REQUEST FOR RESPONSE:

Youth Mobile Crisis Intervention Procurement

SOUTHWEST WASHINGTON

March 17, 2017

In April 2016, Southwest Washington became the first region in Washington to adopt a model of fully integrated managed care for its Medicaid beneficiaries. This decision reflects the community of Southwest Washington's readiness for system change and an acknowledgement that current crisis system practices could be transformed to more effectively meet residents' needs. As the regional Behavioral Health Administrative Services Organization (BH-ASO) Beacon Health Options (Beacon) is charged with the responsibility of improving the experiences of individuals in crisis and the efficiency/efficacy of the crisis system that serves them. A gap in the current crisis system of care in Clark County, WA is the lack of a mobile crisis team focused on responding to youth and families. With this request for response (RFR), Beacon is looking to fill that gap. Youth Mobile Crisis Intervention (MCI) will be the service component through which behavioral health services are provided to children and adolescents experiencing crisis in Clark County.

This document has the following sections:

1. Procurement Goals
2. Procurement Scope
3. Crisis System Overview
4. Qualifications and Competencies for Youth Mobile Crisis Intervention Provider
5. Contract Performance Management
6. RFR Process
7. Exhibit A: Narrative Questions & Response Content
8. Exhibit B: Sample Budget Template
9. Exhibit C: Youth Mobile Crisis Intervention Technical Specifications

PROCUREMENT GOALS

The goal of this RFR is to procure a provider capable of successfully delivering a youth mobile crisis program to Clark County that aligns with the detailed performance specifications located in Exhibit 3. The target launch date of the new program is July 15, 2017. Because it has been several years since the region had a dedicated youth mobile crisis response team, we anticipate a ramp up in services over time as demand grows. The vision is to have 24/7 crisis response, but after consultation with key stakeholders representing youth and children's services, Beacon is seeking initial coverage from 10 am to 10 pm, 7 days per week. Together with the awardee, Beacon will work on setting a timeline for 24/7 coverage.

PROCUREMENT SCOPE

In scope:

- **Services**: Youth Mobile Crisis Intervention as described in detail in Exhibit C
- **Hours of Operation**: Receiving dispatch from 10 am to 10 pm, 365 days a year for initial response, along with follow-up interventions spanning up to an additional 7 days.

- **Population**: Youth age 18 and under. MCI services are available to all youth age 18 and under and their families/caregivers.
- **Catchment Area**: Clark County, WA

Out of scope:

- **Services**: Child Community Crisis Stabilization (CCS) for Medicaid-enrolled youth age 18 and younger is a separate and distinct service. However, MCI provides front-door management into that program and thus a close working relationship and interagency agreements are required.
    - MCI is not intended for the purposes of respite, out-of-home placement, outpatient treatment or to replace existing front-line school-based responses for children and youth.

Funding model:

- Services will be reimbursed on a fee-for-service basis in 15-minute increments, according to an agreed-upon fee schedule.

CRISIS SYSTEM OVERVIEW

The purpose of the crisis system is to respond rapidly, assess effectively, and deliver a person-centered course of treatment intended to promote trauma-informed recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with an individual in crisis, providers are expected to deliver a core service, including crisis assessment, intervention, and stabilization. In doing so, the provider will conduct a crisis behavioral health assessment and offer short-term crisis counseling inclusive of active listening and support. Note that this is a treatment level of care and not a service that is limited to assessment and referral. The provider delivers solution-focused and strengths-oriented crisis intervention aimed at working with the individual and his/her family, existing outpatient provider if any, and/or other natural supports to mutually understand the current crisis, identify solutions, and access resources and services for support, assistance, comfort and treatment.

When it is indicated, the crisis providers arrange person-centered behavioral health services to further treat his/her behavioral health condition based on the assessment completed, the individual's demonstrated medical need and their treatment preferences. The crisis provider coordinates with current service providers and/or newly referred providers to share information (with appropriate consent) and make recommendations for the treatment plan. The provider also connects the individual 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 crisis 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 individual's participation in the treatment, and the number and type of follow-up services. In addition, all members of the interdisciplinary team, with leadership from the Family Partner, collaborate with, offer support and consultation to, and seek expertise from parents, guardians and other caregivers.

It is essential that there is timely access to behavioral health services that individuals may access before and/or instead of mobile crisis services, as well as timely access to services that can best meet their needs following intervention by a crisis responder. More specifically, it is essential to ensure access to urgent outpatient services to intervene in emerging crises earlier and prevent over-reliance on crisis services. Similarly, it is necessary to improve access to inpatient and diversionary levels of care in order to streamline the crisis system's discharge and referral process. Beacon is working in collaboration with the MCOs, service providers and other stakeholders to improve access to urgent outpatient services, diversionary services, and acute inpatient psychiatric services. While the mobile system plays a key role in ensuring access to behavioral health services and timely flow of individuals through that system, it is recognized that

improvement in access cannot be the responsibility of the crisis system alone, or accomplished solely through the redesign of this component of the behavioral health continuum of care.

