

Appendix II: Performance Specifications

GENERAL PERFORMANCE SPECIFICATIONS

These General performance specifications apply to all MBHP network providers at all levels of care. Additionally, **providers are held accountable to the service-specific performance specifications for each level of care for which they are contracted.** All performance specifications are located in the performance specifications section of the Provider Manual, found at www.masspartnership.com. The requirements outlined within the service-specific performance specifications take precedence over these General performance specifications.

Philosophy

The MBHP provider network supports Members of all ages and their families living with severe and persistent mental illness, emotional or behavioral issues, substance use disorders, and co-occurring disorders to improve their level of functioning and live successfully in their communities. In doing so, the MBHP provider network offers a broad continuum of care including emergency, inpatient, outpatient, and diversionary services, emphasizing the least restrictive, community-based services available whenever clinically appropriate. Recognizing that behavioral health and medical conditions co-exist, behavioral health providers incorporate both into the assessment and care planning processes and collaborate with medical providers to improve the outcome of the Member's health. Providers of all levels of care must ensure that, in any setting in which behavioral health levels of care or both behavioral health and non-behavioral health levels of care are co-located, all performance specifications are met for the contracted level(s) of care.

All MBHP network providers incorporate wellness, resiliency, and recovery principles and practices into their care approaches and offer recovery-oriented services. Providers are accepting of Members, both initially as well as upon return after any disruption in services, regardless of resources. Providers engage Members in services as they are able to participate. Care focuses on increasing Members' ability to successfully manage their conditions, symptoms and services; build recovery and resilience; and meet their personal goals. Programs are Member and family driven, using a team approach with shared decision-making that facilitates the development of mutually agreed-upon care plans. With Member consent, active family/guardian/natural supports involvement is integral to treatment and discharge planning unless contraindicated.

Additionally, MBHP network providers deliver behavioral health services in a manner which supports:

- ☐ Clinical excellence and innovation in the provision of care;
- ☐ Ethical care and professional integrity;
- ☐ Member accessibility;
- ☐ Integration of behavioral health and physical health throughout all service delivery processes;
- ☐ Coordination of care including integration with primary care clinicians (PCCs);
- ☐ Data-driven practice, including evidence-based practices, outcomes measurement, and utilization management; and
- ☐ Technical competence and innovation.

Components of Service

Recovery and Wellness

1. All program policies and procedures are designed to promote acceptance of Members into their contracted services within an atmosphere of trust:
 - a. At all levels of motivation and readiness; and
 - b. With any reasonable personal preferences.

Additionally, it is considered best practice to have the capability to accept and treat Members presenting with various co-morbid conditions.
2. Programs promote Members' recovery, empowerment, and use of their strengths and their families' strengths in achieving their clinical, recovery, and wellness goals and improving their health outcomes.
3. Programs integrate peer/family support services whenever possible, within their own programming and/or through active linkages with community resources.
4. Programs 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.
5. Programs provide ongoing, documented in-service training that includes principles of wellness, recovery, and resilience pertaining directly to the population served.
6. Programs incorporate recovery principles and practices in their ongoing service delivery as well as in quality improvement activities.

Cultural Competence	<ol style="list-style-type: none"> 1. The program provides services that accommodate the Member consider the Member's family and community contexts and build on the Member's strengths to meet his or her behavioral health, social, and physical needs. 2. The program staff has the skills to recognize and respect the behaviors, ideas, thoughts, communications, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care and to further support cultural and linguistic competence. 3. The provider makes best efforts to ensure access to qualified clinicians able to meet the cultural, linguistic, ethnic, and other unique needs of all Members served in their local community, directly or by referral, including members of minority groups, those who are homeless, Members who are disabled, Members who are deaf or hard of hearing, and other populations with special needs. <ol style="list-style-type: none"> a. Providers ask Members' language of choice. b. Because clinical staff with linguistic capacity is preferable to interpreters/translators, providers offer the Member a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so. c. The provider has access to qualified interpreters/translators and translation services, experienced in behavioral health care, appropriate to the needs of the population served. If the program must seek interpreter/translation services outside of the agency, it maintains a list of qualified interpreters/translators to provide this service, as well as relevant resources. Interpreter/translator services are provided at a level which enables a Member to participate fully in the provider's clinical program. 4. Any written documentation is made available for Members in a manner, format, and language that can be easily understood by those with limited English proficiency. Such materials, especially discharge documents, are translated into languages considered prevalent. It is considered best practice to have the capability to translate such materials into the Member's preferred language when requested by the Member. 5. Programs provide ongoing in-service training that includes cultural and linguistic competency issues pertaining directly to the population served, to ensure its staff demonstrate an understanding of and respect for Members' diverse cultural, linguistic, and other unique needs.
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	6. Programs include cultural and linguistic competence in their ongoing quality assessment and improvement activities, including identifying and reducing the existence of health care disparities.
Consent for Treatment	<ol style="list-style-type: none"> 1. The provider identifies the Member's custodial status and obtains all consent forms and releases of information in compliance with that status. 2. The provider obtains a consent-to-treatment form signed by the Member or parent/guardian/caregiver. 3. The provider obtains appropriate consent for information sharing in order to coordinate care. 4. The provider is in compliance with current laws and standards regarding consent and release of information and conducts staff training as changes occur. 5. If the Member or parent/guardian/caregiver of a minor declines or restricts the consent for coordination, the provider documents this as such in the Member's health record. Attempts are continually made and documented to engage the Member in giving consent, as appropriate to his/her treatment plan.
Staffing Requirements	
	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP service-specific performance specifications, and the credentialing criteria outlined in the MBHP Provider Manual, Volume I, as referenced at www.masspartnership.com. If there are discrepancies between MBHP performance specifications and any licensing body, the requirements of the licensing body take precedence. 3. Organizations that have staff who do not meet the credentialing criteria for a specific level of care may apply for a waiver for such staff person(s) through MBHP's waiver process as outlined in the MBHP Provider Manual. 4. The provider ensures that program staff are qualified through education, experience, and/or training to provide support and treatment to the population served by the programs. 5. The provider follows documented internal policies and procedures for training and supervising staff, the components of which include:

	<ul style="list-style-type: none"> a. Orientation and ongoing information about the provider's policies and procedures. b. Orientation and ongoing information about MBHP policies and procedures including but not limited to: <ul style="list-style-type: none"> i. Provider Manual; ii. Medical Necessity criteria; iii. Authorization parameters and procedures; iv. Performance Specifications for the level(s) of care provided; v. Per Diem/Per Services Definitions; vi. Adverse Incident Reporting; and vii. Alerts c. At least annual staff training that promotes skill development in clinical and rehabilitation services appropriate to the level of care and the population served, including but not limited to training on recovery and wellness, the consumer/family perspective, and integration and care coordination with PCCs. Provided; d. Staff participation in supervision and consultation appropriate to their degree and licensure level, and in compliance with MBHP's credentialing criteria and service-specific performance specifications. The provider maintains documentation of staff supervision and consultation policies and procedures as well as provider compliance with those policies and procedures, and, upon request, provides this documentation to MBHP. <p>6. For all clinical reviews with MBHP, the provider must utilize an appropriately MBHP-credentialed clinician for that service (see MBHP credentialing criteria at www.masspartnership.com). When requested by MBHP, the provider will make an MD available for physician to physician reviews.</p>
Process Specifications	

Access, Assessment, Treatment/ Care Planning, and Documentation	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. The provider offers hours of operation comparable to those offered to individuals with commercial insurance or to Medicaid Fee-for-Service if only MassHealth Members are served. 3. The provider reports bed/service availability as required by MBHP on the Massachusetts Behavioral Health Access website, www.MABHAccess.com, for all levels of care included in the website 4. The provider manages services to reduce and eliminate the necessity of maintaining waiting lists. Providers who are not able to offer access that complies with the MBHP access standards as outlined in the MBHP Provider Manual, Volume I, as referenced at www.masspartnership.com, must refer Members to another MBHP provider to ensure that Members receive services in a timely manner. Providers contact MBHP for assistance with making referrals as needed. If there are barriers to accessing covered services, the provider notifies the MBHP Clinical Access Line and/or the regional office as soon as possible to obtain assistance. All such activities are documented. 5. With consent, the Member and his/her parent/guardian/caregiver, family members other natural supports are active and integral participants throughout the service delivery process, including assessment, treatment planning , treatment services, discharge planning, and related meetings. All such activity is documented in the Member's health record. 6. The provider makes best efforts to offer meetings, such as treatment planning meetings, and services, such as family therapy sessions, at times and locations convenient to the Member and the family's schedule, including evening and weekend meeting times and the use of teleconferencing.
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	<ol style="list-style-type: none"> 7. With consent, the Member's PCC, other behavioral health providers, state agency staff, and other supports are engaged in treatment and discharge planning meetings. 8. The provider completes an initial written, comprehensive assessment for all Members entering any level of care, which is documented in the Member's health record. 9. The assessment includes, but is not limited to: history of presenting problem; chief complaints and symptoms; strengths; behavioral health, medical, developmental, family, and social history; linguistic and cultural background; for youth in the care/custody of the Commonwealth, history of out of home placements; mental status examination including assessment of suicide and violence risk; previous medication trials, current medications, and any allergies; DSM-5 diagnosis and clinical formulation that are supported by the clinical data gathered, rationale for treatment, and recommendations; level of functioning; current and past substance use; and name of PCC and other key providers. 10. For adults, the initial outcome measurement is administered prior to or on the date of the comprehensive assessment completion to document that the clinical data was integrated into the initial assessment process. Information in the assessment may be gathered from the Member, family/guardian/caregiver, the referral source, past and current treaters, and/or other collateral contacts, with appropriate consent. 11. When requested and/or as indicated by the individual's clinical presentation, the provider conducts and documents in the Member's health record a substance use disorder assessment either directly or by linkage with a provider trained in substance use disorders. 12. The provider completes a comprehensive and individualized initial treatment plan built upon the assessment and developed with the Member and/or parent/guardian/caregiver, and, with consent, family members, the PCC, other involved providers, and supports identified by the Member. <ol style="list-style-type: none"> a. The treatment plan is signed, dated, and documented in the Member's health record. b. The treatment plan includes, but is not limited to: objective and measurable goals, time frames, expected outcomes, the Member's strengths, links to primary care especially for Members with active co-occurring medical conditions, a plan to involve a state agency case manager, when appropriate, and treatment recommendations consistent with the service plan of the relevant state agency, if involved. c. The treatment plan is consistent with the Member's diagnosis, describes all services needed during the course of treatment, and reflects continuity and coordination of care. d. The time frames for the completion of the initial treatment plan are delineated in each of the service-specific performance specifications.
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	<p>13. The provider assigns a multi-disciplinary treatment team to each Member within the time frames delineated in each of the service-specific performance specifications. A multi-disciplinary treatment team meets to review the assessment and initial treatment plan and discharge plan within time frames delineated in each of the service-specific performance specifications.</p> <p>14. The treatment plan is implemented, reviewed, and revised throughout the course of treatment, based on the provider's continual reassessment of the Member and with the Member's participation. The Member's progress in achieving the treatment goals is documented in progress notes and treatment plan updates in the Member's health record.</p> <p>15. If the Member terminates treatment without notice, every effort is made to contact the Member to re-engage in treatment or to provide assistance to transfer the Member to another appropriate source of care prior to discharging the Member. Such activity is documented in the Member's health record. When the Member is identified as having state agency and/or other collateral involvement, or is participating in MBHP's Integrated Care Management Program (ICMP), and appropriate releases of information have been signed by the Member/parent/guardian/caregiver, those collateral contacts, including the Member's PCC, and/or MBHP's integrated care manager are informed of the Member's treatment status.</p>
Care Coordination	<p>1. The provider seeks informed consent from the Member in order to coordinate admissions, assessment, treatment/care planning, and discharge planning with the following collaterals, as appropriate to the level of care. The type and amount of information shared is appropriate to the purpose and the role of those to/from whom the information is being communicated/requested, including the following:</p> <ul style="list-style-type: none"> a. Parents/guardians/caregivers/family/significant other/natural supports; b. PCC; c. ESP and MCI; d. 24-hour levels of care, including psychiatric hospitals, Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT) programs, Community Crisis Stabilization (CCS), etc.; e. State agency personnel (when providing services to Members involved with a state agency), including DMH, DCF, DYS, DPH, DDS, and/or DTA;

