



## FY24 SCOPE OF WORK

 **CONTRACT IS MEDICAID FUNDED**

### **Name of Program/Services**

Mobile Outreach Response Engagement Stabilization (MORES)

### **Description of Services**

Mobile Outreach, Response, Engagement, and Stabilization (MORES) is a mobile intervention for children and adolescents ages 3 through 20 years who are experiencing escalating emotional and/or behavioral needs. MORES team responds to a *crisis that is defined by the person/family experiencing it*. MORES team consists of a team lead, family partner, clinician, and consulting psychiatrist as needed. The team responds to family defined crisis and provides up to 8 weeks of follow-up services to the youth and family. Interventions can include but are not limited to crisis intervention and de-escalation, counseling, behavioral assistance, skill building, medication management, and/or caregiver and youth engagement/support/stabilization services.

### **Goals**

MORES Service is guided by overarching goals for the child and family, the provider, and the overall Child-Serving System.

#### **Goals for the Child and Family**

1. Remain in the community.
2. Assess and eliminate barriers to accessing behavioral health and other services and supports through active family engagement strategies.
3. Linkage to appropriate services and supports.
4. Promote/enhance emotional and behavioral functioning.
5. Empower and educate children and families to monitor, manage, and cope with similar situations as they arise.
6. Establish and build resiliency skills.
7. Strengthen the family and youth's natural support system.

#### **Goals for the Provider**

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



4. Increase community awareness of behavioral health needs by providing education and outreach to children, families, schools, and communities.

#### **Goals for the Child-Serving System**

1. Ensure that all children and their families have access to crisis, prevention, and intervention services and supports.
2. Exhaust all possible options to maintain youth in their homes and communities and prevent placement in more restrictive care settings such as emergency departments, inpatient hospitalization, higher levels of behavioral health residential care, and detention/jail.

#### **Required Elements of the Program/Service**

MORES is a team-based service and will respond face-to-face to the member/guardian call within 1 hour unless deferred response is requested by the guardian.

MORES providers will respond to calls at a minimum of 8 hours per day/5 days a week while they build team capacity to respond 24/7/365.

#### **Practice Model**

The MORES episode of care can be divided into two phases: 1) response and screening/assessment 2) ongoing outreach, stabilization, engagement, and transition to appropriate services and supports. Each phase is comprised of many clinical and supportive activities. MORES Team provides services to children and families with a variety of presenting concerns and in a variety of contexts; thus, there is not a “typical” family. The MORES model is designed for most interventions to be face to face with the youth and or caregiver/guardian.

Specialist will collect the minimal amount of information needed over the phone to deploy MORES Team, which will allow MORES to respond quickly to the situation.

#### **A. Phase One Response, Screening and Assessment**

##### ***Phase One Response***

Mobile and deferred mobile responses are generally provided by one MORES team member, but a team of two is recommended when worker safety is a significant concern, in which case the MORES team may consider teaming with a police officer (CIT Officer preferred) to respond to the crisis. The MORES team Family Partner may also respond to the initial call. Each MORES response option is described below:

- a. *Mobile Initial Response* involves a face-to-face response to the caller’s home, school, an emergency department, or another community location.
- b. *Deferred Mobile Initial Response* occurs only when requested by the caller or the family. Deferred mobile responses occur when the family requests the MORES team to respond



later. Team members should provide the deferred mobile responses in less than 4 hours, but no more than 24 hours after receiving the initial call. Responses provided after 24 hours at the family's request is considered a new call. Follow-up services that occur after the first response should include collateral contacts to arrange services and supports as well as telephonic, and face-to-face contact with the child and family in the home, school, or community. Generally, family preference is the only factor that can determine whether follow-up care is provided somewhere other than the family's home or in the community. Initial referral calls from stakeholders follow Deferred Mobile Initial Response guidelines and when possible, it is best practice for the referring agency to call with the family in order to gain verbal consent from the family.

### ***Phase One Screening and Assessment***

Responding to the initial call, stabilizing the initial crisis, and screening/assessing acuity are the primary focus of the Screening/Assessment phase. The MORES Team responds to a variety of situations involving children and families with diverse needs and presenting concerns.

MORES teams will use the Crisis Assessment Tool (CAT) in Phase One for any crisis calls. Non crisis calls during Phase One do not require a CAT. Completion of the CAT occurs within 72 hours of initial appointment.

The Crisis Assessment Tool (CAT) is an information integration tool that supports decisions and communication of the needs of children and youth experiencing a behavioral health crisis that threatens their safety or well-being or the safety of the community. It is also designed to measure the impact of acute psychiatric services – that is, the change before and after the crisis intervention – to help assessors and programs better understand the crisis and improve their crisis work.

