Mobile Crisis for Behavioral Health Professionals

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

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Overview of State of Nevada Needs Assessment (Mercer)

Nevada is committed to building a Behavioral Health Crisis Care Response System (CCRS)
that is supportive of the unique qualities of its local communities and that is responsive to the needs of its residents in crisis.

The state strives to serve individuals experiencing a behavioral health crisis in a timely, evidence-based, and trauma-informed manner.

This report focuses on the importance of mobile crisis intervention services as one component of the state's vision for the CCRS.

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Overview of State of Nevada Needs Assessment (Mercer)

Following an October 2019 Summit to engage stakeholders in learning about components of a Crisis Care Response System (CCRS), and in response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) release of its "National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit," the state brought stakeholders together for a seven-week immersion series on Nevada's CCRS to assess the state's assets and gaps.

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Overview of State of Nevada Needs Assessment (Mercer)

Leveraging the SAMHSA National Guidelines, participants learned about the four key components of an effective crisis response system, which include the following.

- A crisis call center hub
- Mobile crisis teams
- Facility-based crisis stabilization programs
- Essential principles and practices

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Overview of State of Nevada Needs Assessment (Mercer)

Another important milestone in Nevada's journey to establish a CCRS and to strengthen mobile crisis intervention services infrastructure was the passing of **Senate Bill 390 (SB390)**
in 2021.

This legislation established a telecommunications fee cap and crisis response account to fund crisis call center operations and technology, mobile crisis and crisis stabilization services and defined requirements for mobile crisis teams.

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Overview of State of Nevada Needs Assessment (Mercer)

This report summarizes Mercer's findings from targeted research and offers recommendations to further support Nevada in developing a sustainable, statewide mobile crisis intervention system that is responsive to the needs of local communities and consistent with best and promising practices. Guiding questions utilized to help develop the recommendations contained in this report center on the following:

- What constitutes an allowable, Medicaid-reimbursable mobile crisis response?
- What are the additional requirements that must be met in order for a mobile crisis response to qualify for the time-limited enhanced FMAP associated with Section 1947?
- What are the best practice components of an effective mobile crisis response?
- How can DHCFP and DPBH partner to ensure mobile crisis intervention services are available to all Nevadans?

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Overview of State of Nevada Needs Assessment (Mercer)

The remainder of this report discusses the methodology, background, and key findings and recommendations for Nevada in its development of mobile crisis intervention services under Section 1947 and SB390. Moreover, each recommendation addresses the core requirements detailed in Section 1947 and SB390, including: provider qualifications, training requirements, access and service standards, broad financing options, and state oversight and monitoring considerations.

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Overview of State of Nevada Needs Assessment (Mercer)

Mercer’s research included review of the following:

- An array of background materials specific to Nevada as well as national best practices related to behavioral health crisis systems.
- Nevada's current mobile crisis service capacity and operations, as well as limitations and barriers to expanding mobile crisis services consistent with Nevada’s vision and incompliance with federal and state requirements.
- Nevada’s Medicaid State Plan and existing waiver authorities.
- Medicaid billing for crisis intervention services, including crisis services provided by Certified Community Behavioral Health Centers (CCBHCs).

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Senate Bill 390

Passed in 2021, SB390 was an integral milestone in Nevada's journey to establish a statewide crisis response system16.This legislation established a telecommunications fee cap and crisis response account to fund 988 operations and technology, and mobile crisis and crisis stabilization services, as authorized by 47 U.S.C. 251a.

SB390 defined requirements for three types of mobile crisis teams, which include:

1. Persons professionally qualified in the field of behavioral health and providers of peer recovery support services

2. A provider of EMS that includes persons professionally qualified in the field of behavioral health and providers of peer recovery support services

3. A LE agency that includes LE officers, persons professionally qualified in the field of psychiatric mental health and providers of peer recovery support services. SB390 also gave DPBH broad authority to adopt regulations pertaining to the qualifications of providers and to determine communication and information sharing practices when responding to a behavioral health crisis.

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Senate Bill 390

Since the completion of the 2020 Statewide Assets and Gaps Analysis, and subsequent passage of SB390 and Section 1947, Mercer evaluated the extent to which existing mobile crisis services align with the new federal and state requirements. This report details finding from that analysis and provides recommendations to ensure that future services comport with those requirements.

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Certified Community Behavioral Health Centers (CCBHCs)

9 Core Services

- Crisis Behavioral Health Services
- Screening, Assessment & Diagnosis
- Person-Centered Treatment Planning
- Outpatient Behavioral Health Services & Medication Management
- Primary Care Screening and Monitoring
- Target Case Management
- Psychiatric Rehabilitation
- Peer Support Services
- Community Based Outpatient Behavioral Health Services for Members of the Armed Forces and Veterans

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Certified Community Behavioral Health Centers (CCBHCs) Required Evidence Based Practices

- Assertive Community Treatment Teams (encompassing the 9 core services as clinically needed)
- Screening Tools
- Assessment Tools
- Risk Severity Tools
- ASAM, LOCUS, and CASII Utilization Management Tools
- Direct EBP Interventions

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Crisis Services, Meeting Needs, Saving Lives

&

National Guidelines for Crisis Care – A Best Practice Toolkit

Advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts.

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National Association of State Mental Health Program Directors (NASMHPD)
Substance Abuse and Mental Health Services Administration (SAMHSA)

NASMHPD: Crisis Services, Meeting Needs, Saving Lives

With COVID-19 as a constant stressor and new spotlights on the need to address structural racism in society, it is more important than ever to examine how mental wellbeing in the United States can be supported. Even prior to recent events related to these issues, national attention on alarming increases in suicide rates and opioid-related overdose deaths, homelessness, the over-representation of individuals with mental illness, intellectual and developmental disabilities and substance use disorders in the criminal legal system, all called attention to an urgent need for expanded prevention and intervention strategies for people in dire need of help.

In 2017, the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered in advocating for policy makers to consider what it would take to look “Beyond Beds” in state hospitals as a single solution to all the challenges and instead develop a path toward a robust continuum of accessible, effective psychiatric care.

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NASMHPD: Crisis Services, Meeting Needs, Saving Lives

Now, three years later, NASMHPD and SAMHSA highlight the first point of entry into that continuum of care- to prevent and manage crises in a way that offers an immediately accessible, interconnected, effective and just continuum of crisis behavioral health services. By enhancing crisis response, community needs can be met, and lives can be saved with services that reduce suicides and opioid-related deaths, divert individuals from incarceration and unnecessary hospitalization and accurately assess and stabilize and refer individuals with mental health, substance use and other behavioral health challenges.

