Scope of Services

The Contractor will provide the following specific services for the **EMPS Mobile Crisis Intervention Service** program and will comply with the terms and conditions set forth as required by the Department, including but not limited to the requirements and measurements for scope of services, contract performance, quality assurance, reports, terms of payment and budget. No provisions will be contained in this Part I that negate, supersede or contradict any provision of Part II. In the event of any such inconsistency between Part I and Part II, the provisions of Part II will control.

<table>
<tr><th colspan="3">Program Specific Information</th></tr>
<tr><td colspan="2">Contractor Legal Name:

Service Type:
EMPS Mobile Crisis Intervention Service</td><td>Program Name: (if applicable)</td></tr>
<tr><td colspan="2">Towns Served:</td><td>DCF Area Offices Served by program:
☐ Bridgeport ☐ Middletown ☐ Norwich
☐ Danbury ☐ Milford ☐ Torrington
☐ Hartford ☐ New Britain ☐ Waterbury
☐ Manchester ☐ New Haven ☐ Willimantic
☐ Meriden ☐ Norwalk-Stamford ☐ Statewide</td></tr>
<tr><th colspan="3">Program Contact Information</th></tr>
<tr><td colspan="2">Program Contact:</td><td>Title:</td></tr>
<tr><td>Phone:</td><td>Fax:</td><td>Email Address:</td></tr>
<tr><td colspan="2">Fiscal Contact:</td><td>Title:</td></tr>
<tr><td>Phone:</td><td>Fax:</td><td>Email Address:</td></tr>
<tr><th colspan="3">Program Site(s) Information</th></tr>
<tr><td colspan="2">Address # 1:</td><td>Contact Person (Name, Title, Phone, Email)</td></tr>
</table>

A portion of this program's funding is provided through the Federal Temporary Assistance to Needy Families Block Grant; requirements in Part I, Section D. 5. of this contract apply to this program.

A. DESCRIPTION AND CONTRACT CAPACITY

1. Service Description

EMPS Mobile Crisis Intervention Service (EMPS) is a mobile, crisis intervention service for children experiencing behavioral health or psychiatric emergencies. The service is to be delivered through a face-to-face mobile response to the child's home, school or location preferred by the family, or in rare situations through a telephonic intervention.

The purpose of EMPS is to provide community-based rapid emergency crisis stabilization to children and their families and to provide brief follow-up care to promote continued stabilization and linkage with ongoing supports and services within the community. In addition to the direct provision of crisis intervention and stabilization services, the EMPS Contractor engages in outreach, collaboration, coordination of care, promotion of the service, and other community based activities to enhance access, service quality, child and family outcomes, and stakeholder satisfaction.

2. Contract Capacity

The Contractor will maintain capacity to respond to crisis calls from the target population within their geographic service area during operational hours, seven days per week, 365 days per year. The Contractor must have the ability to be able to handle multiple calls at one time.

B. SERVICE DELIVERY REQUIREMENTS

1. Target Population

The target population for EMPS is any child or youth in the community, under the age of 18, (or under age 19 if still in school) who is in the midst of a psychiatric, behavioral, or emotional crisis for which an immediate response is required and who can be safely served in a community or home setting. The target population includes most children and youth, along with their families, including those who are:

a. uninsured;
b. enrolled in Husky A or B;
c. enrolled in DCF Voluntary Services;
d. involved with DCF Child Protective Services;
e. involved with DCF Juvenile Justice Services;
f. receiving behavioral health services from a community provider;
g. involved with the Court Support Services Division (CSSD);
h. in a DCF or therapeutic level foster, or adoptive home;
i. presenting in psychiatric crisis in a hospital emergency department (ED) and in need of continued stabilization and follow-up care upon discharge from the ED;
j. experiencing a psychiatric, behavioral, or emotional crisis in a school, after school program or other community setting;
k. residing in a Therapeutic Group Home, Short Term Assessment and Respite (STAR) Home, Short-term Family Integrated Treatment (S-FIT) Home, Preparing Adolescents for Self Sufficiency (PASS) Group Home, or Supported Work Education and Training (SWET) Home.

