate level of care, and as further defined in the General Performance Specifications as well as the Performance Specifications for the Emergency Services Program, Adult Community Crisis Stabilization, and Mobile Crisis Intervention, all of which are part of the MBHP Provider Manual which is an extension of this Agreement. "Encounter" also includes any single service or combination of services as described in the program service list for the Mobile Crisis Intervention/Runaway Assistance Program, attached as Exhibit A.

"HIPAA Rules" means those laws and regulations relating to and/or promulgated under the Health Insurance Portability and Accountability Act of 1996, including, but not limited to, 45 CFR Parts 160 and 164.

"Privatization Law" means the Massachusetts statute codified at M.G.L. c.7, §§52, 53, 54, 55 which outlines the process the state must use when seeking to privatize services provided by state employees and the requirements to which successful bidders must adhere when awarded a privatization contract under this law.

"System of Care" means an integrated system of behavioral health services with strong linkages to non-acute components of the behavioral health system and other service systems as described in the RFR Submission.

SECTION 2 STATEMENT OF PURPOSE

2.1 Purpose of Agreement. MBHP and Provider enter into this Agreement to set forth the parties' obligations for the operation and success of the ESP. Provider shall be responsible for providing ESP Services for the _____ catchment area(s) in a clinically appropriate manner that offers a culturally and linguistically competent spectrum of emergency behavioral health services as set forth in this Agreement. Provider shall establish a community-based program aimed at directing Eligible Individuals to appropriate venues for the receipt of crisis behavioral health services other than Emergency Departments ("EDs") when Eligible Individuals are not in need of ED care or do not voluntarily seek care in that setting.

2.2 Order of Precedence. Provider's response to MBHP's RFR served as the basis for this Agreement and is incorporated by reference into the Agreement. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

(a) this Agreement, including all Exhibits, any amendments, and the MBHP Provider Manual pursuant to Section 8.1 of this Agreement;

(b) the RFR; and

(c) the provider's RFR Submission.

SECTION 3 DATA MANAGEMENT AND REPORTING

3.1 Data Management System Capability. Provider shall implement appropriate systems to adequately track data regarding the ESP Services provided to Eligible Individuals ("Data Management Systems"). Such systems are to include, but not be limited to: a) a client management information system; and b) clinical tracking and utilization software. Provider shall be responsible for maintaining the appropriate hardware and software necessary to operate these systems. All Data Management Systems shall be subject to MBHP's reasonable approval. Provider agrees to communicate with MBHP and to modify its Data Management Systems to track ESP Service information as requested by MBHP. Provider shall have sole ownership of the Data Management Systems.

At a minimum, Provider shall use its Data Management Systems to catalogue and manage Eligible Individual data including demographic information, medications and Eligible Individual encounter information.

Provider shall comply at all times with HIPAA Rules. Data Management Systems shall also be designed to allow Provider to comply with applicable required state or federal reporting and documentation requirements.

3.2 Report Generation. The Data Management Systems shall be capable of providing reports required pursuant to this Agreement including, but not limited to, tracking financial data, claims processing and billing, demographics, insurance information, current charges, payments, claim rejections, and outstanding balances at the invoice or service line item level.

SECTION 4 PAYMENT AND FINANCIAL PROVISIONS

For services provided pursuant to this Agreement, MBHP shall pay Provider in accordance with the terms set forth in Exhibit C attached hereto. In the event that MBHP reviews the ESP Services provided by Provider and determines that such services were not provided pursuant to this agreement, MBHP may retroactively deny payment and recoup or offset those amounts that should not have been paid. Any such action by MBHP shall be subject to your rights of appeal set forth in the Administrative Operations section of the Provider Manual.

SECTION 5 MBHP RESPONSIBILITIES AND OVERSIGHT

5.1 Administrative Responsibilities.

(a) MBHP Contact Personnel. MBHP shall designate a primary contact person to act as liaison between Provider and MBHP for the duration of the Agreement. MBHP may change its designation of primary contact person at any time during the Agreement and shall provide Provider with notification of any such change. The primary contact person shall be authorized to represent MBHP in all programmatic and operational aspects of the Agreement.

(b) MBHP Provision of Data. MBHP shall provide Provider with available information and data in its possession as necessary for the successful performance of the Agreement. MBHP shall not be responsible for providing Provider with any information in violation of any federal or state laws and MBHP shall have discretion with regard to providing Provider with any information that it deems to be confidential so long as Provider does not require such information to meet its contractual obligations hereunder.

(c) Report Review. MBHP shall review Provider's submitted reports and shall reserve the right to request additional reports that MBHP deems necessary for monitoring and evaluating the performance of Provider.

5.2 Performance Evaluation.

MBHP shall:

(a) At its discretion, upon reasonable notice during normal business hours, perform periodic programmatic and financial reviews. These may include on-site inspections and audits by MBHP or its agents of the records of Provider relating to the ESP.

(b) Provide reasonable notice to Provider prior to any on-site visit to conduct an audit, and further notify Provider of any records MBHP wishes to review.

(c) Review and evaluate Provider for its successful performance of all contractual obligations and its compliance with the terms of the Agreement.

(d) Inform Provider of the results of any performance evaluations and of any dissatisfaction with Provider's performance, and reserve the right to demand a corrective action plan as set forth in the Section 8.7 or to terminate the Agreement in accordance with Section 6.3 of this Agreement.

SECTION 6 TERM AND TERMINATION

6.1 Term. This Agreement shall be effective for the period from _____ (the "Effective Date") through June 30, 2017 (the "Initial Term") and automatically renew for successive one (1) year terms (each a "Renewal Term") unless either party provides advance written notice of its intent to not renew the Agreement at least ninety (90) days prior to the expiration of the then current term.

6.2 Immediate Termination. MBHP may terminate the Agreement immediately and without prior written notice upon any of the events listed below. If MBHP determines to terminate the Agreement under this Section, it shall notify Provider in writing of the effective date of termination within five (5) business days of its determination.

(a) Provider's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

(b) Provider's admission in writing that it is unable to pay its debts as they mature;

(c) Provider's assignment for the benefit of creditors;

(d) Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against Provider in any such proceeding;

(e) Commencement of an involuntary proceeding against Provider under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within sixty (60) days;

(f) Provider loses any state or federal licenses, accreditations or approvals required to perform services under this Agreement;

(g) Cessation in whole or in part of state or federal funding of the Emergency Services Program as contemplated in the BHP Contract; or

(h) MBHP determines in its sole discretion that the health, safety or welfare of Eligible Individuals requires immediate termination of the Agreement and provides Provider with a detailed description of the facts upon which it has based its determination.

6.3 For Cause Termination.

(a) MBHP may terminate the Agreement for cause based upon material breach of this Agreement by Provider, provided that MBHP shall give Provider written notice specifying the breach and shall afford Provider a reasonable opportunity to correct the breach. If within thirty (30) days after receipt of notice Provider has not corrected the breach or, in the case of a breach which cannot be corrected within thirty (30) days, begun and proceeded in good faith to correct the breach, MBHP may declare Provider in default and terminate the contract effective immediately.

(b) Provider may terminate the Agreement for cause based upon MBHP's failure to make payments when due hereunder, provided that Provider shall give MBHP written notice specifying that payment is late and shall afford MBHP a period of fifteen (15) business days to make payment. If within fifteen (15) days after receipt of notice MBHP has not made payment on all amounts due, Provider may declare MBHP in default and terminate the contract effective immediately.

6.4 Termination Without Cause. MBHP may terminate this Agreement at any time for any reason upon sixty (60) days advance written notice to the Provider.

6.5 Continued Obligations. In the event of termination, expiration or nonrenewal of the Agreement, the obligations of the parties hereunder with regard to Eligible Individuals at the time of termination, expiration or nonrenewal shall continue until the Eligible Individuals no longer require ESP Services. Provider agrees to cooperate with MBHP with regard to the transition of the ESP and ESP Services to another provider as needed. Such transitional services shall include communication with the subsequent provider of ESP Services regarding Eligible Individual data as appropriate and continued provision of ESP Services during any reasonable startup period of the subsequent provider. Any ESP Services provided by Provider following termination of this Agreement in accordance with any transition provisions of this Agreement shall be reimbursed in accordance with the financial terms in effect for the current agreement year at the time of the termination.

SECTION 7 TERMS AND CONDITIONS PURSUANT TO THE MASSACHUSSETTS PRIVATIZATION LAW

7.1 Employee Recruitment. Provider shall offer available employee positions to qualified regular or former DMH employees provided that such employees were terminated because of the privatization of ESP services through this contract and such employees satisfy the hiring criteria of the Provider.

7.2 Health Insurance Coverage and Contributions. Provider shall provide health insurance coverage to every employee employed for not less than twenty hours per week pursuant to this contract. Such health insurance shall also cover the employee's spouse and dependent children. Provider shall pay not less than seventy-five percent (75%) of the cost of health insurance for every employee and employee family member so covered.

7.3 Minimum Wage. For each position in which the Provider will employ any person to perform work in which the duties are substantially similar to the duties performed by regular DMH employees, Provider shall pay to these employees no less than the minimum wage summarized in Exhibit E for such positions.

7.4 Non-discrimination. The Provider agrees to comply with the nondiscrimination and equal opportunity mandates summarized in M.G.L. c. 151B.

7.5 Reporting. Provider shall submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services pursuant to this contract. Such reporting shall be due to EOHHS no later than thirty (30) days following the end of each quarter of the contract. Reports must be submitted to EOHHS.

7.6 Certifications. By signing this Agreement, the Provider certifies that the Provider and any of the Provider's supervisory employees, while in the employ of the Provider, have no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute, including, but not limited to, statutes concerning labor relations,

occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest.

7.7 Applicability. Provider must comply with the terms outlined in Sections 7.1, 7.2, 7.3 and 7.5 through the end of the Initial Term of this Agreement. Section 7.1, 7.2, 7.3 and 7.5 do not apply to any Renewal Term of this Agreement.

SECTION 8 ADDITIONAL TERMS AND CONDITIONS

8.1 Provider Manual. The MBHP Provider Manual setting forth MBHP's procedures is deemed to be part of this Agreement. A copy of the Provider Manual shall be available on MBHP's website and in hard copy, upon request. MBHP will notify Provider of any amendments to the Manual via Provider Alerts. Any such amendments to the Provider Manual will be forwarded to Provider by mail or electronically no less than thirty (30) days (or such lesser period of time as required by applicable law) prior to the date they take effect. The content of all Provider Alerts is incorporated by reference into the Provider Manual and supersede those provisions of the Manual that are inconsistent with such content.

8.2 Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), Provider shall not knowingly have an employment, consulting or other agreement for the provision of items and services that are significant and material to Provider's obligations under the Agreement with any person or entity who is excluded under federal law or regulation from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of Provider's equity, nor be permitted to serve as a director, officer or partner of Provider.

8.3 Disclosure Requirements. Provider shall disclose to MBHP and to the U.S. Department of Health and Human Services information on ownership and control, business transactions, and persons convicted of crimes in accordance with 24 CFR Part 455, Subpart B. In addition, Provider shall comply with all reporting and disclosure requirements of 42 U.S.C. §1396 b(m)(4)(A) if Provider is not a federally qualified health maintenance organization under the Public Health Service Act.

8.4 Agreement Compliance. Provider shall immediately notify MBHP of any occurrence that affects Provider's ability to operate and comply with all or any material part of its responsibilities under the Agreement, along with an assessment of the time and effort necessary to recover.

8.5 Compliance With Laws. Each of the parties shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to its property and the conduct of operations as they become effective.