This paper, *Crisis Services: Meeting Needs, Saving Lives,* furthers the *Beyond Beds* strategy by describing this vision. By knitting together several bodies of work on crisis services, it sets the stage for the next iteration of a national dialogue for developing and expanding that much needed continuum of quality mental health and substance use care for all who need it, when they need it.

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What are Crisis Services?

Crisis services are for anyone, anywhere and anytime.

Examples of crisis level safety net services seen in our communities and around the country include:

- **911** accepting all calls and dispatching support based on the assessed need of the caller,
- **Law enforcement, fire or ambulance personnel** dispatched to wherever the need is in the community, and
- **Hospital emergency departments** serving everyone that comes through their doors from all referral sources.

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Historical approach to Mental Health Crises

- **Short-term & Short-sighed**
- **Escalating costs due to:**
  - Overdependence on hospitalizations
  - Over utilization of expensive services and supports (e.g., psychiatric inpatient assets)
  - Hospital readmissions
- **Overuse of law enforcement**

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Consequences of a Broken System

(1) High rates of incarceration for individuals with mental health challenges,

(2) Crowding of emergency departments that experience lost opportunity costs with their beds,

(3) Higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available,

(4) Human tragedies due to lack of access and appropriate care

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Core Services to Mental Health Crisis Care

The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** integrated crisis system:

Regional Crisis Call Center: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat).

Crisis Mobile Team Response: Available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner.

Crisis Receiving and Stabilization Facilities: Providing short-term(under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

These services are for *anyone, anywhere and anytime.*

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Regional Crisis Call Center

- National number for behavioral health crisis calls: **988**
- Locally 988 is received and triaged by:

Crisis Support Services of Nevada

  - "Hub" for incoming calls statewide
  - Ideally with integrated GPS informed mobile deployment capability.

- Many providers do have their own crisis phone lines; however, access is typically reserved for established clients only.
  - **– Not for anyone, anywhere, anytime.**
- CCBHCs are also required to have crisis phone lines that can be accessed by anyone, regardless of client status. They also have an agreement with Crisis Support Services of Nevada to be available for Mobile Deployment within their catchment areas.
  - **– Almost for anyone, anywhere, anytime. A good example of efforts towards increased integration of systems.**

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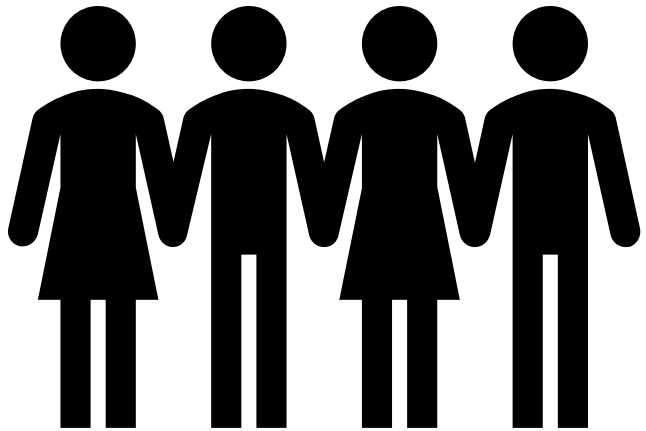
Crisis Mobile Team Response

Currently Nevada has *some* mobile crisis teams:

- Mobile Crisis Response Teams (MCRTs)– Statewide, including rural areas ; however, only serve youth & families of youth.
  - **– Not for anyone, anywhere, anytime.**
- Mobile Outreach Safety Team (MOST) – Not statewide – "MOST clinician will not respond to calls on scene without a MOST law enforcement partner present."
  - **– Not for anyone, anywhere, anytime.**
- Community Behavioral Health Centers (CCBHC) – Not statewide, limited to their catchment area (typically same zip code as the CCBHC facility).
  - **– Almost for anyone, anywhere, anytime, but again limited by catchment area/location of the CCBHC.**



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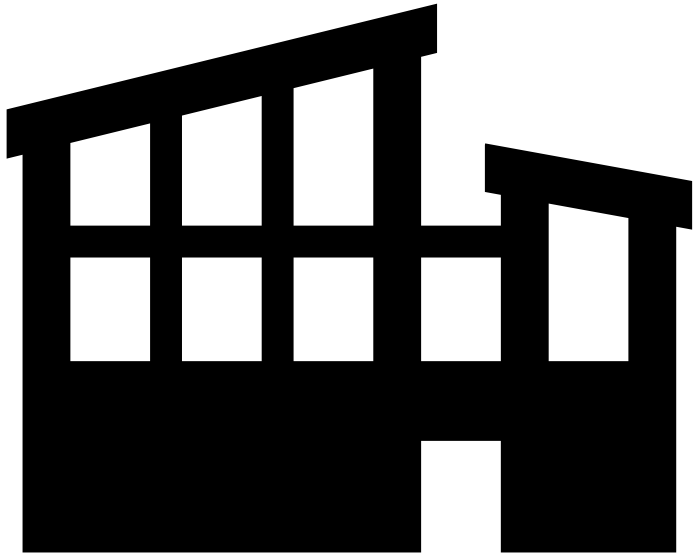
Crisis Receiving and Stabilization Facilities

- Nevada's first approved Crisis Receiving and Stabilization Center is:

Carson Tahoe Hospital's Mallory Behavioral Health Crisis Center



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Mobile Crisis Team Services

National Guidelines for Crisis Care – A Best Practice Toolkit

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Mobile Crisis Team Services

National Guidelines for Crisis Care – A Best Practice Toolkit

Minimum Expectations to Operate Mobile Crisis Team Services

Mobile crisis team services must:

- Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation;
- Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region, or to particular days or times; *and*
- Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

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Mobile Crisis Team Services

National Guidelines for Crisis Care – A Best Practice Toolkit

Best Practices to Operate Mobile Crisis Team Services

To fully align with best practice guidelines, teams must meet the minimum expectations (previous slide) and:

- Incorporate peers within the mobile crisis team;
- Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
- Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
- Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

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Essential Functions & Qualities of Mobile Crisis Teams

National Guidelines for Crisis Care – A Best Practice Toolkit

Essential Functions:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Essential Qualities:

- Safety and security for staff and those in crisis;
- "Suicide Safer" care;
- Trauma-informed care;
- Recovery needs & significant use of peers; *and*
- Law enforcement and emergency medical services collaboration

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Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

- Occurs over the telephone (crisis call hub) with the initial crisis call and again on site with the mobile team.
- Determines the level of risk faced by the individual in crisis.
- Assesses the most appropriate response to meet the need.

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Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

Over the phone (crisis call hub) and Mobile Crisis staff must decide if other first responders, such as police or emergency medical services, should be involved.

