EMPS Mobile Crisis Clinical Practice

Connecticut Department of Children & Families

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I. Overview

EMPS Mobile Crisis Intervention Services (EMPS) is a mobile intervention for children and adolescents experiencing a behavioral or mental health crisis. EMPS can respond immediately by phone or face to face within 45 minutes when a child is experiencing an emotional or behavioral crisis. The purpose of the program is to serve children in their homes, schools, and communities, reduce the number of visits to hospital emergency rooms, divert children from inpatient hospitalization if a lower level of care is a safe and effective alternative, and decrease the number of unnecessary arrests in school or in the community. EMPS provides mobile responses from 8am to 10pm Monday to Friday, and from 1pm to 10pm on weekends and holidays. EMPS provides telephonic responses during all other non-mobile hours. The duration of an EMPS episode of care can be anywhere from a brief phone conversation to a 45 day intervention with referral and linkage to ongoing care.

The EMPS Clinical Practice Model describes the core elements of EMPS services at all stages of the episode of care. It is intended to describe and standardize the delivery of high-quality services across the statewide network of EMPS providers and provide a basis for assessing fidelity to the intervention; thus, the primary audience is EMPS managers, supervisors, clinicians, and other stakeholders.

II. Goals

EMPS clinical services are guided by overarching goals in three areas: Child/Family, Provider, and System.

A. Child /Family Goals

1. Stabilize the presenting crisis
2. Promote/enhance emotional and behavioral functioning
3. Link to existing provider or facilitate linkage and transfer to appropriate level of services and supports.
4. Empower children and families to monitor, manage, and cope with situations that may lead to further crises

B. Provider Goals

1. Provide behavioral health crisis-oriented services that are highly mobile and responsive to child and family needs
2. Provide appropriate screening, early identification, and assessment of suicide risk, trauma exposure, substance use, exposure to and risk of violence, eating disorders, and other clinical presentations.
3. Include family members and informal supports in all aspects of the planning and treatment process, whenever possible.

C. System Goals

1. Ensure that all children and their families have access to crisis, prevention, and intervention services and supports
2. Whenever possible, maintain youth in their homes and communities and prevent placement in restrictive care settings such as emergency departments, inpatient hospitalization, and arrest/incarceration
3. Increase community awareness of behavioral health needs by providing prevention- and treatment-oriented education and outreach to families, schools, and communities.

III. Practice Model

The EMPS episode of care can be divided into two phases: 1) Assessment 2) Ongoing Crisis Stabilization and Transition. Each phase is comprised of a number of clinical and supportive activities. EMPS provides services to children and families with a variety of presenting concerns and in a variety of contexts; thus, there is not a "typical" EMPS episode of care. Episodes can are as brief as responding to the initial call or can last for up to 45 days. As a result, some children and families will receive only a small portion of the clinical services described below whereas others may receive most of these services.

A. Assessment (Phase One)

The Assessment phase is intended to support initial crisis stabilization and the gathering of clinical information that will inform the rest of the episode of care. There are a number of activities that take place during this phase, including responding to the first call, conducting the first EMPS response, assessing initial acuity level, and beginning to administer clinical measures. Each task is described below in more detail.

1. Responding to the First Call of a New Episode of Care

New calls for EMPS services are typically received by a Call Specialist at the EMPS Call Center operated by 211-United Way (although callers are asked to dial 2-1-1 for EMPS services, some callers contact EMPS providers directly). The 211 Call Specialist collects basic information (e.g., demographic characteristics, nature of crisis, location of child) and provides initial triage in order to determine an appropriate call disposition, which can include:

a) Transfer to 911: If there is a medical emergency or a weapon present, the Call Specialist generally will transfer the call immediately to 911 for law enforcement intervention. If it is deemed appropriate, the 211 Call Specialist may also notify an EMPS provider to potentially support law enforcement during or immediately following their intervention.
b) 211 Information Only: The 211 Call Specialist may determine that a behavioral health crisis is not present and the caller is best served with information and resources that best meet their needs.

c) Warm Transfer to EMPS: All other calls to 211 are referred, with a response recommendation, to the local EMPS provider for services.

