GREAT RIVERS BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION, LLC

Request for Proposal (RFP)

Youth Mobile Crisis Outreach Team

Contents

Overview 3
Background 3
Award Information 3
Time Frame for Project .... **Error! Bookmark not defined.**
Response Details 4
Review and Selection 6
General Proposal Requirements 7
Attachments 9

Overview

Great Rivers Behavioral Health Administrative Services Organization, LLC (hereinafter referred to as Great Rivers BH-ASO) is contracted with Washington State Health Care Authority (HCA) to serve as the Behavioral Health Administrative Services Organization in the Great Rivers Regional Services Area (Cowlitz, Lewis, Grays Harbor, Pacific and Wahkiakum counties).

Through its contract with HCA, Great Rivers BHA-SO is issuing this Request for Proposals (RFP) to seek a service provider to administer one Youth Mobile Crisis Outreach Team.

Interested providers must be able to serve the priority population, follow the HCA Mobile Crisis Response Program Guide and Great Rivers BH-ASO's Statement of Work, reflect diversity, equity, and inclusion, and maintain the hours operation and geographic coverage requirements of the program. Licensed behavioral health agencies must complete credentialing with Great Rivers BH-ASO prior to providing services.

Background

The Federal National Suicide Hotline Designation Act of 2020 established a national number (988) for people to call to connect directly to the National Suicide Prevention Lifeline. In response to this legislation, the Washington Legislature passed HB 1477 (E2SHB 1477), the Crisis Call Center Hubs and Crisis Services Act, in 2021 to enhance and expand behavioral health crisis response and suicide prevention services for all people living in Washington State. A key component of E2SHB 1477 was to invest in an enhanced crisis response system by developing and deploying mobile rapid response crisis teams that provide professional on-site, community-based interventions and follow-up support for individuals that are experiencing a behavioral health crisis. Furthermore, Engrossed Substitute Senate Bill 5092 of 2021 invested in new and enhanced mobile crisis teams (MCT) for adult and children, youth, and family teams.

Award Information

This RFP process will allocate dedicated funds for program development including implementation and operations immediately upon contract execution. Great Rivers BH-ASO's intention is to select a BHA that we can continue to contract with for funds allocated. The estimated total available dollars for this RFP is up to $1,480,170.00 annually. Contracts will be structured in the state fiscal year (July – June) and will be contingent upon continued funding. Funding allocations will be evaluated each fiscal year for under/overspending and contracts will be adjusted as needed.

Response Details

In submitting a response, each respondent acknowledges that Great Rivers BH-ASO shall not be liable to any person for any costs incurred therewith or in connection with costs incurred by any respondent in anticipation of Great Rivers BH-ASO action approving or disapproving any proposed agreement. Great Rivers BH-ASO may accept or reject any proposal or proposed agreement without limitation. Nothing in the Request for Proposal or in subsequent negotiations creates any vested rights in any person.

Responses which do not address any items listed in this section will be considered incomplete and will be deemed non-responsive by Great Rivers BH-ASO. Please submit responses using the RFP Response Questions below by **November 15, 2023 at 5:00 pm PST**.

Responses must be limited to no more than ten sheets including the narrative, specific work examples, references, and covers.

Responses are to be submitted in a sealed envelope and marked "RFP Response" or email with the subject line "RFP Response". Proposals submitted by any means other than emailing, courier, or hand delivery will not be accepted.

Submittal Mailing Address:

Great Rivers BH-ASO
P.O. Box 210
Chehalis, WA 98532

Submittal Emailing Address:

contracts@grbhaso.org

All completed responses should be typed and include the following information:

- A cover letter/statement of interest and introduction indicating the respondent's interest in the work and highlighting its qualifications to perform this work. A summary of the agency's experience in requested service areas.

- A Narrative response must include following:
  1. Describe your agency and scope of work under your BHA License or Tribal Clinic License/Certification.
     a. Include information on any youth related programming.
     b. Include any experience with providing crisis response services or crisis-like/urgent behavioral health services.
     c. Include any experience managing after-hours programming.

2. Describe experience coordinating services for the following populations:
   a. Tribal affiliated youth
   b. LGBTQIA+ youth
   c. Justice system involved youth
   d. Youth in foster care
   e. Youth with Developmental Disabilities
   f. Youth with unstable housing
3. Describe awareness or experience implementing the following principles:
   a. Trauma-informed care
   b. Diversity, equity, inclusion, and belonging
   c. Best practices for youth crisis service delivery
   d. Youth suicide intervention strategies
4. Summarize your vision of the Youth Mobile Crisis Outreach Team, including:
   a. Anticipated service start date.
   b. Qualifications of all current or anticipated key staff members who will implement this program.
   c. Personnel used to supervise this program.
   d. Staffing plan for coverage 7-days per week between 0700 – 2300 with the goal of 7-days per week, 24 hours per day, 365 days per year.
5. Plan for coordination with:
   a. Existing Crisis Teams
   b. Schools
   c. Community-based youth programs
   d. Formal support programs (DCYF, JRA, etc.)
   e. Families and natural supports
   f. Primary Care
   g. Managed Care Organizations/Insurance Plans
   h. Other Behavioral Health Providers
6. Describe how your agency would plan and implement this program in accordance with the following:
   a. WAC 246-341 Behavioral Health Licensing and Certification Requirements
   b. RCW 71.34 Behavioral Health Services for Minors
   c. Washington State Health Care Authority Mobile Crisis Response Program Guide
   d. SAMHSA National Guidelines for Behavioral health Crisis Cre Best Practice Tool Kit
   e. Mobile Response and Stabilization Services (MRSS) model
   f. All training requirements set forth by RCW, WAC, HCA, and Great Rivers BH-ASO

7. Describe your basic managerial and fiscal structure including program management, accounting, internal controls, program monitoring and evaluation, and any outside contractors to be utilized in the administration of the program.
8. Describe your agency's ability to collect and submit data relative to this program, including:
    a. The method for collecting/submitting service encounter data in accordance with Service Encounter Reporting Instructions (SERI).
    b. The method for collecting/submitting supplemental data in accordance Great Rivers BH-ASO Data Dictionary.