A safety plan to include what the family will do to remain safe, maintain stabilization as well as strategies to assist in avoiding a major crisis will be completed within 24 hours of completing the Crisis Assessment Tool (CAT).

## **B. Phase Two Ongoing Stabilization, Engagement, and Transition**

### ***Phase Two Ongoing Assessment***

As the presenting crisis during Phase One begins to stabilize, MORES teams use standardized assessment measures to gather more clinical information a strength and needs assessment to determine immediate needs(s) and develop a care plan.

The MORES team will use the *Child and Adolescent Needs and Strengths (CANS) in Phase Two.*

The CANS is a multi-Purpose tool developed to support planning and level of care decision-making, facilitate quality improvement, and monitor for outcomes. The CANS enables the MORES team to gather information based on the youth and parent/caregivers' strengths (assets/areas in life where doing well, has an interest, and/or ability) and needs (areas where a youth and family caregiver need



help/serious in the youth and family/caregiver to know where intensive or immediate action is most needed and where the youth has assets that can be a major part of the service/ care plan.

A Comprehensive Clinical Assessment (CCA) is optional and in addition to the CANS and not in lieu of the CANS.

### ***Phase Two Stabilization, Engagement and Transition***

Some MORES episodes of care end following an initial call or initial response within Phase I. However, many children and families may require follow-up care for up to 8 weeks. The Ongoing Stabilization, Engagement, and Transition phase entails the delivery of ongoing clinical services for the remainder of the episode of care.

It is important to note that many of the activities in the Assessment phase can be, and are, repeated in the Ongoing Stabilization, Engagement, and Transition phase. Service delivery activities during an episode of care rarely proceed in a predictable or linear manner. For example, the needs of the youth and families are continuously assessed, and teams frequently review and update the MORES plans. Each of these activities may in turn affect the interventions that are implemented. The emphasis of this phase is on meeting child and family needs in a way that stabilizes the current situation and prevents further crises from occurring, in alignment with the youth and family, provider, and child-serving system goals identified above.

The list below identifies many clinical activities that may be implemented during this phase. However, the list is not intended to be exhaustive, nor will youth and families typically receive all these services within a single episode of MORES care. In addition, activities below may occur in a different order than what is presented and will occur when clinically indicated.

1. The MORES team will actively engage the family and youth in ongoing safety planning, service planning, problem-solving, and ongoing assessment of acuity.
2. The results of the ongoing assessment will be shared with the family and youth as soon as possible. Sharing this information helps empower families to join as active partners in the care planning and delivery process. This should include an overall case conceptualization and recommendations.
3. The MORES team will work with the youth and family to jointly develop strength-based goals that are solution focused and integrated into a MORES plan that typically includes the safety plan, care plan that addresses stabilization based off the CAT and/or the CANS, recommended supports and services, and follow-up care. The MORES plan will be completed no later than 10 days into the Phase Two.
4. The MORES team addresses the factors contributing to or maintaining the presenting concern. Often this involves identifying unmet needs and underlying concerns such as parent-child conflict, in school behavior problems, anxiety, depression, academic issues, failure to take prescribed psychotropic medications, symptoms related to trauma exposure, social or peer problems, and many other presenting concerns. The MORES team should engage in strengths



discovery to ensure that strengths are incorporated into the stabilization plan and subsequent service delivery. In addition, the MORES team will work with the child, family, and referrer to develop coping strategies and solutions that address these underlying factors.

5. Children who have experienced a trauma may be at increased risk for an acute decline in their baseline functioning or in jeopardy of a change in their current living environment. MORES providers will provide psychoeducation and review with children and families the traumatic events to which children have been exposed. Administration of the CANS may be helpful in this process. MORES teams are trained to screen and refer for trauma-informed care throughout the duration of the intervention.
6. The MORES team will provide ongoing acuity/risk assessment. Acuity level, along with other factors, informs service delivery and decision making. As a result, ongoing acuity assessment is an important part of service delivery. As changes occur in the acuity assessment, there are accompanying changes in the expected intensity and duration of MORES services.
7. If the team and family believe it to be clinically necessary, child will be referred for a psychiatric evaluation. MORES teams will collaborate with the MORES or child's existing psychiatrist, Nurse Practitioner, or Physician Assistant.
8. MORES teams provide case management to assist families in identifying their current strengths and needs. MORES teams assist with developing transition assets and strategies to address those needs using an array of community-based services, supports, and system collaborations. MORES case management includes, but is not limited to, attending/facilitating Child and Family Team meetings, connecting or re-connecting to formal and informal services and supports in the community and ensuring systems collaboration. It may include reviewing insurance and/or entitlement eligibility and linking families to resources and natural supports in the community to meet basic needs that may be a barrier to receiving the appropriate level of treatment. MORES teams also provide psychoeducation about psychological conditions, information about navigating the mental health system, reducing stigma, and overcoming obstacles the child is facing.
9. MORES team will work with youth and families related to engagement in services and following through with their ongoing care plan, post-MORES services. In this effort, MORES team may also review with the child and family the gains and successes that were achieved during participation in MORES.
10. With appropriate consent from the family communication with the original referrer is very important for sharing care plan strategies and generalizing stabilization gains to other settings. This communication helps build a positive reputation for collaboration with community partners. Communication and collaboration with family members/caregivers is required.