8.6 Loss of Licensure. Provider shall report to MBHP if at any time during the Agreement Provider or any material subcontractor loses any applicable license, state approval or accreditation. Such loss shall be grounds for termination of the Agreement under the provisions of Section 6.2.

8.7 Corrective Action Plan. If, at any time, MBHP determines that Provider is deficient in the performance of its obligations under the Agreement, MBHP may require Provider to develop and submit a corrective action plan that is designed to correct such deficiency. MBHP shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. Provider shall, upon approval of MBHP, immediately implement the corrective action plan, as approved or modified by MBHP. Provider's failure to implement any corrective action plan may, in the sole discretion of MBHP, be considered breach of the Agreement, subject to any and all contractual remedies including termination of the Agreement with or without notice.

8.8 Privacy and Confidentiality Requirements. MBHP and Provider shall comply with the terms and conditions of the Privacy and Confidentiality Obligations attached hereto as Exhibit D and made a part hereof. Provider shall designate a custodian of Personal Data, as defined in Exhibit D, who will be responsible for assuring Provider's compliance with all requirements set forth in the Agreement relating to Personal Data, and shall notify MBHP of the identity of the designated custodian in advance of the Effective Date and whenever a change occurs.

8.9 Medical Records.

Provider shall:

(a) Comply with any and all state and federal statutory and regulatory requirements applicable to medical records and protected health information including the requirements set forth in the HIPAA Rules and Massachusetts General Laws, Chapter 66A. In addition, Provider shall at a minimum maintain medical records in a manner that is current, detailed, and organized and that permits effective patient care and quality review and maintain information sufficient to satisfy Section 5 of this Agreement.

(b) Ensure that medical records include sufficient information to identify the Eligible Individual, date of encounter and pertinent information that documents the Eligible Individual's diagnosis; and

(c) Ensure that medical records describe the appropriateness of the treatment and services, the course and results of the treatment and services.

8.10 Recordkeeping, Audit and Inspection of Records. Provider shall maintain books, records and other compilations of data pertaining to the performance of the provisions and requirements of the Agreement to the extent and in such detail as shall properly substantiate claims for payment under the Agreement. All such records shall be kept for a period of six (6) years.

MBHP, or its duly authorized representatives or designees shall have the right at reasonable times and upon reasonable notice to examine and copy the books, records and other compilations of data of Provider which pertain to the provisions and requirements of this Agreement, and to evaluate through inspection or other means the quality, appropriateness and timeliness of services performed by Provider under the Agreement.

8.11 Assignment. Neither party shall assign or transfer any right or interest in the Agreement to any successor entity or other entity without the prior written consent of the other party;

provided, however, that in the event the Commonwealth of Massachusetts requires MBHP to assign or transfer any of its rights or interest hereunder to the Commonwealth or to another party, consent by Provider shall not be required.

8.12 Use and Ownership of Data.

(a) MBHP Rights. All data acquired by Provider from MBHP in the performance of the Agreement (including Personal Data) remain under the control of MBHP. MBHP shall be given full access at all reasonable times to all such data. All finished or unfinished studies, analyses, flow charts, magnetic tapes, design documents, program specifications, programs, computer source codings and listings, test data, test results, schedules and planning documents, training materials and user manuals, forms, reports, and any other documentation and software, including modifications thereto, prepared, acquired, designed, improved or developed by Provider for delivery to MBHP under the Agreement shall be and remain the property of MBHP.

(b) Contractor Limitations

Provider shall:

(1) Not disseminate, reproduce, display or publish any report, map, information, data or other materials or documents produced in whole or in part in satisfaction of its obligations under this Agreement without the prior written consent of MBHP, nor shall any such report, map, information, data or other materials or documents be the subject of an application for patent or copyright by or on behalf of Provider without the prior written consent of MBHP.

(2) Use MBHP-owned data, materials and documents, before or after termination or expiration of the Agreement, only as required for the performance of the Agreement.

(3) Return to MBHP promptly, but in any event no later than one (1) week after MBHP's request, EOHHS-owned or Commonwealth-owned data, materials and documents, in whatever form they are maintained by Provider.

8.13 Indemnification. Provider shall indemnify and hold harmless MBHP and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which MBHP or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with Provider's violation of any federal or state law or regulation or any negligent action or inaction or willful misconduct of Provider, or any person employed by Provider except such as may result from the negligent or wrongful acts or omissions of MBHP or the Commonwealth or its agents, employees or contractors, provided that:

(a) Provider is notified of any claims within a reasonable time from when MBHP becomes aware of the claim;

(b) Provider is afforded an opportunity to participate in the defense of such claims; and

(c) Provider shall not be responsible for the settlement of any claim, demand or lawsuit made by MBHP or the Commonwealth without Provider's written consent.

8.14 Public Communications Protocol. Provider and MBHP shall exercise best efforts to coordinate any statements in response to any media inquiry concerning the ESP and to collaborate with each other when making any public comment in connection with the ESP.

8.15 Insurance For Employees. Provider shall maintain at its expense all insurance required by law for those employees responsible for providing services under this Agreement and provide MBHP with certification of same prior to the Effective Date and by August 1 of each subsequent year.

8.16 Non-Solicitation. Provider shall not solicit and shall ensure that its wholly owned or controlled subsidiaries shall not solicit Eligible Individuals who are enrolled on the Primary Care Clinician Plan of the MassHealth program to join any other health plan. Any such solicitation shall be deemed a material breach of this Agreement and constitute cause for termination. Nothing in this Section shall be construed to limit Provider from discussing with Eligible Individuals who are Provider's patients the terms of the individual's benefits and coverage under their health plan, nor shall Provider be limited from engaging in general marketing or advertising of their health plan participation to Medicaid recipients.

8.17 Counterparts. The Agreement may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

8.18 Entire Agreement. Except as provided in Section 8.19, the Agreement constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations and undertakings not set forth or incorporated herein. The terms of the Agreement shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein.

8.19 Correction of Omissions, Ambiguities, and Manifest Errors. The parties shall negotiate in good faith to cure any omissions, ambiguities, or manifest errors in the Agreement. By mutual agreement, Provider and MBHP may amend the Agreement where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by both parties, and attached to the Agreement.

8.20 No Third-Party Enforcement. This Agreement is entered into by and between the parties hereto and for their sole benefit. There is no intent by either party to create or establish a third-party beneficiary status, or to create any rights in or confer any benefits upon any person or entity not a party to this Agreement (except for such rights as are expressly created and set forth in this Agreement). Except for the foregoing, no third-party shall have any right to enforce or to enjoy any benefit or obligation created or established under this Agreement.

8.21 Section Headings. The headings of the sections of the Agreement are for convenience only and do not affect the construction hereof.

8.22 Waiver. Either party's acceptance or approval of any materials, including those materials submitted in relation to the Agreement, shall not constitute waiver of any requirements of the Agreement.

8.23 Effect of Invalidity of Clauses. If any clause or provision of the Agreement is in conflict with any state or federal law or regulation, that clause or provision shall be null and void; any such invalidity shall not affect the validity of the remainder of the Agreement.

8.24 Remedies. Nothing in this Agreement shall be construed to waive or limit any of MBHP's or Provider's legal rights or remedies which may arise from MBHP's or Provider's unauthorized use or disclosure of any data received by it under the Agreement.

8.25 Interpretation. Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the HIPAA Rules, and any other applicable law pertaining to the privacy, confidentiality, or security of PHI or Personal Data.

8.26 Written Notices. Notices to the parties as to any Agreement matter will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand as follows:

To Provider:

_____
_____
_____

To MBHP:

_____
Massachusetts Behavioral Health Partnership
1000 Washington Street
Suite 310
Boston, Massachusetts 02118-5002

[Signature Page Follows]

IN WITNESS WHEREOF, intending to be legally bound, the undersigned have caused this Agreement to be duly executed on their behalf as of the dates specified.

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP	[PROVIDER]
BY: _____	BY: _____
_____	_____
Name	Name
_____	_____
Title	Title

EXHIBIT A
PROGRAM SERVICES
MOBILE CRISIS INTERVENTION/RUNAWAY ASSISTANCE PROGRAM

Mobile Crisis Intervention/Runaway Assistance Program

1. Definitions.

"Alternative Lock-Up Program (ALP)" shall mean human services agencies contracted with the Commonwealth of Massachusetts Department of Children and Families (DCF) to provide a temporary placement resource for the Commonwealth of Massachusetts state and local police departments in their efforts to comply with federal and state regulations regarding the placement of juveniles in their custody for either status or non-violent delinquent offenses.

"Child Requiring Assistance" shall mean a child between the ages of 6 and 18 who: (i) repeatedly runs away from the home of the child's parent, legal guardian or custodian; (ii) repeatedly fails to obey the lawful and reasonable commands of the child's parent, legal guardian or custodian, thereby interfering with their ability to adequately care for and protect the child; (iii) repeatedly fails to obey the lawful and reasonable regulations of the child's school, (iv) is habitually truant; or (v) is a sexually exploited child.

"Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP) Site" shall mean the site the Provider maintains to operate the MCI/RAP.

"Non-Court Hours" shall mean hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically Monday through Friday between 4:30 PM and 8:30 AM, weekends and holidays.

"Youth" shall mean any Child Requiring Assistance or any minor between the ages of 7 and 18 who has been arrested by the police for a non-violent offense.

2. Provider Obligations.

A. The 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 an Alternative Lock-up Program or other appropriate level of service.

B. The Provider shall:

i. Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.

ii. Maintain an MCI/RAP Site where police can bring Youth during Non-Court Hours.

iii. Greet police officers and Youth who come to the MCRI/RAP Site during Non-Court Hours;

iv. Supervise at least on a one-to-one basis until the Youth:
   a. Is transferred to a hospital level of care;
   b. Is transferred to the care of ALP staff; or
   c. Voluntarily leaves the site.

v. If a Youth who is brought to the MCI/RAP Site chooses to voluntarily leave:
   a. 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);
   b. Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123 §12, and, if determined appropriate, apply for hospitalization of such Youth; and
   c. Submit a critical incident report form to MBHP.

vi. Designate a manager to oversee the MCI/RAP.

C. The MCI/RAP manager designated by the Provider shall oversee the MCI/RAP and shall also:

i. Ensure the MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court ours and be available to MCI/RAP staff for consultation;

ii. Provide back-up coverage for on-call MCI/RAP staff;

iii. Train program staff regarding MCI/RAP procedures;

iv. Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP; and

v. On the business day following the arrival or transfer of a Youth, follow up with the police department that transported the Youth to the MCI/RAP site, and follow-up with any ALP to which the Youth was transferred.

D. Provider 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:

i. The number of Youth who receive a crisis intervention assessment;

ii. Demographics related to Youth served including, but not limited to, age, gender, ethnicity and city/town of residence;
iii. 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;
iv. The number of Youth transferred to the care of ALP staff; and
v. The number of Youth who voluntarily leave the MCI/RAP Site.