Youth Mobile Crisis Intervention Structure

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

Youth Mobile Crisis Intervention services provide a short-term service that is a mobile, on-site, face- to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any.

Described in more detail in the "Technical specifications" located in Exhibit C, Youth Mobile Crisis Intervention services includes an intervention encompassing the following:

1. A comprehensive crisis assessment, including a mental status exam, crisis precipitants, behavioral health and physical health history, medication history and compliance, safety/risk issues with the youth and/or parent/guardian/ caregiver(s), functioning at home, school, and community
2. Providing support, information, understanding and consultation to parents and guardians who are likely experiencing (normal, but often overwhelming) stress, concern, and exhaustion so that they are best equipped to participate in the intervention, make decisions, and support their children
3. Discussing and activating 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
4. Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior
5. Identifying current providers, including state agency involvement,
6. 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)
7. Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support
8. Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, from an on-call child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist
9. Development of a risk management/risk management/safety plan, if the youth/family does not already have one.
10. Crisis intervention, including solution-focused crisis counseling and brief interventions that address behavior and safety.
11. Referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care
12. For youth who are receiving Wraparound with Intensive Services (WISe) Youth Mobile Crisis Intervention staff shall coordinate with the youth's WISe care coordinator throughout the delivery

of the service. Youth Mobile Crisis Intervention also shall coordinate with the youth's primary care physician, any other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

Front-Door Management of CCS
Youth Mobile Crisis Intervention is distinct from the Child Community Crisis Stabilization (CCS) program. MCI manages the front door of referrals into the CCS program, in accordance with applicable Medical Necessity Criteria. Following completion of a Youth Mobile Crisis Intervention, if the MCI clinician determines that CCS may be medically necessary, the MCI team will manage referrals and coordination of care.

MCI Youth Mobile Crisis Intervention providers and Child Community Crisis Stabilization (CCS) providers must have affiliation agreements and effective working relationships and must communicate daily to ensure effective management of the daily census in these programs. Child CCSs are a valuable resource, and MCIs shall play a substantial role in maximizing the efficiency of the service by helping to ensure medically necessary admissions to the CCSs. Mobile Crisis Intervention also coordinates with the youth's Managed Care Organization (MCO) to arrange for dispositions to all levels of care.

MCI Objectives

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

- Early intervention in behavioral health crises with family preservation and community-tenure serving as highly valued priorities
- Delivery of a comprehensive crisis treatment service focused on the child and family that includes a crisis assessment, a course of resolution-focused, harm-reducing intervention, stabilization of crisis, creation of a risk management/safety plan, and linkage as needed to other services
- Support of and consultation to parents, guardians and other caregivers; intended to offer relief, information, acknowledgement of the complex care and parenting needs of their children. Teams offer strength-based engagement and empowerment, viewing and engaging parents as fundamentally credible, capable, intuitive and able to collaborate in the intervention and in decision making.
- Referral to least restrictive and least intensive treatment services consistent with medical necessity, personal and community safety, and family preference that serve to divert unnecessary deep-end services or interventions such as inpatient hospitalization, as well as residential treatment services or detention to the extent that utilization results from the youth's behavioral health condition
- Front-door management of admissions to child Community Crisis Stabilization (CCS)
- Ensuring family connection with the services, which are chosen with the family to meet the child's and family's needs, that will promote recovery, family skill-building, and natural family and community support

MCI Expected Outcomes

Effective Youth Mobile Crisis Intervention shall produce the following outcomes:

- Increased confidence by child and family in crisis self-management
- Increased use of natural supports
- Increased family skills in problem solving and restoration to pre-crisis levels of functioning
- Timely and increased connections to community services
- Timely follow-up with child's treatment service

- Decreased use of hospital emergency departments (EDs)
- Reduced use of inpatient psychiatric services
- Reduced referrals into residential treatment
- Juvenile court/DCF diversions
- Fewer days out of the home
- Reduced out of county placements

MCI Staffing

Youth Mobile Crisis Intervention shall be supported by a dedicated program manager who is responsible for managing the Youth Mobile Crisis Intervention service team. This service shall be further staffed by Child mental health specialists and Family Partners (who have lived experience as a primary caretaker of a child with Serious Emotional Disturbance) who will work in a braided fashion to ensure crisis resolution and successful linkage. A board-certified or eligible child psychiatrist is also included in the staffing pattern.

1. Youth Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and Family Partner staff and maintains staffing levels as warranted by data trends.
2. Youth 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. Youth Mobile Crisis Intervention is also staffed with Family Partners, persons with lived experience as a primary caretaker of a child with Serious Emotional Disturbance.