- Provide a fiscal proposal (limited to 2 pages), identifying expected costs, to include start-up expenses, program staffing, on-going operating expenses, any on-going program related expenses and general administrative costs. Provide rationale and justification for cost estimates.

Review and Selection

- Basic Minimum Criteria: The absolute minimum requirement is to include all requested documentation as listed above.

  Proposals will be evaluated according to the information contained within the written proposal.

- Program Design Elements:
  Proposals meeting the above minimum technical requirements will be further reviewed for program design elements. Each of the following criteria has equal weight:

  1. Potential effectiveness of the plan.
  2. Special population coordination experience.
  3. Experience implementing the principles.
  4. Description of scope of services provided.
  5. Adequacy of partnership description.
  6. Implementation of regulatory requirements.
  7. Description of managerial and fiscal structure.
  8. Ability to meet reporting requirements.
  9. Budget clarity and reasonableness.

- Cost Reasonableness:
  Proposals will be evaluated for cost reasonableness. The Cost will be judged based on a comparison of costs among competing proposals. Cost will also be compared to past costs for similar services, if applicable.

Cost reasonableness will be judged by means of line-item budget analysis. Line items will be reviewed for necessary and reasonable costs.

General Proposal Requirements

- Authorship

  Proposals developed with the assistance of organizations or individuals outside the bidder's own organization should be identified. No contingent fees for such assistance will be allowed to be paid under any contract or grant resulting from this RFP. All proposals submitted become the property of Great Rivers BH-ASO, and it is understood and agreed that the bidder claims no proprietary rights to the ideas contained therein.

- Independent Cost Determination

  The proposer guarantees that in connection with this proposal the cost data have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition. This section does not preclude or impede the formation of a consortium of agencies which intend to respond to this RFP.

- Subcontracting

  Proposers must include any plans for subcontracting of services or activities of the program. It is understood that the contractor(s) is held responsible for the satisfactory accomplishment of the service or activities included in such subcontract. Great Rivers BH-ASO reserves the right to approve all subcontractors.

- Rejection of Proposal

  No applications (Proposals) submitted under this Request for Proposals (RFP) will be returned for correction or clarification. If the application is incomplete, it will be rejected. Verbal, alternative, and late proposals will not be considered for selection. Great Rivers BH-ASO reserves the right to accept or reject any or all proposals received because of this RFP, to negotiate with all qualified sources, or to cancel in part, or in its entirety, this RFP if it is in the best interest of the Great Rivers BH-ASO to do so.

- Appeal Process

  Any agency may appeal the selection of proposals by filing a complaint under the Great Rivers BH-ASO's Complaint & Grievance System. System procedures may be obtained from the SBH-ASO upon request.

- Cancellation of Award

  Great Rivers BH-ASO reserves the right to cancel an award immediately if

new State or Federal regulations or HCA determinations make it necessary to substantially change the project purpose or content or prohibit such a project.

- Cost Warranty
  The proposer warrants that the rates quoted for services in response to this RFP are not unreasonably greater than the rates for the same services performed by the same individuals under any other existing contracts or grants.

- Waivers
  The right is reserved by Great Rivers BH-ASO to waive specific terms and conditions contained in this Request for Proposals. It shall be understood that any proposal is predicated upon the acceptance of all terms and conditions in the RFP unless the proposer has obtained such a waiver.

- Addenda to the Request for Proposals
  In the event it becomes necessary to revise any part of this RFP, addenda will be provided to all proposers who received the RFP.

- Publicity
  No informational pamphlets, notices, press releases, research reports, or similar public notices concerning this proposal will be released by the proposer without obtaining prior written approval of Great Rivers BH-ASO.

- Limitation
  This Request for Proposals does not commit the Great Rivers BH-ASO to award a contract, to pay any costs incurred in the preparation of a proposal to this request, or to procure or contract for services or supplies.

- Signature
  The proposal shall be signed by an official authorized to bind the bidder and shall provide the following information: name, title, address, and telephone number of individual(s) with authority to negotiate and contractually bind the bidder, and who may be contacted during the period of proposal evaluation.

- Contract Award
  The Great Rivers BH-ASO may award a contract based on proposals received; therefore, each proposal should be submitted in the most favorable terms from a budgetary, technical, and programmatic standpoint. Great Rivers BH-ASO reserves the right to request additional data, discussion, or presentation in support of written proposals. Great

Rivers BH-ASO reserves the right to award a contract without further consideration or discussion. Great Rivers BH-ASO also reserves the right to reject any or all proposals.

Attachments

- Washington State Health Care Authority Mobile Crisis Response Program Guide
- Great Rivers BH-ASO Child, Youth, and Family Mobile Crisis Response Program Statement of Work

STATEMENT OF WORK

CHILD, YOUTH, AND FAMILY MOBILE CRISIS SERVICES

EXHIBIT D

1. OVERVIEW

The behavioral health agency (BHA) will deliver crisis services to all children, youth, and families who present with a need for crisis services in To be Determined based on successful proposal. Crisis services will be available twenty-four (24) hours a day, three hundred sixty-five (365) days a year. They will be provided in accordance with WAC 246-341, RCW 71.05, RCW 71.43, and any other documents incorporated by reference. Mobile crisis team (MCT) services offer voluntary, community-based interventions to children, youth, and families in need wherever they are experiencing crisis.

For the purposes of this Statement of Work (SOW), crisis means a behavioral health crisis, defined as a turning point, or a time, a stage, or an event that includes a distinct possibility of an undesirable outcome. Crisis services means providing evaluation and short-term treatment and other services to children, youth, and families with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the individual's health or safety.