EXHIBIT B
CORE STAFFING PATTERN

Position	FTEs by service component					
	ESP mgmt.	***Comm.-based location***	***Adult mobile***	***Child mobile***	***Adult CCS***	***Total***
Estimated encounters	n/a	1,065	1,597	710	1,526	4,898
ESP Director	1.0					1.0
QM/ RM Director	0.4					0.4
Program Manager				1.0		1.0
Clinical Supervisor		0.4	0.7			1.1
Psychiatry		0.3		0.2	0.3	0.8
Psychiatry After-Hours Adult Consult		x				
Psychiatry After-Hours Child Consult				x		
Nursing Manager RN					1	1
Nursing LPN					3.2	3.2
Certified Peer Specialist		1.0				1.0
BS w/CPS preferred			0.5			0.5
BS Milieu w/CPS pref.					4.2	4.2
Paraprofessional (Family Partner)				1.7		1.7
MS Triage Clinician		1.0				1.0
MS Clinicians		2.0			1.5	3.5
MS Clinician Mobile			3.5	1.7		5.2
Safety Staff		1.4		cu		1.4
Admin. Assistant	0.5	0.5			0.3	1.3
Total FTE	1.9	6.6	4.7	4.6	10.5	28.3

This is the staffing pattern included in the ESP cost projections for an average size ESP within the medium volume range. A medium volume ESP is one with volume ranging from approximately 3,000 to 6,000 encounters including MBHP, MassHealth FFS (non-MCE), Medicare/Medicaid, MassHealth MCEs, Uninsured, DMH-only, Medicare-only and all One Care and Care Plus plans.

The above shaded positions will likely vary based on actual volume of each of the ESPs. The remaining positions would be expected to increase slightly for “large volume” ESPs over 6,000 encounters and decrease for “small volume” ESPs, projected to be under 3,000.

EXHIBIT C
COMPENSATION TERMS

MBHP provider reimbursement rates are proprietary information. Rate schedules will be added to this exhibit prior to execution of the provider contract.

EXHIBIT D

Privacy and Confidentiality Obligations

Section 1. Provider's Obligations. (a) Provider shall not use or disclose Protected Health Information ("PHI") other than as permitted or required by this Exhibit D or as required by law, consistent with the restrictions of 42 CFR §431.306(f) and M.G.L. c. 66A. Provider is MBHP's Business Associate for purposes of providing services in connection with the Emergency Services Program pursuant to the Agreement. All references to PHI set forth in this Exhibit D shall be limited to PHI in Provider's possession or control solely as a result of providing administrative services pursuant to the Agreement. The purpose of this Exhibit D is to comply with the Business Associate requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA") and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended) (the "Privacy Rule"). Unless otherwise defined in the Agreement, all capitalized terms in this Exhibit D shall have the meaning given in the Privacy Rule.

(b) Provider acknowledges that in the performance of the Agreement it will receive Personal Data as defined in M.G.L. c. 66A and 42 CFR 431, subpart F, and that in accepting such data it becomes a holder of Personal Data. Provider agrees that, in the performance of its services hereunder and in a manner consistent with the Privacy Rule, it shall comply with M.G.L. c. 66A and any other applicable state or federal law governing the privacy or security of any data received under the Agreement. Provider may only use and disclose Personal Data, and any data derived or extracted from such data, for the purpose of performing services under the Agreement, and may not disclose such data, and any data derived or extracted from such data, to any person or entity other than its authorized agents and subcontractors in the performance of its obligations under the Agreement, or, at the direction of MBHP, to the subject of the data. Provider shall inform each of its employees having any involvement with the Personal Data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

(c) Provider shall make reasonable efforts to ensure the physical security of, and to prevent the unauthorized use or disclosure of, PHI, Personal Data or other confidential information under its control, including but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use to input documents and output documents.

(d) Provider shall immediately report to MBHP, both verbally and in writing, any use or disclosure of PHI not provided for by this Exhibit D of which it becomes aware, together with any harmful effect of such violation of which it becomes aware. Provider shall also immediately report any instance where PHI or any other data obtained under the Agreement is requested, subpoenaed, or becomes the subject of a court or administrative order or other legal process. In

response to such requests, Provider shall take all necessary legal steps to comply with M.G.L. c. 66A, Medicaid regulations including 42 CFR §431.306(f), and any other applicable federal and state law. In no event shall Provider's immediate reporting obligations under this paragraph be delayed beyond two (2) business days from obtaining such knowledge or request for data.

(e) Provider shall take all appropriate legal action necessary to:

1. Cooperate with MBHP's efforts to mitigate any harmful effect known to Provider of a use of disclosure of PHI obtained under the Agreement by it in violation of the requirements of this Exhibit D;

2. Retrieve any PHI used or disclosed by it in a manner not provided for by this Exhibit D; and

3. Take such further action as may be required by any applicable state or federal law concerning the privacy and security of PHI obtained under the Agreement.

Provider shall report to MBHP the results of all mitigation actions taken by it under this provision. Upon MBHP's written request, Provider shall take such further actions as deemed appropriate by MBHP to mitigate, to the extent practicable, any harmful effect known to Provider of a use or disclosure of PHI by it in violation of the requirements of this Section 1.(e). Any actions to mitigate harmful effects of privacy violations undertaken by Provider on its own initiative or pursuant to MBHP's request under this provision shall not relieve Provider of its obligations to report privacy violations as set forth in other provisions of this Exhibit D.

(f) If Provider maintains a Designated Record Set on MBHP's behalf, Provider shall provide MBHP or, upon MBHP's request, the Members, with access to or copies of any PHI maintained by it, as shall be necessary for MBHP to meet its obligations under 45 CFR §164.524 to provide a Member with access to certain PHI pertaining to the Member. Such access or copies shall be provided to MBHP or to the Member at a reasonable time and manner to be specified by MBHP in the request and as shall be necessary for MBHP to meet all time and other requirements set forth in 45 CFR §164.524.

(g) If Provider maintains a Designated Record Set on MBHP's behalf, Provider shall make any amendment(s) to PHI that MBHP requests as shall be necessary for MBHP to meet its obligations under 45 CFR §164.526. Such amendments shall be made promptly in a manner specified in, and in accord with any time requirement under, 45 CFR §164.526.

(h) Provider shall document all disclosures of PHI, and required information related to such disclosures, as would be necessary for MBHP to respond to a request by a Member for an accounting of disclosures of PHI and related information in accord with 45 CFR §164.528. Within ten (10) business days of MBHP's request, Provider shall make a listing of such disclosures and related information available to MBHP, or upon MBHP's direction to the Member.

(i) Provider shall make its internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by it on behalf of MBHP available to the Commonwealth of Massachusetts Executive

Office of Health and Human Services ("EOHHS") or the U.S. Secretary of Health and Human Services, in a time and manner designated by either the Division or the Secretary.

Section 2. Permitted Uses and Disclosures by Provider. Except as otherwise limited in this Exhibit D, Provider may use or disclose PHI or Personal Data to perform its obligations under the Agreement, provided such use or disclosure would not violate the Privacy Rule if done by MBHP or not violate the minimum necessary policies and procedures of EOHHS.

Section 3. Termination for Violation of Exhibit D of the Agreement. (a) Notwithstanding any other provision in the Agreement, MBHP may terminate this Agreement immediately, upon written notice, if MBHP determines, in its sole discretion, that Provider has materially breached any of its obligations set forth in Exhibit D, or any other provision of the Agreement pertaining to the security and privacy of any PHI or any data provided to Provider under this Agreement.

(b) In the event that termination of this Agreement for a material breach of any obligation regarding PHI is not feasible, or if a cure is not feasible, MBHP shall report such breach or violation to EOHHS.

Section 4. Effect of Termination for Violation of Exhibit D. (a) Except as provided immediately below in subsection (b), upon termination of the Agreement for any reason whatsoever, Provider shall return or destroy all PHI and any other Personal Data obtained or created in any form under the Agreement, and Provider shall not retain any copies of such data in any form. This provision shall apply to all PHI and data in the possession of Provider's subcontractors or agents, and Provider shall ensure that all such data in the possession of its subcontractors or agents has been returned or destroyed and that no subcontractor or agent retains any copies of such data in any form. For purposes of this Section 4, PHI shall not include the clinical records maintained by such subcontractors or agents in the treatment of their patients.

(b) Notwithstanding any other provision concerning the term of this Agreement, all protections pertaining to any PHI or other data covered by the Agreement shall continue to apply until such time as all such data is returned to MBHP or destroyed.

Exhibit E

Minimum Wage Table for ESP Positions Comparable to DMH State Positions Providing ESP Services

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
ESP Director	Clinical Social Worker (D) Psychologist IV	Program Director (UFR Title 102)	$62,202.14
QM/ RM Director	Manager VI	Supervising Professional (UFR Title 104)	$52,399.08
Program Manager	Clinical Social Worker (D)	Program Function Manager (UFR Title 101)	$62,202.14
Clinical Supervisor	Clinical Social Worker (C) Human Services Coordinator (D)	Supervising Professional (UFR Title 104)	$52,399.08
Nursing Manager RN	Registered Nurse IV Registered Nurse V	N. Midwife, N.P., Psych N. , N.A., R.N. – MA (UFR Title 107)	$62,225.86
		R.N. – Non-Masters (UFR Title 108)	**$51,552.04**
Nursing RN	Registered Nurse II Community Psychiatric MH Nurse	R.N. – Non-Masters (UFR Title 108)	$51,552.04
Nursing LPN	Licensed Practical Nurse I Licensed Practical Nurse II	L.P.N. (UFR Title 109)	$40,513.20
Certified Peer Specialist	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS w/CPS preferred	Human Services Coord (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**

[1] "the lesser of step one of the grade or classification under which the comparable regular agency employee is paid, or the average private sector wage rate for said position as determined by the executive office for administration and finance…."

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
BS Milieu	Mental Health Worker I Mental Health Worker II	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu w/ CPS preferred	Human Services Coordinator (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Paraprofessional (Family Partner)	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
MS Triage Clinician	Human Services Coordinator (C) Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)[1]
MS Clinicians	Human Services Coordinator (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinician Mobile	Human Services Coordinator (C) Clinical Social Worker (A/B) Clinical Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
Safety Staff	Mental Health Worker I	Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Admin. Assistant	Administrative Assistant I Clerk III	Program Secretarial/ Clerical Staff (UFR Title 137)	**$27,543.92**

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

Emergency Services Program (ESP) Procurement for the 4 ESPs Currently Operated by the Massachusetts Department of Mental Health in the Southeast Region of the State, including Brockton, Cape Cod and the Islands, Fall River, and Taunton/Attleboro

Request for Responses

Issued
7/6/2015

EMERGENCY SERVICES PROGRAM PROCUREMENT

Table of Contents

LIST OF APPENDICES

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 catchment areas: Brockton, Cape Cod and the Islands, Fall River, and Taunton/Attleboro. 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 above, 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 compromise 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; 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 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

Member engagement and de-escalation skills

- Able to engage Member 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 Members in their natural environment
- Ability to modify engagement techniques to meet the individualized needs of the Member
- 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 special populations

Unique competencies are required to assess and intervene with these and other special 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:

- Children, adolescents, and families
- Adults
- Elders
- Veterans
- Culturally and linguistically diverse populations
- Persons with mental health condition
- Persons with substance use conditions
- Persons with co-occurring mental health and substance use conditions
- Persons with intellectual and developmental disabilities
- Persons who are deaf or hard of hearing
- Persons who are blind, deaf-blind, and visually impaired
- Persons who are homeless
- Persons who are gay, lesbian, bisexual, transgendered

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 or 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 Member's return to higher level of functioning
    - Instills Member/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 the ESP 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 philosophies[1]
  - Family voice and choice
  - Team-based (includes child and family)
  - Use of natural supports
  - Collaboration
  - Community-based
  - Culturally competent
  - Individualized
  - Strengths-based
  - Persistence
  - Outcomes-based

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

- MCI Practice Guidelines are located at

  http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/cbhi-resources-for-providers.html

- Crisis planning tool companion guide is located at

  http://www.masspartnership.com/pdf/Crisis-Planning-Tools_Guide_for_ProvidersFinal.pdf

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

[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*

includes staffing infrastructure to provide ESP specific management, clinical supervision, and direct services in proportion to the anticipated 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.
Appendix II: ESP Performance Specifications.