A clinician at the Call Center handles all calls received after EMPS mobile hours (10:00 p.m. to 7:59 a.m. Monday through Friday, and 24 hours a day on Saturday, Sunday, and holidays). All other calls received during mobile hours, that are not triaged as "transfer to 911" or "211 information only," are transferred to an EMPS provider via warm transfer. The Call Specialist includes with the referral their response recommendation of: 1) phone only, 2) deferred mobile response, or 3) mobile response.

Once the call is received by warm transfer from the 211 Call Specialist, the EMPS clinician will conduct a *brief* phone assessment with the referrer and/or child and family, the goals of which are to: 1) conduct a brief safety screen (e.g., presence of weapons in the home, imminent risk of harm to self or others), 2) gather any other referral information that is immediately necessary, and 3) confirm the 211 response recommendation.

If the EMPS clinician plans to provide a mobile response, they are encouraged to keep the initial phone call brief and focused on preparing the caller and/or family for a mobile response. The preference in EMPS services is for crisis intervention and assessment to occur face to face in homes, schools, emergency departments, or other community locations. EMPS clinicians should collect the minimal amount of information needed over the phone which will allow them to respond quickly to the location of the crisis.

2. First EMPS Response

The clinician then determines whether to provide the family with an initial response that is either: 1) non-mobile (conducted over the phone), 2) deferred mobile (face to face, typically between 46 minutes and 4 hours after receiving the call), or 3) mobile response (face to face, 45 minutes or less after receiving the call). Mobile and deferred mobile responses are generally provided by one clinician, but a team of two clinicians is recommended when worker safety is a significant concern, in which case the EMPS team should also consider teaming with a police officer to respond to the crisis. Each EMPS response option is described below:

a) Non-Mobile Initial Response. A non-mobile (telephonic) initial response typically occurs only when received after hours or when specifically requested by the caller or the child's family. Calls that are received after hours will receive telephonic intervention from the Call Center clinician and will be offered a mobile response from an EMPS provider during the next available mobile hours. During the initial non-mobile response, clinicians focus on assessing risk, ensuring safety using a verbal safety plan, and determining appropriate follow-up.

b) Deferred Mobile Initial Response. Only EMPS clinicians provide a deferred mobile response, which typically occurs only when requested by the caller or the family. Deferred mobile responses occur when the family requests that an EMPS

clinician respond to the crisis at a later time. EMPS Clinicians should provide the deferred mobile responses in less than 4 hours, but no more than 24 hours after receiving the initial crisis call.

c) Mobile Initial Response. Only EMPS clinicians provide a mobile response, which involves a face to face response to the caller's home, school, an emergency department, or another community location. The EMPS clinician should arrive at the scene of the crisis in 45 minutes or less after receiving the call. Mobile responses are preferred among all responses that may be provided to families.

Subsequent follow-up services that occur after the initial response should be face to face sessions in the home, school, or community. This is true even if the initial response was over the phone or a deferred mobile response. Generally, family preference is the only factor that can determine whether follow-up care is provided somewhere other than the family's home or in the community.

3. Acuity Levels

During the initial phone contact, in the first few face to face sessions, and throughout the episode of care, the EMPS clinician will determine the child's acuity level based on relevant clinical features such as presenting problem, risk of harm to self or others, mental status, diagnosis, risk level, overall level of functioning, and other characteristics. The subsequent delivery of EMPS services depends, in part, on the assessed acuity level but also takes into consideration family needs and preferences as well as clinical judgment. The phase of intervention, intensity, and duration of care changes accordingly as youth and families experience changes in acuity level, needs, and preferences. At any point in an episode of care, suspected abuse or neglect must be reported to the Careline (1-800-842-2288).

EMPS has three levels of acuity; high, intermediate, and low. Each acuity level corresponds with recommended intensity and duration of EMPS care, described below:

a) *High Acuity*: Youth and families with high acuity receive face-to-face contact every 24 to 48 hours with the EMPS clinician in the home or community, psychiatric consultation as needed and additional phone contact as needed. The purpose of frequent contact when a family is in high acuity is to stabilize the immediate crisis, complete a reactive crisis plan, and reduce risk factors to prevent emergency room visits or inpatient hospitalization when EMPS can provide a safe and effective alternative. If that is not a safe and effective alternative, clinicians may consider referring a child to the emergency department for further evaluation.