2. GOALS AND OBJECTIVES

2.1. Stabilize children, youth, and families as quickly as possible and assist them in returning to a level of functioning that no longer qualifies them for Crisis Services.

2.2. Support and maintain children, youth, and families in their current living situation and community environment, reducing the need for out-of-home placements.

2.3. Support children, youth, and families by providing trauma informed care, as well as solution-focused, person-centered, and recovery-oriented interventions.

2.4. Reduce the use of law enforcement involvement, emergency departments (ED), hospital boarding, and detention centers due to behavioral health crises.

2.5. Coordinate interventions with other community resources, such as medical and behavioral health services, and assist children, youth, and families in accessing and linking to ongoing support and services.

2.6. Include peers in crisis work to build rapport and give people someone to connect with who has similar experiences.

2.7. Expand the definition of crisis to whatever the child, youth, and family experiencing it defines it as to reduce barriers to potential solutions.

2.8. Address systemic barriers by addressing the needs of underserved populations.
2.9. Provide a response within sixty (60) minutes or less of the request with telephonic support, until in-person response arrives.
2.10. The MCT will engage children, youth, and families in crisis first and will resolve the crisis without needing to contact a DCR for an ITA Investigation.

3. STAFFING REQUIREMENTS

3.1. The contractor will comply with applicable staffing requirements in accordance with Chapter 246-341 WAC.
3.2. The goal for each MCT is to have capacity to provide services in the community twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year.
3.3. Team Composition
3.3.1. The MCT will include:
3.3.1.1. At a minimum, eleven (11) full-time equivalents (FTEs).
3.3.1.2. A clinician who is a mental health professional (MHP), capable of assessing the needs of the individual in crisis.
3.3.1.3. One (1) MHP supervisor who can provide 24/7 clinical supervision and oversight of the MCT.
3.3.1.4. Certified Peer Counselors (CPCs) who provide peer support to children, youth, and families in crisis with the focus of building trust and rapport and of helping the children, youth, and families feel heard and understand while receiving crisis services.
3.3.1.5. Mental Health Care Providers (MHCPs), with WAC 246-341-0302 exemption, can respond jointly with a peer in place of a MHP, as long as at least one MHP is available 24/7 for any MHCP or peer to contact for consultation.
3.3.2. Two person teams (dyads) will be put into place within the MCT. The team will require, at a minimum, one (1) MHP or MHCP and one (1) CPC respond jointly.
3.4. Required Training
3.4.1. All individuals providing MCT services will:
3.4.1.1. Complete the HCA training in Trauma Informed Care, De-escalation Techniques, and Harm Reduction.
3.4.1.2. Receive all training identified in WAC 246-341-0510 and by Great Rivers BH-ASO.

3.4.2. Certified Peer Counselors:
   3.4.2.1. Will be credentialed by the Department of Health (DOH).
   3.4.2.2. Will complete the HCA sponsored peer crisis services training(s).
   3.4.2.3. Can only provide services when accompanied by a licensed or credentialed staff or their supervisor. All services provided by a CPC must be provided under the oversight of the MHP Supervisor.

3.4.3. Additional recommended training for MCT members include:
   3.4.3.1. Developmentally appropriate nonviolent crisis intervention,
   3.4.3.2. De-escalation,
   3.4.3.3. Conflict resolution,
   3.4.3.4. Interpersonal violence,
   3.4.3.5. Motivational Interviewing,
   3.4.3.6. Risk Management and Crisis Planning (including WRAP and crisis safety planning tools)
   3.4.3.7. Cultural awareness and responsiveness,
   3.4.3.8. CPR/First Aid, and
   3.4.3.9. Psychiatric medications and side effects.

4. SERVICE REQUIREMENTS.

4.1. The behavioral health agency (BHA) will:

4.1.1. Ensure that MCT services are performed as defined within this SOW.

4.1.2. Demonstrate that it is licensed or certified to provide each crisis service it is contracted to provide.

4.1.3. Adhere to the Health Care Authority's (HCA) mobile crisis response program guide/model and align with MCT practices and values as identified in the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, Mobile Response and Stabilization Services (MRSS), and Great Rivers BH-ASO's policies and procedures.

4.1.4. Have a plan to ensure children, youth, and families who need crisis services have reasonable access to them when a service is requested, which may include responding to a children, youth, and families in a location/area where the crisis is occurring.

4.1.5. Ensure mobile crisis teams respond:

4.1.5.1. Within two (2) hours of the referral to an emergent crisis, and
4.1.5.2. Within twenty-four (24) hours of the referral to an urgent crisis.

4.1.6. Allow children, youth, and families to access crisis services without full completion of an intake/evaluation and/or other screening or assessment process.

4.1.7. Through community outreach and engagement, build and maintain relationships with relevant community providers, such as emergency departments, primary care providers, behavioral health providers, schools, law enforcement, EMS, probation officers, community corrections officers, crisis respite providers, community health care facilities, and managed care organizations.

4.1.8. Demonstrate a plan for referral and coordination of services when a behavioral health service can be appropriately provided through the individual's health insurance plan, including contacting a known behavioral health provider via telephone or secure/encrypted email.

4.1.9. Have a protocol for providing information about and referral to other available services and resources for individuals who are not eligible for Medicaid or General Funds State (GFS)/Federal Block Grant (FBG) funded services.

4.1.10. Maintain privacy and confidentiality of information consistent with federal and state requirements.

4.1.11. The Contractor must document crisis calls, services, and outcomes. The Contractor must comply with record content and documentation requirements in accordance with WAC 246-341-0900 to 0915.

4.1.12. Documentation of each crisis service will be done by the responding clinician. Peers can add to the note, but it must be signed by the clinician and include the following:

4.1.12.1. A summary of each crisis service encounter, including the date, time, and duration of the encounter,
4.1.12.2. The time elapsed from the initial referral to the in-person or telehealth response,
4.1.12.3. The names of the participants,
4.1.12.4. A follow-up plan or disposition, including any referrals for services, including emergency medical services,
4.1.12.5. Whether the individual has a crisis plan and any request to obtain the crisis plan.

