MOBILE CRISIS INTERVENTION (MCI)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

Mobile Crisis Intervention (MCI) is the youth (under the age of 21) -serving component of an Emergency Service Program (ESP) provider. MCI 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 that may result in the development/update of one or more Crisis Planning Tools (e.g., 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 seven (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), MCI staff will coordinate with the youth's ICC Care Coordinator throughout the delivery of the service. MCI 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.

SERVICE COMPONENTS

1. MCI is the youth-serving component of an ESP provider.
2. Providers of MCI services are outpatient hospitals, community health centers, mental health centers and other clinics.
3. MCI is delivered by a provider with demonstrated infrastructure to support and ensure
    a. Quality Management/Assurance,
    b. Utilization Management,
    c. Electronic Data Collection/IT,
    d. Clinical and Psychiatric Expertise, and
    e. Cultural and Linguistic Competence.
4. MCI provides mobile, community-based crisis intervention services, which are intended to reduce the volume of emergency behavioral health services provided in hospital Emergency Departments (ED) 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. MCI 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 seven days.
6. MCI includes, but is not limited to:
    a. conducting a mental status exam;
    b. 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);
    c. assessing the youth's behavior and the responses of parents/guardians/caregivers and others to the youth's behavior;
    d. assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources in Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care;
    e. assessing medication compliance and/or past medication trials;
    f. assessing safety/risk issues for the youth and parents/guardians/caregivers;
    g. taking a medical history/screening for medical issues;
    h. assessing current functioning at home, school, and in the community;
    i. identifying current providers, including state agency involvement;
    j. Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parents/guardians/caregivers.
    k. solution focused crisis counseling;
    l. identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support;
    m. clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to 7 days; and

n. 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.

7. MCI assesses the safety needs of the youth and family. MCI, 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 (e.g., 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, MCI 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 (IHT), outpatient therapist). The tools are reflective of action the family believes may be beneficial.
8. This may include, but is not limited to, the following:
    a. contacts and resources of individuals identified by the family who will be most helpful to them in a crisis;
    b. goals of the Safety Plan or other Crisis Planning tools as identified by the family;
    c. action steps identified by the family; and
    d. an open format (the Safety Plan) that the family can choose to use as needed.
    e. If a youth already has an existing set of Crisis Planning Tools, MCI shall utilize the tools as they apply to the current situation and/or reassess the tool's effectiveness. Where necessary, MCI collaborates with the youth's parents/guardians/caregivers and other providers, to build consensus for revisions to the tools and to share them as directed by the family.
9. MCI identifies all necessary referrals and linkages to medically necessary behavioral health services and supports and facilitates referrals and access to those services. MCI 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.
10. MCI provides the following additional services:
    a. crisis counseling and consultation to the family;
    b. emergency medication management and consultation;
    c. telephonic support to the youth and family; and
    d. coordination with other crisis stabilization providers.
11. For youth who are receiving ICC, and/or IHT, MCI coordinates with the youth's care coordinator/clinician, throughout the delivery of the service. For youth not in ICC/IHT, MCI 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.
12. The MCI provider has policies and procedures relating to all components of this service. The MCI provider ensures that all new and existing staff members are trained on these policies and procedures.

STAFFING REQUIREMENTS

1. MCI utilizes a multidisciplinary model, with both professional and paraprofessional/family partner staff and maintains staffing levels as warranted by data trends.
2. MCI 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. MCI is also staffed with bachelor's level or paraprofessional staff/family partner experienced or trained in providing ongoing in-home Crisis Stabilization Services (CSS) 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 MCI 24 hours a day and must respond within 15 minutes of a request from MCI 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 MCI staff receives crisis specific training through the agency that employs them. Prior to serving families independently, MCI staff also complete 12 hours of on-the-job training in crisis prevention or an 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 MCI staff are trained annually 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; peer supports; conflict resolution; risk management; Substance Use Disorder; partnering with parents/guardians/caregivers; youth development; cultural competency; and related core clinical issues/topics (such as ASD/IDD). This training is documented.
7. MCI 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 to the youth.
8. MCI supervises all staff, commensurate with licensure level and consistent with credentialing criteria.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. As the youth-serving component of ESP providers, MCI is integrated into the ESP's infrastructure, services, policies and procedures, staff supervision and training, and community linkages.
2. MCI, upon completion of a crisis assessment, works with the parents/guardians/caregivers to provide needed CSS and, if necessary, with the youth's insurance carrier to obtain authorization for medically necessary level of care for the youth.
3. MCI will ensure smooth access to MassHealth behavioral health services in the area by maintaining regular communication and interagency relationships (e.g., MOU).