b) *Intermediate Acuity*: Youth and families with intermediate acuity receive face- to-face contact every 48 to 72 hours (or 3-4 times a week) in the home or community, phone contact 3-4 days a week, and psychiatric consultation as needed. This level of contact is generally appropriate for children and families

that are not in an active crisis so the purpose is to maintain stabilization, work on a proactive crisis plan, and to begin planning for discharge which may include linkage and transition to ongoing services and supports.

c) *Low Acuity*: Youth and families with low acuity receive, at minimum, one face to face contact per week in the home or community, two phone contacts per week, and psychiatric consultation as needed. The purpose of this contact is to maintain progress toward the reactive and proactive crisis plans. Generally, youth and families with low acuity will be moving toward discharge from EMPS services which may include linkage and transition to ongoing services and supports.

The recommended intensity and duration of follow-up care is extensive for youth presenting at high acuity. It is important to note, however, that youth typically do not remain at this high level of acuity for more than a day or two. If a child is assessed to be at high acuity for longer than that, EMPS is likely not the appropriate level of care; referral to a higher level of care (including an emergency department referral) is probably indicated.

In addition, given the high demand for EMPS services, EMPS providers must balance the need for immediate crisis stabilization with the need for follow-up care. It is appropriate for EMPS providers to prioritize crisis stabilization of youth presenting with high acuity over follow-up care sessions with youth at lower levels of acuity.

4. Standardized Assessment Measures

Responding to the initial call, stabilizing the initial crisis, and assessing acuity are the primary focus of the Assessment phase; however, as the presenting crisis begins to stabilize, EMPS clinicians use standardized assessment measures to gather more clinical information and develop and implement a care plan. EMPS responds to a variety of crisis situations involving children and families with diverse needs and presenting concerns which requires that EMPS clinicians be familiar with various clinical assessment measures that correspond with the most common presenting concerns.

a. *EMPS Uniform Crisis Intake Assessment.* This assessment document was designed specifically for EMPS and combines narrative and checklist methods to develop a formulation of the child and family at intake. Factors considered include presenting crisis; brief crisis history; treatment history; medical history; family history; strengths and needs discovery; mental status; diagnostic information; clinical formulation; and summary recommendations and disposition.

b. *Acuity assessment*. The EMPS acuity assessment is not a structured assessment document. It is a set of guidelines to help structure clinical judgment around making a risk determination of high, medium, or low. The measure helps clinicians to consider the presence and severity of factors such as suicidality,

homicidality, self-injurious behavior, aggressiveness, psychosis, treatment history, and other factors.

c. *Emergency Certificate*. Effective October 1, 2010, Section 17a-78 of the General Statutes was amended to include subsection (f) pertaining to the issuance of emergency certificates (ECs) by certain EMPS clinicians. EMPS clinicians with the required degree and training are allowed to issue ECs authorizing transport to an emergency department for evaluation and possible inpatient hospitalization. The EC process requires EMPS clinicians to assess whether youth present an imminent risk of harm to self or others, or are "gravely disabled" due to the presence of a psychiatric condition.

d. T*he Structured Assessment for Violence Risk in Youth (SAVRY).*[1] The SAVRY is a risk management tool for assessing level of violence risk among 12 to 18 year old youth. The measure is comprised of 24 research-based items (rated "low," "medium," or "high") and 6 protective factors (rated as "present" or "absent").

e. *The University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index (UCLA PTSD-RI).*[2] The UCLA-PTSD-RI is used to assess traumatic stress symptoms among children ages 6 to 17 years. It is comprised of 20 interviewer-rated items that assess PTSD symptoms, guilt, impulse control, somatic symptoms, and regressive behaviors. The measure yields a total score that can be categorized into severity degree. An alternative to this measure for assessing trauma symptoms is the Child PTSD Symptom Scale (CPSS).

f. *The Global Appraisal of Individual Needs – Short Screen (GAIN-SS).*[3] The GAIN-SS is a brief (3-5 minute) screening instrument for mental health (internalizing and externalizing) and substance abuse disorders rated on a 4-point scale frequency scale. The measure is intended to be brief and to allow clinicians to identify youth in need of further assessment and intervention for these disorders.

g. *The Eating Disorders Inventory – Third Edition (EDI-3).*[4] The EDI-3 is a 91-item self-report measure that yields six composite scores: Eating Disorder, Risk Ineffectiveness, Interpersonal Problems, Affective Problems, Overcontrol, and General Psychiatric Maladjustment.