4.1.12.6. The outcome, including the basis for a decision not to respond in person when a telehealth intervention was provided,

4.1.12.7. The name and credential of the staff person providing the service, and

4.1.12.8. Whether the individual is a member of a Tribe and if any Tribal notifications were made.

4.1.13. Coordinate closely with the regional Managed Care Organizations (MCOs), community court systems, first responders, criminal justice system, inpatient/residential service providers, Tribal governments, Indian Health Care Providers (IHCPs), JRA, CPS, DCYF, DDA, and outpatient behavioral health providers, to maintain processes to improve access to timely and appropriate treatment for children, youth, and families.

4.1.14. Have and maintain protocols that align with the protocols for coordination with Tribes and non-Tribal IHCPs applicable to the Great Rivers Regional Service Area (RSA).

4.1.15. Engage the child, youth, and family in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and maintain the individual's stability.

4.1.16. Have MCT members remain with child, youth, and family in crisis to provide services and support until the crisis is resolved or a reasonable less restrictive option is initiated.

4.1.17. Involve the individual's family or natural supports in the crisis intervention and resolution when possible.

4.1.18. Provide Least Restrictive Alternative (LRA) or Conditional Release (CR) monitoring for individuals who are not eligible for Medicaid and are on an LRA or CR.

4.1.19. Crisis Stabilization services are to be provided to children, youth, and families without Medicaid who are experiencing a behavioral health crisis. These services are to be provided in the children, youth, and families home or another home-like setting. Stabilization services shall include short-term (up to 14 days per episode) face-to-face assistance with service needs identified to reduce the risk of future crises.

5. PROGRAM REQUIREMENTS

5.1. Eligibility

5.1.1. Crisis services are available to any child, youth, and family that is in Great Rivers Regional Service Area at the time of the crisis.

5.1.2. Crisis services are available to any child, youth, and family regardless of their health insurance status and their ability to pay.

5.2. Service Area

5.2.1. The service area for this SOW covers multiple counties.

5.2.1.1. To be Determined based on successful proposal.

5.3. Capacity

5.3.1. The BHA will notify Great Rivers BH-ASO if it is reaching capacity to provide services within the service area.

5.3.2. The BHA will also notify Great Rivers if staffing levels change, and they are no longer able to maintain the program as described in this SOW.

5.4. Policies and Procedures

5.4.1.1. The BHA will have policies and procedures for crisis services that are consistent with WAC 246-341if applicable, and RCW 71.05.700, 71.05.705, 71.05.710, and 71.05.715.

6. REPORTING REQUIREMENTS

6.1. The BHA will maintain daily crisis logs per Great Rivers BH-ASO's specifications and requirements and provide them to Great Rivers BH-ASO as directed.

6.2. The BHA will comply with Great Rivers BH-ASO policies and procedures for reporting encounters and other relevant data.

7. PAYMENT

7.1. The BHA will be reimbursed according to the payment provisions of Exhibit B, Compensation.

7.2. Great Rivers BH-ASO shall reimburse the BHA for actual expenditures incurred while performing services under this agreement, up to the maximum consideration of this agreement.

7.3. Annual Certification of Expenses shall be measured on a fiscal year basis and reviewed by Great Rivers BH-ASO:

7.3.1. Program Direct Expenses – are costs that can be identified specifically with a particular program or service. Includes, but not limited to: compensation for employees who work on the program or deliver services, costs of training or professional development for employees working on the program, costs of supplies and materials necessary specifically for the purpose of the program, travel expenses incurred specifically to carry out the program.

7.3.2. Program Overhead Expenses – are costs that cannot be identified specifically with a particular program or easily allocable to a particular program or service. Annual program overhead expenses should not exceed 40% of the total program direct expenses. Includes, but not limited to management activities that do not involve direct supervision of program or services, general clerical, accounting, budget, contract, and administrative professional services such as auditing and/or legal services.

7.4. The BHA must pursue payment from a third-party insurance company and deduct the revenue collected from the cost of this Statement of Work.

7.5. Payment shall be in accordance with the Payment section in Specific Terms and Conditions in this Agreement.

Washington State
Health Care Authority

Mobile Crisis Response Program Guide

Introduction

A behavioral health crisis can be devastating, and even traumatic, for individuals, families, and our communities. Although we cannot know when a crisis may occur, we can create a system that is agile and responsive when the need arises. We imagine a crisis system in Washington State that minimizes delays, reduces the use of law enforcement and emergency departments, and only looks to the most restrictive responses when no other safe solution can be found. A key component of our state's crisis system must be mobile crisis response (MCR) teams that can be rapidly deployed to the location of the crisis and provide crisis assessment and stabilization services to anyone, anywhere, and at any time.

Purpose

The purpose of this guide is to accompany the Health Care Authority's (HCA) Behavioral Health Administrative Service Organization (BH-ASO) crisis contract language and provide guidance to the contracted mobile crisis response providers in best practices. This will act as a living document that can be updated outside of the strict timelines of contract amendments, and it will change over time as necessary to meet the needs of Washingtonians.

Goal of Implementing New Models

HCA is committed to implementing nationwide best practices for crisis care in alignment with Substance Abuse Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit[1] and the National Association of State Mental Health Program Directors (NASMHPD) to include Mobile Response and Stabilization Services (MRSS) for youth. These best practices for mobile crisis response teams are intended to improve awareness of and utilization of crisis teams when people are in crisis rather than relying on emergency responders such as law enforcement, fire, and EMS. The vision from SAMHSA is to provide someone to talk to, someone to respond, and somewhere to go for a person in crisis and to be able to access support quickly with minimal barriers.