QUALIFICATIONS & COMPENTENCIES FOR YOUTH MOBILE CRISIS INTERVENTION PROVIDER

Core Qualifications

MCI bidders must demonstrate significant expertise in providing and managing services for children, adolescents, and their families by demonstrating experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services. Specific qualifications of successful bidders include:

1. Be a licensed provider in the state of Washington.
2. Have administrative infrastructure that supports the delivery of Youth Mobile Crisis Intervention services as described in Exhibit C, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist.
3. Have training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels, in providing behavioral health services to children, adolescents, and their families. (Reference WAC 388-877A-0230 crisis telephone support, 388-877A-0240 crisis outreach services, WAC 388-877A-0270 crisis peer support services)
4. Relationships with child- and family-focused community resources in the service area.
5. Membership in child-advocacy and/or child-focused trade organizations.
6. Competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services and integrating youth and family voice in organization governance.

7. Outcomes data, quality improvement processes, and satisfaction survey instruments and results from your organization that are specifically focused on services for youth and families.
8. Demonstrated knowledge, commitment, and experience implementing services to children, adolescents, and families consistent with Systems of Care and Wraparound principles.

Core Competencies

Additionally, selected MCI providers shall demonstrate capability in meeting the following competencies:

Agency/programmatic competencies, which will also be reflected in competencies of individual staff:

Crisis services

1. Ability to deliver mobile to home, school and other community setting services requiring crisis response and brief, resolution-focused interventions
2. Success in meeting response requirements in a crisis environment and ability to comply with response -time requirements mandated in Washington Administrative Code Section 388-877A-0200 and detailed in Exhibit C: MCI Performance Specifications.
3. Success in managing resources to respond quickly to fluctuations in demand in a crisis environment
4. Efficiency in the dispatching of individuals or teams, crisis stabilization capacity and referral processes.
5. Ability to hire, develop, and retain staff who are strength-based in orientation, competent at and comfortable with mobile crisis response and treatment intervention, are skilled at risk management, and are able to operate in an independent and self-directed fashion.
6. Use of electronic, telephonic, and other technological tools that optimize efficiency, reduce risk, and/or otherwise support achievement of results.
7. The fast-pace and unpredictable demand for crisis services requires that selected MCI providers pay very close and ongoing attention to service flow and staffing patterns. The need to provide service 'on demand' must be balanced with the need to ensure sufficient staff productivity. Achievement of fluidity in staffing patterns and assignments (through use of strategies such as cross-training, use of on-call staffing, and non-traditional scheduling) to meet fluctuating demands increases consumer, community, and stakeholder confidence in the dependability of MCIs to serve as a first choice for seeking behavioral health crisis services.

Upstream intervention

13. Commitment to intervention at the earliest possible point in the crisis episode.
14. Commitment to facilitating rapid access to a range of urgent treatment services.
15. Commitment to collaborating with other systems in managing behavioral health crises when risk of out-of-home placement is high.

Recovery-oriented treatment

16. Hiring personnel who believe persons with mental illness and substance use conditions can achieve recovery and, if provided with knowledge, tools, and assistance where needed, are best equipped to guide their own treatment and self-manage their illness.
17. Use of peers and family members in consultative, training, and service delivery roles; mechanisms are in place to promote continuous opportunities for peers and families to offer lived experience as persons with mental illness/substance use conditions or a caretaker/family member thereof; effective integration of well-trained Peer and Family Specialists into the

workplace, treatment team, and service delivery plan.

18. Commitment to consumer choice and shared decision-making.
19. Effective utilization of consumer completed advance directives, such as risk management/safety plans and Wellness Recovery Action Plans (WRAP) to guide care.
20. Delivering treatment interventions that are strengths-based and solution-focused.
21. Commitment to promoting the use of natural supports.
22. Knowledgeable communication to consumers and families about a wide range of community resources.

Cultural and linguistic competence

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

Least restrictive treatment

27. Commitment to care that is voluntary and consumer-directed.
28. Commitment to care being delivered in, or as close to, home as possible.
29. Commitment to care that is minimally disruptive.
30. Creation of a service pathway that screens for the need to refer up to, rather than step-down from, hospital-based emergency care.
31. Delivery of resolution-focused crisis treatment services designed to be an end service when possible

Effective use of treatment resources

32. Commitment to ensuring medically necessary services and the right level of care for the right length of time.
33. Ability to measure supply of services and demand for those services, and implement strategies, in collaboration with Beacon, to ensure access.
34. Efficient and timely discharges from the MCI to maximize service capacity.