	<ul style="list-style-type: none"> f. Local education authority (LEA) (applies to all children, whether a regular education or special education student); g. Police departments and local court systems; h. Outpatient treaters and prescribers; i. Other community-based providers, including CBHI services such as In-Home Therapy (IHT) and Intensive Care Coordination (ICC), Community Support Programs (CSPs), and substance use disorder programs; or j. Other collaterals appropriate to the Member and/or the level of care. <ol style="list-style-type: none"> 2. Care coordination efforts are documented in the Member's health record. 3. When additional or complex integrated care coordination is needed, the provider refers Members to MBHP's Integrated Care Management Program (ICMP) according to the referral criteria outlined in the MBHP Provider Manual, Volume 1, as referenced at www.masspartnership.com.
Discharge Planning and Documentation	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. The provider ensures that staff who are responsible for discharge planning are knowledgeable about the continuum of behavioral health and medical services as well as other services and supports in the community, and discharge planning skills and strategies. 3. Staff involved in discharge planning are trained on the use of the www.MABHAccess.com website and are expected to utilize this resource to locate available step-down and other aftercare services for Members. 4. The provider identifies barriers to discharge planning and aftercare and develops strategies to assist the Member with arranging and utilizing aftercare services, making best efforts to ensure that the discharge plan (or other such document(s) that contain the required elements) is consistent with his/her benefit coverage. 5. As appropriate, the provider assists the Member in scheduling a follow-up appointment for the Member with his/her PCC. 6. With the Member's consent, the provider, in collaboration with the Member, his/her family, and/or his/her supports, develops a written, individualized, person-centered, strengths-based discharge plan (or other such document(s) that contain the required elements), prior to the Member's discharge from any inpatient service or, if appropriate,

	<p>any other behavioral health service, that is documented in the Member's health record. Prior to the Member's discharge, the provider provides the Member with a copy of the discharge plan (or other such document(s) that contain the required elements). The plan includes, but is not limited to:</p> <ul style="list-style-type: none"> a. Identification of the Member's needs, including but not limited to: <ul style="list-style-type: none"> i. Housing; ii. Finances; iii. Medical care; iv. Transportation; v. Family, employment, and educational concerns; vi. Natural community and social supports; and vii. For Members discharged from inpatient mental health services and for other Members as clinically indicated, an updated crisis prevention plan for adults that follows the principles of recovery and resilience, or an updated safety plan (as part of the Crisis Planning Tools http://www.masspartnership.com/index.aspx) for youth and their families, and/or a relapse prevention plan, as applicable. Such a plan is directed by the Member and is designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. It identifies triggers that may lead to or escalate a psychiatric crisis, and includes a preferred disposition as well as the Member's preferences. With Member consent, the plan may be implemented by an ESP/MCI provider, a medical or behavioral health provider, the PCC, or another individual as directed by the Member. b. A list of the services and supports that are recommended post-discharge, including identified providers, PCCs, and other community resources available to deliver each recommended service; c. A list of prescribed medication, dosages, and potential side effects; and d. Treatment recommendations consistent with the service plan of the relevant state agency for Members who are state-agency involved; and e. For all ICC-involved youth, the discharge plan is consistent with the youth's Individual Care Plan (ICP).
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	<p>7. For all youth under the age of 21, the provider makes best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any, by:</p> <ul style="list-style-type: none"> a. Linking to necessary services and making appropriate referrals, including Children's Behavioral Health Initiative (CBHI) services and Community Support Program (CSP), if indicated; b. Documenting in the Member's health record all efforts related to these activities, including the Member's and family's/guardian's/caregiver's active participation in discharge planning; c. Reviewing and updating any of the Crisis Planning Tools (safety plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan), in collaboration with the youth, family, ICC provider if enrolled in ICC, and, if indicated, with the youth's ESP/MCI provider, and sending a copy to those providers where consent is given; and d. Educating the youth and family regarding use of the ESP/MCI service if needed in the future including access to their mobile and other community-based services. <p>8. Additional discharge planning requirements for Members who are homeless:</p> <ul style="list-style-type: none"> a. The provider makes all reasonable efforts to discharge any homeless Members to living situations other than emergency shelters. b. The provider provides comprehensive discharge planning for all homeless Members, exhausts all potential avenues to secure placement or housing resources, and utilizes all community resources to assist with discharge planning. c. The provider completes and forwards to DMH within two business days of admission a DMH Service Authorization packet for Members who are homeless, who appear to meet DMH clinical criteria for service eligibility, and who have not already been determined eligible for DMH Continuing Care Services. d. The provider documents in the Member's health record all efforts related to these activities. <p>9. For Members who are minors: if reasonable attempts have been unsuccessful to involve their parents/guardians/caregivers in treatment and discharge planning, and/or the parents/guardians/caregivers are unable to participate in planning meetings, the provider presents</p>
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	<p>treatment findings and recommendations to parents/guardians/caregivers at the time of discharge. These findings and recommendations are documented in the Member's health record.</p>
Service, Community, and Collateral Linkages	
	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. 2. Programs actively engage in collaboration with Executive Office of Health and Human Services (EOHHS)-funded programs, including but not limited to: <ol style="list-style-type: none"> a. Department of Mental Health (DMH)-funded programs, such as Community-Based Flexible Supports; b. Department of Children and Families (DCF)-funded programs that support the safety, permanency and well-being of youth in the Care and Custody of the Commonwealth; c. Bureau of Substance Abuse Services (BSAS)-funded programs for Members, such as recovery homes to promote continuity of services for substance use disorders from acute care to supportive and rehabilitative care and recovery supports; d. Department of Developmental Services (DDS) programs that involve rehabilitative and habilitative services for persons with developmental disabilities; e. Department of Youth Services (DYS) programs that help Members stay in the community and avoid recidivism to DYS; f. Other programs and initiatives within EOHHS, MassHealth, and Department of Public Health (DPH) related to PCC coordination and pharmacy management, including federal and state grant programs; and g. Prevention and wellness programs at the state, regional, and local level. 3. The provider develops a working relationship with the ESP/MCI provider that covers the catchment area in which the program is located. The provider: <ol style="list-style-type: none"> a. Responds to referrals from the ESP/MCI to their programs in a timely fashion. b. Trains staff on the appropriate use of the ESP/MCI services, including services available in the community as alternatives to hospital Emergency Department visits.

	<ul style="list-style-type: none"> c. Ensures that staff educate Members about the availability of ESP/MCI services 24 hours per day, 7 days per week, 365 days per year, including how to access services from the local ESP/MCI in the community. d. Educates staff, Members, and their families about engaging Members in the development of crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable, and, with Member consent, sending a copy of these plans to the ESP/MCI Director at the Member's local ESP/MCI. <p>4. The provider makes reasonable efforts to assist Members with identifying transportation options, when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.</p>
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Primary Care Clinician (PCC) Integration

	<ul style="list-style-type: none"> 1. Throughout the course of treatment, as applicable, and with appropriate consent, to ensure integration of care the provider assesses and makes inquiries about the Member's medical/health status, utilization of medical visits, and compliance with medical treatment through: self-report; communication with the Member's PCC and/or other healthcare professionals identified by the Member; and communication with MBHP. 2. The provider identifies the Member's PCC. If there is none, the provider makes best efforts to assist the Member in obtaining a PCC by: directing him/her to the telephone number for MassHealth's Customer Service Center located on the back of his/her MassHealth ID card; directing him/her to the PCC section of the MBHP website which contains the telephone number for MassHealth's Customer Service Center; or directly providing him/her with the telephone number for MassHealth's Customer Service Center. 3. The provider obtains a release of information to contact the PCC. If the Member declines, the provider documents this in the Member's health record and continues to engage the Member around this issue.
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	<ol style="list-style-type: none">4. The provider communicates with the Member's PCC via telephone or in writing with Member/guardian consent, and such communication is documented in the Member's health record. For inpatient and 24-hour diversionary services, this communication takes place within one business day. For all other services, this communication takes place within five (5) business days.5. The provider contacts the PCC for the following purposes:<ol style="list-style-type: none">a. To notify him/her regarding admission or enrollment in services and the reason(s) for such admission/enrollment;b. To obtain information regarding health status, including but not limited to medical and medication information;c. To coordinate assessment, treatment and discharge planning;d. To share diagnostic and treatment/care plan information;e. To coordinate medication, if applicable; andf. To notify him/her of discharge and involve him/her in discharge and/or aftercare planning as indicated.6. With appropriate consent, the provider maintains ongoing communication and collaboration with the PCC for these purposes, as well as to provide information to the PCC about the course of the Member's behavioral health treatment, including psychopharmacology and notable metabolic studies and/or other medical information. The provider utilizes information from the PCC to inform the Member's assessment, treatment/care plan and discharge plan on an ongoing basis.7. To facilitate communication between the behavioral health provider and the PCC, providers of all levels of care are encouraged to utilize the "Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form." This form can be located at www.masspartnership.com in both the "For PCCs" and "For BH Providers" sections.
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Quality Management (QM)	
Compliance With Laws and Regulations	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted. Providers are required to comply with all applicable state and federal laws, regulations, licensing, policies, and accreditation requirements. The provider immediately notifies MBHP of the revocation, limitation, suspension or other conditions placed on the license, certification, or accreditation.
Quality Measurement and Improvement Initiatives	<ol style="list-style-type: none"> 1. Providers are expected to participate in and implement results from the quality measurements and improvement initiatives conducted by MBHP. Providers integrate these quality improvement opportunities into their Quality Improvement Plans as referenced below. MBHP quality measurement and improvement initiatives include but are not limited to: <ol style="list-style-type: none"> a. On-site program reviews; b. Health record reviews; c. Outcomes measurement initiatives; d. Utilization management initiatives; e. Member satisfaction surveys conducted on-site, telephonically and/or via written survey by consumer satisfaction teams; f. Provider satisfaction surveys; and g. Provider profile reports. 2. The provider maintains utilization management policies and procedures to ensure that medical necessity and level of care criteria are met and documented in the assessment, treatment plan, and progress notes in each Member's health record, and that appropriate lengths of stay are managed across the program.
Measurement of Treatment Outcomes	<ol style="list-style-type: none"> 1. Providers are expected to select and utilize a standardized outcomes measurement tool, approved by MBHP, and implement all requirements relative to this initiative as outlined in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.