The priorities for EMPS intervention are children and youth who lack a current relationship with a qualified mental health provider, but having a current relationship with a qualified provider does not preclude access to an EMPS response.

Children or youth residing in a psychiatric inpatient unit, sub-acute unit or Psychiatric Residential Treatment Facility (PRTF), or a residential treatment center are **not eligible for EMPS intervention.**

2.. Hours of Operation

a. The Contractor must retain the capacity to receive and immediately respond to crisis calls/inquiries for crisis intervention, seven days a week, 365 days per year.
b. The Contractor must maintain capacity for mobile response between the hours of 6:00 AM to 10:00 PM, Monday through Friday, and 1:00 PM to 10:00 PM on Saturday, Sunday, and the following Holidays: New Years, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas.
c. The Contractor must retain the ability to respond to multiple calls within the same time frame and the flexibility in staffing to respond effectively to predictable peak periods of demand.

3. Referrals

a. The Contractor will receive referrals for emergency crisis response from the EMPS Crisis Intervention Service Statewide Call Center ("the Call Center"). The Call Center is operated by the United Way of Connecticut 211.
b. The Contractor will maintain a protocol with the Call Center that serves as a point of connection between the local EMPS program, the Call Center, and families/individuals seeking emergency crisis services. Additionally, the contractor will maintain a schedule including on-call and back-up clinicians' names and phone numbers on a weekly or monthly basis. Any updates or changes to the schedules must be made by the Contractor and shared with the Call Center. Changes to the protocol with the Call Center must be approved by the DCF contract manager.
c. The Contractor will receive calls, by conference or warm-line transfer, from the Call Center that have been triaged by the Call Center EMPS Call Specialists.
d. The Contractor is responsible for responding to all calls in their service area during hours of operation.
e. After hours calls will be handled by the Call Center (i.e. 10:00 PM through5:59 AM M-F and 10:00 PM through 12:59 PM Saturday, Sunday, & Holidays) and the Call Center will notify the Contractor of all calls received during the "after hours" period for follow-up by the Contractor in the morning.
f. The Contractor's protocols will provide coverage availability during operational hours, 365 days per year and the Contractor must have a qualified member of the EMPS team immediately available to accept all referrals from the Call Center.
g. If a request for emergency mobile assistance is received directly by the Contractor rather then through the Call Center, the Contractor is responsible for entering the referral information into the DCF Provider Information Exchange (PIE) in order to "register" the family.
h. The Contractor will develop and maintain a system to provide back-up to other EMPS contractors in contiguous areas.

4. Mobile Responsiveness

a. A minimum of 90% of EMPS responses must be mobile, consisting of the immediate dispatch of staff to the client home, school, or other community based setting based on the family's or caregiver's preference.
b. The Call Center will screen out and respond to routine requests for information and referrals.
c. Individuals or families who prefer an office based response at a later time may be best served through referral for urgent access to the local Enhanced Care Clinic rather than an EMPS emergency crisis intervention.
d. The Call Center will notify the Contractor when a call seeking an EMPS response was directed to 911 because of immediate safety or risk issues. If the Contractor determines that its involvement in that situation would be appropriate, it may contact the ED.

5. Time Frames for Response

a. The Contractor must maintain availability during hours of operation to be immediately "conferenced" into calls determined by the Call Center to require an immediate emergency crisis response.
b. EMPS clinicians are expected to be on site in the home, school, or other community setting within 45 minutes of their receipt of the call.

c. Whenever possible, prior to the end of the initial intervention, a Crisis Plan will be developed with the family and a copy provided to all participants. This initial Crisis Plan should be provided to other key players (e.g. therapist, case manager, school staff, coach) with appropriate consent within one (1) business day of development.
d. Initial follow-up with the child/family must occur within one week of the initial crisis intervention or sooner if clinically indicated. Whenever possible, follow-up should be provided by or include a community provider in a position to provide ongoing care, or by the EMPS staff if no care provider has been engaged.

