FY2018 Statement of Work
Children's Mobile Response & Stabilization

1.0 INTRODUCTION

1.1 Contractor shall provide the resources necessary to operate a Mobile Response and Stabilization System for children, youth and young adults and their families, up to the age of 25. The Mobile Response and Stabilization System is a mobile intervention service for children, youth, and young adults experiencing behavioral health emergencies. Mobile invention services shall include, but not be limited to: community-based rapid emergency crisis stabilization for individuals with immediate, overwhelming behavioral problems that severely impair their ability to function in the community; community-based emergency intervention for other behavioral health emergencies; collaboration with community stakeholders to help ensure client success; outreach and engagement for crisis intervention service recipients who are not existing clients; follow-up care to promote continued stabilization; coordination of care; and other community-based activities to enhance access, service quality, child and family outcomes, and stakeholder satisfaction.

2.0 DEFINITIONS

2.1 LMHP— Licensed Mental Health Professional as defined in Title 43A 1-103(11)

2.2 LBHP— Licensed Behavioral Health Professional as defined in Administrative Rule 450:1-1-1.1.

2.3 CC— Care Coordinator

2.4 FSP— Family Support Provider as defined in Administrative Rule 450:1-1-1.1.

2.5 PRSS— Peer Recovery Support Specialist as defined in Administrative Rule 450:53.

2.6 BHA- Behavioral Health Aide as defined in Administrative Rule 450:1-1-1.1.

2.7 Deferred Call – A call in which the family requests that an MRT respond face to face to the emergency at a later time.

3.0 WORK REQUIREMENTS

3.1 Contractor shall provide a Mobile Response and Stabilization System for children, youth and young adults up to the age of 25. These children, youth and young adults shall be eligible regardless of payer source or ability to pay. Exclusions include youth in Residential Treatment Facilities, Inpatient Hospitals.

3.1.1 Contractor shall maintain capacity to respond to emergency calls from the target population within their geographic service area 24 hours a day, 7 days a week, 365 days a year.

3.1.1.1 The Contractor shall have a published telephone number accessible on a 24 hour basis, seven days a week.

3.1.1.2 The Contractor must have the ability to handle and respond to multiple calls at one time.

3.1.1.3 The Contractor must respond to calls within 1 hour of the call, unless the call is identified as a deferred call.

3.1.1.4 The Contractor must respond to deferred calls within 24 hours of call.

3.1.2 Contractor shall maintain capacity to staff a **Mobile Response Team (MRT)** 24 hours a day, 7 days a week, 365 days a year to provide on-site, face-to-face emergency response to assist with behavioral health emergencies through the provision of face to face mobile intervention services designed to deescalate the emergent situation, prevent placement disruption, inpatient hospitalization, detention and homelessness. The overall goal is restore the youth and family to a pre-emergency level of stabilization.

3.1.3 Contractor shall ensure that the following staffing requirements are met:

3.1.3.1 Face-to-face emergency response shall be provided by a Care Coordinator, Family Support Provider, Peer Recovery Support Specialist, Behavioral Health Aide or other qualified staff, with immediate access to a Licensed Mental Health Professional (LMHP).

3.1.3.1.1 Immediate access to a LMHP is defined as face to face access or access through an on-call system (e.g. telehealth).

3.1.3.1.2 Face-to-Face emergency interventions that take place in a hospital emergency room are to be provided by a LMHP.

3.1.3.2 Mobile Response and Stabilization teams of two or more staff is preferred, but an exception can be made by a LMHP according to the policy of the Contractor.

3.1.3.3 At a minimum, staff should have training in crisis theory, risk assessment, and trauma informed interventions for the developmental levels being served (this includes any core training required by the ODMHSAS), and the ability to provide trauma informed, systems-based and strengths-based approaches for the assessment of children and adolescents in crisis.

3.1.3.3.1 Training requirements include: Cultural Linguistic Competency; Traumatic Stress and Trauma Informed Care; Functional Assessment; Crisis and Safety Planning; Motivational Interviewing; NIMH, Columbia, Crisis Assessment, Planning and Intervention for LBHP; and Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SIBIRT).

3.1.4 Contractor shall ensure that children, youth and families accessing mobile response and stabilization teams are able to access referral and linkage assistance for evaluation and assessment for mental health and substance use disorder services; and have access to a comprehensive array of behavioral health treatment and support services.