Provider Quality Improvement Programs and Plans	<ol style="list-style-type: none"> 1. Network providers are required to have internal processes, policies, procedures, programs and/or activities aimed at monitoring and improving quality of care. 2. The provider identifies a manager responsible for the provider's quality improvement process. 3. Providers work collaboratively with MBHP staff in developing, implementing and monitoring quality improvement plans in response to adverse incidents, concerns and grievances, or such quality initiatives as provider profiles, health record reviews, etc. 4. Providers engage Members, families, and other relevant stakeholders in their quality management activities.
Adverse Incident Reports	<ol style="list-style-type: none"> 1. Providers of all levels of care are required to comply with the guidelines for reporting all Adverse Incidents, identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section. 2. All 24 hour level-of-care providers are required to report all Adverse Incidents within 24 hours of their occurrence. 3. Providers of all other levels of care – outpatient and all non-24 hour levels-of-care, with the exception of ECT – are required to report, within 24 hours of their occurrence, Member deaths, serious injuries requiring urgent or emergent treatment that occurred while a Member was at a practitioner/provider site, and serious attempted suicides that occur during the time span that a Member is receiving services from the provider, during and outside a treatment session.
Concerns and Grievances	<ol style="list-style-type: none"> 1. Any concerns and dissatisfaction with MBHP's services, access to care, and/or the quality of care received from network providers can be reported to any MBHP staff, or directly to MBHP Quality Management Specialists. A verbal concern and/or a written grievance can be submitted to MBHP for investigation and resolution. All related requirements are identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.
Provider Concerns	<ol style="list-style-type: none"> 1. MBHP encourages its network providers to relay any concerns they have regarding any aspect or action of MBHP or its providers. This includes, but is not limited to, quality of care, administrative operations, and access to care. All requirements and the review process are further identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.

Restraint and Seclusion	<ol style="list-style-type: none"> 1. MBHP supports the principles that guide the use of restraints and/or seclusion put forward by the Massachusetts Coalition for the Prevention of Medical Errors. Network providers are responsible for compliance with all applicable federal and state laws and regulations governing the restraint and/or seclusion of Members (104 CMR 27.12 and 28.05, and 42 CFR 441.151 subpart D and 483 subpart G). All requirements are identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.
Member Rights	<ol style="list-style-type: none"> 1. Network providers are responsible for compliance with Massachusetts laws, policies, and regulations governing Member rights and privileges. All requirements are identified in the MBHP Provider Manual, Vol. 1, as referenced at www.masspartnership.com, in the Quality Management section.
Health Record Maintenance	<ol style="list-style-type: none"> 1. Providers are required to meet all requirements related to maintenance of health records, including documentation of the following in the Member's health record: demographic information; clinical history; behavioral health clinical assessments; treatment plans; services provided; contacts with the Member, his/her family, guardians, or significant others; and treatment outcomes. 2. Health records are made available to MBHP when requested. Requests to review health records on-site can occur within 24 hours of notice. Health records requested by MBHP must be received at MBHP offices within 10 business days of request.
Satisfaction Surveys	<ol style="list-style-type: none"> 1. Providers are expected to work with MBHP to improve services based on data derived from Member and provider satisfaction surveys conducted by MBHP. 2. Providers are encouraged to conduct satisfaction survey(s) including the following: <ol style="list-style-type: none"> a. Members b. Family members c. Other stakeholders such as referral sources, other behavioral health providers, community resources, state agencies, PCCs 3. Members are encouraged to utilize data derived from satisfaction surveys to inform provider's quality improvement efforts.

EMERGENCY SERVICES PROGRAM (ESP)

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers contracted for this service and all contracted services are held accountable to the General performance specifications**, located at the beginning of the performance specifications section of the Provider Manual, found at www.masspartnership.com. Additionally, providers contracted for this service are held accountable to the Mobile Crisis Intervention performance specifications, as well as to the Community Crisis Stabilization performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those within the General performance specifications.

Philosophy

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.

The mission of the 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, wellness, and recovery.

Components of Service

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The ESP provider is contracted to provide crisis behavioral health services in a specified catchment area in the Commonwealth of Massachusetts.
3. The Emergency Services Program (ESP) is a comprehensive, integrated program of crisis behavioral health services, including services delivered through the ESP's mobile crisis intervention services for adults, through MCI services for youth, in the ESP's accessible, community-based location, and in the ESP's Community Crisis Stabilization (CCS) program.
4. This covered service includes the following: crisis screening, which for the purposes of these performance specifications will be referred to as "crisis assessment"; short-term crisis counseling, which for the purposes of these performance specifications will be referred to as "short-term crisis counseling" as well as "crisis intervention"; crisis stabilization, which will be referred to as "crisis stabilization" in these performance specifications; and medication evaluation and Specialing, both of which are arranged by ESP providers when needed by Members participating in ESP services. While the "core" ESP services are referred to throughout this document as "crisis assessment, intervention, and stabilization," it is understood that all recipients of ESP services have access to all the services listed above: crisis screening, short-term crisis counseling, crisis stabilization, medication evaluation, and Specialing.
5. The ESP provides a discrete level of care that minimally includes the core ESP services – behavioral health crisis assessment, intervention, and stabilization – to all recipients of ESP services in all ESP service components and venues.
6. The ESP conducts 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 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)