6. Crisis Planning

a. The Crisis Plan developed by the Contractor and the family will use the DCF statewide uniform Crisis Plan format which is informed by the structure and approach described by Grealish (2006) in The Comprehensive Guide to Crisis Intervention Planning.
b. Each Crisis Plan will include kinship, natural, and family supports and, when possible, a Wraparound Child and Family Team meeting to the extent possible.
c. The Contractor will continually update the Crisis Plan for each family throughout the course of their EMPS intervention.
d. The Crisis Plan will be in writing, included in the client record, and copies provided to the family and key resources, in particular schools with appropriate consent.

7. Follow-up Care

a. Follow-up care to support continued crisis stabilization, strengthening of supports, and linkage to ongoing services and supports (including natural, family and kin) is a required and critical element of EMPS.
b. As part of the initial crisis response, the duration of follow-up care should not exceed 45 days. In rare cases where extended follow-up may be required, the Contractor must notify the DCF contract manager for EMPS regarding the circumstance and reason for an exemption from the follow-up duration.
c. EMPS teams will maintain a balance between maintaining capacity for mobile response to initial crises and providing sufficient follow-up care to support continued stabilization and linkage.
d. Follow-up care will conform to the values and principles in the Practice Standards of Connecticut Community KidCare including: family driven, youth guided, community based, linguistically and culturally competent, strength based, and promoting the use of informal community based supports.

8. Episodes of Care

Episodes of Care will be defined in three categories:

a. Crisis Response Initial Telephone Only
The only contact that has occurred has been a phone intervention and the immediate crisis was resolved and the caller did not want a face-to-face follow-up intervention from the EMPS team. (only at the request of the caller.) *(Note: for purposes of PIE, first contact = warm transfer from 211.)*

b. Immediate Face to Face Crisis Response
The caller was identified as in need of a mobile (within 45 min) or deferred-mobile, face-to-face response in the community (most commonly at home or at a location requested by the caller) and the crisis response intervention was concluded within five calendar days from the date of the original call. *(Note: for purposes of PIE, first contact = first face-to-face contact.)*

c. Immediate Crisis Response Stabilization with Follow-up
The caller was identified as in need of a mobile (within 45 min) or deferred-mobile, face-to-face response in the community (most commonly at home or at a location requested by the caller) and the crisis response intervention was NOT concluded within five calendar days from the date of the original call.

The total period of time for the crisis intervention should not exceed more than forty-five (45) days from the date of the original call to the last follow-up visit. (Extensions beyond 45 days require a notification to the DCF contract manager as specified in section 7b.)
(Note: for purposes of PIE, first contact = first face-to-face contact.)

9. Staffing and Team Composition

a. All EMPS operational hours must be staffed by a dedicated EMPS team or teams of clinicians.
b. Each EMPS provider will have an FTE dedicated as the "Facility Liaison" working with high-needs children. These are children who are on overstays in hospital Emergency Departments or Inpatient Units or at risk of this; and children at risk for placement in a Crisis Stabilization Program or Psychiatric Residential Treatment Facility (PRTF) or other behavioral health congregate setting for crisis management. The Facility Liaison will work to prevent and divert high-needs children from going to the ED or being placed in these settings for crisis management. This work will include ongoing communication and coordination with other EMPS providers, ED's and other behavioral health congregate and community based programs in support of maintaining high-needs children in their homes and in the community.
c. The Contractor is expected to support the community and schools following an untimely death or death by suicide.
d. 80% or more of the members of the EMPS teams providing coverage during the hours of mobility must work at least half-time within the EMPS program.
e. The Contractor may use part-time and/or per diem staff to augment its coverage.
f. All clinicians working with the EMPS team must be licensed or license eligible for independent practice as a clinical psychologist, clinical social worker, marriage and family therapist, licensed professional counselor, or licensed alcohol and drug counselor. Exceptions to these clinician credentialing requirements may be allowed with prior approval from the DCF EMPS program manager, or their designee.
g. The Contractor may use paraprofessional staff to assist a clinician in an initial crisis call or may use paraprofessional staff for follow-up and ongoing support and linkage when clinically appropriate. A paraprofessional may not respond to an initial crisis call nor to a subsequent crisis call without an EMPS clinician.
h. EMPS staff providing direct service to clients must be appropriately supervised by a clinical director who is a Connecticut licensed mental health provider with significant clinical and managerial experience. The clinical director will be responsible for the overall management and performance of the EMPS program.
i. The Contractor must provide access to a psychiatrist or APRN under the supervision of a psychiatrist, for psychiatric assessment, psychiatric consultation, and short-term medication management that is sufficient to meet the needs of staff, children, and families.
j. The contractor may need to add staff through the use of additional third party reimbursements as call volume increases.