Some of the goals of these models are:

- Reduce dependence on law enforcement, fire, EMS, and emergency departments for behavioral health crisis situations
- Provide a robust crisis workforce who are well trained to respond and address urgent and emergent needs
- Include peers in crisis work to build rapport and give people someone to connect with who has similar experience/s
- Expand the definition of crisis to whatever the person experiencing in the situation defines it as to reduce barriers to potential solutions
- Address systemic barriers by addressing the needs of underserved populations

As our state implements these best practice models, we will learn from the examples provided by other states while continually working with stakeholders to make adjustments that meet the unique needs of Washington.

Background

The National Suicide Hotline Designation Act of 2020[2] established a national, 3-digit easy to remember number to call, 9-8-8, for people to connect directly to National Suicide Prevention Lifeline services. In response to this

[1] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[2] https://www.congress.gov/bill/116th-congress/senate-bill/2661

legislation, the Washington legislature passed HB 1477 (E2SHB 1477[3]), the Crisis Call Center Hubs and Crisis Services Act, in 2021 to enhance and expand behavioral health crisis response and suicide prevention services for all people in Washington State. The E2SHB 1477 was signed into law on May 13, 2021. A key component of E2SHB 1477 is to invest in an enhanced crisis response system by developing and deploying mobile rapid response crisis teams that provide professional on-site, community-based interventions and follow-up support for individuals that are experiencing a behavioral health crisis.

Scope

Mobile crisis response (MCR) services offer voluntary community-based intervention to individuals in need wherever they are including at home, work, school, juvenile courts, or anywhere else in the community where the person is experiencing a crisis. The caller, not the provider, defines the crisis.

Keys to Success

- Triage/screening, including explicit screening for suicidality and risk of harm to others
- Respond without law enforcement accompaniment, unless special circumstances warrant inclusion, to support true justice system diversion
- Reduce the use of emergency departments
- Assessing for risk and opportunities to resolve the crisis in the least restrictive setting
- Developmentally appropriate de-escalation/resolution
- Peer support; including family peers or youth peers
- Coordination with medical and behavioral health services
- Crisis planning and follow-up

Minimum requirements and mobile crisis team standards

Mobile crisis response services must be available to individuals experiencing a behavioral health crisis. Services should be provided in person for youth and to adults if they request an outreach. Trained staff should remain, in person or on the phone, with the individual in crisis to provide stabilization and support until the crisis is resolved or referral to another service is accomplished[4].

Team Composition

A mobile crisis response team must provide coverage 24 hours per day, every day of the year with at least one team of two staff per shift. Overall team composition can be flexible based on regional need and staff availability. Teams must include, at a minimum two staff to outreach. This should include a Mental Health Professional (MHP) or a Mental Health Care Provider (MHCP) with approved DOH exemption[5]and a certified peer counselor responding together to all crisis referrals. Each team shall have a mental health professional supervisor and an MHP will be available 24 hours per day for clinical consultation. The consulting MHP does not have to be the team supervisor. At the discretion of the provider, teams may also include other professional or paraprofessionals with expertise in developmentally appropriate behavioral health crisis intervention.

Location of Services

Mobile crisis response services should be provided wherever the individual in need is located including at home, school, work, or anywhere else in the community where the person is experiencing a crisis. Team will assess for risk and opportunities to resolve the crisis in the least restrictive setting.

Mobile crisis response services reduce the need for and the utilization of law enforcement, other first responders, and emergency departments. Enhanced Federal Medicaid Assistance Percentage (FMAP), the amount of federal dollars provided per state dollar, may not be available for MCR services provided in an emergency department. Services provided in an emergency department can still be billed and paid but will not qualify for the higher match.

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[3] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20220914155211
[4] WAC 246-341-0900
[5] WAC 246-341-0302

Best Practice: Teams will respond with a multi-disciplinary team of clinicians and a peer. This will give the person in crisis and the team multiple perspectives to problem solve.

Availability

Mobile crisis response services must be available 24 hours a day, every day of the year, and be able to respond to an emergent crisis within 2 hours of the referral for an emergent crisis and within 24 hours for an urgent crisis. Telephonic support will be provided until in-person response arrives[6].This telephonic support can include the caller with a call back number, the NSPL or RCL staying on the line with them depending on need, or mobile response team cell phone numbers for callback.

Referral type	Definition
Emergent	An emergent crisis is an extreme risk and requires a 2-hour response time.
Urgent	Urgent crises are moderate to serious risk and require a 24-hour response.
Routine/Follow-up	Routine/Follow-up care occur after crisis response services are provided.

Best Practice: Best practice response time to all crisis referrals is 60 minutes or less.

To ensure safety for responders and clients, mobile crisis response team shift schedules shall be designed to build in respite and downtime in lieu of responders being "on-call" for days at a time. These schedules should be focused on workforce selfcare and stress reduction to improve workforce retention. Schedules can be adjusted according to outreach activities or peak times for calls, and rural vs. urban demand. Shifts in urban areas may be 8-hour shifts, or 12-hour shifts, while rural areas may consider employing fire schedules such as 24 on 48 off or any similar combination. This staffing pattern will ensure safety, improve critical decision making and rapport building with clients, support work life balance, and improve recruitment and retention efforts.

All members of the team must be trained in trauma-informed care, de-escalation strategies, and harm reduction. Youth mobile crisis teams shall be trained in developmentally appropriate trauma informed care, de-escalation, harm reduction, and crisis and safety planning for youth and families. Additional recommended training for team members will continue to be developed and could include developmentally appropriate nonviolent crisis intervention, conflict resolution, interpersonal violence, motivational interviewing, risk management and crisis planning (including WRAP and crisis safety planning tools), cultural awareness and responsiveness, CPR/First Aid, and basic overview of psychiatric medications and side effects.