Intersystem knowledge, planning, and affiliation

35. Demonstrates broad knowledge of the community behavioral health system:
    - Excellent collaborative skills – uses collateral information effectively
    - Knows what services are provided in the community, how they are funded, and how clients access them; develops professional relationships with peers in these agencies
    - Able to use system resources in order to complete work in an efficient fashion and to facilitate access to services by clients

36. Knowledge of referral streams into the crisis system and ability to collaborate with referring sources to prevent overuse, misuse, overly restrictive use or coercive use of services
37. Identification and amelioration of barriers to early, voluntary, upstream intervention
38. Active and strategic leadership in crisis systems of care initiatives and collaboratives

Commitment to Continuous Quality Improvement

39. Utilizes continuous quality improvement process, including outcomes measures and satisfaction surveys, to measure and improve quality of care and service delivered to persons served, including youth and their families, and services to special populations.
40. Routinely tracks service volume and type by day and by shift so that staffing and service patterns are optimally efficient.
41. Achievement of linkage timeframe targets in areas such as:
    - Urgent psychiatric appointments
    - WISe linkages
    - Admission to diversionary services

Youth and Family Focus

42. Comprehension of grief and trauma in children and adolescents.
43. Diagnostic accuracy in the assessment of children and adolescents.
44. Awareness of the differences in manifestation of mental health and substance use conditions in children versus adolescents, versus adults.
45. Risk assessment and management skills in working with children, adolescents, and families.
46. Client engagement and de-escalation skills with children, adolescents, and their families.
47. Competency in crisis theory and in the use of interventions with children, adolescents, and families that are compatible with principles or resiliency and recovery and likely to stimulate self-help including techniques utilized in:
    - o Solution-Focused Therapy
    - o Cognitive Behavioral Therapy
    - o Stages of Change
    - o Motivational Interviewing
    - o Shared Decision-making
    - o Demonstrated broad knowledge of the community behavioral health system for children, adolescents, and families
48. Documented understanding of Crisis Theory, Recovery-Oriented Care, *Wraparound*[1] planning process, and *Systems of Care* principles and philosophy at all levels of the organization's management, and preferably experience in the implementation of these approaches.
49. Training, licensing, certification, accreditation, and/or other documented verification of expertise and experience at agency, supervisory, and clinician levels, in providing behavioral health services to children, adolescents, and their families.

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

50. Experience providing behavioral health services to children and adolescents, including behavioral health assessment, crisis intervention, and/or treatment services; administrative infrastructure that supports the delivery of Youth Mobile Crisis Intervention, including access to consultation with a child-trained supervisor and board-certified or eligible psychiatrist.
51. Ability to integrate youth and family voice in organization governance.
52. Solicits and values the youth's view of the crisis situation and possible solutions.
53. Competence working in partnership with youth, parents, and other caregivers of youth with mental health needs, including success in engaging the youth and family in behavioral health services.
54. Articulation and adherence to a program philosophy that:
    - Values a young person's return to natural environment
    - Values and supports parents and guardians; continuously improves understanding of the lived experience of parents of youth with complex and high risk behavioral health needs; engages parents and guardians as experienced, capable, credible, intuitive, and able to collaborate
    - Expects client's return to higher level of functioning
    - Instills client/family with hope for the future
    - Expects improvement by the end of intervention
55. Outcomes data, quality improvement processes, and satisfaction survey instruments and results that are specifically focused on services for youth and families.
56. Takes a lead role in continuously advancing relationships and collaborations with child- and family-focused community resources in the service area, including but not limited to, child-serving state agencies and social service providers, schools, residential programs, family and youth organizations, pediatric primary care providers, and ability to coordinate care and treatment across providers and service agencies.

Clinical competencies

Clinical assessment

57. Demonstrated ability to perform a focused and comprehensive assessment of youth across the ages of 0-18 who are in crisis who are experiencing a mental health and/or substance use related crisis.
58. Family Partners effectively engage parents and other caregivers, consult to the rest of the interdisciplinary team, assure that family voice, choice is heard and understood; guides team in use of approaches that are strength-based, empowering and activating.
59. Protocol for multi-disciplinary evaluation when indicated
60. Development of a clinical formulation based on the comprehensive assessment.

Diagnostic accuracy

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

Client engagement and de-escalation skills

64. Able to engage youth and his/her family using a person/family-centered orientation
65. Able to engage client in a manner that is both professional and calming.
66. Able to identify cues that might indicate the best means of communicating with the client.
67. Able to identify, consider, and respect cultural/lifestyle differences and the impact on treatment.
68. Able to work with clients in their natural environment.
69. Ability to modify engagement techniques to meet the individualized needs of the client.
70. Skilled in verbal and non-verbal de-escalation techniques.

Risk assessment and management skills

71. Able to identify potential risks to client or others, and to develop and implement a plan of action to reduce those risks
72. Ability to recognize lethality risk in special populations
73. Utilizes problem-solving skills by considering various options and potential outcomes in a creative yet timely manner
74. Identifies the need for, seeks, and utilizes supervision/consultation
75. Seeks consensus-driven dispositions
76. Competent crisis providers are in every way respectful of the perspective of the service recipient, family, and other stakeholders in assessing risk and identifying resources and solutions. Crisis assessments, though focused in nature, must address a broad array of risks, including those present in the daily living environment.