	<ul style="list-style-type: none"> • Interface with MBHP for contract management purposes <ol style="list-style-type: none"> 7. The ESP provides services to all uninsured individuals as well as those enrolled in or covered by the following payers: MassHealth plans including the PCC Plan (MBHP), the MassHealth-contracted MCEs and MassHealth fee-for-service or “unmanaged” plans, DMH only, Medicare, and Medicare/Medicaid. <ul style="list-style-type: none"> • Payment will not be provided to ESPs for ESP or CCS services for individuals with commercial insurance. ESPs are not mandated to provide ESP and/or CCS services to those populations, and any resulting contract with MBHP shall not require ESPs to provide ESP and/or CCS services to such populations. ESPs are encouraged to seek contracts with commercial payers for the provision of ESP and CCS services to their members. 8. ESP services are available to Members of all ages. 9. ESP services are available to Members who present with mental health, substance use, and/or co-occurring mental health and substance use disorders. 10. The ESP ensures that ESP services are accessible throughout the entire catchment area 24/7/365. 11. The ESP responds to all requests for crisis assessment, intervention, and stabilization in a timely fashion, in order to be responsive to the Member’s and/or caretakers’ sense of urgency, intervene in behavioral health crises early, and prevent the adverse impact that treatment delay may have on Members, families, and settings in which those Members await these services, particularly hospital emergency departments (EDs), in order to minimize the duration of Members’ time in this more restrictive setting, thereby contributing to efforts to reduce ED overcrowding and boarding. The ESP ensures that a maximum response time of 60 minutes from the time of the Member’s readiness for ESP crisis assessment is provided in every encounter and maintained across its program. 12. All ESP services in a given catchment area are accessed by phone through a toll-free number (TFN), which may include an 800, 888, 877, or 866 number, operated by the contracted ESP provider 24/7/365. The TFN is generally expected to operate at the ESP’s community-based location. The TFN, accessible by voice or Teletype (TTY), is published in all major telephone directories in the ESP’s catchment area, under both “Mental Health Services” and “Substance Abuse Services.” 13. The ESP triages calls to its most appropriate ESP service component, the one that will provide crisis behavioral health services to the Member in the least restrictive setting, ensuring safety and responsiveness to Member and family choice. 14. The ESP ensures that, upon the request of a court clinician conducting a psychiatric evaluation pursuant to M.G.L. c. 12312(e), a crisis assessment is provided, appropriate diversionary services are identified, and assistance is provided to access the diversionary service.
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	<p>15. The ESP's priority is to ensure safety by providing immediate intervention in life-threatening situations involving imminent risk of suicide, homicide (except in cases where law enforcement is clearly needed), or significant violence directed toward self, person(s), or property.</p> <p>16. The ESP supports resiliency, wellness, and recovery of all Members to whom it provides crisis behavioral health services, by integrating mental health, substance use disorder, and integrated wellness and recovery principles and practices throughout the service delivery model and implementing specific recovery-oriented services, including Peer Specialist and Family Partner services.</p> <p>17. The ESP must provide 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.</p> <p>18. The ESP operates a community-based location that serves as a primary venue through which the ESP provides community-based access to the core ESP services of crisis assessment, intervention, and stabilization.</p> <ul style="list-style-type: none"> a. The ESP provides ESP services on site at its community-based location for a minimum of 12 hours per day on weekdays and 8 hours per day on weekends. Recommended minimum hours are 7 a.m. to 11 p.m. on weekdays and 11 a.m. to 7 p.m. on weekends. ESPs operate adult mobile crisis intervention services, MCI services for youth and the CCS 24/7/365. b. It is generally expected that all ESP services are located at, and in the case of adult mobile crisis intervention services and MCI for youth, dispatched from, the ESP's community-based location. c. The ESP's community-based location must be an easy-to-find, centrally located, handicap accessible site in a population center within the catchment area and perceived as "in the community" to those who live there. The site must be accessible to persons relying on public transportation. d. The ESP's community-based location offers an environment that encourages Members and families to seek crisis services in this less restrictive, community-based setting. The physical environment and interpersonal climate is one that is welcoming and communicates respect, patience, compassion, calmness, comfort, and support. Concurrently, the environment communicates that this is a setting to receive help for crisis behavioral health needs rather than for routine services or general support and socialization. e. The ESP may operate more than one community-based location and/or operate mobile services from more than one location throughout the catchment area. <p>19. The ESP provides mobile crisis intervention services to both adults and youth (via MCI services for youth) as an integral part of its comprehensive behavioral health crisis services continuum and as a key strategy in reducing the use of unnecessary hospital ED and</p>
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	<p>inpatient psychiatric services. (Refer to the MCI performance specifications for more details about ESP/MCI provider requirements relative to that ESP service component).</p> <p>20. The core ESP service of crisis assessment, intervention, and stabilization is provided to adults primarily through the ESP's adult mobile crisis intervention services, in addition to ESP services provided to adults at the ESP's community-based location. The ESP provides 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 are provided in residential programs and hospital EDs. Upon request, ESPs are also expected to conduct crisis behavioral health assessments on medical floors in hospitals within the ESP's catchment area. ESP performance is measured against established targets for the percentage of services that are provided on a "mobile" basis, exclusive of hospital EDs.</p> <p>21. The ESP operates a Community Crisis Stabilization (CCS) program that serves adults ages 18 and older, which shall include services under the Children's Behavioral Health Initiative (CBHI) for young adults from ages 18 to 21. The ESP's CCS is co-located with the ESP community-based location. (Refer to the CCS performance specifications for more details about ESP provider requirements relative to that ESP service component).</p> <p>22. The ESP provides adult and child psychiatric consultation 24/7/365 to ESP/MCI clinicians and supervisors. The ESP provides access to routine, urgent or emergent face-to-face psychiatric and medication evaluations through which medication is prescribed according to written policies and procedures and applicable Massachusetts General Laws and Regulations.</p> <p>23. The ESP continually assesses risk for Members who participate in ESP services, as well as for staff who provide them, and takes action to mitigate risk to the extent possible. Strategies include but are not limited to:</p> <ul style="list-style-type: none"> a. Offering various venues for services, obtaining supervisory consultation around these triage decisions, and utilizing the hospital ED for those Members who require the services of that setting b. Technology resources, including cell phones with GPS and laptops c. Staffing infrastructure, including Certified Peer Specialists, Family Partners, and bachelor's-level staff, who provide support and comfort to Members 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 adult mobile crisis intervention services and MCI services for youth. d. Specific "safety" staffing in the ESP's community-based location, whose role and title is defined by the ESP in a manner that helps to promote a calm and safe environment, mitigate risk, and facilitate safety in this setting. The ESP chooses to use these positions in a variety of ways that contribute to a safe environment. In part, this staffing will enable the provider to
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	<p>ensure that at least two staff are present in the community-based location during at least high-volume operating hours.</p> <p>24. Subject to applicable state and federal regulations that entitle MassHealth Members to seek emergency services for an Emergency Medical Condition, the ESP strives to interrupt patterns of over-reliance on hospital EDs as the first point of contact in the event of a behavioral health crisis. The ESP is 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. The ESP develops and implements specific strategies to change referral and utilization patterns in its communities and shift volume from hospital EDs to its community-based services, specifically its adult mobile crisis intervention services and MCI services for youth, ESP community-based locations, and CCSs. The ESP creates a service pathway that screens for the need to refer up to a hospital ED rather than step-down from hospital-based emergency care.</p> <p>25. The ESP identifies and implements strategies that maximize utilization of community-based diversionary services and reduce unnecessary psychiatric hospitalization, in a manner that is consistent with medical necessity criteria.</p> <p>26. The ESP is responsible for arranging transportation for Members, inclusive of private ambulances, to the appropriate levels of care determined for disposition. The ESP also provides transportation arrangement for Members and their families to and from the ESP, home setting, or appropriate outpatient and/or medication service following an ESP intervention. The ESP assists Members to arrange MassHealth transportation benefits.</p> <p>27. The ESP practices in accordance with all Alerts issued by MBHP, including:</p> <ul style="list-style-type: none"> a. Network Alert #87, July 2001 Medical Clearance Guidelines for Emergency Services Programs (ESP) & Acute Inpatient Facilities: A Consensus Statement b. Provider Alert #24, October 2007 Emergency Behavioral Health Services Policies and Procedures for Emergency Services Programs and Hospital Emergency Departments for MBHP Members and Uninsured Consumers c. Provider Alert #116, June 2012 Behavioral Health Care Access, Quality, and Discharge Protocol for DYS and MBHP d. Provider Alert #113, April 2012 Protocol for Accessing Acute Behavioral Health Care Services for Youth Involved with the Department of Children and Families (DCF) <p>28. The ESP implements protocols developed by MBHP regarding medical evaluation or “clearance.” The ESP refers deferentially to hospital EDs and primary care clinicians, within a timeframe that is based on the</p>
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	<p>urgency of that need.</p> <p>29. The ESP develops protocols for obtaining information related to crisis prevention plans and safety plans as part of the Crisis Planning Tools for youth, communicating the status to ESP clinicians and MBHP (if a crisis prevention plan and/or safety plan was not developed in conjunction with MBHP), and notifying relevant providers, family members, and significant others, as necessary and with the appropriate informed consent.</p> <p>30. The ESP ensures that all service delivery integrates the following populations:</p> <ul style="list-style-type: none"> • Children, adolescents, and their families • Adults • Persons with mental health conditions • Persons with substance use disorder conditions • Persons with co-occurring mental health and substance use disorder conditions • Persons with co-occurring behavioral health and medical conditions <p>31. The ESP ensures that service delivery facilitates communication, access, and an informed clinical approach with special populations including but not limited to:</p> <ul style="list-style-type: none"> • 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 <p>32. ESPs should consistently utilize the Massachusetts Behavioral Health Access website (www.MABHAccess.com) to locate services for any and all populations, including commercial payers.</p> <p>33. The ESP bills for all available third-party revenue and bills MBHP and Medicaid in accordance with the billing requirements as outlined in the ESP Amendment to Exhibit A annual contract.</p>
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Staffing Requirements

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP service-specific performance specifications, and the credentialing criteria outlined in the MBHP Provider Manual, Volume I, as referenced at www.masspartnership.com.
3. It is expected that the provider organization contracted as an ESP provider has resources to support the management and delivery of ESP services, including administrative and financial oversight, medical leadership, and technology infrastructure.
4. The ESP uses its staffing resources in an integrated and flexible manner, utilizing all available resources to respond to the needs of Members who require its services on a daily basis, with fluctuations in volume, intensity, location of services, etc.
5. ESP staffing is based on a multi-disciplinary team, including the following positions:
 - a. ESP Medical Director: This is a psychiatrist who meets MBHP's credentialing criteria 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.

	<p>b. 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.</p> <p>c. 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.</p> <p>d. Clinical Supervisors: 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.</p> <p>e. 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</p>
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	<p>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.</p> <ul style="list-style-type: none"> f. 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. g. Psychiatry: These MDs and psychiatric nurse mental health clinical specialists (PNMHCS) who meet MBHP's credentialing criteria provide consultation across all ESP service components. h. 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. Certified Peer Specialists (CPSs) help to make community-based ESP services welcoming, comfortable, supportive, and responsive to Members who utilize them and their families. i. 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 or more Certified Peer Specialists to work in the ESP's community-based locations. j. 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
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	<p>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.</p> <p>k. Included in the staffing model for MCI services for youth are paraprofessional staff, many of whom shall also be Family Partners. ESPs are required to hire at least one Family Partner in their MCI program, preferably upon initiation of the ESP contract, or within the first six months thereof. 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 MCI services. (Refer to the MCI performance specifications for more details about ESP provider requirements relative to that ESP service component.)</p> <p>l. "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.</p> <p>6. The ESP cooperates with hospitals that require ESP clinicians to be credentialed in order to provide crisis assessments in the hospital ED, according to Network Alert #19 General Hospitals Credentialing ESPs.</p> <p>7. The ESP provides consultation by a psychiatrist or PNMHCS, 24/7/365. The psychiatric clinician is available for phone consultation to the ESP clinician or supervisor within 15 minutes of request. The ESP provides access to child psychiatry as detailed in the MCI performance specifications.</p> <p>8. The ESP ensures access to routine, urgent or emergent face-to-face psychiatric and medication evaluations for Members assessed during an ESP intervention who require such access to these services. The ESP may utilize psychiatric staffing in its ESP and/or in its or other providers' outpatient mental health clinics to access these services.</p> <p>9. The ESP ensures that all ESP clinicians and other ESP staff receive training and meet core clinical competencies in serving the following populations who represent the majority of Members who utilize ESP services. The ESP ensures 24/7/365 access to clinical staff with expertise that is consistent with the populations served:</p> <ul style="list-style-type: none"> • Children, adolescents, and their families • Adults • Persons with mental health conditions • Persons with a substance use disorder conditions • Persons with co-occurring mental health and substance use disorder conditions
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	<ul style="list-style-type: none"> • Persons with co-occurring behavioral health and medical conditions <p>10. The ESP ensures that all ESP clinicians and other ESP staff receive training and meet core clinical competencies in serving the following special populations. The ESP ensures 24/7/365 access to clinical staff with expertise that is consistent with the populations served:</p> <ul style="list-style-type: none"> • 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 <p>11. All ESP staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with MBHP's credentialing criteria. For Certified Peer Specialists and Family Partners, this supervision includes peer supervision. The ESP shall ensure that any licensed subcontractor shall provide direct supervision of its clinical staff consistent with the requirements of its license.</p>
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Process Specifications

Triage, Crisis Assessment, Treatment Planning, Crisis Intervention, Stabilization, and Documentation

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. Within the populations defined in items #7-9 in the section Components of Service earlier in this document, the ESP accepts requests/referrals for ESP services directly from Members who seek them 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 clinicians, residential programs, schools, state agency personnel, law enforcement, courts, etc.
3. The ESP triages calls to its most appropriate ESP service component that will provide crisis behavioral health services to Members in the least restrictive setting, which ensures safety and is responsive to Member and family choice. The ESP has written triage protocols, including procedures for obtaining supervisory review of triage decisions in potentially high-risk situations.
4. Triage calls may be answered by master's-level staff, or by bachelor's-level staff with master's-level clinicians and supervisors available to consult with bachelor's-level staff and take calls when indicated. The ESP is expected to develop and maintain written protocols for this back-up and decision-making regarding access to master's-level clinicians.
5. An ESP clinician begins a crisis assessment as soon as possible and no later than one hour from time of readiness.
 - a. *Readiness* is the point at which the Member is able to participate in a behavioral health assessment. If the assessment occurs in a hospital ED, Members are considered to be ready for the behavioral health evaluation to begin when *medical clearance* has been completed, as required by each hospital ED's protocol. If the evaluation occurs in the community, *medical clearance* may or may not be required, depending on the presentation of the Member.
 - b. *Readiness* also assumes that the Member is awake and sufficiently cleared from the effects of substances so that he or she may participate in the evaluation.
 - c. The determination of whether a client may be psychiatrically evaluated ("time of readiness") or transferred to another level of care following an evaluation should not be based exclusively on the results of a urine or serum drug or alcohol test.
6. For all calls requesting mobile crisis intervention services:
 - a. The ESP accepts calls from referral sources, such as residential programs and hospital EDs, that initially provide the ESP with early notification that a Member will be referred, then follow up with a second call to the ESP as soon as the Member is ready for an assessment. The ESP uses this early notification for triage,