- EMS or police intervention should only be used when the nature of the crisis indicates that these services are required. EMS or police intervention is ***not*** the preferred approach unless appropriately indicated.
- **For example, if the person in crisis poses an imminent threat of harm, coordination with emergency responders *is* appropriate.**

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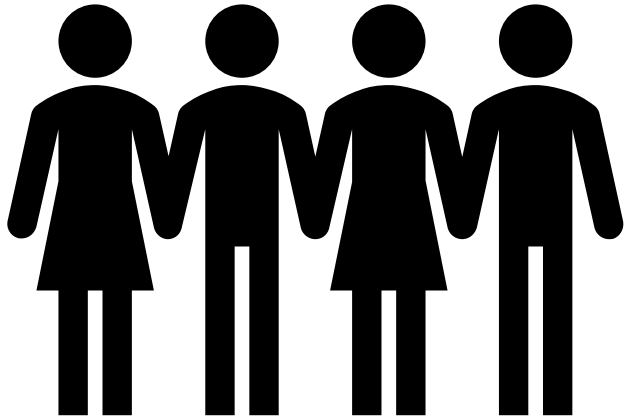
Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit



Another part of the mobile team triage and screening process will be to ensure that the most appropriate services are being utilized.

- For example, the behavior of a person in crisis may result from a physical condition or reaction that then triggers a mental or behavioral response.
- Physical, mental and behavioral health conditions can affect a person at the same time, so it is crucial to determine if the person in crisis describes a serious medical condition.

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Triage & Screening

It can be helpful to create a list of important questions to ask a person who is experiencing a behavioral health crisis.

What are some important triage related questions to ask before diving into assessment?

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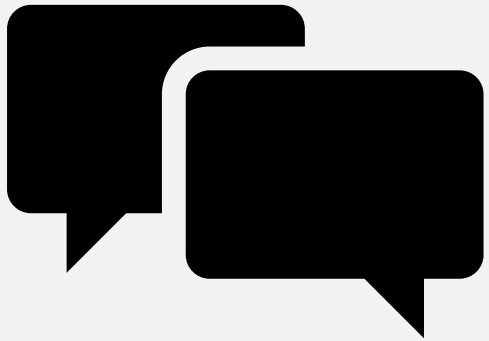
Triage & Screening

Additional Questions you can ask during triage and screening:

- Do you have any weapons on you?
- Are you hearing voices or seeing things that others cannot see?
- Have you been drinking, or have you taken any drugs?
- Do you have a behavioral or mental health condition that we should know about?



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Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

If determined over the phone that emergency responders are needed the mobile crisis team can…

Meet the emergency responders at the site of the crisis and work together to resolve the situation.

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Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of screening both over the phone and by the mobile crisis team.

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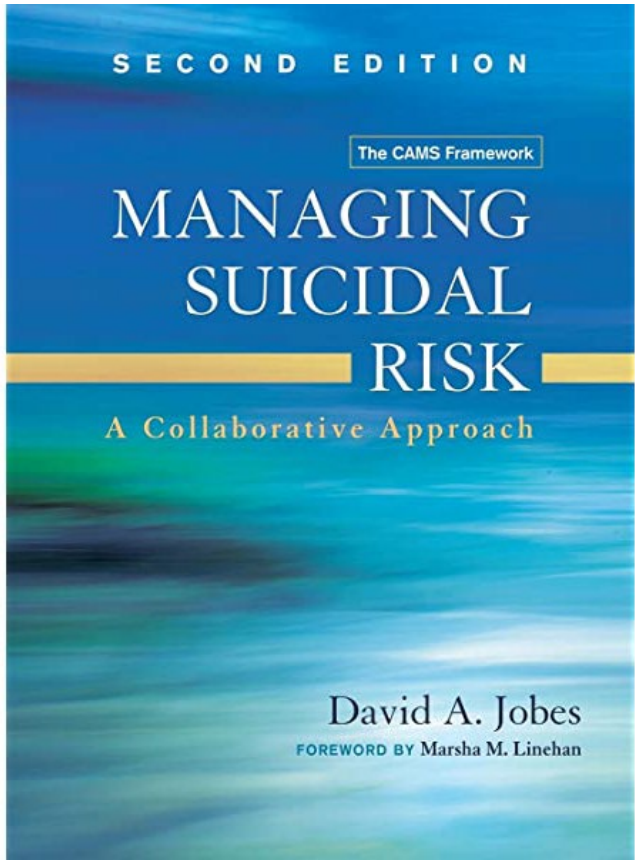
Screening for Suicidality



Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		**High Risk**

988 SUICIDE & CRISIS LIFELINE

If **YES** to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is **YES**, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

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CAMS

Columbia Suicide Severity Rating Scale

Screening for Suicidality

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: *Clinical judgment can always override a negative screen*).
- If patient answers **"Yes"** to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen.** Ask question #5 to assess acuity:
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - Patient requires a **STAT** safety/full mental health evaluation. **Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. **Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

ASQ

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

SAFE-T

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ZERO SUICIDE

https://zerosuicide.edc.org/

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Zero Suicide / Safer Suicide Care

National Guidelines for Crisis Care – A Best Practice Toolkit

The following seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Developing a competent, confident, and caring workforce;
3. Systematically identifying and assessing suicide risk among people receiving care;
4. Ensuring every individual has a pathway to care that is both timely and adequate to meet his or her needs and includes collaborative safety planning and a reduction in access to lethal means;
5. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Providing continuous contact and support; especially after acute care; *and*
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

- See more at http://zerosuicide.sprc.org/about

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ZERO SUICIDE

Zero Suicide / Safer Suicide Care

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members.*
- *Mandate completion of Applied Suicide Intervention Services Training (ASIST) or similar training by all team members serving individuals who receive crisis services.*
- *Incorporate suicide risk screening, assessment and planning into the crisis provider's practices.*
- *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record of the crisis provider.*
- *Commit to a goal of Zero Suicide as a state and as a crisis system of care.*

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SUICIDE IS PREVENTABLE

ZERO SUICIDE IN NEVADA

ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

To learn more visit: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/About/Budget/FY20-21/CrisisZeroSuicide.pdf

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Assessment

National Guidelines for Crisis Care – A Best Practice Toolkit

A licensed behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. The assessment at minimum should address:

- Causes leading to the crisis event including psychiatric, substance use and misuse, social, familial, and legal factors;
- Safety and risk for the individual and others involved including an explicit assessment of suicide risk;
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
- Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
- Medications prescribed as well as information on the individual's compliance with the medication regimen; *and*
- Medical history as it may relate to the crisis.