Clinical Referral and Linkages

77. Able to identify the most appropriate, least restrictive and medically necessary service(s) for any referrals made for post crisis follow up.
78. Able to coordinate and communicate with multidisciplinary providers, including current providers already involved with the youth and/or family.

PERFORMANCE MANAGEMENT

Beacon will measure the performance of the MCI contract through a variety of quantitative and qualitative indicators that are designed to reflect the goals of the SWWA Crisis System. Beacon will establish performance indicators to measure the MCI provider requirements delineated in the Youth Mobile Crisis Intervention Performance Specifications (Exhibit C). The indicators may include but not be limited to:

- timeliness of MCI response;
- delivery of a comprehensive crisis service that minimally includes crisis assessment, intervention, and stabilization;
- percentage of MCI services that are delivered via community-based, non-ED mobile services;
- clinical appropriateness of disposition, including use of diversionary services when clinically indicated;
- percentage of community based dispositions, i.e., hospital diversions
- compliance with standards of care;
- satisfaction survey data; and

- identifying and implementing quality improvement initiatives.

Beacon will monitor and manage provider performance. Beacon will work with contractor to set initial targets for these performance indicators for the first year of contract implementation. Targets will be adjusted as more data on MCI performance and other data sources becomes available over time.

RFR PROCESS

Attached as **Exhibit A** is a set of questions to be used as prompts for information sought under this RFR. The Exhibit contains some broad questions and some specific questions — with additional detail for those respondents who may have already been developing a project or may be able to provide a more comprehensive response. Respondents do not need to answer every question to submit a response. Respondents should answer the questions that are applicable to their organization.

Required Submission Documents

1. Maximum of 15-page Narrative response to questions in Exhibit A.
2. Two letters of supports from key stakeholders in Clark County supporting your proposal.
3. Sample Budget that reflects initial 10 am to 10 pm coverage and proposed timeline to move to 24-7 coverage.
4. Organizational Chart of key organizational leadership with reporting structures for key MCI staff, including peer/family partner(s).
5. Résumés from current staff member(s) in your organization at director- level positions and above who have five or more years of experience providing behavioral health services to youth and families and would be involved in your organization's provision of Youth Mobile Crisis Intervention.
6. Job descriptions for any staff members who would be staffing the Youth Mobile Crisis Intervention service in any capacity, including the Youth Mobile Crisis Intervention program manager, child psychiatric clinicians, child-trained supervisors, child-trained clinicians, paraprofessionals and/or family partners.
7. Proposed workflow for MCI intervention across the crisis system continuum of care.
8. Three sample management and quality monitoring reports generated from your organizations management information system.

Project Narrative/Design

The project narrative may not be any longer than ten (15) pages in total with no less than eleven (11) point **Arial** font, and margins no less than one (1) inch.

Guidelines:

- Specific responses detailing what you have done and will do will be the most helpful in evaluating your proposal.
- Bulleting/tables/charts in lieu of narrative are welcome if such a format better enables you to provide specific information in a succinct fashion.
- Please make clear throughout the response whether you are describing current versus proposed practice at your organization.

Inquiries

Please submit questions or inquiries regarding this RFR to the following email address: BeaconWAASO@beaconhealthoptions.com

Submission Instructions

Please submit responses by **Friday, April 28, 2017, 5 p.m. PST**. Please include a face sheet (format provided) and narrative response to the following email address: BeaconWAASO@beaconhealthoptions.com. **Faxed or mailed applications will not be accepted.**

Schedule

Actions	Date
RFR issued	March 17, 2017
Q&A Teleconference for Bidders	11 am – 12 pm Wednesday March 29
RFR Response deadline	April 28, 2017, 5 p.m. PST
Optional interviews	May 1 – May 5, 2017
Contract announcement	May 5, 2017
Ramp up and implementation planning	May 5 – June 20, 2017
Readiness Assessment	July 6, 2017
Go live	July 15, 2017

Q&A Teleconference

Beacon will hold a webinar teleconference to answer questions from interested parties. The details for the teleconference are:

DATE: Wednesday March 29, 2017
TIME: 11 am – 12 pm PST
WEBINAR REGISTRATION LINK:
https://beaconhealth.webex.com/beaconhealthoptions/j.php?MTID=m435f653be243743a498f68991aabbc73

Evaluation of Responses

A selection committee will review the responses received by the submission deadline and make the final selections. Each proposal will receive a score based on the narrative response. The selection of an MCI provider is based on the proposal with the highest score using a consistent point system. In addition to the total score, consideration will be given to other factors, including the committee's letters of support and tenure of the bidder's presence and services in the Clark County. In addition, please note that Beacon reserves the right to exclude any catchment area from this procurement at any time prior to the announcement of contract awards.