Community Coordination

Due to 24/7 availability requirements and the unpredictability of community crisis needs, mobile response team staff shall not be expected to maintain a quota of direct contact hours. If teams are not responding to crisis referrals, they should be building relationships in the community through outreach and engagement. These efforts work to educate the public and providers on mobile crisis response and offer opportunities for upstream interventions. Working relationships with NSPLs, RCLs, emergency departments, schools, providers, primary care clinics, Indian Community Health Programs (ICHP), Tribal Nations, community corrections officers, respite care providers, community health care facilities, behavioral health care facilities, universities, rural and agricultural extension offices, fire departments, EMS responders, law enforcement, probation officers, inpatient discharge planners, 23-hour triage and stabilization facilities, substance use providers, foster care social workers, parents, caregivers and managed care organizations (MCOs) will encourage use of MCR teams over the ED and offer true justice system diversion. These efforts will increase the likelihood of a person in crisis receiving an appropriate response from a trained crisis team and establish mutual relationships with emergency response system providers.

Privacy and Confidentiality

Teams must maintain privacy and confidentiality of information consistent with federal and state requirements. Minors aged 13-17 may initiate and consent to evaluation and treatment for mental health, substance use disorder treatment, or withdrawal management without parental knowledge or consent.

[6] WAC 246-341-0900

Documentation

Documentation of mobile crisis response must be completed by the on-scene clinician responding. This can be a MHP or MHCP (with approved DOH exemption) under the supervision of the MHP supervisor[7]. Peers can add additional note to the documentation, but it must also contain the clinician's notations and be signed by the clinician. Documentation must include the following[8], as applicable to the crisis service provided:

- A summary of each crisis service encounter, including the date, time, nature of the crisis, and duration of the encounter
- The time elapsed from the initial referral to the in-person or telehealth response
- The names of the participants
- A follow-up plan or disposition, including any referrals for services, including emergency medical services
- Whether the individual has a crisis plan and any request to obtain the crisis plan
- The outcome, including the basis for a decision not to respond in person when a telehealth intervention was provided; and
- The name and credential of the staff person providing the service.

Teams should document services provided as soon as they are able to do so. This will ensure they are able to provide notes to any follow-up services about the encounter. Documentation should be done in an EHR following employer guidelines and procedures and within confidentiality laws.

Staff roles and descriptions

Required Staff

Below is an outline of staffing expectations for mobile crisis teams. Teams are required to have a licensed or credentialed Mental Health Professional as a supervisor. Teams have flexibility in overall team composition. Outreach should occur via a team of at least two staff. Preferably with one clinician and one peer Teams need to have an MHP available 24/7 for support and clinical consultation. This does not have to be the supervisor if other MHPs are on staff.

Supervisor MHP

Provides clinical supervision and oversight of the mobile response teams. Is responsible to ensure the service provided by the team meets medical necessity, is clinically appropriate, and meets all necessary requirements. The person in crisis is assumed to need crisis intervention based on them reaching out for help. Further services will need to be made with clinical judgement on medical necessity.

Minimum position requirements

Must meet the requirements as a Mental Health Professional and meet all licensure or credentialing requirements from DOH to provide services. Recommended to have experience supervising and overseeing crisis services.

SPA definition

Mental Health Professional means:

(A) A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapter 71.05 and 71.34 RCW;

(B) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional.

(C) A person who meets the waiver criteria of RCW 71.24.260 which was granted prior to 1986.

(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

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[7] WAC 246-341-0910.

[8] WAC 246-341-0900 and WAC 246-341-0910

(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265. This includes qualified individuals with an agency affiliated credential or associate license who qualify as an MHP.

Clinician

Provides crisis services and uses clinical judgement within the scope of their education and training to deescalate and stabilize the individual in crisis and assist them in next steps. These positions may be filled by MHPs or MHCPs that meet the additional requirements below. Mobile crisis response staff must have immediate access to an on-call MHP, 24/7, to provide clinical oversight and supervision when needed. This MHP does not need to be the supervisor of the team.

Minimum position requirements

Must have at least a BA/BS degree or higher in a behavioral health field and be licensed and/or credentialed by DOH to provide services.

MHCP exemption requirements

For the clinician who qualifies as an MHCP to provide initial services with a peer the provider agency must obtain an exception from rule from DOH using the process outlined in WAC 246-341-0302.

SPA definition

"**Mental Health Care Provider**" means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years of experience in the mental health or related fields.

Certified Peer Counselor (CPC)

Provides peer support to a person in crisis with the focus of building trust, rapport, and helping the person in crisis feel heard and understood while crisis services work to resolve the crisis or find the next steps to resolve the crisis.

Minimum position requirements

Must be a certified peer counselor and credentialed by DOH to provide services, typically as an Agency Affiliated Counselor. Peers will receive additional training on providing crisis peer services in the future to improve service delivery and resilience for the workforce. This training will not be required for the current workforce until it is available on a wider basis. CPCs can only provide services when accompanied by a licensed or credential staff or their supervisor. All services provided by CPC must be provided under the oversight of the MHP supervisor.

WAC definition

"Peer counselor" means a person recognized by Medicaid agency as a person who:

(a) Is a self-identified consumer of behavioral health services who:

> (i) Has applied for, is eligible for, or has received behavioral health services; or
>
> (ii) Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;

(b) Is a counselor credentialed under chapter **18.19** RCW;

(c) Has completed specialized training provided by or contracted through the Medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in (a), (b) and (d) of this subsection by January 31, 2005, the person is exempt from completing this specialized training;

(d) Has successfully passed an examination administered by the Medicaid agency or an authorized contractor; and

(e) Has received a written notification letter from the Medicaid agency stating that the Medicaid agency recognizes the person as a "peer counselor."