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 already managed by MBHP and not included in the RFP). An entity may provide ESP services in more than one of the catchment areas, providing that all requirements are discretely met for each distinct catchment area.

C. System Level Structure

1. Contract management

MBHP is responsible for contract management, financial management, as well as the consistency and quality of ESP services. MBHP is responsible for claims payment for MBHP and uninsured consumers. 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

- *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 as determined by the state pursuant to M.G.L. c. 7 §54(2). 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. The ESP is expected to contract with all MassHealth Managed Care Entities (MCE's).

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 bidders 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 following positions. Listed below are those positions that have management responsibility across all ESP service components and/or those that represent staffing in two or more of those components. Positions that are specific to one service component will be described in the section of this document related to that given service component.

- *ESP Medical Director***:** This is a psychiatrist who meets MBHP's credentialing criteria and is responsible for clinical and medical oversight and quality of care across all ESP service components. It is expected that the ESP provider agency will appoint one of the psychiatrists, who is in the staffing pattern for the ESP and/or CCS and works directly in one or both of those service components on at least a part-time basis, as the ESP Medical Director. This individual coordinates the functions of his/her ESP medical director role, the psychiatric care delivered by him/herself and/or other psychiatric clinicians during business hours, and the after-hours psychiatric consultation function fulfilled by him/herself and/or other psychiatric clinicians. Included is the responsibility for supervising all psychiatric clinicians performing psychiatric functions in any of the ESP service components. The ESP Medical Director is responsible for developing and maintaining relationships with medical providers and other stakeholders in the catchment area, including medical directors at local outpatient, diversionary, and inpatient services programs, hospital emergency department (ED) physicians, and primary care clinicians. This individual is available for clinical consultation to ESP staff members and community partners, including negotiating issues related to medical clearance and inpatient admissions.

- *ESP Director*: The ESP Director is a full-time position. This master's- or doctoral-level, licensed behavioral health clinician shares responsibility with the ESP Medical Director for the clinical oversight and quality of care across all ESP service components. He/she is also responsible for the administrative and financial oversight of the ESP contract, along with administrative and financial leadership of the contracted ESP provider agency. The ESP Director is the primary point of accountability to MBHP for the ESP contract and is responsible for all subcontracts and interface with public payers. The ESP Director ensures compliance with all requirements set forth by MBHP, including standard clinical assessment tools, electronic encounter forms, and other data collection mechanisms. The ESP Director is responsible for ensuring the provision of the core ESP services of crisis assessment, intervention, and stabilization to Members of all ages in all ESP service components and locations, including both mobile crisis intervention services and those provided on-site in the ESP's community-based location. He/she is responsible for staff recruitment, orientation, training, and supervision. He/she provides administrative and clinical supervision to key program-level supervisory staff. The ESP Director also

develops and maintains working relationships with all appropriate community stakeholders.

- *Quality Management/ Risk Management Director*: This master's- or doctoral-level staff person has a behavioral health background and is responsible for developing and implementing the quality and risk management program across all ESP service components. The Quality Management/Risk Management Director is responsible for all MBHP reporting requirements and for utilizing data reporting to track and trend quality indicators, ensure compliance with standards of care, and implement quality improvement initiatives. This individual is responsible for managing, resolving, and reporting all adverse incidents, complaints, and grievances. The Quality Management/Risk Management Director advises clinical staff on risk assessment, crisis prevention/safety planning, and risk management. This individual is responsible for implementing and utilizing all assessment and/or outcomes tools as required by the ESP contract with MBHP and implementing stakeholder satisfaction surveys.

- *Clinical Supervisor*: These licensed, master's- or doctoral-level behavioral health clinicians provide clinical supervision to all direct service staff across the ESP service components. Clinical supervisors of clinicians providing ESP services to children and adolescents must be child-trained clinicians.

- *Triage Clinicians*: These master's- or doctoral-level behavioral health clinicians answer all incoming phone calls and are responsible for triaging calls to the appropriate ESP service component, or to another appropriate resource, including 911 in acute emergencies. Bachelor's-level staff may answer triage calls with master's-level clinicians and supervisors available to consult with and take calls when indicated. Triage clinicians provide general information to callers, serving as a resource by assisting them in accessing care throughout the behavioral health system. Triage clinicians facilitate access to diversionary services, including setting up urgent psychopharmacology appointments, etc.

- *Clinicians*: These master's- or doctoral-level behavioral health clinicians provide crisis assessment, intervention, and stabilization services across all service components. Clinicians providing ESP services to children and adolescents must be child-trained clinicians.

- *Psychiatry:* These MDs and psychiatric nurse mental health clinical specialists (PNMHCS) who meet MBHP's credentialing criteria provide consultation across all ESP service components.

- *Psychiatric Consultation (after hours):* These psychiatrists and/or PNMHCSs who meet MBHP's credentialing criteria provide access to child and adult psychiatry consultation outside regular business hours. This consultation is provided to ESP staff members and others involved in the assessment, treatment, and/or disposition planning for Members.

The core ESP services of crisis assessment, intervention, and stabilization shall be provided in the ESP community-based location by master's level behavioral health clinicians, whose work shall be enhanced by the presence of the staff outlined below.

- *Certified Peer Specialists (CPSs)* help to make community-based ESP services welcoming, comfortable, supportive, and responsive to Members who utilize them and their families. Certified Peer Specialists provide support to the Member, update them on the ESP process as it unfolds, and offer such concrete assistance as food and drink. CPS staff convey hope and provide psycho-education, including information about recovery, wellness, and crisis self-management. They have in-depth knowledge of the particular catchment area served by the ESP and facilitate access to specific community-based resources, including recovery-oriented and consumer-operated programs. Certified Peer Specialists assist in arranging the services to which the Member is being referred after the ESP intervention, and they work with the Member and family to support them during the transition to those follow-up services. CPS staff also provide similar services in the ESP's adult mobile crisis intervention service and CCS, as staffing and time permit. The ESP is required to employ one FTE or more Certified Peer Specialists to work in the ESP's community-based locations.

- *Bachelor's-level staff* supports the master's-level clinicians in providing ESP services to Members, particularly during adult mobile crisis intervention services, as well as in the community- based location. These staff members help to support the Member and his/her family, and they perform such tasks as assisting with implementing the disposition determined by the master's-level clinician. This additional support brings efficiency to the system by allowing adult mobile response master's-level clinicians to focus exclusively on the provision of direct clinical services. ESP providers are encouraged to hire bachelor's-level staff who are also credentialed as Certified Peer Specialists.

- *Family Partner or Bachelor's Level Clinician (paraprofessional staff)* primarily attend to the experience of parents and caregivers as they navigate the crisis services process and support/make decisions for their children. Although the primary focus of the Bachelor's Level Staff person during an MCI intervention is attending to the experience of the parent/caregiver, the use of the title "Family Partner" is reserved for a person with lived experience as parent/caregiver of a child with a behavioral health condition and who uses that experience to inform their intervention and support. This specific attention to the experience of parents within the MCI service is stabilizing and can be change-activating. When parents/caregivers are activated to take a lead in their child's care, there is more effective use of and adherence to any subsequent treatment or safety plans. Family Partners purposefully use and share their lived experience when it is useful to a parent/guardian of a child in crisis. It can be incredibly helpful for some parents/caregivers, as it is rare to talk to someone else who has lived it. This type of peer to peer support is an innovation in the behavioral health crisis field and is supportive, stabilizing, empowering and change-activating.

- *"Safety" staff positions* in the ESP community-based location serve as a flexible resource to support ESPs in maintaining a calm and safe environment, mitigating risk, and

allowing services to be delivered safely in a community-based setting. ESPs may choose to use these positions in a variety of ways that contribute to a safe environment. In part, this staffing will enable providers to ensure that a minimum of two people are present in the ESP's community- based location during at least high-volume operating hours, or during low-volume hours when fewer clinical staff are working.

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 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.
- 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 three 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. 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.

4. 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 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 provide 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 by 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 bidder 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) shall be overseen and supported by the ESP staff who relate to all ESP service components, as listed in Appendix IV, Core Staffing Pattern. 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.

5. 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 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. See also 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 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.

6. 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 ours 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

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, 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:

> "*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.

[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

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 FTE 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 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.

IV. PROVIDER QUALIFICATIONS

A. Qualifications to Bid on an ESP Contract

The qualifications of a provider agency seeking to apply for selection as an ESP are outlined below. Each contract will be issued to one provider who may enter into subcontracts with other organizations for the purpose of delivering ESP services.

Required qualifications

- Licensed as an outpatient mental health clinic by the Department of Public Health (DPH) or licensed as a hospital by the DPH and/or the Department of Mental Health (DMH)
- A currently contracted MassHealth provider; a provider with the intent to become a contracted MassHealth provider within 3 months of contract award; or an organization of DMH employees pursuant to M.G.L. c.7 §54(5) and committed to becoming a contracted MassHealth provider within 3 months of the contract award.
    - Pursuant to M.G.L. c. 7 § 54(5), DMH will provide resources and assistance to an organization of DMH employees interested in submitting a bid to provide the services that are the subject of this RFR.
- At least three years' experience providing behavioral health services to a wide range of populations, including children, adolescents, and adults
- Organizational infrastructure to provide clinical, medical, quality, technical, and financial oversight and management of all components of the ESP program described herein
- Ability to fully implement all aspects of the ESP program model contained herein within 3 months of award and comply with all requirements
- ESP core competencies articulated in Section II. H., including, but not limited to, capacity and preferably direct experience in providing and managing:
    - Crisis services
    - Mobile services

  - Recovery-oriented services
  - Culturally and linguistically competent services
  - Services tailored to meet the needs of special populations
  - Quality improvement
  - Intersystem planning and affiliation
- Demonstrated knowledge of the community's needs and resource, particularly the local community crisis continuum and its strengths and limitations, resources, barriers, and practice patterns, as well as established relationships with stakeholders therein

Preferred qualifications

- Physical presence in catchment area
  - An established physical location within the catchment area for a minimum of one year prior to the submission of an application for an ESP contract is preferred.
  - Consideration will be given to provider agencies with a physical location within the catchment area for less than one year.
  - Further Consideration will be given to provider agencies with a physical location in a contiguous catchment area for a minimum of one year.
  - If your organization does not already have a physical location in an area where you would like to be an ESP, you will be asked in the Response Requirements Section of this RFR to include a detailed plan for how your organization will successfully establish a physical location in the catchment area by the expected start date and a strong rationale as to why you wish to operate in the catchment area.

B. Qualifications for an ESP Provider to Directly Implement the Mobile Crisis Intervention Component

ESP bidders, who meet the criteria above, "Qualifications to bid on an ESP contract," must also demonstrate significant expertise in providing and managing services for children, adolescents, and their families by demonstrating substantial evidence of the characteristics below if they plan to directly implement the Mobile Crisis Intervention component of their ESP program. Bidders should document experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services, including:

- Administrative infrastructure that supports the delivery of Mobile Crisis Intervention services 24/7/365, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist
- 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
- Relationships with child- and family-focused community resources in the service area
- Membership in child-advocacy and/or child-focused trade organizations

- 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 and integrating youth and family voice in organization governance
- Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families
- Demonstrated knowledge, commitment, and experience implementing services to children, adolescents, and families consistent with *Systems of Care* and *Wraparound* principles
    - Youth-centered and family-focused
    - Individualized
    - strengths-based
    - Partnership with families and youth
    - Reflective of youth and family values and preferences
    - Culturally and linguistically competent
    - Collaborative
    - Team-based, delivered in partnership with youth and family
    - Community-based, takes place in the least restrictive setting possible that safely promotes youth and family integration into home and community life
    - Coordinated services and community supports
    - Inclusive of natural supports (e.g., extended family networks, faith-based organizations)
    - Least restrictive, appropriate setting
    - Planned transition to adult services
    - Individual and system outcome measurements
    - Continuous quality improvement
- 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.