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[1] Borum, R., Bartel, P., Forth, A. (2006). *Manual for the Structured Assessment of Violence Risk in Youth (SAVRY).* Odessa, FL: Psychological Assessment Resources.

[2] Rodriguez, N., Steinberg, A., & Pynoos, R. S. (2001). *The Child Posttraumatic Stress Reaction Index,* Revision 2.

[3] Dennis, M.L., Chan, Y-.F., & Funk, R.R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. *The American Journal on Addictions, 15*, 80-91.

[4] Garner, D. M. (2004). *Eating Disorder Inventory-3. Professional Manual.* Lutz, FL: Psychological Assessment Resources, Inc.

h. *The Ohio Scales.*[5] The Ohio Scales is a 40-item measure that yields two scale scores for Problems and Functioning. The measure has parallel versions that are completed by parents and workers of youth between 5 and 18 years old. A youth-report version is available for 12 to 18 year olds. The Ohio Scales are one of the primary outcome measures for EMPS.

i. *The Strengths and Difficulties Questionnaire (SDQ).*[6] The SDQ is a 25-item outcome measure that yields four problem scores (Emotional Problems, Conduct Problems, Hyperactivity/Inattention, Peer Relationships) and one strength score (Pro-social Behaviors). The measure can be administered quickly, is easy to score, has good psychometric properties, and is available for free in multiple languages.

Summary of Tasks for Assessment Phase:

1) Receive all calls and referrals from 211 and other referral sources (keeping initial calls brief, emphasizing mobility)
2) Conduct brief safety screen and determine appropriate response plan (single clinician response, paired clinician response, joint police response)
3) Provide appropriate initial response to child and referrer (non-mobile, deferred mobile, mobile), emphasizing rapid mobile responses over all other options
4) Begin to stabilize the presenting crisis
5) Provide accurate acuity assessment to determine immediate risk level
6) Maintain youth in their homes and communities when EMPS and community-based care is a safe and effective alternative to emergency departments, inpatient hospitalization, and arrest/incarceration
7) Administer other screening and assessment measures as indicated
8) Begin completing the EMPS Standardized Intake
9) Communicate with family and original referrer (if different than family)
10) Enter all relevant data into EMPS web-based system

B. Ongoing Crisis Stabilization and Transition (Phase Two)

Some EMPS episodes of care end following an initial call or initial response within the Assessment phase; however, many youth and families will receive follow-up care for up to 45 days. The Ongoing Crisis Stabilization and Transition phase entails the delivery of ongoing clinical services for the remainder of the episode of care. It is important to note that many of the activities in the Assessment phase can be, and are, repeated in the Ongoing Crisis Stabilization and Transition phase. Service delivery activities during an episode of care rarely proceed in a predictable or linear manner. For example, youth and families are repeatedly assessed for risk and acuity level and clinicians frequently

[5] Ogles BM, Melendez G, Davis DC, et al. *The Ohio Youth Problem, Functioning, and Satisfaction Scales: Technical Manual.* Columbus, OH: Ohio Department of Mental Health, 2000.
[6] Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, **38**, 581-586.

review and update the proactive and reactive crisis plans. Each of these activities may in turn affect the interventions that are implemented.

The emphasis of this phase is on meeting child and family needs in a way that stabilizes the current crisis and prevents further crises from occurring, in alignment with the child/family, provider, and system goals identified above. The list below identifies a number of clinical activities that may be implemented during this phase; however, the list is not likely to be exhaustive, nor will children and families typically receive all of these services within a single episode of EMPS care. In addition, activities below may occur in a different order than what is presented and will occur when clinically indicated.

1. Review Results of Assessment Measures

At some point in service delivery, the results of all assessment measures that were administered should be shared with the family as well as with the child, if appropriate, and the original referrer (if different than the family and upon signature of an appropriate release of information). Sharing this information helps empower families to join as active partners in the care planning and delivery process. This should include an overall case conceptualization or clinical formulation that is derived from the Assessment phase in its entirety.

2. Develop a Care Plan

The clinician will work with the family to jointly develop symptom- and solution-focused goals that are integrated into a comprehensive care plan. EMPS providers generally have care plans that conform to the standards of various accrediting, licensing, and funding entities.

