EMERGENCY SERVICES PROGRAM (ESP)

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

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 Enrollees 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 an Enrollee 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 an Enrollee 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 Enrollee and their 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 Enrollee selects to further treat their behavioral health condition based on the assessment completed and the Enrollee'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 Enrollee and their 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 Enrollee's participation in the treatment, and the number and type of follow-up

services.

ESP services are directly accessible to Enrollees 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 to bring treatment to Enrollees in crisis, allow for Enrollee 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.

SERVICE COMPONENTS

1. The ESP provider is contracted to provide crisis behavioral health services in a specified catchment area in the Commonwealth of Massachusetts.
2. 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.
3. 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 Enrollees 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.
4. 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.
5. 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:
    a) Staff recruitment, hiring, training, supervision, and evaluation
    b) Triage
    c) Clinical and medical oversight
    d) Quality management/risk management
    e) Information technology, data management, and reporting

f) Claims and encounter form submission
g) Oversight of subcontracts
h) Interface with payers including the MassHealth-contracted Managed Care Entities (MCEs)
i) Interface with the Plan for contract management purposes

6. 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, OneCare, CarePlus, DMH only, Medicare, and Medicare/Medicaid.
    a) 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 the Plan 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 Enrollees.
7. ESP services are available to Enrollees of all ages.
8. ESP services are available to Enrollees who present with mental health, substance use, and/or co- occurring mental health and substance use disorders.
9. The ESP ensures that ESP services are accessible throughout the entire catchment area 24/7/365.
10. The ESP responds to all requests for crisis assessment, intervention, and stabilization in a timely fashion, in order to be responsive to the Enrollee's and/or caretakers' sense of urgency, intervene in behavioral health crises early, and prevent the adverse impact that treatment delay may have on Enrollees, families, and settings in which those Enrollees await these services, particularly hospital emergency departments (EDs), in order to minimize the duration of Enrollees' 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 Enrollee's readiness for ESP crisis assessment is provided in every encounter and maintained across its program.
11. All ESP services in each 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."
12. The ESP triages calls to its most appropriate ESP service component, the one that will provide crisis behavioral health services to the Enrollee in the least-restrictive setting, ensuring safety and responsiveness to Enrollee and family choice.
13. 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.
14. 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.

15. The ESP supports resiliency, wellness, and recovery of all Enrollees 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.
16. 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.
17. 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.
    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 (MCI) 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 MCI 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 Enrollees and families to seek crisis services in this less-restrictive, community-based setting. The physical environment and interpersonal climate are 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.
18. The ESP provides MCI 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 inpatient psychiatric services. (Refer to the MCI performance specifications for more details about ESP/MCI provider requirements relative to that ESP service component).
19. The core ESP service of crisis assessment, intervention, and stabilization is provided to adults primarily through the ESP's adult MCI services, in addition to ESP services provided to adults at the ESP's community-based location. The ESP provides adult MCI services to any community-based location, including private homes, from 7 a.m. to 8 p.m. Outside of those hours, adult MCI 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.
20. 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).

21. 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.
22. The ESP continually assesses risk for Enrollees 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:
    a) Offering various venues for services, obtaining supervisory consultation around these triage decisions, and utilizing the hospital ED for those Enrollees 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 Enrollees 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 ensure that at least two staff are present in the community-based location during at least high-volume operating hours.
23. Subject to applicable state and federal regulations that entitle MassHealth Enrollees 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 Enrollees 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 MCI 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.
24. 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.
25. The ESP is responsible for arranging transportation for Enrollees, inclusive of private ambulances, to the appropriate levels of care determined for disposition. The ESP also provides transportation arrangement for Enrollees and their families to and from the ESP, home setting, or appropriate outpatient and/or medication service following an ESP intervention. The ESP assists Enrollees to arrange MassHealth transportation benefits.