3.1.4.1 MRTs shall provide crisis diversion, resource support, stabilization and care coordination for emergency situations that are not a mental health or substance use crisis.

3.1.4.1.1 When emergencies rise to a level needing a clinical intervention, MRTs shall access an LBHP via telehealth or face to face.

3.1.4.2 MRTs shall respond to emergent situations and attempt to work with the family to de-escalate and

connect with follow up services, while linkages for community based services and/or the Wraparound process are established. This can include, but is not limited to:

3.1.4.2.1 Functional assessment to help the family to determine immediate challenges and the resources needed to overcome those challenges, including communication and coping skills to help prevent future emergencies.

3.1.4.2.2 Developing a plan for emergencies to aid in preserving the stabilization.

3.1.4.2.3 Follow-up appointments and planning, completing releases for engaging informal supports (Schools, OJA, DHS, etc.)

3.1.4.3 If the emergency is not a mental health or substance use crisis, and the MRT is not successful in deescalating the situation, the MRT will attempt to locate a respite provider for the child or youth. Flex funding will be available for assistance with brief respite. For children in state custody, a protocol will be followed, notifying the OKDHS caseworker who will utilize mental health consultation to determine the next best placement option immediately.

3.1.4.4 When an emergency is determined to be a clinical crisis, the MRT will Link with an LBHP and the LBHP will conduct an assessment in order to determine if there is a mental health or substance use crisis that is of immediate danger to self or others. If so, prior authorization will be issued by OHCA at that time and the MRT will work locally to get the child and family to the closest children's crisis center or inpatient facility bed available. The family or law enforcement will then transport the child or youth to the inpatient facility. The MRT will at that time make a referral to link the family with a local HH/Wraparound agency to begin preparing the family for reunification, and begin working with the inpatient facility on discharge planning. This will enable return to the community as seamlessly and quickly as possible.

3.1.4.4.1 If the LBHP has difficulty making a final determination, an inpatient LBHP at the OHCA will be accessible to make the final assessment of whether an acute level of inpatient mental health care is immediately necessary.

3.1.4.4.2 The MRT shall make contact with inpatient facility within 48 hours after inpatient admission to discuss discharge planning of those who go inpatient or a residential setting.

3.1.4.5 Follow-up care and coordination of services by the MRT after the emergency intervention will last up to 72 hours, to promote continued stabilization. There is also an option to continue to follow-up for 8 weeks, as needed. All follow-up must be under close supervision of an LBHP.

3.1.4.5.1 Contractor shall create an organized system to deliver post emergency services to child and family.

3.1.4.5.2 These services shall be designed to promote continued stabilization of the family system and minimize the movement of children from one living arrangement to another, including within foster homes; prevent inappropriate hospitalization or re-hospitalization; improve the functioning of children in all life domains, including social, behavioral, emotional and educational; respond to the individual needs of families and children, focusing on the importance of their participation in treatment; provide timely, on-site access to assessment and evaluation in a wide array of settings; and manage appropriate levels of risk and disruption in the home and community.

4.0 PERFORMANCE MONITORING

4.1 Department will monitor the performance of the contractor in conjunction with systems partners, will be accountable for concrete outcomes that reflect the commitment to maintaining ties among children, families, and communities while delivering effective clinical care and support services for children with emotional and behavioral challenges. Desired outcomes include:

4.1.1 Improved clinical outcomes and emotional/ behavioral stability.
4.1.2 Improved permanency in community placements.
4.1.3 Reduced re-admissions to acute psychiatric hospitals.
4.1.4 Improved crisis management and stability in living environments for families and caregivers.
4.1.5 Improved educational performance and overall social functioning for children.
4.1.6 Reduction in delinquent behavior among youth involved with services.
4.1.7 Improved access to assessments and evaluations and improved access and timeliness of service delivery in all settings, including youth in detention centers or juvenile shelters
4.1.8 Improved satisfaction and increased participation in treatment by families and children.

4.2 Contractor shall provide requested information and reports per federal grant requirements, and as requested by ODMHSAS.

5.0 COMPENSATION

5.1 Contractor shall submit invoices for payment in accordance with procedures determined by the Department, and based on a Department approved budget. Payment shall be subject to Department approval.

5.2 Invoices shall be sent to: contracts@odmhsas.org

Or

Contracts
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