C. Subcontracts

Bidders must propose program models in which they, as the contracted ESP provider, will directly provide the majority of ESP services themselves, i.e., with staff employed by the contracted provider. Bidders may propose subcontracts for one or more

- ESP service components throughout the catchment area

- ESP service components for a given population or geographic area within the catchment area

Bidders who qualify as a licensed outpatient mental health clinic must operate the ESP community-based location. Bidders who qualify as a licensed hospital may subcontract out for the ESP community-based location. In all cases, the bidder's proposed program model must ensure that strategies to promote community based responses are integral.

Designated EDs

An ESP may choose to sub-contract ESP services to an ED for Member's age 21 and older who present for emergency behavioral health services at that designated ED. This model may be advantageous to ESPs that have high volume EDs in their catchment area.

The ESP must retain programmatic and performance oversight and administrative responsibilities of a subcontracted component of service.

Subcontractor requirements

All subcontractors must meet the same requirements as the ESP, except consideration will be given to:

- Subcontractors that may be in process of becoming a MassHealth-contracted provider
- Subcontractors must have at least one year experience providing behavioral health services.

Subcontractors for the Mobile Crisis Intervention services must also meet the requirements for providers of that service component as described in section I.V.B. above.

D. Additional Requirements Pursuant to Massachusetts Privatization Law

Bidders must agree to implement the following pursuant to the Massachusetts Privatization Law codified in M.G.L. c.7 §§ 52, 53, 54, and 55:

- Offer available positions to qualified DMH employees whose employment is terminated as a result of this contract, and who satisfy the hiring criteria of the successful bidder;
- Comply with a policy of nondiscrimination and equal opportunity for all persons protected by Chapter 151B and take affirmative steps to provide such equal opportunity for all such persons;
- Provide health insurance to each employee and the employee's spouse and dependent children for employees who work 20 hours or more a week under the contract, and pay not less than a percentage, comparable to the percentage paid by the Commonwealth for state employees, toward the cost of this health insurance. For state fiscal year 2015, the Commonwealth contributed 80% toward the cost of health insurance for DMH employees. The successful bidder must pay for employee health

insurance at no less than the rate the Commonwealth pays for DMH employees for state fiscal year 2016 for the contract period;[3]

- Pay the minimum wage rate identified in Appendix V for each position in which the bidder will employ any person to perform duties that are substantially similar to the duties currently performed by regular DMH employees; and
- Submit quarterly payroll records to MassHealth pursuant to M.G.L. c. 7 §54(2).

Bidders must also comply with any relevant federal or state regulatory statutes including, but not limited to statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest.

V. PERFORMANCE REQUIREMENTS

A. General Performance Specifications

All providers responding to this RFR agree to abide by the MBHP General Performance Specifications. This "general" performance specification applies to all MBHP network providers at all levels of care. Additionally, **providers will be held accountable to the service-specific performance specifications for each level of care for which they are contracted.** For ESP providers, the following service-specific performance specifications will apply: ESP, Mobile Crisis Intervention, and Adult Community Crisis Stabilization. See the General Performance Specifications located in Appendix II.

B. ESP Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for Emergency Services Program services. See the performance specifications located in Appendix II.

C. Mobile Crisis Intervention Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for Mobile Crisis Intervention services. See the performance specifications located in Appendix II.

D. Adult Community Crisis Stabilization (CCS) Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for adult CCS services. See the performance specifications located in Appendix II.

[3] The Commonwealth's employer contribution rate for state employee health insurance for state fiscal year 2016 is expected to be no more than 80% and may possibly go down. The FY 2016 Commonwealth health insurance contribution rate will be included in the FAQs to be released on August 5, 2015. For planning purposes, bidders should assume the FY 2016 rate will be no higher than 80% and use that rate as a placeholder until the actual FY 2016 rate is made available.

VI. PROCUREMENT PROCESS

A. Timeline

RFR COMPONENT	DATE
RFR release	July 6, 2015
Question submission begins	July 6, 2015
Bidders' conference	July 22, 2015
Question submission deadline	July 27, 2015
FAQ release date	August 5, 2015
Letter of Intent deadline	August 10, 2015
RFR response deadline	September 1, 2015
Recommendations forwarded to State Agency	September 25, 2015
Bidder's notified of recommendations	September 28, 2015
Award date	Dependent upon review by the State Auditor
Implementation	Within ninety (90) days of the final contract award date

B. Bidders' Conference

A bidders' conference will be conducted to allow potential bidders the opportunity to ask clarifying questions about the RFR.

The bidders' conference is not mandatory; however, potential bidders are encouraged to send one or two representatives to the conference. We recommend bringing a copy of the RFR to the conference to reference during the discussion.

Date: July 22, 2015

Time: 10:00 a.m. to 12:00 p.m.

Location: One Lakeshore Center, 3rd Floor
Bridgewater, MA 02324

C. Written Questions

Clarifying questions concerning this RFR will also be accepted in writing. They must be submitted by July 27, 2015. Questions can be sent to ESPRFR@valueoptions.com. Questions will not be answered on an individual basis.

D. Frequently Asked Questions (FAQ)

Responses to frequently asked written questions and frequently asked questions from the bidders' conference will be posted by close of business on August 5, 2015 at http://www.masspartnership.com/provider/ESP/2015ESPRFR.aspx. It is the responsibility of the bidder to check the web site for updates.

E. Letters of Intent

Any bidder planning to submit an RFR response for one or more ESP catchment areas must submit separate letters of intent for each catchment area by 5 p.m. on August 10, 2015. Bidders must utilize the Letter of Intent for located in Appendix VI for this purpose.

The Letter of Intent form should be sent to:

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

- **Letter of intent forms may be submitted by email or postal mail. Faxed forms will not be accepted.**
- **Any letter of intent not meeting the response deadline will not be accepted or considered. Additionally, any RFR response that was not preceded by a letter of intent will not be accepted or considered.**
- **If no letters of intent are submitted for a given service area, MBHP will post those service areas on the web sites and will invite letters of intent for those service areas only within a specified extended timeframe.**

F. Response Submission Deadline and Requirements

In order for responses to be considered, each bidder must meet all the following submission requirements for each catchment area on which the provider is bidding:

- Submit an electronic copy of the response via e-mail **and**
- Deliver one (1) bound original and four (4) unbound copies of the completed response and all required attachments in a package or box labeled with the bidder's name, address, and catchment area.
- Complete both of the above submissions **NO LATER THAN** 5 p.m. on September 1, 2015 to the following:
    - ***Electronic copies via e-mail to***: ESPRFR@valueoptions.com
    - ***Hard copies to***:

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

It **is** acceptable for the electronic submission to include the cover sheet and the narrative response section only. Bidders must include attachments to the one (1) bound and four (4) unbound copies. However, bidders may choose to include attachments to the electronic submission.

Staples or paper clips should **not** be used in <u>any part</u> of the response, including the attachments. It is acceptable to use binder clips to bind the four (4) required unbound copies of the responses.

- **Any response not meeting the response deadline in full, including both the electronic and hard copies, will not be accepted or considered.**
- **Faxed transmissions are not acceptable.**
- **Submissions by postal mail must be received by the stated deadline as well.**

G. Evaluation of Responses

A selection committee comprised of MBHP staff will review the responses received by the submission deadline and make the final selections for each of the 4 catchment areas included in this procurement. Each proposal will receive a score based on the narrative response. The selection of an ESP provider for each catchment area is based on the proposal with the highest score using a consistent point system. In addition to the total score, consideration will be given to other factors, including the committee's review of financial documents, corrective action plans and/or sanctions, letters of support, and tenure of the bidder's presence and services in the given ESP catchment area. If no acceptable proposals are received for a particular catchment area, the selection committee reserves the right to put the catchment area back out for resubmission of proposals by posting a notice on the MBHP web site.

The following table summarizes the scoring scale against which each proposal will be evaluated:

RFR Section	Maximum Points
VII.B. 1 General Qualifications and Infrastructure	30
VII.B. 2 ESP Core Competencies	100
VII.B. 3 ESP Service Components	100
VII.C Technology Specifications and Response Requirements	20
VII.D Fiscal Specifications and Response Requirements	Required Part of Submission; No Points
Maximum Total Points	250

H. Selection of Contractors

After soliciting and receiving bids, MBHP will select the winning bidder(s) on behalf of MassHealth.

Before a contract or contracts may be awarded, the state agency must submit to the State Auditor copies of the proposed privatization contract(s) and certify to the State Auditor that:

1. it has complied with all provisions of this section and of all other applicable laws;
2. the quality of the services to be provided by the designated bidder is likely to satisfy the quality requirements summarized in the Privatization Law;
3. the contract cost will be less than the estimated cost of regular DMH employees providing the subject services;
4. the designated bidder and its supervisory employees, while in the employ of said designated bidder, have no adjudicated record of substantial or repeated willful noncompliance with any relevant federal or state regulatory statute including, but not limited to, statutes concerning labor relations, occupational safety and health, nondiscrimination and affirmative action, environmental protection and conflicts of interest; and
5. the proposed privatization contract is in the public interest, in that it meets the applicable quality and fiscal standards set forth in the Privatization Law.

The final award of the contract is subject to review by the State Auditor pursuant to M.G.L. c. 7 §55(a) and contingent on a binding commitment of funding from MassHealth.

VII. RESPONSE SUBMISSION REQUIREMENTS

All questions contained within this section must be answered and all required attachments provided.

A. Format of Response

All responses to the Narrative, Technology, and Fiscal Response sections must be in the following format:

- Type-written, Times New Roman, 12-point font, single-spaced, one-inch margins
- 8 1/2 x 11 inch white paper, single-sided
- Question number (and title if applicable), followed by response. For example:

  2.1.1 Crisis services

  2.1.1.1 (response)

  2.1.1.2 (response)

Page limits are identified for each of the response sections below. We request that the narrative response section be paged numbered, with page numbers located in the lower right-hand corner of the response. Proposals with a narrative response section that does

not meet the response specification requirements outlined above will **NOT** be accepted or considered. Attachments are not included in the page limits. However, bidders should be judicious in their use of attachments and include only those required; bidders may add optional attachments only if they will help reviewers evaluate their proposals. Bidders may not submit any non-written material (i.e., videotapes, disks, etc.). Attachments **MUST** be on letter-size paper. Glossy brochures or other attachments not on letter-size paper should **not** be included as part of the submission. If these are included, they will be removed from the response, and they will not be considered as part of the response. The ONLY exception will be audited financial statements which may be on legal-size paper, though it is preferred for those documents to be on letter-sized paper.