	<p>dispatching, and staff management purposes.</p> <ul style="list-style-type: none"> b. The ESP triage clinician or other staff keeps the referral source informed about the anticipated response time, including if the ESP is unable, in rare circumstances, to respond within the required one-hour timeframe. The ESP arranges the necessary staff resources or otherwise ensures a response as close to this timeframe as possible, keeping the referral source informed in the process. c. If an occurrence of the ESP being unable to arrive within one hour of time of readiness occurs in a hospital ED setting with MBHP Members, the ED has the option to perform the crisis assessment and intervention utilizing their own staff and then present the clinical information directly to the MBHP Clinical Access Line for review and authorization of care. If the ED chooses to do so: <ul style="list-style-type: none"> i. The ESP informs the MBHP Clinical Access Line that the ED will be doing so. If the ED has not received confirmation from the ESP that the Clinical Access Line has approved of its doing so, the ED may call the Clinical Access Line directly. ii. The ED must use a master's- or doctoral-level behavioral health clinician to perform the assessment. iii. When an ED does the assessment under these circumstances, it is expected that it will also complete the bed search, if needed, and follow the case through to disposition. <p>7. Triage and disposition decisions are made in conformance with the medical necessity criteria of MBHP or the individual's other payer, for authorization into each level of care within the payer's continuum of care. For MBHP Members, the ESP contacts MBHP, presents all relevant assessment information, and obtains authorization for subsequent services based on MBHP medical necessity criteria.</p> <p>8. Upon presentation to the ESP, the ESP asks the Member, significant others accompanying him/her, and/or community providers about the existence of an established crisis prevention plan and/or safety plan, and/or accesses any crisis prevention plan and/or safety plan on file at the ESP for the given Member.</p> <p>9. During the ESP intervention, the clinician updates any existing crisis prevention plan and/or safety plan or creates one with the Member. The plan includes the presenting problem, the specific problem to be addressed along with a treatment plan, preferred disposition plan, and the involvement of others who may be available to support the Member before or during crises (i.e., providers, agencies, significant others, and/or family members). The purpose of this plan is to expedite a Member-focused disposition based on the experience gained from past treatment interventions.</p> <p>10. The ESP ensures that each crisis assessment, intervention, and stabilization episode is documented in writing. To do so, the ESP is</p>
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required to utilize the adult and MCI standardized documentation forms. The documentation of each ESP encounter includes but is not limited to: name of Member; date and time of request; start time; location; presenting problem; mental status exam; involvement of other person(s) and agencies; action taken; clinical/diagnostic formulation; reason for rule-out of less restrictive alternatives; time of disposition; target problems to be addressed at the next level of care; and identifying information, signature, and title of staff person. The assessment includes short-term treatment planning with goals focused on pre-crisis and crisis intervention, stabilization, and disposition(s) in accordance with written crisis prevention plans and/or safety plans when available.

11. ESP assessments and dispositions are reviewed on a scheduled basis for clinical appropriateness by the ESP director, medical director, and/or designee and documented in the Member's health record within 48 hours of the intervention. Where there is a subcontract, the ESP ensures there is a similar process in place for the ESP or the subcontractor to review the subcontracted vendor's assessments and dispositions. The ESP implements an ongoing feedback loop to continually educate staff about opportunities to improve quality of care, including the identification of diversion opportunities.
12. Under the supervision of the ESP's medical director, the ESP follows written procedures for assessing medical needs (with specific sensitivity to recognizing valid medical concerns of those presenting with mental health and/or substance use disorder conditions), including the need for a medical evaluation, medical stabilization, or a referral to a hospital for emergency medical services.
13. The ESP manages the flow of communication throughout the ESP process with a given Member. ESP staff checks in with and updates Members and the family/significant others accompanying them regarding the status of the evaluation and/or disposition process no less than every 30 minutes. The ESP will similarly keep informed the referral source and/or stakeholders in the setting in which the ESP services are being provided, such as a school, residential program, or a hospital ED.
14. During and subsequent to the crisis assessment, the ESP clinician provides crisis counseling and crisis intervention. The ESP clinician listens and offers support. The ESP clinician 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.
15. Telephonic contact is recognized as therapeutic and may be utilized when clinically indicated and as defined by internal program policies and procedures (e.g., telephone "check-in" of a Member in a residential placement as part of his or her crisis prevention plan and/or safety plan or non-life-threatening crisis calls responsive to telephonic support and problem solving).
16. While it is expected that all ESP encounters minimally include the three

	<p>basic components of crisis assessment, intervention, and stabilization, crisis intervention requires 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.</p> <p>17. The ESP is responsible for the completion and electronic submission of an encounter form for every ESP/MCI intervention provided. For each subsequent day in an intervention, the ESP is responsible for the completion and electronic submission of an abbreviated subsequent ESP/MCI follow-up encounter. These subsequent encounters are connected to the full encounter by a unique encounter ID. The ESP ensures that encounter forms are electronically submitted to MBHP within the timeframe established by MBHP.</p>
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Disposition Planning and Documentation	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. The ESP develops and maintains protocols for assisting the ESP clinician and consulting with others in the event that there is a question and/or disagreement regarding the level of care that is medically necessary for a given Member. Protocols include the clinician's review of the disposition plan with the ESP Director and/or Medical Director and/or ESP psychiatric clinician. These ESP staff members are available to consult and collaborate with others, such as ED physicians, MBHP clinicians, and MBHP psychiatrists, to resolve the medical necessity determination and disposition as needed. 3. The ESP arranges the medically necessary behavioral health services that the Member requires to further treat his/her behavioral health condition based on the crisis assessment completed and the Member's medical needs and preferences. 4. 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. 5. The ESP 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. 6. For Members assessed to meet medical necessity criteria for inpatient mental health service or another 24-hour level of care, the ESP conducts a bed search to arrange admission. 7. The ESP promotes continuity of care for Members who are readmitted to inpatient mental health services by offering them readmission to the same provider when there is a bed available in that facility. 8. For Members who meet medical necessity criteria for inpatient mental health services, or another 24-hour level of care, the ESP arranges an admission to the closest facility with a bed available, consistent with the provider network and policies and procedures of the Member's health insurance payer. The following guidelines are utilized: <ul style="list-style-type: none"> • Closest proximity – Referrals within the ESP's DMH Area • Moderate proximity – Referrals within a contiguous DMH Area • Extended area – Referrals in a non-contiguous DMH Area 9. For uninsured adults who meet medical necessity criteria for inpatient mental health services, the ESP must first refer to acute care (general) hospitals in closest, moderate, and extended areas, as defined above. If no general hospital has an available bed, the ESP should refer to a private psychiatric hospital. 10. MBHP recognizes that there are times that inpatient disposition has been delayed during periods of high volume. If an ESP has contacted all MBHP in-network facilities and has been unable to secure a bed, the ESP is expected to call the MBHP Clinical Access Line or MBHP regional office. During business hours, MBHP regional staff will then assist the ESP in accessing an inpatient admission through direct contact with MBHP network providers. After hours, the MBHP Clinical Access Line will support the ESP with
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- information on potential bed availability. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals.
11. In the event that there are still no in-network beds available and no discharges are expected from in-network facilities within a reasonable time period of no more than six hours of the beginning of the bed search, the ESP may call out-of-network facilities. If needed, the ESP may ask the MBHP Clinical Access Line for suggestions of out-of-network facilities and related contact information. If a bed is located in an out-of-network facility, the ESP may then request an out-of-network authorization from the MBHP Clinical Access Line. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals.
 12. For youth receiving ESP services in a hospital ED and assessed to meet medical necessity criteria for inpatient services or another 24-hour level of care, and there is a delay in accessing a bed, it may be necessary to board youth under age 19 for a short period of time on pediatric units or in EDs. It is the ESP's responsibility to negotiate the need for boarding with the hospital and to request a boarding authorization from the MBHP Clinical Access Line for the boarding of MBHP child/adolescent Members. If all appropriate in-network and out-of-network inpatient facilities have been contacted and a bed has not been secured for the Member, a boarding authorization will be considered by the MBHP Clinical Access Line beginning at 5 p.m., as it is less likely that new beds will become available after this time. MBHP may also authorize Specializing during boarding of children/adolescents to ensure Member safety. The ESP is encouraged to follow appropriate protocols and/or call other payers for assistance in similar situations with their covered individuals.
 13. When a youth is boarded, the ESP remains responsible for continuing the bed search on an ongoing basis until disposition. Additionally, the ESP is required to re-evaluate the Member if 24 hours have elapsed since the original ESP evaluation and determination of level of care. During this process, the ESP keeps the Member, his or her accompanying parent or guardian, and the hospital ED informed on a regular basis about the status of this process.
 14. For continued authorization of boarding of youth who are MBHP Members, it is the ESP's responsibility to call the MBHP Clinical Access Line daily. The ESP provides the MBHP reference number to the boarding hospital to ensure payment of the claims later submitted by the hospital. Youth who meet the medical necessity criteria for inpatient services or another 24-hour level of care should not be sent home due to the lack of an available inpatient psychiatric bed.
 15. When the ESP secures a bed for a given MBHP Member, the ESP obtains an authorization (or reference number for uninsured individuals) from the MBHP Clinical Access Line and arranges transfer of the Member to the admitting facility. For individuals with other health insurance coverage, the ESP follows the appropriate authorization policies and procedures.