26. The ESP practices in accordance with all Alerts and provider communications issued by MassHealth and MassHealth-contracted payers.
27. The ESP implements protocols developed by the Plan regarding medical evaluation or "clearance." The ESP refers deferentially to hospital EDs and primary care clinicians, within a timeframe that is based on the urgency of that need.
28. 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 the Plan (if a crisis prevention plan and/or safety plan was not developed in conjunction with the Plan), and notifying relevant providers, family members, and significant others, as necessary and with the appropriate informed consent.
29. The ESP ensures that all service delivery integrates the following populations:
    a) Children, adolescents, and their families
    b) Adults
    c) Persons with mental health conditions
    d) Persons with substance use disorder conditions
    e) Persons with co-occurring mental health and substance use disorder conditions
    f) Persons with co-occurring behavioral health and medical conditions
    g) The ESP ensures that service delivery facilitates communication, access, and an informed clinical approach with special populations including but not limited to:
    h) Intellectual and developmental disabilities
    i) Deaf and hard of hearing
    j) Blind, deaf-blind, and visually impaired
    k) Culturally and linguistically diverse populations
    l) Elders
    m) Veterans
    n) Homeless
    o) Gay, lesbian, bisexual, transgendered
30. ESPs should consistently utilize the Massachusetts Behavioral Health Access website (www.MABHAccess.com) to locate services for all populations, including commercial payers.
31. 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.

STAFFING REQUIREMENTS

1. 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.
2. The ESP uses its staffing resources in an integrated and flexible manner, utilizing all available resources to respond to the needs of Enrollees who require its services daily, with fluctuations in volume, intensity, location of services, etc.
3. ESP staffing is based on a multi-disciplinary team, including the following positions:

a) ESP medical director: This is a psychiatrist who meets the Plan'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 their ESP medical director role, the psychiatric care delivered by them and/or other psychiatric clinicians during business hours, and the after-hours psychiatric consultation function fulfilled by them 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.

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. They are 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 the Plan 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 the Plan, 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 Enrollees of all ages in all ESP service components and locations, including both MCI services and those provided on-site in the ESP's community-based location. They are responsible for staff recruitment, orientation, training, and supervision. They provide administrative and clinical supervision to key program-level supervisory staff. The ESP director also develops and maintains working relationships with all appropriate community stakeholders.

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 Plan 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 the Plan and implementing stakeholder satisfaction surveys.

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.

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 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.

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 the Plan's credentialing criteria provide consultation across all ESP service components.

h) Psychiatric consultation (after hours): These psychiatrists and/or PNMHCSs who meet the Plan'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 Enrollees.

i) Certified peer specialists (CPSs) help to make community-based ESP services welcoming, comfortable, supportive, and responsive to Enrollees who utilize them and their families. Certified peer specialists provide support to the Enrollee, 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 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 Enrollee is being referred after the ESP intervention, and they work with the Enrollee and family to support them during the transition to those follow-up services. CPS staff also provide similar services in the ESP's adult MCI 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 Enrollees, particularly during adult MCI services, as well as in the community-based location. These staff members help to support the Enrollee and their family, and they perform such tasks as assisting with implementing the disposition determined by the master's-level clinician. This additional support brings efficiency to the system by allowing adult mobile response master's-level clinicians to focus exclusively on the provision of direct clinical services. ESP providers are encouraged to hire bachelor's-level staff who are also credentialed as certified peer specialists.

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.)

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.