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TIP: Toolkit = Behavioral Health Professional (BHP)
NV Medicaid = Qualified Mental Health Professional (QMHP)

Trauma-Informed Care

National Guidelines for Crisis Care – A Best Practice Toolkit

Trauma-informed care is *urgently* important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis; *especially those with trauma histories*.

An established resource for further understanding trauma-informed care is provided by **SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services* (TIP 57)**. It includes the following guiding principles:

- Safety;
- Trustworthiness and transparency;
- Peer support and mutual self-help;
- Collaboration and mutuality;
- Empowerment, voice and choice; *and*
- Ensuring cultural, historical and gender considerations inform the care provided.

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Trauma-Informed Care

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
- *Apply assessment tools that evaluate the level of trauma experienced by the individual served by the crisis program and create action steps based on those assessments.*

Assessment examples:

- **Life Events Checklist for DSM-5 (LEC-5)**
- **Adverse Childhood Experiences (ACEs)**

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De-escalation and Resolution

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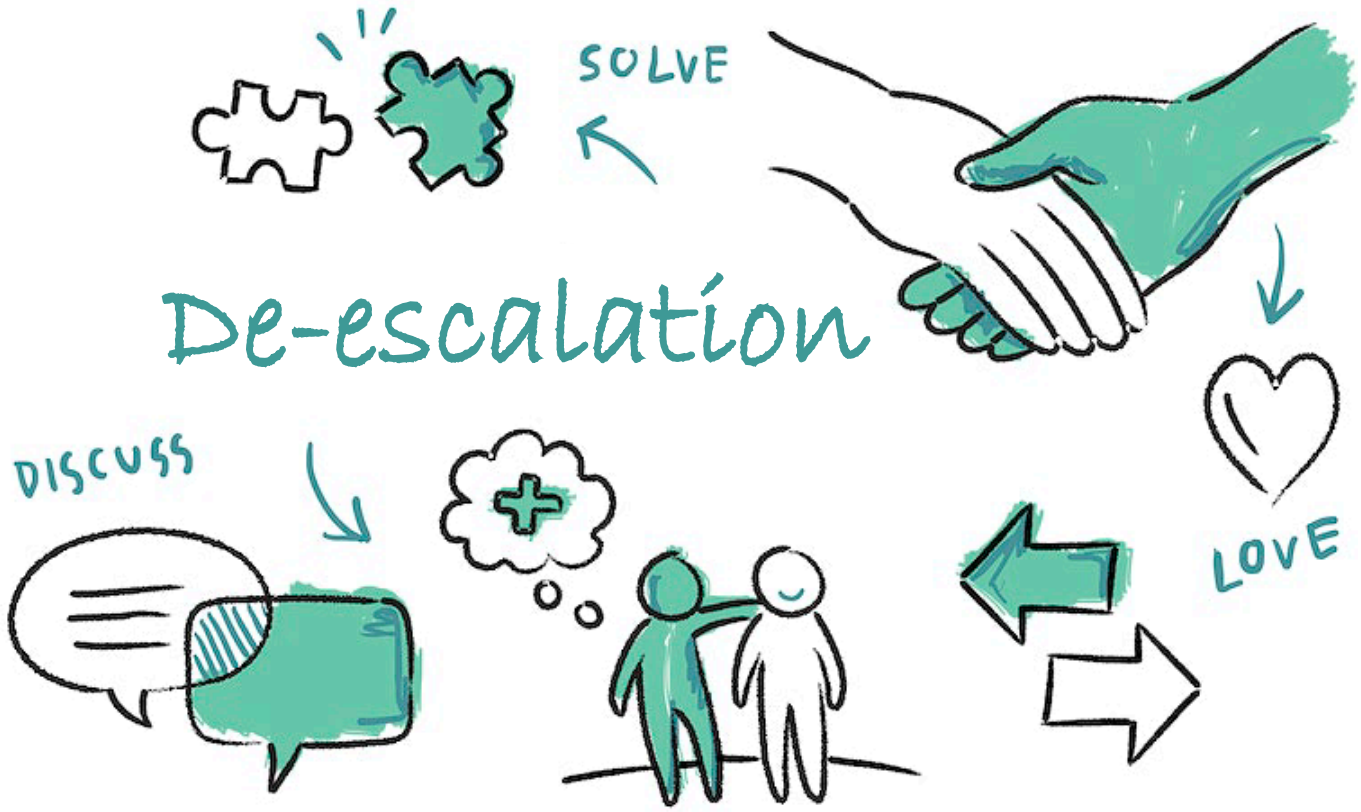

- Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis.
- The goal is not just to determine a needed level of care to which the individual should be referred, but to

Resolve the situation so a higher level of care is not necessary.

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TIP: PICS has a Verbal De-escalation 101 webinar available at casatlearning.org

De-escalation and Resolution

- Talk to the person, not the action, when communicating with an individual experiencing a mental health or substance use crisis.
- De-escalation can support and protect everyone involved during the mental health crisis.
- De-escalation can assist in building a positive connection with the individual in crisis, which can aid in their recovery journey.
- De-escalation will not work on every individual. Always attend to your own safety first.

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TIP: PICS has a Verbal De-escalation 101 webinar available at casatlearning.org

VERBAL DE-ESCALATION

Safe Space

Ensure the environment is safe: Have team backup and clear the area of potential weapons.

Respect personal space by remaining at least 2 arms lengths away.

Maintain safe body language: Remain calm and keep an open body posture.

Use Simple Language

Be concise, using short sentences and simple language.

Use a calm, low tone of voice.

Speak slowly to be easily understood.

Build a Collaborative Relationship

Listen carefully to understand what provoked the agitation.

Identify the individual's wants and feelings.

Agree as much as possible with the truth, the underlying principle, or the odds.

Provide genuine EMPATHY & VALIDATION throughout the entire intervention.

Do Set Limits

Set limits to ensure safety and maintain a collaborative relationship.

Continue to speak slowly and use simple language.

Inform the individual of potential consequences for crossing boundaries.

Uphold Optimism & Unveil Choices

Provide optimism by offering choices.

Agitation may prevent the individual from "seeing" all their options.

Having choices can be empowering!

Evaluate Effectiveness

Evaluate the ongoing situation to decide if a different intervention is needed.

Mobilize help if necessary.

Debrief with your team to reflect on the outcome of the verbal de-escalation intervention.