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| | <p>16. If an ESP psychiatrist, or an ED in which they are providing services, has concerns that an inpatient provider or provider of another 24-hour level of care is requesting additional medical tests beyond what is usual and customary in order to admit a Member, the ESP psychiatrist and/or ED physician with reservations should discuss the matter with the inpatient psychiatric unit physician requesting the tests. Hopefully, both parties will come to an agreement. If not, for MBHP Members and uninsured individuals, the ESP or ED may call MBHP's Clinical Access Line to notify them of this situation and be prepared to provide the following information: date, calling facility, name of caller, facility requesting additional testing, region of requesting facility, name of Member, and what tests were requested. MBHP will address this issue with the inpatient facility on the next business day. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals.</p> <p>17. The ESP follows written protocols for follow-up with the Members who received ESP services, particularly those who successfully remain in the community after ESP services, to ensure stabilization and facilitate the disposition.</p> |
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Service, Community, and Collateral Linkages

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| | <ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. 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. 3. 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 for the populations listed in the Staffing Requirements section, items #9 and 10 above. 4. 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. |
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5. 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.
6. The ESP is knowledgeable about community-based outpatient and diversionary services, inpatient psychiatric services, and substance use disorder treatment services, including Acute Treatment Services (ATS) and Enhanced Acute Treatment Services (E-ATS), and develops working relationships with the providers of those services, ensuring effective consultation and referral processes and seamless transfer and coordination of care.
7. 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:
 - a. Primary care services and hospitals
 - b. State agencies
 - c. Schools
 - d. Residential programs
 - e. Law enforcement entities
8. 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.
9. The ESP disseminates information to Members who receive ESP services 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.
10. The ESP develops and maintains relationships with the hospitals in its catchment areas characterized by ongoing and consistent communication, problem solving, and planning. 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.
11. When necessary, the program arranges transportation for crisis evaluation and disposition into each level of care within MBHP's continuum of care.

	<ol style="list-style-type: none"> 12. When consent is given, consultations with current providers are to be made as early as possible in the assessment and disposition formulation phase and are documented within the Member's health record, including notification to an outpatient provider of where a Member was hospitalized, with appropriate consent. 13. The ESP develops and maintains a comprehensive community resource directory that is updated on an ongoing basis and is readily available to clinical staff, Members, and families. Reasonable provisions should be made to allow Members to make copies of the directory. The directory should include, but not be limited to: <ol style="list-style-type: none"> a. the name of the resource; b. the location/address; c. the phone number; d. the services available; e. the hours of operation, including evenings and weekends; and f. accepted payment methods.
Quality Management (QM)	
	<ol style="list-style-type: none"> 1. The provider complies with all provisions of the corresponding section in the General performance specifications. 2. The ESP develops and maintains a quality improvement plan, at least annually, that contains improvement goals in accordance with MBHP's overall statewide improvement goals for ESPs. 3. The ESP implements all quality management tools and initiatives required by MBHP, including standardized assessment instruments, outcomes measures, stakeholder satisfaction services, health record reviews, reporting requirements, review of ESP Continuity of Care reports (profiling data), etc.

Mobile Crisis Intervention

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers of this service and all contracted services will be held accountable to the “General” performance specifications.**

Mobile Crisis Intervention is the youth (under the age of 21) -serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will 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, 7 days a week.

The service includes: A crisis assessment; engagement in a crisis planning process which may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

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

Components of Service

1. Mobile Crisis Intervention is youth-serving component of an emergency service program (ESP) provider.
2. Providers of Mobile Crisis Intervention services are outpatient hospitals, community health centers, mental health centers and other clinics.
3. Mobile Crisis Intervention is delivered by a provider with demonstrated infrastructure to support and ensure
 - a. Quality Management / Assurance
 - b. Utilization Management
 - c. Electronic Data Collection / IT

	<ul style="list-style-type: none"> d. Clinical and Psychiatric Expertise e. Cultural and Linguistic Competence <ol style="list-style-type: none"> 4. Mobile Crisis Intervention provides mobile, community-based crisis intervention services, which are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner. 5. Mobile Crisis Intervention provides crisis assessment and crisis stabilization intervention services 24 hours a day, 7 days a week, and 365 days a year. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to 7 days. 6. Mobile Crisis Intervention includes, but is not limited to: <ul style="list-style-type: none"> • 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; and • 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).
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	<ul style="list-style-type: none"> • Solution focused crisis counseling; • Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support; • Clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to 7 days; • 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. <p>7. Mobile Crisis Intervention assesses the safety needs of the youth and family. Mobile Crisis Intervention, with the consent of and in collaboration with the youth and family, guides the family through the crisis planning process that is in line with the family's present stage of readiness for change. This includes a review and use of the set of Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) where appropriate and in accordance with the Companion Guide for Providers. As the family chooses, Mobile Crisis Intervention engages existing service providers and/or other natural supports, as identified by the youth and family, to share in the development/update of the Crisis Planning Tools (e.g., ICC, In-Home Therapy Services, outpatient therapist). The tools are reflective of action the family believes may be beneficial. This may include, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Contacts and resources of individuals identified by the family who will be most helpful to them in a crisis; • Goal(s) of the Safety Plan or other Crisis Planning tools as identified by the family; • Action steps identified by the family • An open-format (the Safety Plan) that the family can choose to use as needed. <p>If a youth already has an existing set of Crisis Planning Tools, Mobile Crisis Intervention shall utilize the tools as they apply to the current situation and/or reassess the tool's effectiveness. Where necessary Mobile Crisis Intervention collaborates with the youth's parent/guardian/caregiver(s) and other provider(s), to build consensus for revisions to the tools and to share them as directed by the family.</p>
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	<p>8. Mobile Crisis Intervention identifies all necessary referrals and linkages to medically necessary behavioral health services and supports and facilitates referrals and access to those services. Mobile Crisis Intervention also works with the youth's health plan to arrange for dispositions to all levels of care, including inpatient and 24-hour services, diversionary services, outpatient services, and ICC.</p> <p>9. Mobile Crisis Intervention provides the following additional services:</p> <ul style="list-style-type: none"> • Crisis counseling and consultation to the family; • Emergency medication management and consultation; • Telephonic support to the youth and family; and • Coordination with other crisis stabilization providers. <p>10. For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention coordinates with the youth's care coordinator, throughout the delivery of the service. For youth not in ICC, Mobile Crisis Intervention will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers who provide services to the youth throughout the delivery of the service.</p> <p>11. The Mobile Crisis Intervention provider has policies and procedures relating to all components of this service. The Mobile Crisis Intervention provider ensures all new and existing staff members are trained on these policies and procedures.</p>
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Staffing Requirements

1. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff and maintains staffing levels as warranted by data trends.
2. Mobile Crisis Intervention is staffed with master's level clinicians trained in working with youth and families, with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de-escalation techniques.
3. Mobile Crisis Intervention is also staffed with bachelor's level or paraprofessional staff experienced or trained in providing ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system that support brief interventions that address behavior and safety.
4. A board-certified or board-eligible child psychiatrist or child trained Psychiatric Nurse Mental Health Clinical Specialist is available for phone consultation to Mobile Crisis Intervention 24-hours a day and must respond within 15 minutes of a request from Mobile Crisis Intervention staff and is available for face-to-face appointments with the youth for urgent medication management evaluations or urgent medication management appointments within 48 hours of a request if the youth has no existing provider
5. All Mobile Crisis Intervention staff receives crisis specific training through the agency that employs them. Prior to serving families independently, Mobile Crisis Intervention staff also complete 12 hours of on-the-job training in CPI or equivalent program. A master's level clinician with at least two years of crisis intervention experience supervises this training. This training is documented.
6. All Mobile Crisis Intervention staff are trained in the following: performance specifications, clinical criteria, and per diem definitions for all MCE behavioral health covered services; Systems of Care philosophy and the Wraparound process; medications and side effects; First Aid/CPR; youth-serving agencies and processes (e.g., DCF, IEP, DYS, etc.); family systems; conflict resolution; risk management; partnering with parents/guardians/caregivers; youth development; cultural competency; and related core clinical issues/topics. This training is documented.
7. Mobile Crisis Intervention staff members are knowledgeable about available community mental health and substance use disorder services within their geographical service area, the levels of care, and relevant laws and regulations. They also have knowledge about other medical, legal, emergency, and community services available

	<p>to the youth.</p> <p>8. Mobile Crisis Intervention supervises all staff, commensurate with licensure level and consistent with credentialing criteria.</p>
Service, Community, and Collateral Linkages	
	<ol style="list-style-type: none"> 1. As the youth-serving component of ESP providers, Mobile Crisis Intervention is integrated into the ESP's infrastructure, services, policies and procedures, staff supervision and training, and community linkages. 2. Mobile Crisis Intervention upon completion of a crisis assessment, works with the parent/guardian/caregiver(s) to provide needed crisis stabilization services and, if necessary, with the youth's insurance carrier to obtain authorization for medically necessary level of care for the youth. 3. Mobile Crisis Intervention will ensure smooth access to MassHealth behavioral health services in the area by maintaining regular communication and interagency relationships (e.g. MOU). 4. Mobile Crisis Intervention coordinates all behavioral health crisis response with the youth's existing providers, including Intensive Care Coordination (ICC), In-Home Therapy Services and outpatient providers (e.g., mentors, therapists), other care management programs and primary care provider (PCP)/primary care clinician (PCC). Mobile Crisis Intervention facilitates referrals for, and provides information on, both Medicaid and non-Medicaid services (e.g., ICC, PAL, DCF, voluntary services, in-home therapy). 5. Mobile Crisis Intervention, with required consent, makes referral to ICC, In-Home Therapy Services or other services as needed. 6. Mobile Crisis Intervention supports 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.). 7. For youth with ICC/In-Home Therapy Services that provide 24-hour response, Mobile Crisis Intervention staff contacts the provider for care coordination and disposition planning. The ICC/In-home Therapy Services staff and Mobile Crisis Intervention staff communicate and collaborate on a youth's treatment throughout the mobile crisis intervention or crisis stabilization to develop a disposition plan that is consistent with the youth's Individual Care Plan (ICP)/treatment plan. With required consent, the ICC care coordinator/In-Home Therapy Services clinician is required to participate in all meetings that occur during the youth's tenure with Mobile Crisis Intervention.