The response must be divided in sections, in the following order:

1. **Cover sheet**
    - Complete the cover sheet found in Appendix VII.
2. **Narrative response**
    - Begin with a divider page labeled "Narrative Response."
    - Answer all questions in Section VIII.B.
    - Maximum page limits: 45-50 as specified below
        - B.1 General qualifications and infrastructure: 5 Pages
        - B.2 ESP core competencies: 15 Pages
        - B.3 ESP service components: 25 Pages
        - B.4 Additional response requirements, if applicable to bidder
            - B.4.1: 1 page
            - B.4.2: 1 page
            - B.4.3: 3 pages
3. **Technology response**
    - Begin with a divider page labeled "Technology Response."
    - Answer all questions in Section VIII.C.
    - Maximum page limit: 3 pages
4. **Fiscal response**
    - Begin with a divider page labeled "Fiscal Response."
    - Answer all questions in Section VIII.D.
    - Maximum page limit: 5 pages
5. **Attachments** *(Please place a divider page at the beginning of the Attachments and between each of the following sections of Attachments.)*
    - Narrative Response Attachments (required and optional)

- Technology Response Attachments (required and optional)
- Fiscal Response Attachments (required and optional)
- Letters of support from local organizations in the proposed catchment area such as state agencies, community agencies, consumer/youth/family organizations, cultural organizations, hospitals, and others (optional)
    - Letters should describe the specific nature of the bidder's affiliation with the local organization, the ways in which the affiliation will strengthen the bidder's ability to provide ESP services and benefit the individuals and families served, and why the local organization recommends the bidder to be the ESP provider in the proposed catchment area. No points are associated with letters of support but they will be considered in the overall evaluation of your response. If the bidder chooses to submit letters of support, these letters must be included as attachments to the submission. Please DO NOT send letters of support individually to MBHP.

B. Narrative Response Requirements

Guidelines:

- Specific responses detailing what you have done and will do will be the most helpful in evaluating your proposal.
- Bulleting/tables/charts in lieu of narrative are welcome if such a format better enables you to provide specific information in a succinct fashion.
- Please address both (1) adults and (2) children/adolescents/families throughout your response.
- Please make clear throughout the response whether you are describing current versus proposed practice at your organization.
- **Applications for More than One Catchment Area**

  For organizations interested in bidding on an ESP contract in more than one local catchment area, a separate response is required for each proposed service area. The purpose of this requirement is to ensure that all responses are specific to the needs of local communities. Bidders must describe the regional infrastructure and how they would gain efficiency/improve performance by serving more than one catchment area.

1. *General qualifications and infrastructure:* ***(30 points)***

   (Note: Please "cut and paste" questions 1.1 through 1.4.2.1 into your response.)

   1.1 Licensure:

   1.1.1 Licensed as an outpatient mental health clinic by the Department of Public Health (DPH)

   ❑ Yes ❑ No

   1.1.2 Licensed as a hospital

1.1.2.1 by the DPH ❑ Yes ❑ No

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

1.2 Accreditation:

1.2.1 Accredited by a national organization ❑ Yes ❑ No

1.2.2 If yes, please list accreditation(s).

_____

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

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

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

1.4.1.1 Number of youth served in CY14: _____

1.4.2 Number of years providing behavioral health services to adults: _____

1.4.2.1 Number of adults served in CY14: _____

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

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

1.5.1 Please complete the questions below regarding your current physical location within the catchment area for which your organization is applying for an ESP contract.

1.5.1.1 Number of years in which your organization operated an uninterrupted physical location at which you have provided direct services within the proposed catchment area

1.5.1.2 Address of location meeting the above criteria, where your organization has operated for the longest duration

1.5.1.3 If your organization does not already have a physical location in the catchment area where you would like to be an ESP, include a detailed plan for how your organization shall successfully establish a physical location in the catchment area within ninety (90) days of the contract award and a strong rationale as to why you wish to operate in the catchment area.

1.5.2 Provide a brief assessment of the proposed catchment area's needs and resources, particularly the local community's crisis continuum and its strengths and limitations, resources, barriers, gaps, and practice patterns.

1.5.3 Briefly describe your organization's established relationships with stakeholders in the catchment area and how they strengthen your ability to be effective as the potential ESP provider therein.

1.5.4 Explain how your organization interfaces with the existing crisis program in this catchment area and supports interventions that are community-based, resolution-focused and that promote community tenure.

1.6 Continuum of care: Briefly describe the continuum of care operated by your organization and how you would utilize all the resources of your organization to strengthen your ESP, meet the stated goals of ESP and this procurement, and benefit the individuals and families served.

1.7 Administrative infrastructure: Identify key staff positions within your organization and other infrastructure elements that will enable your organization to provide administrative and financial oversight and management of an ESP contract and service delivery system.

1.8 Medical and clinical infrastructure: Identify key staff positions and other infrastructure elements that will enable your organization to provide medical and clinical oversight and management of an ESP contract and service delivery system.

1.9 Quality Management (QM) infrastructure

1.9.1 Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of an ESP contract and service delivery system.

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

1.9.3 Briefly describe how your organization employs quality management tools and strategies to measure, monitor, and continuously improve quality of clinical care and service delivery. (If this is adequately described in your QM plan, please indicate that here. An additional summary is then not necessary.)

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

2. ESP core competencies: ***(100 points)***

2.1 Crisis services

2.1.1 Please describe the experience your agency has had with providing crisis intervention services, including the specific services, clinical competencies, populations, payers, and durations of your organization's operation of such services.

2.1.2 Please describe the extent to which you have been successful in delivering services requiring crisis or rapid response. Include responses to the following items as well as attachments as needed:

2.1.2.1 Data and other information about your experience in meeting 24/7/365 response time requirements in an crisis environment and the specific strategies you shall utilize to do so as an ESP provider

2.1.2.2 Data and other information about your experience and efficiencies in providing telephonic crisis support, triaging, dispatching, and managing resources to respond quickly to fluctuations in demand in a crisis environment, across multiple venues, and the specific strategies you shall utilize to do so as an ESP provider

2.1.2.3 Data and other information about your experience in hiring, developing, and retaining staff who are competent at providing services in an emergency environment, preferably in a behavioral health crisis intervention role, are skilled at risk management, and are able to operate in an independent and self-directed fashion, and the specific strategies you shall utilize to do so as an ESP provider

2.2 Mobile services

2.2.1 Please describe the experience your organization has had with providing services on a "mobile" basis in individuals' homes and other natural settings in the community, including the specific service, population, and duration of your organization's operation of such services.

2.2.2 Please describe specific strategies you have used and/or plan to use as an ESP provider to establish a culture among your staff and within your community that values the provision of mobile services in the community as the primary and preferred service delivery model.

2.2.3 Please describe the challenges you anticipate in establishing a culture and practice of prioritizing mobile services and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met.

2.2.4 Please describe the experience of your organization with working with and collaborating with the community behavioral health system for children, adolescents, and families including Children's Behavioral Health Initiative (CBHI) services.

2.3 Diversion

2.3.1 ED diversion

2.3.1.1 Please describe your organization's experience in achieving diversions from hospital emergency departments (EDs). Include data and the specific strategies you have employed.

2.3.1.2 Please describe how you shall create a culture within your organization and community that embraces the vision that most behavioral health crises can be effectively addressed in the community rather than in the hospital ED setting.

2.3.1.3 Please delineate specific strategies you shall implement to shift behavioral health utilization from the EDs in the proposed catchment area to community-based alternatives including the services and venues outlined in the ESP model described in this RFR. Address strategies for specific populations and stakeholders with whom you shall collaborate to achieve this goal.

2.3.1.4 Please describe the challenges you anticipate in establishing a culture and practice of shifting behavioral health utilization from hospital EDs and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met.

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

2.3.2.1 For each hospital ED in the proposed catchment area, attach a specific plan for how your organization shall collaborate with the hospital to achieve the goals related to ED diversion and ensure timely response when individuals do present in that setting. Please indicate the status of your negotiations with each hospital relative to these plans. If you have already developed a formal agreement with any hospitals, please attach those agreements. In each attached hospital-specific plan:

2.3.2.1.1 Please describe how you shall work with the hospital in an ongoing, collaborative, and integrated fashion.

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

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

2.3.2.1.4 Describe how you shall ensure that your ESP responds as quickly as possible, and no later than the required timeframe, to individuals who do present in the specific ED for behavioral health services. Based on historical volume, what resources do you expect to devote to this response? How will you monitor compliance with response time, in real time, and on an ongoing basis, and adjust staffing to meet the need?

2.3.2.1.4.1 Do you plan to implement any affiliations, subcontracts, or other arrangements relative to ESP services in this ED? (e.g. designated ED). If

so, please indicate which ED(s) you will enter into a subcontract with.

2.3.2.1.4.2 If yes, describe how the above will be a value-add to the crisis system of care

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

2.3.3.1 Please describe your organization's experience in collaborating with individuals in crisis in developing alternatives to avoidable psychiatric hospitalizations and other out-of-home placements.

2.3.3.2 Please describe how you shall create a culture and educate others in your organization and community, including families, stakeholders in hospital EDs, state agencies, and others, to foster acceptance of community-based alternatives rather than defaulting to inpatient psychiatric care.

2.3.3.3 Please delineate specific strategies and resources you shall leverage in order to maximize the use of diversionary services as alternatives to inpatient psychiatric care and other out-of-home placement.

2.3.3.4 If implementing a "designated ED" model, explain how you will ensure this happens if individuals are seen in the designated ED

2.4 Recovery-oriented services

2.4.1 Hiring practices

2.4.1.1 Please describe your organization's experience in recruiting and hiring personnel who are recovery-oriented in their beliefs.

2.4.1.2 Please describe specific strategies you have used and/or plan to use to recruit recovery-oriented personnel specifically in your ESP program

2.4.2 Integration of peers and family members

2.4.2.1 Describe how your organization's commitment to recovery-oriented services is and/or shall be reflected in areas such as board membership, committee membership, and organizational policies and procedures.

2.4.2.2 Please describe your organization's current and planned use of peers and family members in consultative, training and service delivery capacities.

2.4.2.2.1 Include specific strategies and implementation plans you shall employ to hire and integrate Certified Peer Specialists and Family Partners into your ESP staffing and services including the specific role and functions of Certified Peer Specialists and Family Partners. Address how you shall ensure that these staff members have access to peer supervision in an ongoing fashion.

2.4.3 Adherence to recovery principles

2.4.3.1 List, or attach, professional development activities and trainings that your organization has provided for staff at all levels of the organization relative to resiliency, rehabilitation, and recovery within the two years prior to the due date for your RFR response.

2.4.3.2 Please describe how your organization ensures and/or plans to ensure integration of recovery principles into practice, including those listed in Section II.B Core Competencies, under "recovery oriented treatment" and Section II.C Clinical Competencies under "recovery-promoting treatment approach."

2.4.3.3 Please describe the challenges, if any, you anticipate in shifting fully to a recovery-orientation and specific strategies you shall utilize to mitigate those challenges to ensure program goals are met.

2.5 Culturally competent services

2.5.1 Population and related experience

2.5.1.1 Describe the racial, ethnic, cultural, and linguistic composition of the population in the catchment area for which your organization is applying for an ESP contract.

2.5.1.2 Document your organization's experience in providing services to the cultural and linguistic populations in the proposed catchment area, including data.

2.5.1.3 Describe any culturally and linguistically tailored program models that you currently operate. Describe the degree to which the staff and management of these programs reflect the cultural and linguistic populations served.

2.5.1.4 Describe your organization's current or planned efforts to engage populations your organization believes are underutilizing or not fully benefiting from ESP services in the catchment area for which your organization is applying for an ESP contract.