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CASAT Center for the Application of Substance Abuse Technologies

Citation: Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, J., Zeller, S. L., Wilson, M. P., Rifai, M. A., & Ng, A. T. (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. The Western Journal of Emergency Medicine, 13(1), 17–25. https://doi.org/10.5811/westjem.2011.9.6864

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Safety & Security for Staff and People in Crisis

National Guidelines for Crisis Care – A Best Practice Toolkit

Keys to safety and security in crisis delivery settings include:

- Evidence-based and trauma-informed crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas “fishbowl” observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing “no force first” prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry;
- Strong relationships with law enforcement and first responders; *and*
- Policies that include the roles of clinical staff (and law enforcement if needed) for management of incidents of behavior that places others at risk.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Safety & Security for Staff and People in Crisis

National Guidelines for Crisis Care – A Best Practice Toolkit

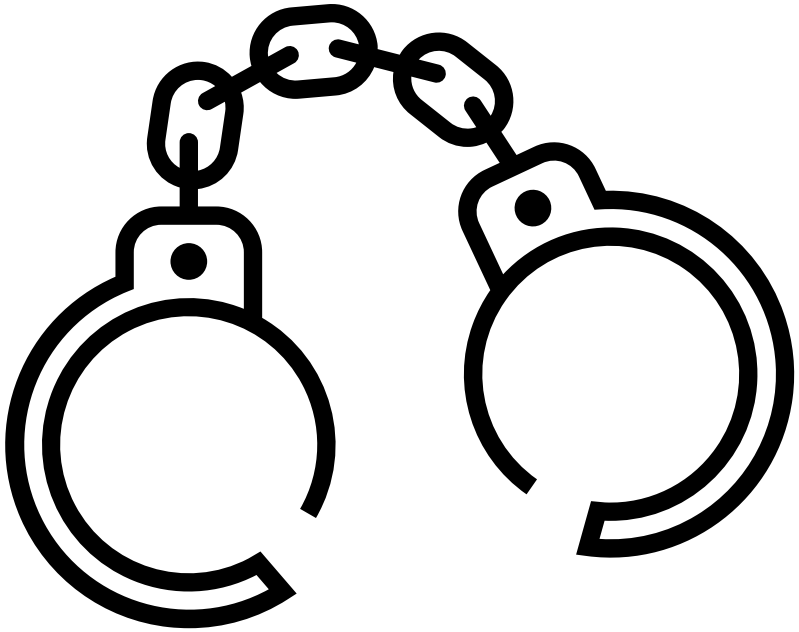
Implementation Guidance

- *Commit to a no-force-first approach to care.*
- *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
- *Remember that barriers do not equal safety. The key to safety is* ***engagement and empowerment*** *of the individual served while in crisis.*
- *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
- *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
- *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Law Enforcement & Crisis Response – An Essential Partnership

National Guidelines for Crisis Care – A Best Practice Toolkit



Strong partnerships between crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care justice system diversion and the elimination of psychiatric boarding in emergency departments.

The absence of comprehensive crisis systems has been the major “front line” cause of the criminalization of mental illness and a root cause of shootings and other incidents that have left people with mental illness and officers dead.

Collaboration is the key to reversing these unacceptable trends.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Law Enforcement & Crisis Response – An Essential Partnership

National Guidelines for Crisis Care – A Best Practice Toolkit

Police officers are critical to mobile crisis services.

(1) They provide support in potentially dangerous situations when the need is assessed.

(2) They are a referral source delivering warm hand-offs to mobile crisis teams.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Law Enforcement & Crisis Response – An Essential Partnership

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Have local crisis providers actively participate in CIT (Crisis Intervention Team) training or related mental health crisis management training sessions.*
- *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
- *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
- *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Peer Support

National Guidelines for Crisis Care – A Best Practice Toolkit

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Peer Support

National Guidelines for Crisis Care – A Best Practice Toolkit

- For community-based mobile crisis programs, incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services.
- Peers should not reduplicate the role of behavioral health professionals, but instead should establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis.
- They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Significant Role of Peers

National Guidelines for Crisis Care – A Best Practice Toolkit

Including peers—especially people who have experienced suicidality and suicide attempts and have learned from these experiences—can be a ***safe and effective*** program mechanism for assessing and reducing suicide risk for persons in crisis.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Peer Support

Peer Support Services in Crisis Care – SAMHSA Advisory June 2022

Peer support workers demonstrate that recovery is possible and act as an advocate for the individual.

Inclusion of peer support workers on your Mobile Crisis Team can help improve outcomes, such as:

- Reducing trauma and agitation
- Increasing trust
- Reducing hospitalizations and emergency department usage
- Reducing recurrence of symptoms
- Decreasing recidivism.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Peer Support Specialists

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*
- *Develop support and supervision that aligns with the needs of your program's team members.*
- *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

TIP: PICS will have a **Mobile Crisis for Peers & Other Qualified Behavioral Health Professionals** **August 2023** casatlearning.org

PICS
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Coordination of Care

National Guidelines for Crisis Care – A Best Practice Toolkit

- Community-based mobile crisis programs should focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises.
- These services may include crisis stabilization or acute inpatient hospitalization and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Crisis Planning & Follow-up

National Guidelines for Crisis Care – A Best Practice Toolkit

- During a mobile crisis intervention, the Behavioral Health Professional and peer support professional should engage the individual in a crisis planning process; resulting in the creation or update of a range of planning tools including a safety plan.
- When indicated, mobile crisis service providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs.

PICS
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Designated Mobile Crisis Teams

PICS
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Designated Mobile Crisis Teams

Definition: DMCTs are a new Medicaid reimbursable specialty type, scheduled to be effective **July 1, 2023**, pending CMS approval.

- Medicaid Provider Type 87, Crisis Services:
  - Specialty #31 – Designated Mobile Crisis Team
  - Specialty #32 – Designated Mobile Crisis Team attached to a CCBHC

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Designated Mobile Crisis Teams

At the time of this webinar DMCT enrollment Criteria has not been finalized; however, the following proposed criteria are likely to be included as the official requirements from Medicaid:

1. Staffing
2. Provider Training
3. Services – Screening
4. Services – Assessment
5. Services – Crisis & Safety Plans
6. Services – Psychiatric Advance Directives
7. Services – Harm Reduction
8. Services – Coordination of Care
9. Services – Privacy & Confidentiality
10. Access
11. Payment Operations
12. Reporting Requirements

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*DMCT Criteria: Staffing Requirements

Mobile crisis services are provided by a **Multidisciplinary Team** comprised of the following:

Led by:

At least one behavioral health professional who is authorized to conduct an assessment in accordance with Nevada scope of practice requirements, including:

- Physicians
- Physician assistants
- Licensed practitioners/Qualified mental health professionals (QMHPs):
  - Licensed psychologists
  - Licensed marriage and family therapists (LMFTs)
  - Licensed clinical social workers (LCSWs)
  - Licensed clinical professional counselors (CPCs)
  - Advanced practice registered nurses (APRNs)
  - Interns (under the supervision of a licensed clinician)
- Qualified mental health associates (QMHAs) working under the 24/7/365 supervision of a physician, physician assistant, or licensed practitioner/QMHP

Other members of the team may include:

- QMHAs
- Qualified behavioral aides (QBAs)
- Peer supporters
- Substance use disorder (SUD) specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), and/or certified alcohol and drug counselor (CADCs)

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Staffing Requirements

Staff supervision:

- All clinical supervision must align with existing requirements in Nevada Medicaid Services Manual 403.2A.
- Real-time clinical consultation and supervision is available 24/7/365.