	<p>8. For youth engaged in services that do not provide 24-hour response, Mobile Crisis Intervention staff contacts the provider for the purpose of care coordination and disposition planning. Mobile Crisis Intervention staff communicates with the provider and collaborate on a youth's treatment to develop a disposition plan that is consistent with the youth's treatment plan.</p> <p>9. Mobile Crisis Intervention establishes formal relationships (e.g., MOU) including collaborative education and training with local police, emergency medical technicians (EMTs), schools, child welfare, local healthcare professionals and juvenile justice to promote effective and safe practices related to the management of emergency services for youth with mental health issues and their parent/guardian/caregivers(s).</p> <p>10. With obtained consent, crisis assessments occur in the youth's home setting or appropriate alternative community setting. Crisis assessments 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 services in home or alternative community settings; or if request for Mobile Crisis Intervention services originates from a hospital emergency department.</p> <p>11. In those instances in which a youth is sent to a hospital emergency department (ED), Mobile Crisis Intervention 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.</p>
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Quality Management (QM)	
	1. Mobile Crisis Intervention participates in all ESP network management, utilization management, and quality management initiatives and meetings.
Process Specifications	
Treatment Planning and Documentation	<ol style="list-style-type: none"> 1. Telephonic requests for Mobile Crisis Intervention are triaged through the established phone triage system of the ESP team. All calls are answered by the ESP by a live staff person. An answering machine or answering service is not permitted, including those directing callers to call 911 or to go to a hospital emergency department (ED). Mobile Crisis Intervention arrives within one (1) hour of receiving a telephone request 24 hours a day, 365 days a year. For remote geographical areas, Mobile Crisis Intervention arrives within the usual transport time to reach the destination. 2. Mobile Crisis Intervention includes both a master's level clinician trained in working with children and families, with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de-escalation techniques; and a paraprofessional or a Family Support and Training staff (Family Partner) experienced or trained in providing ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system who supports brief interventions that address behavior and safety; that mobilize to the home or other site where the youth is located (e.g., school, group home, residential program, etc.), 24 hours a day, 7 days a week. Between the hours of 10pm and 7am, Mobile Crisis Intervention staff may be on-call and dispatched by pager. 3. If Mobile Crisis Intervention determines that the situation warrants intervention by police or EMT personnel, Mobile Crisis Intervention calls and coordinates with them to ensure safety, and Mobile Crisis Intervention also responds in person to the location of the crisis.

	<ol style="list-style-type: none"> 4. Mobile Crisis Intervention immediately works to de-escalate the situation and intervenes to ensure the safety of all individuals in the environment, utilizing the interventions and services listed under the “components of service” section above. 5. Mobile Crisis Intervention completes a comprehensive crisis assessment, including the elements listed under the “components of service” section above and engages in delivering crisis stabilization services. 6. To complete the crisis assessment and crisis intervention, Mobile Crisis Intervention seeks consent to speak with collateral contacts (e.g., ICC care coordinator, In-Home Therapy Services clinician, outpatient therapist, psychiatrist, DCF worker, etc.) and natural supports (e.g., friends, neighbors, extended family, etc.) to enlist their support in stabilizing the situation and developing/updating the set of Crisis Planning Tools and aftercare plan. 7. For youth enrolled in ICC, Mobile Crisis Intervention staff collaborates with the ICC provider to ensure coordination of care around the youth’s Individual Care Plan (ICP) and, the set of Crisis Planning Tools, developed by the ICC care planning team. ICC providers are available 24/7 by phone or pager to answer calls from Mobile Crisis Intervention. Mobile Crisis Intervention coordinates with the ICC provider throughout the intervention. 8. The child psychiatrist or child trained Psychiatric Nurse Mental Health Clinical Specialist responds to Mobile Crisis Intervention staff requests for consultation within 15 minutes of the request, 24-hours per day, and 365 days per year. For urgent medication evaluations or urgent medication management appointments, the Mobile Crisis Intervention provider ensures face-to-face appointments with the youth’s existing prescriber or with Mobile Crisis Intervention’s psychiatric clinician within 48 hours. 9. If the crisis assessment indicates that placement outside of the home in an acute 24-hour behavioral health level of care (e.g., Crisis Stabilization setting, acute inpatient hospital, community based acute treatment (CBAT) setting, or intensive community based acute treatment (ICBAT) setting) is medically necessary, Mobile Crisis Intervention obtains authorization as needed; arranges transfer and admission to an appropriate facility; and consults with the receiving provider to assist the receiving provider to develop a plan for stabilizing the crisis that was addressed by the Mobile Crisis Intervention. 10. If the crisis assessment indicates that the youth is stable to remain in the community or current placement, Mobile Crisis Intervention obtains authorization for medically necessary community-based services and coordinates with the youth and family and the community-based service provides to ensure that the youth is receiving medically necessary services.
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	<p>11. If the youth is not already enrolled in ICC, Mobile Crisis Intervention may arrange a follow-up appointment with the ICC provider in the youth's service area and coordinates with the ICC provider for the following 7 days to ensure that the youth is receiving medically necessary services.</p>
Discharge Planning and Documentation	<ol style="list-style-type: none"> 1. For youth who remain in the community, Mobile Crisis Intervention will be in contact with the family for a period of up to 7 days following discharge from a mobile crisis intervention, to ensure that the aftercare plan developed during the intervention has been implemented and will offer assistance as necessary in order to ensure that the plan is implemented. 2. For youth with ICC, Mobile Crisis Intervention plans and coordinates <i>all</i> referrals for aftercare services with the ICC care coordinator. Mobile Crisis Intervention conducts at least one phone call or face-to-face meeting with the ICC provider and the family to facilitate the transition. 3. For youth with In-Home Therapy Services (or who Mobile Crisis Intervention has referred for In-Home Therapy Services), Mobile Crisis Intervention conducts at least one phone call or face-to-face meeting with the In-Home Therapy Services provider and the family to facilitate the transition. 4. Mobile Crisis Intervention facilitates access to Crisis Stabilization Services, ICC, In-Home Therapy Services, or other levels of care/covered services as medically necessary and ensures that families have established a connection with the services and supports identified through Mobile Crisis Intervention assessment and intervention. Mobile Crisis Intervention remains involved with the youth and his/her parent/guardian/caregiver(s) until aftercare services are established and work has begun with the identified aftercare provider(s). Simply making a referral for an aftercare service does not meet the criteria for ensuring that the youth and his/her parent/guardian/caregiver(s) have established a connection with a provider. If the parent or guardian declines aftercare supports and services, this must be clearly documented in the youth's medical record. 5. With required consent, the Mobile Crisis Intervention provider sends copies of the crisis assessment to all necessary providers as identified by the youth and parent/guardian/caregiver, including state agency, school, and juvenile justice personnel. With signed consent, a copy of any Crisis Planning Tools is shared with all individuals and/or providers as identified by the youth and family.

Adult Community Crisis Stabilization (CCS)

Providers contracted for this level of care will be expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers of this service and all contracted services will be held accountable to the “General” performance specifications**, located at the beginning of this section of the *MBHP Provider Manual*.

The adult **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 – 21 under the Children’s Behavioral Health Initiative (CBHI). Adult CCS provides a distinct level of care where primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing, medically necessary treatment and support services. Adult CCS staff provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; psychiatric evaluation and medication management; peer-to-peer support; and mobilization of natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

This program is required to have a home-like, consumer-friendly, and comfortable environment that is conducive to recovery. CCS staff provides psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual’s specific community. Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. In the case of young adults who are involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings.

Note that the primary differences between CCS and inpatient level of care is the acuity of the consumer, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to the CCS occur 24/7/365 based on determinations made by mobile and site-based ESP staff. Discharges from the CCS occur 24/7/365, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Criteria	
Admission Criteria	<p><i>All of the following criteria (1-5) are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual demonstrates active symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis, which requires and can reasonably be expected to respond to intensive, structured intervention within a brief period of time. 2. The individual demonstrates a significant incapacitating or debilitating disturbance in mood/thought/behavior interfering with ADLs to the extent that immediate stabilization is required. 3. Clinical evaluation of the individual's condition indicates recent significant decompensation with a strong potential for danger to self or others, and the individual cannot be safely maintained in a less restrictive level of care. 4. The individual requires 23-hour observation and supervision but not the constant observation of an inpatient psychiatric setting except where being used as an alternative to an inpatient level of care. 5. Clinical evaluation indicates that the individual can be effectively treated with short-term, intensive crisis intervention services and returned to a less intensive level of care within a brief time frame. <p><i>One of the following criteria (6-7) is also necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. A less intensive or restrictive level of care has been considered or tried. 2. Clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care, and it is reasonably expected that a short-term crisis stabilization period in a safe and supportive environment will ameliorate the individual's symptoms.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following criteria (1-6) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting. 2. The individual's medical condition is such that it can only be safely treated in a medical hospital.

	<ol style="list-style-type: none"> 3. The individual/family/guardian does not voluntarily consent to admission or treatment. 4. The individual can be safely maintained and effectively treated in a less intensive level of care. 5. The primary problem is social, economic, medical, or involving threat to others without a concurrent major psychiatric episode meeting criteria for this level of care. 6. Admission is being used for purposes of convenience or as an alternative to incarceration, protective services, or simply as respite or housing. 7. The individual does not have a disposition in place prior to discharge.
Continued Stay Criteria	<p><i>All of the following criteria (1-11) are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual's condition continues to meet admission criteria at this level of care. 2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate or is available. 3. Care is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan. 4. Treatment planning is individualized and age appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family/guardian or other support systems, social, occupational, educational, and interpersonal assessment with involvement unless contraindicated. Expected benefits from all relevant modalities, including family and group treatment, are documented and expected to improve the individual's condition in a relatively short period of time. 5. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. 6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident. 7. The individual is actively participating in treatment to the extent possible consistent with the individual's condition.

	<ol style="list-style-type: none"> 8. Family, guardian, and/or custodian are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them. 9. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated. 10. There is documented active discharge planning beginning from admission. 11. There is documented active coordination of care with behavioral health providers, the PCP (primary care physician), and other services. If coordination is not successful, the reasons are documented.
Discharge Criteria	<p><i>Any of the following criteria (1-6) is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged at an alternate level of care. 2. The individual no longer meets admission criteria or meets criteria for a less or more intensive level of care. 3. The individual, family, guardian, and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment. 4. Consent for treatment is withdrawn by the individual and/or guardian, and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an inpatient level of care. 5. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured, including focus on transitional services as deemed appropriate based on individual need. 6. The patient is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care.

ADULT COMMUNITY CRISIS STABILIZATION PROGRAM (CCS)

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers of this service and all contracted services will be held accountable to the “General” performance specifications**, located at the beginning of this section of the *MBHP Provider Manual*.

The adult **Community Crisis Stabilization program (CCS)** provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18-21 under the Children’s Behavioral Health Initiative (CBHI). Adult CCS provides a distinct level of care where primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing, medically necessary treatment and support services. Adult CCS staff provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Services at this level of care include crisis stabilization; initial and continuing bio-psychosocial assessment; care management; psychiatric evaluation and medication management; peer-to-peer support; and mobilization of natural supports and community resources. CCS services are short-term, providing 23-hour observation and supervision, and continual re-evaluation.

This program is required to have a home-like, consumer-friendly, and comfortable environment that is conducive to recovery. CCS staff provides psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual’s specific community. Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. In the case of young adults who are involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings.