MORES staff will actively help families transition to post-MORES services and supports. Transition planning occurs throughout the episode of care. Families are supported in accessing natural supports to address identified challenges. It is expected that many treatment referrals are made to other contracted



service providers and other community resources with guardian choice. Referrals will be documented in the clinical record. MORES team members will assist youth and families in developing assets that help manage and persevere during transition times.

### **C. Acuity Levels:**

During the initial phone contact, in the first few face-to-face sessions, and throughout the episode of care, the MORES team will continue to assess the child's acuity level based on relevant clinical features such as presenting problem, risk of harm to self or others, mental status, diagnosis, risk level, overall level of functioning, behavioral history, and other characteristics. The subsequent delivery of MORES services depends, in part, on the assessed acuity level but also takes into consideration family needs and preferences as well as clinical judgment. The phase of intervention, intensity, and duration of care changes accordingly as youth and families experience changes in acuity level, needs, and preferences.

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

1. **High Acuity:** Youth and families with high acuity receive face-to-face contact every 24 to 48 hours by the team in the home or community, psychiatric consultation as needed and additional phone contact as needed. The purpose of frequency of contact when a family is in high acuity is to stabilize the immediate situation, complete a MORES plan, and reduce risk factors to prevent emergency room visits, inpatient hospitalization, and incarceration when MORES can provide a safe and effective alternative. If there is not a safe and effective alternative, clinicians will refer a child for inpatient evaluation.

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

2. **Intermediate Acuity:** Youth and families with intermediate acuity receive face-to-face contact every 48 to 72 hours (or 3-4 times a week) in the home or community, phone contact 3-4 days a week, and psychiatric consultation as needed. This level of contact is generally appropriate for children and families that are not in an active crisis so the purpose is to maintain stabilization and begin planning for discharge which may include linkage and transition to ongoing services and supports. In this phase of stabilization, family engagement strategies are a focus and Family Partners are likely highly utilized. A MORES plan is developed to aid in transition to appropriate services and supports.



3. **Low Acuity:** Youth and families with low acuity receive, at minimum, one face-to-face contact per week in the home or community, two phone contacts per week, and psychiatric consultation as needed. The purpose of this contact is to maintain progress toward the reactive and proactive crisis plans. Generally, youth and families with low acuity will be moving toward discharge from MORES services which may include linkage and transition to ongoing services and supports. The MORES team will stay connected with the family until they are firmly established and engaged with the services and supports to meet their needs.

In addition, given the high demand for MORES services, MORES Team balances the need for immediate crisis response/stabilization with the need for follow-up stabilization services. It is appropriate for MORES providers to prioritize crisis stabilization of children presenting with high acuity over follow-up care sessions with children at lower levels of acuity.

#### **Entrance Criteria**

*MORES Team Responds to Family Defined Crisis.* A crisis occurs when any or all the following are present:

- One's sense of balance is disrupted.
- Coping and problem-solving skills that worked in the past are not working.
- Life functioning is disrupted (family, living situation, school and/or community environments)
- At risk of out of home placement choice by caregiver
- *Crisis is defined by the person/family experiencing it and the family must be the caller to the MORES team.*

#### **Discharge Criteria:**

Any of the following criteria is sufficient for discharge from this level of care:

- Child's goals for the MORES service have been met, barriers to service engagement have been addressed, and youth/family has started and engaged services with appropriate service provider.
- The assessment indicates that the youth need a higher or lower intensity of service and the youth has started and is engaged with this higher or lower level of services.
- The caregiver/family has withdrawn consent for treatment and there is no court order requiring such treatment.