Below is the link for the Medicaid Services Manual:

https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_20_02_01.pdf

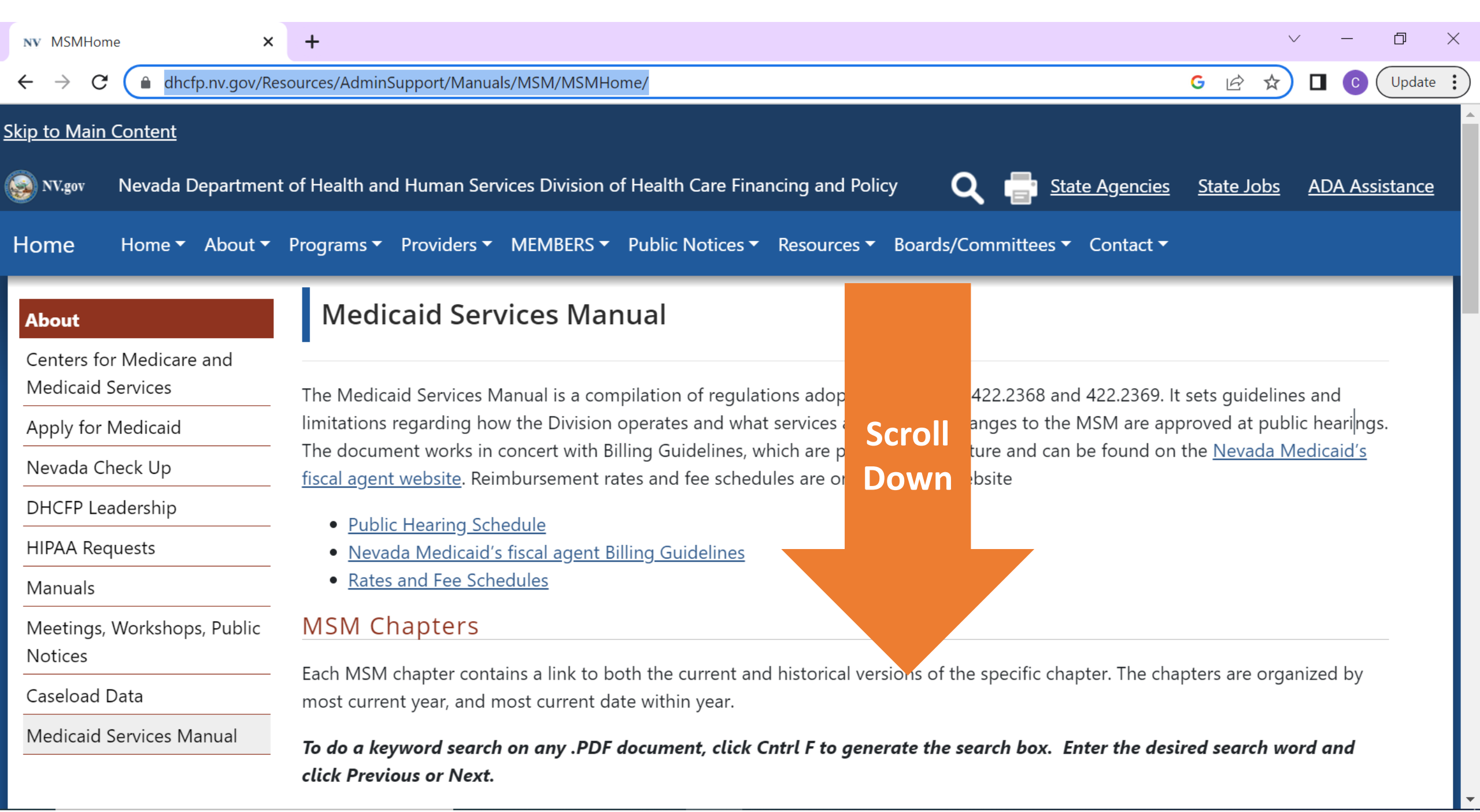
PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

Nevada Medicaid Services Manual

Step 1: Search “Nevada Medicaid Services Manual” in your search engine, OR go directly to:

https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/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Public Notices
Resources
Boards/Committees
Contact
About
Centers for Medicare and Medicaid Services
Apply for Medicaid
Nevada Check Up
DHCFP Leadership
HIPAA Requests
Manuals
Meetings, Workshops, Public Notices
Caseload Data
Medicaid Services Manual
Medicaid Services Manual
The Medicaid Services Manual is a compilation of regulations adop
422.2368 and 422.2369. It sets guidelines and limitations regarding how the Division operates and what services
anges to the MSM are approved at public hearings. The document works in concert with Billing Guidelines, which are p
ture and can be found on the Nevada Medicaid's fiscal agent website. Reimbursement rates and fee schedules are o
bsite
Scroll Down
Public Hearing Schedule
Nevada Medicaid's fiscal agent Billing Guidelines
Rates and Fee Schedules
MSM Chapters
Each MSM chapter contains a link to both the current and historical versions of the specific chapter. The chapters are organized by most current year, and most current date within year.
To do a keyword search on any .PDF document, click Cntrl F to generate the search box. Enter the desired search word and click Previous or Next.

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Step 2: Scroll down until you find the **MSM Chapter Links** list, and then click on: 400 Mental Health and Alcohol and Substance Abuse Services (commonly referred to as “Chapter 400”).

MSM Chapter Links

- Medicaid Services Manual - Complete
- 100 Medicaid Program
- 200 Hospital Services
- 300 Radiology Services
- 400 Mental Health and Alcohol and Substance Abuse Services
- 500 Nursing Facilities
- 600 Physician Services
- 700 Rates and Supplemental Reimbursement
- 800 Laboratory Services
- 900 Private Duty Nursing
- 1000 Dental
- 1100 Ocular Services
- 1200 Prescribed Drugs
- 1300 DME Disposable Supplies and Supplements
- 1400 Home Health Agency
- 1500 Healthy Kids Program
- 1600 Intermediate Care for Individuals with Intellectual Disabilities
- 1700 Therapy
- 1800 1915(i) - Home and Community Based State Plan Option Adult Day Health Care and Habilitation Service
- 1900 Transportation Services
- 2000 Audiology Services
- 2100 Home and Community Based Waiver for Individuals with Intellectual Disabilities
- mmunity Based Waiver for the Frail Elderly

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- Today’s current and most recent publication became effective September 28, 2022.