4. MCI coordinates all behavioral health crisis response with the youth's existing providers, including ICC, IHT and outpatient providers (e.g., mentors, therapists), other care management programs and primary care provider (PCP)/primary care clinician (PCC). MCI facilitates referrals for, and provides information on, both Medicaid and non-Medicaid services (e.g., ICC, PAL, DCF, voluntary services, IHT).
5. MCI, with required consent, makes referral to ICC, IHT or other services as needed.
6. MCI supports linkages with the family's natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g., Family Resources Center, Parental Stress Line, AA, PPAL, etc.).
7. For youth with ICC/IHT services that provide 24-hour response, MCI staff contacts the provider for care coordination and disposition planning. The ICC/IHT staff and MCI 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 ICP/treatment plan. With required consent, the ICC Care Coordinator/IHT clinician is required to participate in all meetings that occur during the youth's tenure with MCI.
8. For youth engaged in services that do not provide 24-hour response, MCI staff contacts the provider for the purpose of care coordination and disposition planning. MCI 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.
9. MCI establishes formal relationships (e.g., MOU) including collaborative education and training with local police, Emergency Medical Technicians (EMT), 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 parents/guardians/caregivers.
10. With obtained consent, crisis assessments occur in the youth's home setting or appropriate alternative community setting. Crisis assessments occur only in a hospital ED if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuses required consent for service in home or alternative community settings; or if request for MCI services originates from a hospital ED.
11. In those instances, in which a youth is sent to a hospital ED, MCI mobilizes to the ED. The number of hospital-based interventions will be closely monitored to ensure that MCI services are delivered primarily in community settings.
12. If a youth is evaluated by an MCI team and is awaiting placement for a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP)
    a. MCI has daily contact with the caregiver to facilitate safety planning and stabilization in the home, and
    b. MCI has daily contact with the IHT and/or ICC provider for care coordination.
13. If the youth is determined to not meet level of care for a 24-hour behavioral health placement
    a. MCI meets with the youth and caregiver to update the safety plan and provide stabilization, and
    b. MCI coordinates with the youth's existing provider to ensure referrals are made to appropriate community-based services to stabilize youth in the community.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. Telephonic requests for MCI 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 ED. MCI arrives within one hour of receiving a telephone request 24 hours a day, 365 days a year. For remote geographical areas, MCI arrives within the usual transport time to reach the destination.
2. MCI 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 CSS and in navigating the behavioral health crisis response system who supports brief interventions that address behavior and safety; the team mobilizes 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, MCI staff may be on-call and dispatched by pager.
3. If MCI determines that the situation warrants intervention by police or EMT personnel, MCI calls and coordinates with them to ensure safety, and MCI also responds in person to the location of the crisis.
4. Services shall be provided to the youth and family in the home/community. Providers may deliver services via a HIPAA-compliant telehealth platform at the family's request and if the service can be effectively delivered via telehealth. Services delivered through a telehealth platform must conform to all applicable standards of care. When providing services via telehealth, providers shall follow the current MassHealth and MCE guidelines regarding telehealth.
5. MCI 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 "Service Components" section above.
6. MCI completes a comprehensive crisis assessment, including the elements listed under the "Service Components" section above and engages in delivering CSS.
7. To complete the crisis assessment and crisis intervention, MCI seeks consent to speak with collateral contacts (e.g., ICC Care Coordinator, IHT 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
8. For youth enrolled in ICC, MCI staff collaborates with the ICC provider to ensure coordination of care around the youth's 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 MCI. MCI coordinates with the ICC provider throughout the intervention.
9. The child psychiatrist or child trained Psychiatric Nurse Mental Health Clinical Specialist responds to MCI 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 MCI provider ensures face-to-face appointments with the youth's existing prescriber or with the MCI psychiatric clinician within 48 hours.

10. 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, MCI 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 MCI.
11. If the crisis assessment indicates that the youth is stable to remain in the community or current placement, MCI 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.
12. If the youth is not already enrolled in ICC, MCI 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 seven (7) days to ensure that the youth is receiving medically necessary services.

Discharge Planning and Documentation

1. For youth who remain in the community, MCI will be in contact with the family for a period of up to seven (7) days following discharge from a MCI, 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, MCI plans and coordinates all referrals for aftercare services with the ICC Care Coordinator. MCI 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 IHT (or who MCI has referred for IHT), MCI conducts at least one phone call or face-to-face meeting with the IHT provider and the family to facilitate the transition.
4. MCI facilitates access to CSS, ICC, IHT, 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 MCI assessment and intervention. MCI remains involved with the youth and his/her parents/guardians/caregivers until aftercare services are established and work has begun with the identified aftercare providers. Simply making a referral for an aftercare service does not meet the criteria for ensuring that the youth and his/her parents/guardians/caregivers 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 MCI 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.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.