10. Use of Uniform Forms and Record Keeping

The Contractor will utilize forms and record keeping systems provided by DCF for the purpose of establishing/supporting uniform practices in the delivery of EMPS. Forms may include but are not limited to the following;

a. Intake/Assessment Forms;
b. Crisis/Safety Plans;
c. Discharge Plans.

11. Substance Abuse Services

EMPS teams will have the capacity to provide, at the site of the crisis, substance abuse screening and referral for children and adult family members. EMPS teams will utilize the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool and process to assess for substance use problems.

12. Relationships with Emergency Departments (EDs)

a. The Contractor will collaborate with and maintain relationships with the EDs within its service area and will also establish relationships with EDs outside their service area that serve a significant number of children and youth from within its service area.
b. The relationship with each ED will be demonstrated by the following:
    i. a Memorandum of Understanding (MOU) outlining roles and responsibilities of each party. The Contractor will provide DCF with a copy of each MOU;
    ii. outreach to high sources of referral to the ED to facilitate diversion from the ED;
    iii. collaboration with each ED to facilitate rapid discharge of ED patients to the community via the provision of education/consultation regarding diversion options and by follow-out/follow-up care by the EMPS provider.

13. Relationships with Schools

a. The Contractor will establish relationships with each school system within its service area to facilitate appropriate referral to EMPS services as an alternative to ED referral.
b. The Contractor will utilize a variety of methods to better engage school systems such as: Memorandums of Understanding, policy and protocol regarding school referrals, outreach and liaison to schools and school systems, training of school staff, consultation to school staff, obtaining releases in advance of EMPS intervention for those youth at high risk for EMPS intervention. The Contractor will provide DCF with a copy of each MOU.
c. The Contractor will make specific outreach activities to engage school systems that have arrest rates above the state wide average.

14. Relationships with Law Enforcement

The Contractor will establish and maintain relationships with each Police Department within its service area and will work closely with law enforcement to reduce the trauma suffered by children who witness the arrest of their care giver..

15. Relationships with the Foster Care System

a. The Contractor will establish and maintain relationships with entities involved in the management and provision of foster care services and organizations that advocate on behalf of foster parents and foster children. These relationships could include local DCF Foster Care and Adoption Service Units (FASU), DCF Office of Foster Care and Adoption Services (OFAS), private/therapeutic level foster care provider agencies, and foster parent advocacy and support organizations.
b. The Contractor will utilize a variety of methods to better engage the foster care system, including but not limited to: policy and protocol regarding foster care referrals; outreach and liaison to and education of foster care support/resource groups, foster care collaboratives, advocacy organizations and private foster care agencies; training of private foster care and advocacy organizations' staff; consultation to private foster care and advocacy organizations' staff; and obtaining releases in advance of EMPS intervention for those foster youth at high risk for EMPS intervention.

16. Other Key Relationships

In addition to those relationships outlined above, the Contractor will develop and maintain relationships with:

a. all local Systems of Care/Community Collaboratives within their service area;
b. all local managed service systems within their service area;
c. all DCF local offices within their service area;

d. all Enhanced Care Clinics;
e. key service providers including, but not necessarily limited to: outpatient, extended day treatment, intensive outpatient, intensive in-home, respite, mentoring, care coordination, crisis stabilization, sub-acute, and psychiatric inpatient providers;
f. key community resources (e.g., social service agencies and programs, recreation, faith-based) that are likely to be a significant source or point of access for natural and informal supports that may be of value to families in crisis;
g. CT Behavioral Health Partnership network management staff, Intensive Care Managers, and Peer Specialists; and
h. Short Term Assessment and Respite (STAR) homes, Short-term Family Integrated Treatment (S-FIT) homes, and therapeutic group homes.