Note that the primary differences between CCS and inpatient level of care is the acuity of the consumer, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to the CCS occur 24/7/365 based on determinations made by mobile and site-based Emergency Services Program (ESP) staff. Discharges from the CCS occur 24/7/365, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is minimally evaluated on a daily basis, and the length of stay is expected to be very brief.

Components of Service

1. The ESP operates a CCS 24/7/365 for adults ages 18 and older. Admissions and discharges occur 24/7/365.
2. The CCS provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization.
3. The CCS is 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 sufficient service capacity, and the admission criteria are met. ESP's outcomes are measured relative to the proportion of diversionary versus step-down admissions, with the expectation being that the majority are the former.
4. The CCS provides a distinct level of care where primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing medically necessary treatment and support services.
5. CCS services are short-term, providing 23-hour observation and supervision, and daily re-evaluation and assessment of readiness for discharge. Through this process, the CCS strives to meet benchmarks for length of stay against which the program is measured by MBHP.
6. The CCS provides continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services.
7. CCS services include crisis stabilization; initial and continuing biopsychosocial assessment; care management; psychiatric evaluation and medication management; peer-to-peer support; mobilization of and coordination with family and other natural supports, community treaters and other resources; psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual's specific community.

	<ol style="list-style-type: none"> 8. Individuals who are admitted to the CCS must have a community-based disposition in place at the time of admission to the CCS. 9. The CCS is co-located with the ESP's community-based location in order to enhance service continuity and increase administrative efficiency to benefit those served. The overall ESP program operates in a fashion that ensures fluidity among ESP mobile services, site-based crisis services at the ESP community-based location, and the adult CCS and minimizes inconvenience to individuals in crisis. 10. The CCS has a home-like, consumer friendly, and comfortable environment that is conducive to recovery.
Staffing Requirements	
	<ol style="list-style-type: none"> 1. The ESP maintains appropriate staffing patterns in the CCS to safely care for all persons 24/7/365. The ESP has a written plan that delineates, by shift, the number and qualifications of its staff, including psychiatry, nursing, clinicians, milieu workers, and other staff in relation to its average daily census. 2. The CCS provides awake staffing 24/7/365. 3. With the use of fluidly trained staff and cross-scheduling, programs demonstrate the ability to respond to varying levels of demand in the ESP's three primary three service components: adult and youth mobile services, the ESP community-based location, and the adult CCS program. All staff members are expected to share expertise in terms of clinical knowledge, service delivery (as appropriate for each discipline), and discharge planning. 4. The CCS utilizes a multidisciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions of adults. 5. The medical and clinical care of the CCS is managed by the ESP medical director and the CCS nurse manager. The medical director is a board-certified or board-eligible psychiatrist, and the nurse is a registered nurse. 6. The ESP ensures adequate psychiatric coverage to ensure all CCS performance specifications are met. 7. The CCS has an attending psychiatrist who may be the ESP medical director or another psychiatrist. When the attending

	<p>psychiatrist is not available, he/she designates a consistent substitute, as much as possible, to ensure that the Member receives continuity of care. The psychiatrist may delegate some psychiatric functions to a psychiatric nurse mental health clinical specialist.</p> <ol style="list-style-type: none"> 8. The CCS ensures 24/7/365 availability of a psychiatric clinician, either a board-certified or board-eligible psychiatrist, or a psychiatric nurse mental health clinical specialist, including nights and weekends. The psychiatric clinician is available for a psychiatric phone consultation within 15 minutes of request and for a face-to-face evaluation within 60 minutes of request, when clinically indicated. 9. The CCS's psychiatric clinicians provide psychiatric assessment, medication evaluations, and medication management, and contribute to the comprehensive assessment and discharge planning. 10. The nurse manager has overall responsibility for the CCS and accountability to the ESP director. She/he fills physician orders; administers medication; takes vital signs; coordinates medical care; contributes to comprehensive assessment, brief crisis counseling, individualized crisis prevention planning, and provider psycho- education; and assists with discharge planning and care coordination. The nurse manager leads treatment team meetings, or assigns a staff member to do so. The nurse manager also supervises LPNs and other staff working in the CCS. The nurse manager is a full-time position and works first shift or business hours unless otherwise approved by MBHP. 11. Licensed practical nurse (LPN) staffing, appropriate to licensure level, assist the nurse manager with filling physician orders, administering medications, and monitoring vital signs. They also work with the bachelor's level staff in ensuring an environment that promotes safety, recovery, and treatment. They contribute to the assessment, individualized crisis planning, discharge planning, and care coordination. The ESP provides adequate LPN staffing to ensure that all performance specifications are met. This staffing is generally expected to include an LPN on second and third shift on weekdays and all three shifts on weekends for average size adult CCS programs, unless otherwise approved by MBHP. 12. Master's level clinicians are primarily responsible for conducting comprehensive assessments, brief crisis counseling, psycho- education, and treatment team functions as noted below. The ESP provides adequate master's level clinician staffing to ensure that all performance specifications are met. This staffing is generally
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	<p>expected to include a master's level clinician working at least one shift per day, unless otherwise approved by MBHP.</p> <p>13. The CCS provides bachelor's level milieu staff, preferably who are also credentialed as Certified Peer Specialists (CPS). These staff ensure an environment that promotes safety, recovery, and treatment. They contribute to the assessment, individualized crisis planning, discharge planning, and care coordination. Those who are certified as a CPS also provide peer-to-peer support and psycho-education about rehabilitation and recovery. As resources and time permit, the adult CCS will also have access to the Certified Peer Specialists who primarily staff the ESP's community-based location. The ESP provides adequate bachelor's level milieu staffing, with CPS preferred, to ensure that all performance specifications are met. This staffing is generally expected to include a bachelor's level staff 24/7/365 for average size adult CCS programs, unless otherwise approved by MBHP.</p> <p>14. All ESP staff participate in ongoing supervision appropriate to their discipline and level of training and licensing. For Certified Peer Specialists and Family Partners, this supervision includes peer supervision.</p> <p>15. The ESP ensures that CCS staff are included in all appropriate ESP staff training, including training required in the ESP Performance Specifications.</p>
Service, Community, and Collateral Linkages	
	<ol style="list-style-type: none"> 1. With Member consent, treatment providers, family members, and other collaterals are contacted within 24 hours of admission. 2. In the case of young adults who are involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings. 3. The CCS refers all pregnant, substance-abusing female MBHP Members to MBHP's Intensive Case Management (ICM) Program, as well as other MBHP Members as indicated. All such referrals are documented in the Member's medical record. 4. The CCS adheres to established program procedures for referral to a more restrictive, medically necessary behavioral health level of care when the patient is unable to be treated safely in the CCS. 5. The CCS adheres to established program procedures for determining the necessity of a referral to a hospital when a Member requires non-psychiatric medical screening or stabilization.

	<ol style="list-style-type: none"> 6. The ESP and CCS maintain knowledge of, and relationships with, behavioral health levels of care and other resources to which the CCS makes referrals for aftercare. 7. CCS and other ESP management and direct care staff hold regular meetings and communicate on clinical and administrative issues to enhance continuity of care.
Process Specifications	
Assessment and Treatment Planning	<ol style="list-style-type: none"> 1. The CCS ensures that a comprehensive assessment and initial treatment plan is completed, a multidisciplinary treatment team has been assigned, and that the treatment team has met to review the assessment and initial treatment plan within 24 hours of admission. 2. A psychiatric clinician conducts a psychiatric assessment, including a medication evaluation, of each individual within 24 hours of admission during weekdays. On weekends and holidays, a master's level clinician may alternatively conduct an assessment and review the assessment, including the current medication regimen, and initial CCS treatment plan, with a psychiatric clinician by phone within six hours of the admission. A psychiatric clinician then conducts a psychiatric assessment within 24 hours, i.e., on Monday for weekend admissions or the subsequent day for holiday admissions. Subsequent to the psychiatric assessment and medication evaluation, a psychiatric clinician provides ongoing, face-to-face assessment, stabilization, treatment, and medication management services to the Member during the duration of their stay, as indicated by the CCS treatment plan. 3. All consultations indicated in the CCS treatment plan should be ordered within 24 hours of admission and provided in a timely manner.
Stabilization and Treatment	<ol style="list-style-type: none"> 1. Adult CCS staff provides 23-hour observation, supervision, and support, and daily re-evaluation and assessment of readiness for discharge. 2. The CCS staff engages Members in structured therapeutic programming seven days per week, including treatment activities designed to stabilize the individual; restore functioning; strengthen the resources and capacities of the individual, family, and other natural supports; prepare for timely return to a natural setting and/or least restrictive setting in the community; develop and/or strengthen an individualized risk management/safety plan; and link to ongoing, medically necessary treatment and support services.

	<ol style="list-style-type: none"> 3. The CCS staff provides psycho-education, including information about recovery, rehabilitation, crisis self-management, and how to access recovery and rehabilitation services available in the individual's specific community. 4. Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. 5. The CCS staff carefully coordinates treatment with existing and/or newly established treatment providers.
Disposition Planning and Risk Management/Safety Planning	<ol style="list-style-type: none"> 1. Upon admission, the CCS: <ol style="list-style-type: none"> a. assigns a clinician or other appropriate staff to be responsible for risk management/safety planning, discharge planning, and ensuring a smooth transition to medically necessary services, if any; and b. documents all efforts related to these activities, including the individual's participation in discharge planning. 2. CCS staff confirms that, upon presentation to the ESP, the ESP clinician asked the individual, significant others accompanying him/her, and/or community providers as to the existence of an established risk management/safety plan, and/or accessed any risk management/safety plan on file at the ESP for the given individual. The CCS staff obtains the risk management/safety plan from the ESP clinician. 3. During the ESP intervention, the ESP clinician updates any existing risk management/safety plan or creates one with the individual. The plan includes the presenting problem, the specific problem to be addressed along with a treatment plan, preferred disposition plan, and the involvement of others who may be available to support the individual before or during crises (i.e., providers, agencies, significant others, and/or family members). The purpose of this plan is to expedite a client-focused disposition based on the experience gained from past treatment interventions. The CCS staff obtains the updated or newly created risk management/safety plan from the ESP clinician and updates it further during the course of treatment at the CCS. 4. Upon discharge from the CCS, the CCS staff provides a copy of the updated risk management/safety plan to the individual, and with consent, to family members, the ESP, continuing or new community treaters, and/or other collaterals. 5. The CCS schedules post-discharge appointments for Members as follows: within seven business days of discharge for outpatient services, if medically necessary; and within 14 business days of discharge for medication monitoring, if medically necessary.