3. Address Factors Contributing to or Maintaining the Crisis

The EMPS clinician addresses the factors contributing to or maintaining the presenting crisis. Often, this involves identifying unmet needs and underlying concerns such as parent-child conflict, in-school behavior problems, anxiety, depression, academic issues, failure to take prescribed psychotropic medication, symptoms related to trauma exposure, social or peer problems, and many other presenting concerns. In addition, EMPS clinicians should engage in strengths discovery in order to ensure that strengths are incorporated into the care plan and subsequent service delivery. The EMPS clinician will work with the youth, family, and referrer to develop in the youth coping strategies and solutions that address these underlying factors.

4. Address Trauma Exposure and Symptoms of Traumatic Stress

EMPS providers review with children and families the traumatic events to which children have been exposed. Initial and/or repeated administration of the UCLA PTSD-RI may be helpful in this process. EMPS clinicians are trained to deliver trauma-informed care

throughout the duration of the intervention. Once again, when clinicians suspect abuse or neglect at any point during an episode of care they must report to the DCF Careline.

5. Develop and Review Reactive and Proactive Crisis Plans

The Reactive Crisis Plan is developed to help stabilize the immediate crisis at the moment in which it is occurring. The Proactive Crisis Plan is intended to put formal and informal services and supports into place that address the factors that contribute to and maintain crises, and therefore prevent further recurrence of crisis events. This helps contribute to ongoing stabilization of the child and their family. Child and family strengths should be incorporated into these plans as well.

6. Provide Ongoing Acuity/Risk Assessment

Acuity level, along with other factors, informs service delivery and decision-making. As a result, ongoing acuity assessment is an important part of service delivery. As changes occur in the acuity assessment, there are accompanying changes in the expected intensity and duration of EMPS services.

7. Refer for Psychiatric Evaluation

If the clinician and family believe it to be clinically necessary, youth may be referred for a psychiatric evaluation. In this case, EMPS clinicians will collaborate with the contracted EMPS psychiatrist who oversees medication management activities.

8. Provide Coordination of Care

EMPS clinicians provide case management in order to assist families in identifying their current strengths and needs. EMPS Clinicians assist with developing strategies to address those needs using an array of community-based services, supports, and system collaborations. EMPS case management includes, but is not limited to, attending PPT meetings, connecting or re-connecting to formal and informal services and supports in the community, ensuring systems collaboration, reviewing insurance and/or entitlement eligibility (such as HUSKY) and linking families to resources in the community to meet basic needs that may be a barrier to receiving the appropriate level of treatment. EMPS clinicians also provide psychoeducation about psychological conditions, understanding and navigating the mental health system, reducing stigma, and overcoming obstacles their child is facing.

9. Enhance Motivation to Participate in Ongoing Care

EMPS clinicians will work with families to enhance readiness for following through with their ongoing care plan, post-EMPS. This can be accomplished using techniques from Motivational Interviewing. In this effort, clinicians may also review with the child and their family the gains and successes that were achieved during participation in EMPS.

10. Communicate with the Original Referrer

Communication with the original referrer is very important for sharing care plan strategies, generalizing treatment gains to other settings, and building a positive reputation for collaboration with community partners. Communication and collaboration with family members is required, and EMPS clinicians are also encouraged to communicate regularly with other referrers and collateral contacts. Activities may include regular phone contact, written communication of progress, sharing the care plan, or attendance at PPT meetings.

11. Facilitate Transition to Ongoing Services and Supports

EMPS clinicians will help families transition to post-EMPS services and supports, as needed. Because transition planning occurs throughout the episode of care, ongoing crisis stabilization and transition activities often occur in parallel.