17. Outreach Activities

The Contractor will make available EMPS posters and other marketing materials (as provided by DCF) to families, behavioral health providers, social, recreational, faith-based and other local establishments to assist in a general community EMPS outreach campaign.

Additionally, the Contractor will complete a minimum of 24 formal outreach activities annually per Contract Service Area. Priority will be given to schools, law enforcement, foster care providers and identified high volume referrers to local EDs. A formal outreach activity is defined by:

a. in person presentations lasting at least 30 minutes, but preferably 60 minutes, using the EMPS PowerPoint slides and including distribution to attendees of marketing materials and other EMPS resources;
b. in person presentations that are at least one hour duration in which EMPS and the criteria for using EMPS is discussed; (this would include workshops, conferences, or similar gatherings);
c. outreach presentations that are not in person which may include workshops, conferences, or similar gatherings in which the EMPS marketing video, banner, and table skirt are set up for at least 2 hours with marketing materials made available to those who would like them;
d. other additional outreach activities that are not described above, but that the Contractor believes to be appropriate and that have been discussed with and received approval from the EMPS Performance Improvement Center (PIC).

18. Multicultural and Linguistically Competent Training and Service Delivery

The Contractor will:

a. provide culturally and linguistically competent training for their staff members; and
b. assure multicultural competence in the implementation of EMPS.

The preferred method of ensuring culturally competent care is the hiring of bilingual or multilingual EMPS clinicians. Limited use of interpretive services is permitted, where no bilingual staff is available. Materials provided by the Contractor to families served by the program should utilize language that is understandable by the general population being served.

19. Training

a. The Contractor will have all members of the EMPS team (including sub-contractors, if any) participate in training: including training offered internally and offered by the PIC, DCF or the representatives of PIC or DCF. The Contractor will ensure all staff complete their training as outlined in the Annual Training Plan.
b. Required training modules:
    i. crisis assessment and intervention;
    ii. suicide assessment and prevention;
    iii. violence assessment and prevention;
    iv. substance use assessment and prevention; utilizing the SBIRT screening tool and other materials;
    v. principles and practices of the System of Care;

vi. crisis planning; strength based assessment and care planning;
vii. Emergency Certificate*
viii. identification and use of natural supports;
ix. traumatic stress and trauma informed service provision;
x. culturally and linguistically competent care;
xi. working with foster families and the behavioral health needs of children in foster care;
xii. parent Support and behavior management;
xiii. worker safety and self care;
xiv. training in standardized risk assessment and treatment protocols.

*EMPS staff who are Licensed Clinical Social Workers, Advanced Practice Registered Nurses, or Licensed Professional Counselors, will participate in a mandatory training as it relates to Public Act No. 10-170 AN ACT CONCERNING THE ISSUANCE OF EMERGENCY CERTIFICATES BY CERTAIN STAFF OF THE EMPS CRISIS INTERVENTION SERVICE PROGRAM and the minimum training requirements associated with that public act. The training will prepare qualified EMPS staff for the possibility of utilizing an "Emergency Certificate", to direct a child to an Emergency Department for a mandated crisis assessment.