MSM Chapter 400 - Mental Health and Alcohol and Substance Abuse Services

MSM Home

2022

- Current - Effective Sep 28, 2022
- Mar 30, 2022
- Mar 21, 2022

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2021

- Jun 30, 2021
- Mar 31, 2021

MSM Chapter Links

- Medicaid Services Manual - Complete
- 100 Medicaid Program
- 200 Hospital Services
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Step 4: Download, save and review.

1

2

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 27, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES Casey Angres (Oct 27, 2022 11:45 PDT)
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Alcohol/Substance Abuse Services are being proposed to the Provider Qualifications for Individual Rehabilitative Mental Health (RMH) providers to clarify the qualifications, competencies, and training requirements for Nevada Medicaid enrollment. Additional clarifications were made to the Outpatient Service Delivery Models under which the Outpatient Mental Health (OMH) and RMH services are delivered as outlined in Chapter 400.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers

Nevada Medicaid Services Manual

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Step 5: For a quick search of something specific press and hold keyboard keys, **“Ctrl” and “F”**.

- A search box will appear up in the right top corner of the screen.
- Type the word, phrase, and/or number you are wanting to find.

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2

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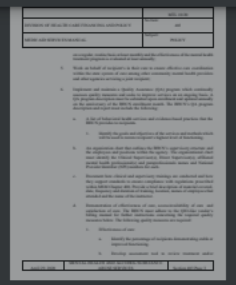

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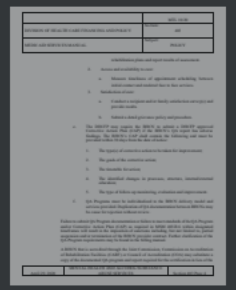

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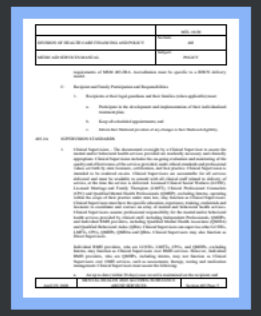

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b. Keep all scheduled appointments; and

Inform their Medicaid providers of any changes to their Medicaid eligibility.

403.2A SUPERVISION STANDARDS

1. Clinical Supervision – The documented oversight by a Clinical Supervisor to assure the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values set forth by state licensure, certification, and best practice. Clinical Supervision is intended to be rendered on-site. Clinical Supervisors are accountable for all services delivered and must be available to consult with all clinical staff related to delivery of service, at the time the service is delivered. Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Clinical Professional Counselors (CPC) and Qualified Mental Health Professionals (QMHP), excluding Interns, operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, including Independent Professionals, QMHPs, and Individual RMH providers, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors can supervise other LCSWs, LMFTs, CPCs, QMHPs, QMHAs and QBAs. Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are LCSWs, LMFTs, CPCs, and QMHPs, excluding Interns, may function as Clinical Supervisors over RMH services. However, Individual RMH providers, who are QMHPs, including interns, may not function as Clinical Supervisors over OMH services, such as assessments, therapy, testing and medication management. Clinical Supervisors must assure the following:

a. An up to date (within 30 days) case record is maintained on the recipient; and

*DMCT Criteria: Staffing Requirements

Mobile crisis teams have policies and clinical supervision procedures in place, including a ***staffing plan*** that identifies the supervisory structure and the employees and positions within the agency, and must ensure:

- Case records are kept updated
- Protocols on when/how to engage the on-call clinician are updated
- QMHAs discuss the case with their supervisor in person or via phone, and shall document the time and outcome of that supervisory discussion
- The supervisor reviews and co-signs the QMHAs' documented screening within 24 hours or next business day
- Documentation of supervisory contacts, including date of supervisor review, date of observation, log of indirect supervision contacts (e.g., paperwork reviewed), and date, agenda, and action plan for conferences with supervisee
- QMHAs have the necessary training, competencies, and skills to conduct mental health screens.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Provider Training

Mobile crisis providers have developed a staff training and competency plan to be reviewed annually. The training plan includes all required trainings and other core competencies defined by the state.

The training plan should indicate all of the following:

- That all team members must receive annual refresher trainings on required training topics,
- That all team members must pass post-tests on each topic to demonstrate competency in the topic.
- That each topic is covered in a separate training module dedicated to the specific topic.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Provider Training

All mobile crisis team members are trained in the following areas prior to participating in a mobile response:

- **Safety/Risk screening:**
  - Adapt to cultural and linguistic needs of individuals during the screening process
  - Select the appropriate screening tool
  - Engage with collaterals
  - Interpret screening tool results
- **Stabilization/Verbal de-escalation techniques**, including when and how to adjust, depending on the circumstances.
- **Harm reduction strategies** for individuals with SUD:
  - Use of naloxone in the field
  - How to educate individuals at risk (and their significant others) about naloxone use
  - How to educate individuals about harm reduction techniques and resources
- **Crisis/Safety planning**
- **Privacy and confidentiality** policies and procedures
- **Use of telehealth equipment**
- **Electronic Health Record** or other systems used in the provision, documentation, and/or reporting of mobile crisis services.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Provider Training

Additionally:

The training plan indicates that all team members will receive training on **trauma-informed care within 90 days of employment.**

The mobile crisis provider has established policies and procedures indicating how it will maintain documentation to demonstrate satisfactory and timely completion of all trainings.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Screening

Mobile crisis teams have policies and procedures in place to ensure consistent screening of all individuals and documentation of all screenings and screening findings

Mobile crisis teams must have policies and procedures in place indicating that only QMHPs and QMHAs, who have continuous access to a QMHP for consultation, may conduct screenings.

Mobile crisis teams have selected screening tools that include adopted tools for evaluation of risk, violence, and suicidality.

Screening tools include the State-required Columbia Suicide Screening Tool (Columbia) and other tools that meet State requirements.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Assessment

Mobile crisis teams have policies and procedures in place to ensure only licensed practitioners and QMHPs (as outlined in Staff section) complete behavioral health assessments and document the findings, when indicated.

Selected assessments tools include the State-required Collaborative Assessment & Management of Suicidality and other tools that meet State requirements.

Screening assessments support evaluations necessary for an involuntary hold, when a hold is initiated.

Mobile crisis teams have policies and procedures in place that ensure consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances.