Verbal Presentation

The selection committee may meet with finalists in this selection process for a verbal review of the proposal and to address questions. If so, bidders will be given a minimum of 48 hours' advance notice of a meeting that would be conducted at the Beacon office: 1220 Main St, 4th floor, Vancouver, WA 98660.

EXHIBIT A

NARRATIVE QUESTIONS AND RESPONSE CONTENT FORM

Name of individual/ organization completing RFR response: Click here to enter text.

Address Click here to enter text.

City/State/Zip Click here to enter text.

Phone of primary contact Click here to enter text.

Email of primary contact Click here to enter text.

1) General qualifications and infrastructure: *(36 points up to 3 each)*

a) Licensure: Licensed as an outpatient mental health clinic by the Washington State Department Behavioral Health and Recovery Services (DBHR)

Indicate: Yes ☐ / No ☐ If yes, license #: Click here to enter text.

b) Certifications: Certified to provide crisis mental health services WAC 388-877A-0230 crisis telephone support, 388-877A-0240 crisis outreach services, WAC 388-877A-0270 crisis peer support services

Indicate: Yes ☐ / No ☐

c) Accredited by a national organization *Indicate:* Yes ☐ / No ☐

If yes, please list accreditation(s): Click here to enter text.

d) Briefly describe the behavioral health services your organization has provided and the populations to which your organization has provided these services. Click here to enter text.

e) Number of years providing behavioral health services to children, adolescents and families: ____

f) Number of youth served in Calendar Years: 2015 _____ 2016 _____

g) Number of years in which your organization operated an uninterrupted physical location at which you have provided direct services in Clark County, WA: _____

h) Briefly describe your presence in and knowledge of the Clark County, WA. Click here to enter text.

i) If your organization does not already have a physical location in Clark County, include a detailed plan for how your organization shall successfully establish a local presence by 7/1/2017 and a strong rationale as to why you wish to operate in the catchment area. Click here to enter text.

j) Provide a brief assessment of Clark County's needs and resources, particularly the local community's crisis continuum and its strengths and limitations, resources, barriers, gaps, and

practice patterns. Click here to enter text.

k) Administrative infrastructure: Identify key staff positions within your organization and other infrastructure elements that will enable your organization to provide administrative and financial oversight and management of the MCI contract. Click here to enter text.

l) Medical and clinical infrastructure: Identify key staff positions and other infrastructure elements that will enable your organization to provide medical and clinical oversight and management of a MCI contract and service delivery system. Click here to enter text.

m) **Required attachment:** Please submit an organizational chart with key leadership and reporting structures for key MCI staffing positions, including the peer/family partner role.

2) Provider Information Systems *(10 points – up to 5 each)*

a) Describe your organization's ability track all service encounters and submit claims electronically as of the 7/1/2017 implementation date. Click here to enter text.

b) **Required attachment:** Please submit up to three of your most useful examples of Management Information System (MIS) reports used for ongoing management and/or quality improvement purposes.

3) Recovery-oriented services *(10 points – up to 5 each)*

a) Please describe your organization's experience in recruiting and hiring personnel who are recovery-oriented in their beliefs and how this has influenced policy and/or practice. Click here to enter text.

b) Include specific strategies and implementation plans you shall employ to hire and integrate Family Partners into your MCI staffing and services. Address how you shall ensure that these staff members have access to peer supervision in an ongoing fashion. Click here to enter text.

4) Quality management *(15 points – up to 5 each)*

a) Identify key staff positions and other infrastructure elements that will enable your organization to provide quality management and risk management of a MCI contract. Click here to enter text.

b) Provide specific examples how you will use data and information to ensure and continuously improve the quality of MCI services and the performance of the MCI contract. Click here to enter text.

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

5) Mobile Crisis Intervention Service Model & Capabilities *(40 points – up to 5 each)*

a) Describe the experience your organization has had with providing services on a "mobile" basis in individuals' homes and other natural settings in the community, including the specific service, population, and duration of your organization's operation of such services. Click here to enter text.

b) Provide a brief program description that summarizes your overall MCI program model addressing, at a minimum, program philosophy and culture, service delivery model, and flow of services. Click here to enter text.

c) Continuum of care: Briefly describe the continuum of care operated by your organization and how you would utilize all the resources of your organization to strengthen your mobile crisis response, meet the stated goals of MCI and this procurement, and benefit the individuals and families served. Click here to enter text.

d) Describe specific strategies you have used and/or plan to use as an MCI provider to establish a culture among your staff and within your community that values the provision of mobile services in the community in line with the specifications in Exhibit C. Click here to enter text.

e) Describe the challenges you anticipate in establishing a culture and practice of prioritizing mobile services and specific strategies you have and/or shall use to mitigate these challenges to ensure program goals are met. Click here to enter text.

f) Describe your organization's experience in providing brief crisis treatment, achieving diversions from unnecessary psychiatric hospitalizations and other out-of-home placements. Click here to enter text.

g) Delineate specific strategies and resources you will leverage to maximize the use of diversionary services as alternatives to inpatient psychiatric care and other out-of-home placement. Click here to enter text.

h) Describe how you shall establish linkages with other youth services including WISe and child CCS as well as other child behavioral health services, and how you shall utilize these linkages to ensure care coordination, continuity of care, and diversions from inpatient psychiatric services and other out of home placement. Click here to enter text.

i) Describe your experience engaging and partnering with parents/guardians in culturally-consistent, strength-based and collaborative fashion. Click here to enter text.