Service Delivery and Modalities

Mobile crisis response services consist of many different modalities to ensure services are delivered in a safe and effective manner. These modalities include but are not limited to the following:

Triage/Screening

The initial step in providing mobile crisis response is to determine the level of risk present in the crisis and determine the most appropriate response. This screening process must include screening for suicide or self-harm and risk of harm to others. The triage and screening process may be completed by crisis call line staff, by the mobile crisis response team staff, or both. When the initial triage/screening is done by crisis call line staff they must share this information with the mobile crisis team. As part of the triage and screening process, a determination should be made regarding the need for support from law enforcement and/or emergency medical personnel. When making this decision, special consideration should be given to any risk of harm to self and/or others and whether the individual is known to have the means to act on those thoughts and whether they have a history of dangerousness or potential dangerousness.

Best Practice: To support true justice system diversion, respond without law enforcement accompaniment unless special circumstances warrant inclusion

Scene Safety

Ensure that responding staff members have access to any available information regarding dangerousness or potential dangerousness of the individual experiencing the crisis. This information must be made available without unduly delaying the crisis response in compliance with WAC 246-341-0900.

When responding to non-secure locations, ensure that two staff members are present for safety and that team members have mobile devices that can be used to call for help if needed. Crisis response staff cannot be required by their employer to respond to a crisis without a second person. Best practice is to always respond to crisis calls with two staff members[9].

Best Practice: Respond to all crisis referrals with a team of two staff members regardless of the location or risks identified.

When arriving to the location of the crisis, it is important to take a few moments to assess the location for safety for both staff members and individuals in crisis. Pay special attention to the location of exits, potentially dangerous implements or weapons, and signs of agitation or hostility from anyone in the vicinity.

Best Practice: Ensure other team members know the exact location you are responding to and when they should expect to get contact from you. GPS monitoring through mobile apps or cell phones is used in other states for safety.

Assessment

The MHP, MHP supervisor, or clinician responding to the crisis are responsible for completing an assessment. This assessment should address the causes leading to the crisis event, any safety concerns for the individual or others, strengths, resources available to the person in crisis, recent inpatient hospitalizations and/or enrollment with mental health providers, any prescribed medication and compliance with those medications, and any related medical history. Determine if the individual in crisis has a crisis plan or mental health advance directive (MHAD) and request a copy, if available.

Best Practice: Assess collateral contacts for distress and provide support when possible. People supporting other people in crisis are affected and need support too. Supporting them can help resolve the crisis quicker with better outcomes.

De-escalation/Resolution

Mobile crisis response providers engage the individual in counseling throughout the encounter and actively work to de-escalate the crisis. Providers may utilize therapeutic models such as such as Motivational Interviewing and Brief Therapy to help resolve the crisis and avoid the need for a higher level of care.

Crisis Peer Response

Incorporating peers into mobile crisis response teams can provide the individual in crisis with someone to relate to who has their own experience with the behavioral health symptoms and the crisis system. Peers should focus on building rapport, sharing experiences, and strengthening engagement. They may also engage family members or other natural supports to provide ideas around self-care and providing support. When engaging the individual in

[9] WAC 246-341-0900

crisis, it is often most effective for the CPC to take the lead. Documentation for peers should be completed by the clinician noting the peer's presence and interactions with person in crisis.

Coordination

An important focus for mobile crisis response teams should be identifying and addressing the recovery needs of individuals and families by linking them with needed medical and behavioral health services that can help resolve the current crisis and help prevent a return to a crisis state in the future. Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis.

Transport

When working with individuals in crisis, they may need transportation to places that can help resolve their crisis. These places can be pharmacies, food banks, crisis stabilization or other facilities, or other locations relevant to their current challenges. MCR teams may arrange for transport or provide transportation to these places when safe[10].

ITA Investigations

Individuals in crisis may present at imminent or serious risk of harm to themselves or others or be unable to care for their basic needs of health and safety due to their behavioral health symptoms. When they are unwilling to engage in safety planning and other stabilization efforts by MCR team members or there is no appropriate or available alternative that could mitigate the level of risk, it is important to work with DCRs to ensure that an Involuntary Treatment Act (ITA) investigation is completed, if appropriate.

Best Practice: Whenever possible, MCR teams should engage a person in crisis first and attempt to resolve the crisis with interventions less restrictive than hospitalization, before bringing in a DCR for an ITA investigation. Persons in crisis may respond best to a MCR intervention lacking the legal authority dynamic inherent to the DCR role.

Crisis Planning and Follow-up

As part of the mobile crisis response intervention, team members should initiate a crisis planning process that can help the individual prevent future crises. This process may include the development or modification of a safety plan. This is a good time to introduce Mental Health Advance Directives (MHAD), if the individual does not already have one, and support the individual in developing their MHAD. Youth 13-17 can create a MHAD, and have it executed, and teams should work with the youth and/or families to create this when clinically appropriate. When appropriate, telephonic, or in-person follow-ups should be provided to determine if any services the individual was referred to were provided and if they met their needs.

Peers can help a person start or complete a WRAP plan[11] with the individual to provide agency and insight for the person to manage their current crisis and prevent future crisis. Documentation for the development of a WRAP plan needs to be done by the clinician.

Mobile Response and Stabilization Services (MRSS) for Children, Youth and Families

Purpose

MRSS is a child and family specific crisis intervention model that recognizes the developmental needs of children, young adults, parents, and caregivers. Caregivers and children are interconnected in their relationship and thus, crisis situations for children impact the parent's ability to respond to the crisis and de-escalate the situation. Supporting the caregiver's response to the behavioral health crisis decreases the likelihood of child welfare and juvenile justice involvement.

A comprehensive crisis continuum acknowledges that youth can be screened upstream of a crisis event and stabilized and connected to resources and supports downstream. This reduces return to an acute crisis phase, improves

[10] WAC 246-341-0900

[11] https://www.wellnessrecoveryactionplan.com/what-is-wrap/.

outcomes, and offers a cost-effective alternative to the re-traumatization and stress of costly out of home interventions.