Mobile crisis teams have policies and procedures in place that ensure documentation of assessment results.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Crisis & Safety Plans

Mobile crisis teams have developed individualized crisis and safety plans for every service recipient, and have policies and procedures in place to ensure crisis and safety plans are shared with the recipient and documented in their clinical record.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Psychiatric Advance Directives

Mobile crisis teams have policies in place regarding when to consider and assist with the completion of a PAD, in accordance with Nevada laws and regulations.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Harm Reduction

Mobile crisis teams have policies in place regarding when to educate individuals on harm reduction practices.

Mobile crisis teams carry harm reduction supplies, including fentanyl test strips.

Mobile crisis teams carry naloxone.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Coordination of Care

Mobile crisis teams have policies and procedures in place that require follow up with an individual by phone or in person within 72 hours of engagement with the mobile crisis team. The policy states that follow-up is exempt for individuals admitted to a crisis stabilization center (CSC), inpatient hospital, or residential setting.

Mobile crisis teams have policies and procedures in place to coordinate timely follow-up services and/or referrals with providers, social supports, and other services, as needed, including but not limited to:

- Assigned case managers
- Managed care organizations (MCOs)
- Primary care providers
- Current (or referred) behavioral health providers/care teams, including mental health and SUD providers
- Recovery and peer-led organizations for mental health and SUD support, where available
- Harm reduction resources, where available.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Coordination of Care

Mobile crisis teams have policies and procedures in place for follow up due to suicidality, indicating that a member of a mobile crisis team must make at least three attempts to contact the individual to assess continued stabilization.

Mobile crisis teams have policies and procedures in place indicating that this follow-up must be documented in the individual's clinical record.

Mobile teams have policies and procedures in place requiring documentation of an individual's discharge from the crisis episode when the following criteria are met:

- Acute presentation of the crisis is resolved
- Appropriate referral(s) and service engagement to stabilize the crisis are completed, including transfers to a CSC or other level of care
- Recommendations for ongoing services, supports, or linkages have been documented

Post-crisis follow-up has been completed within 72 hours of the crisis contact**.**

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Coordination of Care

Mobile crisis teams have policies and procedures in place regarding the provision of bridge services and supports to individuals for up to 45 days to support continued stabilization until the first appointment with the receiving provider. The policies and procedures outline when this is necessary and clinically appropriate.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Privacy & Confidentiality

Mobile crisis teams have privacy and confidentiality policies and procedures to protect beneficiary information in accordance with federal and State requirements, addressing what can and cannot be shared, especially in emergency situations.

Mobile crisis teams have formal, written, collaborative protocols, memorandums of understanding (MOUs) and other agreements with the following partners:

- Local law enforcement agencies
- Local emergency medical service providers
- 988 call centers/dispatch centers and other crisis providers

Medicaid MCOs, as applicable in their catchment area

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Privacy & Confidentiality

Mobile crisis teams have protocols in place that allow family members or other collateral contacts to represent an individual in crisis.

Mobile crisis teams have established data-sharing agreements with the partners listed above.

Mobile crisis providers have policies and procedures in place to ensure these partners are securing any data covered by federal or State privacy regulations.

Mobile crisis teams have established data-sharing protocols and member information release authorization with other behavioral health and medical providers, allowing access to and review of screenings, assessments, crisis plans, and/or PADs and other medical records/treatment information that will support crisis intervention activities.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place indicating that mobile crisis services are available 24/7/365 and ensure 24/7 on-call coverage and back-up availability.

Mobile crisis teams have policies and procedures in place, indicating that mobile crisis services shall not be restricted to certain locations or days/times within the covered area.

Mobile crisis teams have policies and procedures in place, indicating that mobile crisis services are provided to all Nevadans in the provider's catchment area, including specialty populations. The individual served does not have to be a current or previously established client to receive mobile crisis services.

Mobile crisis teams have continuity of operations/disaster plans developed, regularly updated, and submitted annually, or as requested by the state.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place outlining response requirements:

- Teams respond to wherever the recipient is in the community, including private homes, schools, group homes, social service settings, etc.
- Individuals in crisis are never required to come to the crisis team
- Teams respond to the preferred location based on client and/or caregiver preference
- Teams respond with the least restrictive means possible, only involving public safety personnel when necessary

Teams prioritize community-based response; however, may respond to facilities

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis service providers have policies and procedures to ensure services are delivered in a manner that is culturally and linguistically appropriate.

Mobile crisis teams have policies and procedures in place to ensure individuals with limited English proficiency or language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and Americans with Disabilities Act-compliant services (e.g., sign language interpreters, TTY lines).

Mobile crisis teams have policies and procedures in place to ensure that all written materials meet cultural and linguistic appropriateness standards.

Mobile crisis teams have policies and procedures in place to ensure that services provided to children and youth up to 18 years old must adhere to the Department of Health and Human Services, Division of Child and Family Services system of care core values and guiding principles.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis services are provided timely to individuals in a behavioral health crisis, as defined by State policy, regulations, and/or guidance.

Mobile crisis teams have policies and procedures in place indicating that designated mobile crisis teams (DMCTs) will be dispatched through designated call center(s).

Mobile crisis teams have GPS devices linked to the designated call center(s) and a means of direct communication, such as a cellular phone or radio for dispatch, available at all times.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place, indicating that teams may not refuse a request for dispatch unless safety considerations warrant involvement of public safety:

- When public safety is involved, the policies and procedures include standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, and medical emergency, imminent risk of harm)
- Policies appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history)
- Ensure all interventions are offered in a clinically appropriate manner that respects the preferences of the individual in crisis while recognizing the need to maintain safety

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place, indicating how they will use available technology to support care coordination activities and to determine access to available post-crisis care options (e.g., access to health information technology, prior treatment information, including crisis and safety plans, hospital/provider bed availability, appointment availability/scheduling)

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Payment Operations

Mobile crisis service providers submit claims/encounters to MCOs (as applicable) and the State (for fee for service claims) in accordance with MCO requirements (as applicable), State-defined policy, regulations, and/or guidance.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Reporting Requirements

Mobile crisis service providers have policies and procedures to collect and report cost, utilization, and grievance data for mobile crisis services.

Mobile crisis service providers report cost, utilization, and grievance data for mobile crisis services to MCOs (as applicable) and the State, in accordance with prescribed timelines, MCO requirements (as applicable), State-defined policy, regulations, and/or guidance.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

Continuous Quality Improvement

- Framework for Developing Performance Measures: pg. 56
  - Timely
  - Safe
  - Accessible
  - Least Restrictive
  - Effective
  - Consumer and Family Centered
  - Partnership

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PATHWAYS IN CRISIS SERVICES PROJECT

Continuous Quality Improvement Continued

- Model for CQI Plan
  - Policy
  - Training
  - Monitoring
  - Follow up TA and Training
  - Continuous

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The End, Thank You!

Questions & Answers

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