6) Budget narrative *(10 points – up to 5 each)*

a) Submit a budget narrative that further defines and explains the program budget that is submitted in the template found in Exhibit B. The budget narrative provides the bidder with an opportunity to highlight what is unique or different about their program and MCI cost model. Click here to enter text.

b) Mobile Crisis Services will be paid for on a fee-for-service basis using the following service codes. Crisis services – H2011 – will pay at two rates: one for a master's level and above and one for bachelor's level or below. H0038 will be the billable code for the family partner services. In the event that psychiatric consultation is required, the evaluation and management codes below would be available for billing. Please submit a rate proposal in accordance with fee schedule below**.**

Code	Description	Units	Proposed Rate
H2011	Crisis Services by Master's level or above	15 minutes	
H2011 HM/HN	Crisis Services by Bachelor's level or below	15 minutes	

H0038	Self-help peer services	15 minutes	
99201	Office or other outpatient visit for the evaluation and management of a new patient, 10 minutes face-to-face with the patient and/or family.		
99202	Office or other outpatient visit for the evaluation and management of a new patient, 20 minutes face-to-face with the patient and/or family.		
99203	Office or other outpatient visit for the evaluation and management of a new patient, 30 minutes face-to-face with the patient and/or family		
99204	Office or other outpatient visit for the evaluation and management of a new patient, 45 minutes face-to-face with the patient and/or family		
99213	Office or other outpatient visit for the evaluation and management of an established patient, 15 minutes		
99214	Office or other outpatient visit for the evaluation and management of an established patient, 25 minutes		
99215	Office or other outpatient visit for the evaluation and management of an established patient, 40 minutes		

EXHIBIT B

Estimated Program Operations Budget

Provider:

	FTE	Position	Base Salary	Salary
a				$ -
b				$ -
c				$ -
d				$ -
e				$ -
f	Total Salaries (sum a thru e)			$ -

Percentage

g	*Benefits (percentage)*		**0%**
h	Benefit Costs (f * g)	$	-
i	Total Labor Expense (f + h)	$	-

Administrative Expenses

j	*Telephone*		**0%**
k	Supplies	$	-
l	Travel/Mileage	$	-
m	Office Space		
n	Other (describe)		
o	Total Administrative Expense (*sum j – n*)		

P	Total Administrative Expense (sum j thru n)	$	-
Q	Labor and Administrative Expenses	$	-
R	Overhead (percentage)		0%
S	Overhead (p * q)	$	-
T	**Total Provider Expense**	$	-

EXHIBIT C: YOUTH MOBILE CRISIS INTERVENTION TECHNICAL SPECIFICATIONS

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. The goal eventually is for this service to be provided 24 hours a day, 7 days a week. Initially, the service will be offered from 10 am to 10 pm, 365 days per year.

The service includes: A crisis assessment and engagement in a crisis planning process, 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 Wraparound with Intensive Services (WISe), Mobile Crisis Intervention staff will coordinate or partner with the youth's WISe 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 the crisis continuum of care.
2. 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
    d. Clinical and Psychiatric Expertise
    e. Cultural and Linguistic Competence
3. 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), to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner.
4. 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.
5. Mobile Crisis Intervention teams will respond in the following timeframes:
    a. Triage calls within 15 minutes of initial request
    b. Respond in person within 90 minutes.
6. Mobile Crisis Intervention 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 parent/guardian/caregiver(s) and others to the youth's behavior; d. Discussing and activating 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; e. Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care; f. Assessing medication compliance and/or past medication trials; g. Assessing safety/risk issues for the youth and parent/guardian/caregiver(s). h. Taking a medical history/screening for medical issues; i. Assessing current functioning at home, school, and in the community; j. Identifying current providers, including state agency involvement; and k. 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). l. Solution focused crisis counseling; m. Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support; n. Clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to 7 days; o. 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. 6. 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. As the family chooses, Mobile Crisis Intervention engages existing service providers and/or other natural supports. 7. 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