Outreach and Engagement

Successful MRSS teams perform robust outreach and engagement to inform regional, family, community, and system partners about the availability of MRSS crisis response. Law enforcement should consider the team a reliable, consistent referral for any youth encounter, day, or night. States delivering youth crisis services under the MRSS model are reporting successful ED diversion by building relationships with local school districts.

Other outreach areas for consideration include pediatric primary care providers, emergency departments, inpatient adolescent units, juvenile justice, schools, Department of Children, Youth, and Families (DCYF), foster parents, after school programs, substance use, co-occurring disorder providers, and shelters.

Crisis Mobile Response (up to 72 hours)

The crisis response, or intervention phase, is the initial response and can last up to 72 hours. Since MRSS may be the first point of contact a family has with the behavioral health system, the team should build a trusting relationship of mutual respect and provide individualized care including family voice.

Teams should intentionally include parents, caregivers, natural supports, and relevant treatment providers to stabilize the person in crisis. This should be in accordance with Washington state law when encountering youth ages 13-17, and within the limits of confidentiality.

The responding team can assess risk and safety needs, provide developmentally appropriate de-escalation, deliver peer support, help caregivers secure the home, or increase supervision depending on safety concerns. Safety planning is a collaborative process that includes the identified client, caregivers, natural supports, and existing providers. When creating or updating existing safety plans, teams will empower the family to recognize their needs, risk factors, triggers, and identify existing strengths that can inform coping skills moving forward. Teams should identify and connect families with existing systems of care and natural supports through warm handoffs, including to the stabilization phase.

This service should be billed using service encounter code H2011 - Crisis Intervention Services[12].

Crisis Response Goals:

- The crisis is defined by the youth, young adult, parent, or caregiver
- The team responds in person to the location of the person in crisis, home, school, or community within 2 hours and with telephone support available until arrival.
- Respond without law enforcement
- Work with the youth and caregivers to reduce unnecessary admissions to EDs, inpatient adolescent units, unnecessary contact with law enforcement, detention centers, residential treatment centers, or foster care transitions
- Initial response should include developmentally appropriate de-escalation, a children or youth risk assessment, safety planning, peer support, and skill-building
- Support and maintain youth in their living and community environment, reducing out of home placements
- Promote and support safe behavior in the home, schools, and community
- Ensure staff are trained in culturally responsive, developmentally appropriate trauma-informed care, de-escalation, safety planning for youth and families, and harm reduction

Stabilization

After families have experienced an initial mobile crisis response encounter, best practices in MRSS include an in-home stabilization phase, which is separate but must be connected to the mobile response phase. A stabilization phase provides *up to* 14 days of intensive in-home services. Funding for stabilization services is approved by the MCOs, fee for service, BH-ASO for uninsured, or commercial carriers. MCOs and commercial insurance carriers are

[12] http://hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri

required to cover this intervention as part of their network adequacy. In-home stabilization supports the child's ability to manage daily activities and establishes clear connections to treatment service and community supports to reduce the likelihood of returning to the acute crisis phase. Providers may need to support families in accessing and following through with ongoing care.

This phase can include identifying and addressing ongoing needs, reviewing safety plans, skill building, youth and/or family peer support, parent support and skill building, and care coordination to identify and connect families with community providers through family facing systems of care, and natural supports. Community connections are linked to inherent strengths and interests of the youth and provide opportunity for connection, relationships, skill building, and built-in community-based respite support. This may include extracurricular activities, after school programs, sports, arts, community events, church groups, 4-H, neighbors, and family members.

This service should be billed using service encounter code S9484 – Stabilization Services[13].

Stabilization Goals

- Support and maintain youth in their current living situation and community
- Services are provided face to face in the youth's natural environment, home, school, and community
- Support youth and families with developmentally appropriate and culturally appropriate trauma-informed care
- Assist youth and families in identifying, accessing, and linking to community systems of care and refer to additional clinical services if needed
- Care coordination to assist youth and families in identifying and linking to ongoing natural and system supports to reduce return to the crisis phase. Include peer support for youth or caregivers as appropriate

Implementation

Shared understanding of the MRSS model with system partners will aide in implementation of MRSS best practices. Collaboration with community partner and stakeholders to understand care pathways and interruption points will provide early identification and prevention of more costly interventions. Working with the following systems and implementing a system of care language is essential to the success of MRSS.

- Behavioral Health Administrative Service Organizations
- Managed Care Organizations
- Juvenile Justice, Law Enforcement and Family Courts
- Schools and Universities
- Pediatric Primary Care Providers
- Department of Health
- Department of Children, Youth and Families
- Emergency Departments, Inpatient Adolescent Units, and Children's' Hospitals
- Community Mental Health Providers and Mental Health Agencies
- Community Organizations, Shelters
- Center for Parent Excellence (COPE), Family Youth System Partner Round Tables (FYSPRTs)

Looking Forward

This guide will evolve with the implementation of HB 1477. Future versions will incorporate tools developed through the technical and operational plan and best practices developed from it. This guide will continue to align further with

[13] http://hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri

SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practices toolkit and MRSS. As tools and trainings allow for implementation of other aspects, the plan will also evolve based on recommendations from the CRIS committee and sub-committees set up through HB 1477.

This guide will also evolve with feedback from MCR teams and BH-ASOs. These models we are introducing are based on successful models from other states, but we need to adapt it to work for all of Washington. Your feedback is important to ensure MCR can meet the needs of our people.

References

SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit

Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response Services

Hoover, S., Bostic, J. (2020). Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm. Alexandria, VA: National Association of State Mental Health Program Directors.

2022 SAMHSA's *Children's Crisis Response and Stabilization* – (publication in process)

2018 NASHHPD *Making the Case for a Comprehensive Children's continuum of Care*

Crisis mental health services – General – WAC 246-341-0900

Crisis mental health services – Outreach services – WAC 246-341-0910

Agency licensure and certification—Exemptions and alternative means or methods – WAC 246-341-0302

Behavioral Health Data Guide for Supplemental Data

Service Encounter Reporting Instructions