#### **Service Exclusions:**

- Persons receiving enhanced services which have their own first responder responsibilities.
- Members receiving Innovations services
- Inpatient Hospital Services
- Facility Based Crisis



**Provider Requirements:**

Outreach requirements

- Priority will be given to key stakeholders and high-volume referrers to local Emergency Departments, including but not limited to:
  - Local Schools
  - Law Enforcement
  - Department of Social Services
  - Foster Care Providers
  - Department of Public Safety - Juvenile Justice
  - Pediatricians/Physicians
  - Emergency Medical Services
- Minimum of 24 formal outreach activities per year.

**Staffing Requirements:**

**The MORES Team Lead:**

- Must meet the requirements of a Qualified Professional with the population at minimum
- 1 or more years working with children and families across various disciplines (Mental Health, Substance Use, Intellectual/Developmental Disabilities)
- Proven experience in crisis intervention & stabilization
- Supervise and evaluate the team's performance in all aspects of their positions
- Lead team coaching typically once per week to monitor adherence to the MORES principles and program protocols
- Provide individual supervision at least monthly, preferably weekly, and author the staff supervision plans
- Provide training of theory and application of MORES services and assist in a variety of ways to ensure the success of the program
- Provide ongoing supervision to the MORES team

**The MORES Clinician:**

- Must be licensed as an associate or full LCSW, LMFT, LCMHC, LCAS
- Have training & knowledge in dual diagnosis (MHSU & IDD)
- Certified in CANS/CAT

**Family Support Partners:**

- Must have lived experience as a primary caregiver for a child who has/had mental health, substance use disorders, or intellectual/developmental disability





- Experience in navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems
- Bachelor's degree in a human services field from an accredited university and one year of experience working with children and families; or associate's degree in a human service field from an accredited school and two year of experience working with children/adolescents/transition age youth; or high school diploma or GED and a minimum of four years of experience working with children/adolescents/transition age youth

All MORES Team members

Knowledge in:

- Safety and crisis planning
- Behavioral health service array including PRTF and other child/adolescent behavioral health residential placement criteria; federal, state, and local resources
- System of Care Values and Wraparound principles Family driven and youth guided care including the client's and family/caregiver's right to make decisions about all aspects of their child's care

Skills in:

- Engagement of youth and family/caregiver
- De-escalation – observing, interrupting, and shifting dynamics, education, and skill introduction.
- Assessment – strengths, triggers, communication, contexts (medical, mental health, trauma, development, patterns of behavior, collateral outreach)
- Planning – safety, crisis and transition, alternative strategies
- Identifying services within the established services system and uncovering natural supports to meet the client's needs
- Motivational interviewing, behavior change strategies

Ability to:

- Demonstrate a positive regard for youth and their families
- Develop rapport and communicate with persons from diverse cultural backgrounds
- Offer Family driven and youth guided care including the youth's and family/caregiver's right to make decisions about all aspects of their child's care

**MORES Team Training & Competency:**

Participation of the team in all technical assistance and support activities offered by the Innovations Institute learning community, coaching calls and Subject Matter Expert sessions.

**First 90 days**

Crisis Prevention Intervention (CPI)/Non-Violent Crisis Intervention Training (NVCI)

Crisis Response Protocol

Suicide Prevention



CANS/CAT certification  
Mental Health 101  
Domestic Violence  
Trauma Informed Care  
Youth Mental Health First Aid  
Introduction to Motivational Interviewing

**Within 6- 12 months**

Family Partner 101 (Family Partners only)  
Adolescent Development  
Substance Use  
Family Dynamics  
Cultural Competency  
CFT 1  
CFT 2  
High Fidelity Wraparound Overview Training

**Within 18 months**

Family Partner National Certification

**Collaboration**

Staff will collaborate with all local crisis service systems, emergency departments, mobile crisis, care management and child and family serving systems.

**Documentation Requirements**

Services shall be documented in accordance with the *DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM)* **prior** to seeking reimbursement. The services require a full-service note, which includes Items 1 through 12, under Contents of a Service Note, Chapter 7 of the RMDM

**Outcomes**

**Program Requirements**

- MORES monthly report completed and submitted electronically to Alliance by the 10<sup>th</sup> of each month at [pndproviderreports@alliancehealthplan.org](mailto:pndproviderreports@alliancehealthplan.org)
- One note per encounter. Encounters must be submitted as non-paid claims using the encounter code below in addition to the weekly claims code.

**Utilization Management**

There is no prior authorization for this service. MORES is provided under EPSDT.

**Finance**

\$580 per week. The weekly billing code is H2011 22  
Weeks are Sunday through Saturday, so claims are for services delivered within that period.  
Encounter codes are required for tracking purposes using code: H2011 TS



You may not bill H2011 22 and H2011 TS on the same day.

**Start date: July 1, 2023**

**End date: June 30, 2024**