	WISe. 8. Mobile Crisis Intervention provides the following additional services up to 7 days after the initial response: 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. 9. For youth who are receiving WISe, Mobile Crisis Intervention coordinates with the youth's care coordinator throughout the delivery of the service. For youth not in WISe, 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. 10. 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.
Staffing Requirements	
	1. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and Peers with lived experience (Family Partner) 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 a Peer (Family Partner) 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-fact 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, *Systems of Care* philosophy and the *Wraparound process*; medications and side effects; First Aid/CPR; youth-serving agencies and processes; 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 to the youth. 8. Mobile Crisis Intervention supervises all staff, commensurate with licensure level and consistent with credentialing criteria.
Service, Community, and Collateral Linkages	
	1. As the youth-serving component of the crisis continuum of care, Mobile Crisis Intervention takes a strategic, leadership role in improving the crisis system infrastructure, building collaborations, improving efficiencies and effectiveness of crisis services. 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 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 WISe, In-Home Therapy Services and outpatient providers (e.g., mentors, therapists), other care management programs and primary care provider (PCP). Mobile Crisis Intervention facilitates referrals for, and provides information on, both Medicaid and non-Medicaid services (e.g., WISe, voluntary services, therapy). 5. Mobile Crisis Intervention, with required consent, makes referral to WISe, 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 support groups, AA, etc.). 7. For youth with WISe/In-Home Therapy Services that provide 24-hour response, Mobile Crisis Intervention staff contacts the provider for care coordination and disposition planning. The WISe/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 treatment plan. 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. 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). 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 service in home or alternative community settings; or if request for Mobile Crisis Intervention services originates from a hospital emergency department. 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.
Quality Management (QM)	
	1. Mobile Crisis Intervention participates in all network management, utilization management, and quality management initiatives and meetings.
Process Specifications	
Treatment Planning and Documentation	1. 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. 2. 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. 3. To complete the crisis assessment and crisis intervention, Mobile Crisis Intervention seeks consent to speak with collateral contacts (e.g., WISe care coordinator, therapist, psychiatrist, social worker, etc.) and natural supports (e.g., friends, neighbors, extended family, etc.) to enlist their support in stabilizing the situation and developing an aftercare plan. 4. For youth enrolled in WISe, Mobile Crisis Intervention staff collaborates with the WISe provider to ensure coordination of care. Mobile Crisis Intervention coordinates with the WISe provider throughout the intervention. 5. 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.

	6. 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) is medically necessary, Mobile Crisis Intervention consults with the Designated Mental Health Professional (DMHP) team and arranges for an assessment. If the youth meets criteria for a higher level of care, MCI 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 7. 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. 8. If the youth is not already enrolled in WISe, Mobile Crisis Intervention may arrange a follow-up appointment with the WISe provider in the youth's service area and coordinates with the WISe provider for the following 7 days to ensure that the youth is receiving medically necessary services.
Discharge Planning and Documentation	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 insure that the aftercare plan developed during the intervention has been implemented and will offer assistance as necessary in order to insure that the plan is implemented. 2. For youth with WISe, Mobile Crisis Intervention plans and coordinates *all* referrals for aftercare services with the WISe care coordinator. Mobile Crisis Intervention conducts at least one phone call or face-to- face meeting with the WISe provider and the family to facilitate the transition. 3. For youth receiving therapy, (or who Mobile Crisis Intervention has referred for Therapy Services), Mobile Crisis Intervention conducts at least one phone call or face-to-face meeting with the provider and the family to facilitate the transition. 4. Mobile Crisis Intervention facilitates access to Crisis Stabilization Services, WISe, 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.
Coordination with CCS Program	
Screening,	Youth Mobile Crisis Intervention manages the front door of referrals into the Child

referral and ensuring continuity of care for community crisis stabilization (CCS) program	Community Crisis Stabilization (CCS) program. Following completion of a Youth Mobile Crisis Intervention, if the MCI clinician determines that CCS may be medically necessary in accordance with applicable Medical Necessity Criteria, then the following steps shall be followed: 1. <u>Screening and referral:</u> • Describe to the youth and parent the purpose of the child CCS service, which shall be available to youth based on medical necessity and shall be short-term, home based services and no more than 14 days. Plan for daily contact with the youth, parents, and community providers until discharge from the MCI service. • Obtain informed consent to refer to the CCS service • Confirm that the youth will return to his/her previous living setting or that an alternate placement is firm and immediately available at discharge 2. <u>Ensures continuity of care</u> The Child Mobile Crisis Intervention clinician shall: • Develop with the youth and family a brief and focused treatment plan (with actions identified for the youth, parent, and providers, as indicated) that shall guide the course of treatment in the child Community Crisis Stabilization (CCS) program • Convey a copy of the behavioral health assessment and the brief, focused treatment plan to the child CCS program provider so that targeted services can begin immediately. • Work with the parent or guardian to ensure that any prescribed medications are in their original container, are labeled with instructions and the prescribing physician's name/phone number. • With consent, alert all providers who shall be expected to attend a treatment meeting with CCS.