2.5.2 Organizational capacity

2.5.2.1 Describe your organization's capacity to provide culturally and linguistically competent behavioral health services to children, families, and adults including the extent to which your organization's staff and governance reflect the significant cultural and linguistic populations within the ESP service area as well as your efforts to ensure that all staff members develop cultural competence. Address:

2.5.2.1.1 current composition of governance and senior management relative to this issue;

2.5.2.1.2 any initiatives undertaken in the past two years by your organization's Board of Directors to strengthen the cultural diversity of Board and/or senior management, and the results of those efforts;

2.5.2.1.3 the number of bilingual/bicultural staff employed by your organization and the extent to which your direct care staff reflect the significant MassHealth-enrolled cultural and linguistic populations in the proposed catchment area;

2.5.2.1.4 your organization's access to interpreter services (including ASL) for whom the organization does not currently have sufficient bilingual/bicultural staff; and

2.5.2.1.5 list or attach professional development activities and trainings that your organization has provided for staff at all levels of the organization relative to cultural competence within the two years prior to the due date for your RFR response.

2.5.2.2 Describe or attach any of the following that are currently in place within your organization with regard to delivering culturally and linguistically competent care: mission statements, definitions, policies, and procedures reflecting the organization's dedication to providing culturally competent care.

2.5.2.3 Document any organizational initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity.

2.5.3 Describe any experience you have had in forming partnerships with minority, community-based organizations, mutual assistance agencies, or multi-service agencies for immigrants and refugees to meet the care and support needs of clients.

2.6 Other special populations: Describe your organization's experience and expertise in providing behavioral health services to the following populations, and articulate how you shall modify your program, offer specific ESP service components, and/or otherwise ensure access to ESP services for these populations as well clinically appropriate assessment and intervention.

2.6.1 Elders

2.6.2 Veterans

2.6.3 Persons who are homeless

2.6.4 Persons with substance use conditions

2.6.5 Persons with co-occurring mental health and substance use conditions

2.6.6 Persons who are deaf and hard of hearing

2.6.7 Persons who are blind, deaf-blind, and visually impaired

2.6.8 Persons who are involved with the Department of Mental Health (DMH)

2.6.9 Youth and families involved with the Department of Children and Families (DCF)

2.6.10 Youth and families involved with the Department of Youth Services (DYS) and/or the juvenile court system

2.6.11 Youth who are on the Autism Spectrum

2.6.12 Persons who are receiving services from Department of Developmental Disabilities (DDS)

2.7 Intersystem planning and affiliation

2.7.1 Describe your organization's experience in convening a collaborative structure to integrate services across agencies.

2.7.2 Describe what processes and structures you would utilize to collaborate with other stakeholders in implementing, monitoring, and overseeing the performance of your ESP program. For example, would you establish a community advisory board, utilize a specific existing forum for obtaining feedback and recommendations about the functioning of your ESP, etc.?

2.8 Please describe how your organization shall train, develop, support, and evaluate all ESP staff individually and your ESP program as a whole, both initially and on an ongoing basis, to ensure that the core competencies described in 2.1 – 2.7 are consistently implemented in all ESP service components.

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

3.1 Emergency Services Program (ESP): overall program

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

How shall you change the perception which may exist in your organization and/or in your community that the ESP's function is to conduct "hospital screening"? What operational and cultural changes shall your organization make to ensure the delivery of ESP services that consist of a comprehensive and discrete level of care, incorporating crisis assessment, resolution-focused intervention, and stabilization?

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

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

3.1.5 Describe how your ESP's 800# and triage function shall operate, noting any variance by time of day or day of week.

3.1.6 Describe how you shall cover the entire geography in the proposed catchment area 24/7/365. Does your organization have resources, such as various locations you can leverage, as part of your strategy?

3.1.6.1 How shall you ensure a one-hour response time, from the time of readiness for ESP intervention, throughout the proposed catchment area 24/7/365? Do you anticipate any particular challenges with meeting this requirement in any areas within that catchment area, and if so, how shall you mitigate those challenges?

3.1.7 While a goal of this procurement is to ensure that the implementation of the ESP model shall be substantially consistent statewide, describe and give a rationale for any variances in the service model described in this RFR that you think are indicated to accommodate local needs, preferences, and/or resources in the proposed catchment area. Include but do not limit your response to any variance from the requirements included in Section II.D.2 Community-based location, under "description."

3.1.8 Location of services:

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

Service component	**Address(es) where service will be delivered or dispatched from**	**Days/hours of operation**		**Other services at this location**
		Of the service component	**Of the physical site**	
ESP Management functions				
800# and triage		24/7/365		
Community-based location				
Mobile Crisis Intervention		24/7/365		
Adult Mobile Crisis Intervention		24/7/365		
Adult CCS		24/7/365	24/7/365	
RAP		4:30p-8a; 24 hours weekends and holidays		

3.1.8.2 If you intend to change locations or make substantive changes to any existing physical plants prior to service start date or within the first six months of operation, please describe those plans here.

3.1.9 ESP management

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

3.1.9.1.1 ESP Director

3.1.9.1.2 Quality/Risk Management Director

3.1.9.1.3 Medical Director

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

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

3.1.11 Safety: Articulate specific strategies you plan to employ to assess, and mitigate risk during the provision of ESP services in the community-based location and adult CCS as well as through Mobile Crisis Intervention services.

3.2 Community-based location

3.2.1 Describe your ESP's proposed community-based location(s) including:

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

3.2.1.2 Data supporting the fact that the location is centrally located in a major population center within the catchment area

3.2.1.3 Rationale for how this location is "in the community" and shall be perceived as such by those who utilize ESP services

3.2.1.3.1 Optional attachment: letters of support endorsing the selected location

3.2.1.4 Proximity and access to public transportation

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

3.2.1.6 How you shall concurrently communicate that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization

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

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

3.2.3 Staffing

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

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

3.3 Adult Mobile Crisis Intervention

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

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

3.4 Adult Community Crisis Stabilization (CCS)

3.4.1 Provide a brief program description that summarizes your planned adult CCS addressing, at a minimum, program philosophy and culture, target population, staffing pattern, service delivery mode, and flow of services.

3.4.2 Physical plant

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

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

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

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

3.4.3.2 State whether co-location shall be in place at the implementation of the ESP contract.

3.4.3.3 If it will not, attach an implementation plan outlining how and when co-location shall be achieved within three months of the initiation of the contract. (Note that failure to achieve co-location within three months may result in termination of the contract.)

3.4.4 If a bidder wishes to propose changes to the required minimum CCS capacity allocated to each catchment area, please describe your recommendations and related justification, including how the bidder proposes to increase the CCS capacity within the cost projections for each catchment area.

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

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

3.5 Mobile Crisis Intervention (MCI) Response Section
(Note: An incomplete or unsatisfactory response to this element could exclude a bidder's proposal from consideration.)

3.5.1 Statement of intention:

☐ The bidder intends to directly operate the Mobile Crisis Intervention component of the ESP and shall demonstrate competency in the section that follows.

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

3.5.2 Provide a rationale for your organization's decision reflected in question 3.3.1 above and a brief summary of how your proposed subcontractor meets the provider qualifications for providing the subcontracted service component

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

3.5.3.1 Documented experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis prevention, resolution-focused crisis intervention, parental engagement and support, and/or treatment services, such as contracts for the provision of such services at various levels of care, clinical tools used to deliver effective resolution-focused intervention in collaboration with children and families, and/or data reflecting the number of children and adolescents served in the past year

3.5.3.2 Evidence of knowledge, commitment, and experience implementing services to children, adolescents, and families consistent with *Systems*

of Care and *Wraparound* principles (refer to Section II.D of this RFR)

3.5.3.3 Evidence of 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

3.5.3.4 Policies, procedures, and/or clinical protocols developed specifically for the provision of behavioral health services to youth and families, including treatment strategies that differ from the strategies used for adults and how long these policies and procedures have been in effect

3.5.3.5 Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families

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

3.5.3.7 Infrastructure that supports the delivery of Mobile Crisis Intervention

3.5.3.7.1 Résumés from current staff member(s) in your organization at director-level positions and above who have five or more years of experience providing behavioral health services to youth and families and would be involved in your organization's provision of Mobile Crisis Intervention

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

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

3.5.3.9 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, and pediatric primary care providers. Evidence may include demonstrated ability to coordinate care and treatment across providers and service agencies, affiliation agreements with such organizations, and/or one sample of meeting

minutes demonstrating integration with other organizations' focus on youth and family services.

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

3.5.4 Mobile Crisis Intervention

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

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

3.5.4.2 Describe how you shall manage staff resources to meet the variance in the needs of families and therefore the fluctuations in the intensity and duration of this service.

3.5.4.3 Describe how you plan to ensure that following an MCI intervention, for a calendar period of up to 7 days, the MCI shall provide continued intervention with a goal of crisis resolution, support family-specific alternatives to out of home placement, collaborate with other system providers to assure coordination of care stabilization and follow-up services. Address how you shall manage staff resources to meet the variance in the needs of families and therefore the fluctuations in the intensity and duration of this service.

3.5.5 Describe how you shall establish linkages with other CBHI services including Intensive Care Coordination (ICC) as well as other child behavioral health services, and how you shall utilize these linkages to ensure care coordination, continuity of care, and diversions from inpatient psychiatric services and other out of home placement.

3.6 Runaway Assistance Program (RAP)

Describe how your ESP program shall operate a Mobile Crisis Intervention/Runaway Assistance Program ("MCI/RAP") 24/7/365 to youth between the ages of 6 to 18. Identify the manager as well as the number of on-call FTE separate from the MCI staffing dedicated to this program.

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

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

4.1 Hospitals as bidders

4.1.1 For hospitals that are bidding on an ESP contract, articulate how you are positioned to achieve the goals of ESP and this procurement, including

diversion from hospital EDs and establishing a robust community-based presence.

4.2 Bidders submitting responses for multiple catchment areas

4.2.1 If your organization is the successful bidder in more than one catchment area, describe how this outcome shall affect your vision and organization of your ESP program, your implementation plan, and your staffing pattern.

4.2.2 Describe the strengths you would realize through serving multiple catchment areas from a quality and community perspective, and the efficiencies you would achieve.

4.3 Subcontracts

4.3.1 For any ESP service component for which your organization plans to enter into subcontract arrangements with other provider organizations, detail:

4.3.1.1 The name of the subcontracting agency and main reasons for selecting this agency to perform the given ESP service component

4.3.1.2 The ESP service component(s) for which you plan to subcontract with that agency

4.3.1.3 Specifically if the subcontract will encompass the given service component for the entire catchment area and population, or if it is specifically for a specific population, geographic area within the catchment area (e.g. Designated ED), or other subset

4.3.2 Describe how your organization shall, as the contracted ESP provider, oversee, monitor, and hold the subcontracted provider(s) accountable for all aspects of service delivery, including clinical, quality, and administrative.

4.3.3 Given any planned subcontracts, summarize how your organization shall meet the requirement that you as the contracted ESP contract holder must propose a program model that ensures that your organization directly provides the majority of ESP services.

C. Technology Specifications and Response Requirements *(20 points)*

(Note: Please "cut and paste" any questions below into your response that lend themselves to doing so, such as 2.1, 3.1-3.8 and 4.1.)

1. *Technology Infrastructure: General*

Specifications

It will be important that ESPs have robust Information Technology (IT) infrastructure to ensure the efficient operations of all responsibilities and activities of the ESP, including: service delivery, flow of information, support of community-based interventions, record keeping, appointment scheduling, obtaining authorizations, data management and reporting, billing, and interface with the Virtual Gateway.