Summary of Tasks for Ongoing Crisis Stabilization and Transition Phase

1) Provide follow-up services in the home or other community locations
2) Regular re-assessment of acuity and modifying interventions accordingly
3) Interpreting assessment measures and incorporating findings into care plan
4) Accurately identifying and intervening with factors that contribute to and/or maintain behavioral crises
5) Identifying unmet needs and strengths and incorporating into the care plan
6) Proficiency with various EMPS and agency-specific documents and documentation procedures, including the care plan, proactive crisis plan, and reactive crisis plan
7) Delivering trauma-informed care
8) Coordinating care with psychiatrists
9) Regular communication and collaboration with referrers and other collateral contacts such as schools, emergency departments, and primary care physicians
10) Familiarity with care coordination processes and procedures
11) Motivational Interviewing strategies
12) Familiarity with community-based, formal and informal services and supports for ongoing care
13) Facilitating transition to ongoing services and supports

A Family Vignette

Phase One: Assessment

Initial Call
211 receives a call from a parent who is concerned about her 10 year old child expressing a wish to die. The child is underneath his bed, crying and scratching his wrist with a paperclip. 211 assesses that the child does not need to be immediately referred to an emergency department, assigns a recommendation for a mobile response, and transfers the call to an EMPS Crisis Intervention provider. The EMPS Crisis Intervention provider assures that the child and family will maintain safety until they can arrive to the location of the child and notifies the parent that they are on their way to provide a mobile response.

Mobile Initial Response
An EMPS Crisis Intervention provider arrives at the family's home and identifies that the source of the child's distress is that he is being bullied at school. They help the child to calm down by taking ten deep breaths, coax the child out from underneath the bed, and eventually help convince the child to give the paperclip to his parent. The parent cleans the scratches. EMPS prompts the child to sit on the couch and begins the process of further assessing and intervening with the current crisis. During this initial visit, the EMPS Crisis Intervention provider determines that the child's acuity level is "1" (highest acuity) due to such factors as suicidal ideation, cutting behaviors, and school avoidance. At the end of the first visit, the family agrees to meet with the EMPS Crisis Intervention provider the next day.

Phase Two: Ongoing Crisis Stabilization and Transition
On a follow-up visit the next day, the EMPS Crisis Intervention provider meets with the family again at their home. The child reports that he has been anxious and sad since the beginning of the school year and has thought about dying for the past month. The parent expresses that she has attempted to address the bullying with his teacher. The parent also wonders if the child is part of the crisis reaction is related to the sudden death of his dog about one month ago.

EMPS provides psycho-education to the parent and child on typical responses to being bullied and on grief and loss, ensures that the child will be under constant supervision and develops a proactive plan to address the child's safety and distress. The parent, child and EMPS Crisis Intervention clinician agree that goals for the EMPS intervention are for the child to maintain safety, to experience a remittance in his thoughts of dying, to move through his grief around the loss of his dog, to stop the bullying at school and to link the child with ongoing treatment to further help him cope with his difficulties. The parent and child agree to follow the proactive crisis plan.

EMPS and the parent determine that the child is in need of a high level of EMPS intervention; EMPS establishes a plan to call the family later that night and to provide another follow-up visit the next day. During the follow-up visit the child expresses that

he has not had thoughts of dying since EMPS left the day before. He and his parent are able to engage in solution-focused strategies to further enhance the child's safety and work towards the day his anxiety and sadness no longer distresses him. EMPS and the parent determine that the child's acuity level is now level 2 (intermediate) which requires a less intensive level of EMPS intervention. EMPS arranges to call the family each day and to do a home-based intervention session in three days. During the next three days the parent plans to ask for a meeting with the teacher, the school social worker, and the principal in order to find a resolution to the bullying. She also agrees to call a local therapist to arrange for ongoing treatment for her child.

During the next visit the parent reports success in arranging a meeting with the school and in securing follow-up care for her child. The child says that he feels hopeful that he will feel better and will continue to avoid thoughts of suicide. EMPS and parent determine that the child is now at level 3 Acuity (low) and schedules the next follow-up session at the home for five days later.

EMPS, the parent, and the child review gains made during the EMPS intervention. The child has used the coping strategies developed in the proactive safety plan. He reports feeling less sad about his dog and less anxious about going to school now that the school has addressed the bullying. He has had no thoughts of suicide since EMPS first saw him. The parent and child agree to attend an appointment scheduled with an outpatient therapist the following day. EMPS has the parent sign a release of information to talk with the therapist and later that day calls the therapist to pass on pertinent information about the child's crisis, proactive safety plan, and ongoing treatment needs. The parent agrees to call EMPS after the appointment with the therapist. A few days later, the parent calls the EMPS provider to say the appointment went well, and they jointly agree to end the EMPS episode of care with the understanding that EMPS should be called any time a crisis re-emerges in the future.