4. The ESP cooperates with hospitals that require ESP clinicians to be credentialed to provide crisis assessments in the hospital ED, according to Network Alert #19 General Hospitals Credentialing ESPs.
5. 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.
6. The ESP ensures access to routine, urgent or emergent face-to-face psychiatric and medication evaluations for Enrollees 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.
7. 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 most Enrollees who utilize ESP services. The ESP ensures 24/7/365 access to clinical staff with expertise that is consistent with the populations served:
    a) Children, adolescents, and their families
    b) Adults
    c) Persons with mental health conditions
    d) Persons with a substance use disorder conditions
    e) Persons with co-occurring mental health and substance use disorder conditions
    f) Persons with co-occurring behavioral health and medical conditions
8. 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:
    a) Intellectual and developmental disabilities
    b) Deaf and hard of hearing
    c) Blind, deaf-blind, and visually impaired
    d) Culturally and linguistically diverse populations
    e) Elders
    f) Veterans
    g) Homeless

h) Gay, lesbian, bisexual, transgendered

9. All ESP staff receive ongoing supervision appropriate to their discipline and level of training and licensure, and in compliance with the Plan'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.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. 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 the Plan, initiates strategies aimed at strengthening service pathways and the safety net of resources.
2. 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 Plan's 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 Enrollee and their families, including recovery-oriented and consumer-operated resources and resources for the populations listed in the Staffing Requirements section.
3. 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.
4. 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.
5. 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.
6. 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
7. With Enrollee consent, the ESP collaborates with the Enrollee's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.
8. The ESP disseminates information to Enrollees 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.

9. 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 Enrollees 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.
10. When necessary, the program arranges transportation for crisis evaluation and disposition into each level of care within the Plan's continuum of care.
11. 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 Enrollee's health record, including notification to an outpatient provider of where a Enrollee was hospitalized, with appropriate consent.
12. The ESP develops and maintains a comprehensive community resource directory that is updated on an ongoing basis and is readily available to clinical staff, Enrollees, and families. Reasonable provisions should be made to allow Enrollees to make copies of the directory. The directory should include, but not be limited to:
    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.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. Within the populations defined in the Service Components section, the ESP accepts requests/referrals for ESP services directly from Enrollees 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.
2. The ESP triages calls to its most appropriate ESP service component that will provide crisis behavioral health services to Enrollees in the least-restrictive setting, which ensures safety and is responsive to Enrollee and family choice. The ESP has written triage protocols, including procedures for obtaining supervisory review of triage decisions in potentially high-risk situations.
3. 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.

4. 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 Enrollee can participate in a behavioral health assessment. If the assessment occurs in a hospital ED, Enrollees are 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 Enrollee.
    b) Readiness also assumes that the Enrollee is awake and sufficiently cleared from the effects of substances so that they 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.
5. For all calls requesting MCI 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 an Enrollee will be referred, then follows up with a second call to the ESP as soon as the Enrollee is ready for an assessment. The ESP uses this early notification for triage, dispatching, and staff management purposes.
    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 Enrollees, 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 Clinical Line for review and authorization of care. If the ED chooses to do so:
        i. The ESP informs the Clinical Line that the ED will be doing so. If the ED has not received confirmation from the ESP that the Clinical Line has approved of it doing so, the ED may call the Clinical 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.
6. Triage and disposition decisions are made in conformance with the medical necessity criteria of the Plan for authorization into each level of care within the Plan's continuum of care. For the Plan's Enrollees, the ESP contacts the Plan, presents all relevant assessment information, and obtains authorization for subsequent services based on the Plan's medical necessity criteria.
7. Upon presentation to the ESP, the ESP asks the Enrollee, significant others accompanying them, 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 Enrollee.

8. During the ESP intervention, the clinician updates any existing crisis prevention plan and/or safety plan or creates one with the Enrollee. 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 Enrollee before or during crises (i.e., providers, agencies, significant others, and/or family members). The purpose of this plan is to expedite an Enrollee-focused disposition based on the experience gained from past treatment interventions.
9. The ESP ensures that each crisis assessment, intervention, and stabilization episode is documented in writing. To do so, the ESP is required to utilize the adult and MCI standardized documentation forms. The documentation of each ESP encounter includes but is not limited to name of Enrollee; 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.
10. 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 Enrollee'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.
11. 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.
12. The ESP manages the flow of communication throughout the ESP process with a given Enrollee. ESP staff checks in with and updates Enrollees 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.
13. During and after 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 Enrollee and their family and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment.
14. 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 an Enrollee in a residential placement as part of their crisis prevention plan and/or safety plan or

non-life- threatening crisis calls responsive to telephonic support and problem solving).