Response requirements

1.1 Please describe your organization's current IT infrastructure, including the following:

1.1.1 Staffing resources (number of IT staff, titles, and hours of availability of IT support)

1.1.2 Telephone (including availability of conference phones at your site)

1.1.3 Management information system hardware and software

1.1.3.1 Specify whether you have or shall establish LAN and/or WAN configuration and networking software.

1.2 Electronic medical record capacity

1.2.1 Describe your agency's information system with regard to collecting and tracking clinical data.

1.2.2 Describe your agency's ability to share this clinical data throughout your organization's system so clinicians have immediate access to clinical information

2. *Communications*

Specifications

MBHP is committed to ensuring that all providers have equipment, policies, and procedures in place to ensure timely communication in both crisis and routine situations. This is essential to service delivery effectiveness as well as safety. Bidders should note that cell phones have been budgeted for all master's level clinicians and bachelor's level staff who work in Adult or Mobile Crisis Intervention.

Response requirements

2.1 Please describe your communications by answering the following questions:

2.1.1 Percentage of ESP clinicians who shall have on-site and remote access to e-mail ____%

2.1.2 Percentage of ESP clinicians who shall have access to on site and remote access to voice mail ____%

2.1.3 Percentage of ESP clinicians who shall have cell phones with GPS ____%

2.1.4 Planned frequency of structured staff meetings with all ESP staff ____

21.5 Percentage of ESP clinicians who shall have laptops or equivalent devices to perform required functions remotely. ___%

2.2 Describe how your agency has put the above communication systems in place, including coordinating communication with MBHP. If your agency has no system currently in place, describe how you would put the above system in place, including implementation timeframes.

2.3 Identify the unique communications challenges you would expect in operating an ESP contract and the specific strategies you plan to implement to ensure timely and effective communication, to facilitate quality, service coordination, and safety.

3. Provider Information Systems

Specifications

ESP providers shall be expected to have the capacity to perform the following function, and to implement these functions, as of the implementation date:

- Electronic submission of claims – Please note that single-claim submissions require Internet Explorer 8 or better; batch (multiple) claim submissions require EDI software; requires Windows 2000 or Windows XP to run (earlier versions of Windows and Windows Vista are not compatible).

Electronic submission of encounter form data Electronic Funds Transfer (EFT)

Additional software specifications

Providers shall need Internet Explorer 8 or better, e-mail, and an office suite of applications to handle any documentation sent to them or required from them.

Hardware specifications

Providers shall need sufficient PCs to accommodate whatever number of staff they have who shall need PC access. Additionally, bidders should note that laptops have been budgeted for all MS clinicians and BS staff who work in Adult or Mobile Crisis Intervention.

Response requirements

3.1 Describe your Management Information Systems (MIS) hardware by answering all of the following questions:

3.2

Type (check)	*Number of*		*Identify all operating systems you use:*
Servers ❑			
PCs ❑			
MACs ❑			
WS ❑			
Laptops ❑			
Tablets ❑			
Other ❑			

3.3 Do you have enough PCs, laptops, and/or tablets to accommodate all staff that shall need to have computer access?

❑Yes ❑ No

3.3.1 Do the laptops you provide in the field have broadband access directly through a wireless connection, so staff are able to access to any web-based applications? ❑Yes ❑ No

If not, do you plan to provide this access? ❑Yes ❑ No

3.3 Do you have a hospital management system or an automated claims/billing system?

❑Yes ❑ No

- If yes, name of system:_____

_____

3.4 Do you have 24/7 broadband access? ❑ Yes ❑ No

- If yes, what is the maximum speed? _____

3.5 Do you have web access? ❑ Yes❑ No

- If no, would you acquire Internet access if required? ❑ Yes ❑ No

3.6 Do you currently submit claims electronically? ❑ Yes ❑ No

- If no, briefly describe your plans to do so within ninety (90) days of the contract award.

3.7 If your organization is currently a contracted ESP provider, do you currently submit encounter forms electronically? ❑ Yes ❑ No

- If no, briefly describe your plans to do so within ninety (90) days of the contract award.

3.8. Do you currently receive payments via Electronic Funds Transfer (EFT)? ❑ Yes ❑ No

- If no, briefly describe your plans to do so within ninety (90) days of the contract award.

4. Data and Information Management

4.1 For the following areas, please indicate whether your Management Information System (MIS) **is capable of producing** reports in each topic area. Then note whether your organization currently **uses** these reports for ongoing management and/or quality improvement purposes:

	MIS Capability	*Currently in Use*
Financial Reports	❑	❑
Utilization Reports	❑	❑
Clinician Profiling	❑	❑
Client Profiling	❑	❑
Quality Measurements	❑	❑
Statistical Analysis	❑	❑

4.2 **Required attachment:** Please submit up to three of your most useful examples of MIS reports pertaining to some of the above categories.

5. Encounter Forms

MBHP requires completion of daily Emergency Service Program (ESP) Encounter Forms for every individual served.

5.1 Describe how your organization shall ensure completion of these forms according to MBHP policies and procedures, including staff training and complete and timely electronic submission to MBHP.

5.2 Describe your organization's capacity and planned practices to produce and use Encounter Form data for tracking, reporting, and quality improvement purposes, including your ability to report daily, monthly, and annually on encounter data by population, location, clinician, disposition, service component, and/or other variables as identified or requested.

D. Fiscal Specifications and Response Requirements

(There are no points for the following questions, but the responses will be considered in the overall evaluation of the proposal. Information provided in this section could exclude your proposal from consideration.)

Specifications

MBHP will provide reimbursement for the following populations: The PCC plan, uninsured, DMH-only, Medicare-only and Health New England Be Healthy (HNE).

The MassHealth Health Plans listed below will provide reimbursement for services delivered to their Members.

- Boston Medical Center Health Plan (BMCHP)
- All CarePlus Plans
- Celticare
- Fallon Community Health Plan
- Health New England Be Health (HNE)
- Neighborhood Health Plan (NHP)
- All OneCare Plans
- Tufts Health Plan – Network Health

Volume History

- Volume data by catchment area may be found in Appendix IX "Volume Data for Two (2) Previous Years." This appendix lists volume data by age group, i.e., child/adolescent and adult.
- Volume data include utilizers from the other MassHealth Managed Care Entities (MCEs).
- Volume data do not include any commercial volume given that this population is not in the mandated scope of ESP services.

ESP contracts and rates

- ESP providers shall contract with MBHP for the provision of ESP services to the populations and payers included in the scope of ESP services.
- ESP providers shall be expected to accept reasonable rate offers and contract with the other MassHealth MCEs.
- ESP providers shall be encouraged to negotiate contracts and rates with commercial insurance providers whose members are outside the mandated or funded scope of ESP services delineated in Section II, but who may benefit from access to them, as long as the ESP is staffed adequately to ensure there is no disruption in delivery of services to contracted payer members.
- ESP services unbundled from ESP rates: for the following required services, ESP providers will be reimbursed through outpatient billing via their licensed outpatient mental health clinics rather than through ESP funding, rates, or billing:
  - Risk management/safety planning provided by the ESP without the need for crisis intervention, evaluation, or stabilization (i.e., before or to prevent the need for an ESP encounter)
  - Urgent psychopharmacology services (face to face) referred by ESP

Response requirements

1. *Fiscal year program budget response requirements*

1.1 Required attachment: submit a proposed program budget by completing the ESP Cost Report located in Appendix VIII, outlining program capacity, anticipated expenditures, and all funding sources. The ESP Cost Report was created to facilitate the collection of detailed provider information regarding the costs of providing ESP services and the volume of services being provided. This ESP Cost Report was developed based on the MH, PDT, and SA Supplemental Schedules from the MA Uniform Financial Report (UFR). The bidder should use the following data included in the appendices in designing their program models and developing their program budgets: projected cost by catchment area, volume history by catchment area, and core staffing pattern.

- When completing the required ESP Cost Report, the bidder must include all anticipated expenditures and revenue including any projected offsets.

- The bidder must detail the number of FTEs associated with each payroll line item.
- The bidder should utilize Appendix IV (Core Staffing Patterns) and Appendix V (Minimum and Suggested Compensation Levels) as guidelines in designing their staffing patterns and related budgets to meet the needs of the proposed catchment area. This appendix represents a recommended staffing pattern for an average size ESP to carry out the program model described in this RFR. It also informs the bidder about key aspects of the methodology on which the cost projections have been based. Providers will retain control over their business practices, such as salary levels.

2. Budget narrative response requirements

2.1 Submit a budget narrative that further defines and explains the program budget that is submitted via the ESP Cost Report found in Appendix VIII. The budget narrative provides the bidder with an opportunity to highlight what is unique or different about their program and corresponding cost report.

The narrative must include the following:

- The source of any projected offsets, methodology for arriving at offsetting revenue projections, how and when projected offsets will be collected, and how they will benefit the program
- How revenues will be billed and collected from MBHP, Medicaid Fee-for-Service, and other insurance that are anticipated to be billed to these entities
- The number of hours considered Full-Time Equivalent (for example, 35, 37.5, 40)
- Regarding the staffing pattern reflected in the ESP Cost Report, justification for any variance in the proposed staffing pattern and related expense as compared to the Core Staffing Pattern in Appendix IV.

3. Business component response requirements

MBHP is committed to ensuring that ESP providers are financially viable. Financial viability is defined as the ability to adequately support the specific operations of each service or program that is under consideration for contracting for the full duration of the contract.

3.1 Audited financial statements

- Required attachment: independently audited financial statements for the two most recent fiscal years
- Narrative: Briefly address any qualified opinions contained in the audited financial statements.

3.2 Pre-Qualification Required attachment, if applicable: If your organization is required to complete a Pre-Qualification package as specified by EOHHS attach documentation that you have achieved pre-qualified or qualified financial status from the EOHHS for this fiscal year.

- Narrative: Briefly address any reasons for not attaining pre-qualified or qualified status and for any corrective action plans that may be underway.

3.3 Working capital

- Required attachment: documentation that demonstrates sufficient working capital to support three months of operating expenses. For this application, capital is defined as: bank lines of credit, equity holdings or contributions, and cash on hand.
- Narrative: Briefly qualify or describe the bidder's status relative to working capital.

3.4 Accounts payable

- Required attachment: documentation that identifies the bidder's history of accounts payable turnaround time
- Narrative: Briefly qualify or describe the bidder's status relative to accounts payable.

3.5 Accounts receivable

- Required attachment: documentation that describes the history of accounts receivable days outstanding
- Narrative: Briefly qualify or describe the bidder's status relative to accounts receivable.

3.6 Government action

- Required attachment, if applicable: documentation that addresses their current and recent historical data (five most recent fiscal years) pertaining to state or federal government held liens due to failure to pay payroll tax liabilities
- Narrative: Briefly qualify or describe any government action taken.

3.7 Other corrective actions or sanctions

- Narrative, if applicable: If your organization has been placed on any other corrective action plan or has had any other sanctions imposed by any state or federal agency or managed care company in the past five years, please indicate the nature of the corrective action, the steps your organization has taken to ameliorate the situation, and the current status.

3.8 Payroll obligations

- Required attachment: documentation that addresses the bidder's ability to meet payroll obligations on time during the previous three years
- Narrative: Briefly qualify or describe the bidder's ability to meet payroll obligations.

3.9 Insurance coverage

- Required attachments: documentation of malpractice insurance coverage for the organization and a comprehensive general liability policy with respect to the proposed location and worker's compensation insurance covering bidder's employees.

- Narrative: Briefly qualify or describe the bidder's status relative to malpractice insurance coverage.

3.10 Privatization Law Assurances

- Required attachment: review and sign the form contained in Appendix X acknowledging your organization's commitment to implementing the privatization requirements outlined in M.G.L. c. 7 §§ 52, 53, 54, and 55.