C. DATA AND OUTCOME REPORTING REQUIREMENTS

1. Quality Improvement

The Contractor will maintain a quality improvement system to monitor performance and correct identified problems.

a. Indicators within the quality improvement system may include:
   i. number of children/families served as a percentage of population and DCF caseload data;
   ii. percentage of children/families served with an initial mobile response;
   iii. response times for mobile and telephonic intervention;
   iv. percentage of children/families linked to ongoing care within the 45 days target;
   v. effective stabilization of children/families served;
   vi. rate of ED diversion of children/families served;
   vii. rates of inpatient hospitalization and residential placement during/immediately following EMPS intervention;
   viii. consumer / family satisfaction;
   ix. timely completion and dissemination of crisis plan;
   x. successful linkage to follow-up care;
   xi. other.

b. Provider Specific Annual Performance Improvement Plan

As part of its quality improvement system, the Contractor will develop a Performance Improvement Plan (the Plan) on an annual basis with quarterly reviews documenting changes and progress on the plan.

i. The Contractor's Plan will identify areas of strength supported by data, i.e. areas of practice that the Contractor believes are being accomplished in the most beneficial way possible. In addition, the Plan will include a description of the internal practice the EMPS provider uses to achieve these successes. This information will be shared with DCF and when combined with that of other Contractors, will form a "best practice" document.

ii. The Contractor's Plan will identify a minimum of two areas of practice in which improvement seems needed. These areas should also be supported by data, and should be consistent with what the Department has identified as priority practice issues. The Plan should articulate strategies that the Contractor believes will have a positive effect on the identified areas.

iii. The Contractor's Plan will identify a Data Quality Monitoring process that ensures that data entry is efficient, effective and minimizes the possibility of data errors. The process will include the review of critical data at least weekly if not daily.

c. Contractor Performance Improvement Team
The Contractor will establish a Performance Improvement team which meets at minimum four (4) times a year with four (4) primary functions:

i. to provide input into the creation of the Plan;
ii. to support and assist in the implementation of the Plan (when possible);
iii. to regularly review the Plan;
iv. to provide input to update the Plan as necessary.

The Committee will include at least three individuals per Service Area: Including the manager/supervisor of EMPS, an individual knowledgeable about data and/or EMPS (individual may or may not be employed by the EMPS provider).

d. Statewide EMPS Performance Improvement Team
The Contractor will send at least one agency representative from their Performance Improvement Team, to participate in a statewide EMPS Performance Improvement Team that will meet at least two times each year. The purpose of the statewide team will be to review the EMPS data and identify areas of practice needing improvement, in order to better meet the needs of families utilizing the EMPS service.

e. Results Based Accountability (RBA) Report Card
The Contractor, as part of their ongoing performance improvement activities, will formally create on a quarterly basis an RBA report card. The report card will follow standard RBA guidelines and address the questions (1) How Much Did We Do?; (2) How Well Did We Do It?; and (3) Is Anyone Better Off? The report cards should include data on episodes of care, meeting the mobility and response time benchmarks and the results of the Ohio Scales.

2. Reporting
The Contractor will submit individual, client level data to the Department's Provider Information Exchanger (PIE), or other system as required by the Department. The Contractor will ensure that the data submitted under PIE, or other system, is in conformance with the applicable data specifications and pick-lists. Furthermore, the data must use the conventions and logic as determined by the Department to ensure accurate, unduplicated client counts. This data will, as set forth by DCF, be sent to the Department and/or the Department's designated vendor(s) at an interval specified by DCF.

3. Outcomes
a. Process Outcomes
The Contractor will meet the following expectations on process/performance indicators:

i. at least **80%** of all mobile responses will take place in 45 minutes or less from the end of the triage call;
ii. at least **90%** of children and youth will receive a mobile response, among those for whom a mobile response was recommended by the Call Center;
iii. each quarter, the volume of children (families) served will be no less than 10 children per 1,000 children in the population within its service area.

b. Client Outcomes
The Contractor will meet the following expectations for client outcome indicators:

i. **90%** of clients served will report positively (Agree or Strongly Agree)when asked the following:
   (a) "EMPS helped my child/family get the services needed",
   (b) "EMPS made contact with my current service provider",

(c) "The services or resources my child and/or family received were right for us";

ii. at least **90%** of families will be satisfied with services received as evidenced by the Youth Satisfaction Survey - Family (YSS-F);

iii. on average, children served will demonstrate an improvement from intake to discharge on the Ohio Scales, Problems and Functioning Scales.

Template Approval Date: 11/12/15