15. While it is expected that all ESP encounters minimally include the three basic components of crisis assessment, intervention, and stabilization, crisis intervention requires flexibility in the focus and duration of the initial intervention, the Enrollee's participation in the treatment, and the number and type of follow-up services.
16. 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 the Plan within the timeframe established by the Plan.

Discharge Planning and Documentation

1. The ESP develops and maintains protocols for assisting the ESP clinician and consulting with others if there is a question and/or disagreement regarding the level of care that is medically necessary for a given Enrollee. 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, Plan clinicians, and Plan psychiatrists, to resolve the medical necessity determination and disposition as needed.
2. The ESP arranges the medically necessary behavioral health services that the Enrollee requires to further treat their behavioral health condition based on the crisis assessment completed and the Enrollee's medical needs and preferences.
3. 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.
4. The ESP provides the Enrollee and their family with resources and referrals for additional services and supports, such as recovery-oriented and consumer-operated resources in their community.
5. For Enrollees 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.
6. The ESP promotes continuity of care for Enrollees 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.
7. For Enrollees 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 Enrollee's health insurance payer. The following guidelines are utilized:
    a) Closest proximity – Referrals within the ESP's DMH Area
    b) Moderate proximity – Referrals within a contiguous DMH Area
    c) Extended area – Referrals in a non-contiguous DMH Area
8. 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.

9. The Plan recognizes that there are times that inpatient disposition has been delayed during periods of high volume. If an ESP has contacted all Plan in-network facilities and has been unable to secure a bed, the ESP is expected to call the Clinical Line. During business hours, the Plan regional staff will then assist the ESP in accessing an inpatient admission through direct contact with Plan network providers. After hours, the Clinical Line will support the ESP with information on potential bed availability. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals.
10. If there are still no in-network beds available, and no discharges are expected from in-network facilities within a reasonable 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 Clinical Line for suggestions of out-of- network facilities and related contact information. If a bed is in an out-of-network facility, the ESP may then request an out-of-network authorization from the Clinical Line. The ESP is encouraged to call other payers for assistance in similar situations with their covered individuals.
11. 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. It is the ESP's responsibility to negotiate the need for boarding with the hospital and to request a boarding authorization from the Clinical Line for the boarding of the Plan child/adolescent Enrollees. If all appropriate in-network and out-of-network inpatient facilities have been contacted and a bed has not been secured for the Enrollee, a boarding authorization will be considered by the Clinical Line beginning at 5 p.m., as it is less likely that new beds will become available after this time. The ESP is encouraged to follow appropriate protocols and/or call other payers for assistance in similar situations with their covered individuals.
12. When a Enrollee 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 Enrollee every 24 hours since the original ESP evaluation and determination of level of care and provide update via the Expedited Authorization Application. During this process, the ESP keeps the Enrollee, their accompanying parent or guardian, and the hospital ED informed on a regular basis about the status of this process.
13. For continued authorization of boarding Enrollees, it is the ESP's responsibility to call the Clinical Line daily. The ESP provides the reference number to the boarding hospital to ensure payment of the claims later submitted by the hospital. When the ESP secures a bed for a given Enrollee, the ESP obtains an authorization (or reference number for uninsured individuals) from the Clinical Line and arranges transfer of the Enrollee to the admitting facility. For individuals with other health insurance coverage, the ESP follows the appropriate authorization policies and procedures.
14. 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 Enrollee, 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 Enrollees and uninsured individuals, the ESP or ED may call the Clinical 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 Enrollee, and what tests were requested. The Plan 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.

15. The ESP follows written protocols for follow-up with the Enrollees who received ESP services, particularly those who successfully remain in the community after ESP services, to ensure stabilization and facilitate the disposition.

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.