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CCBHC-E National Training and Technical Assistance Center

CCBHC Crisis Services Learning Community

Session 2: CCBHC Crisis Services 101 - Parts III & IV

February 22, 2024

CCBHC-E National Training and Technical Assistance Center

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  - Kat Catamura, National Council
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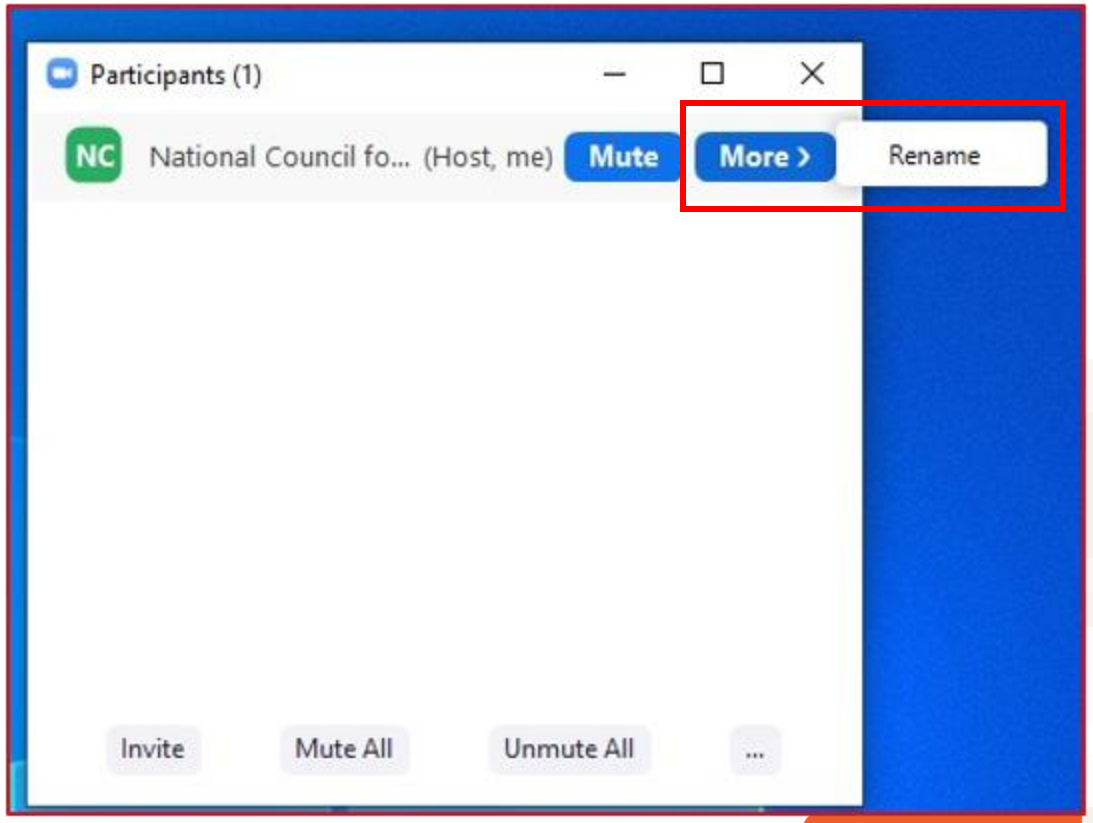

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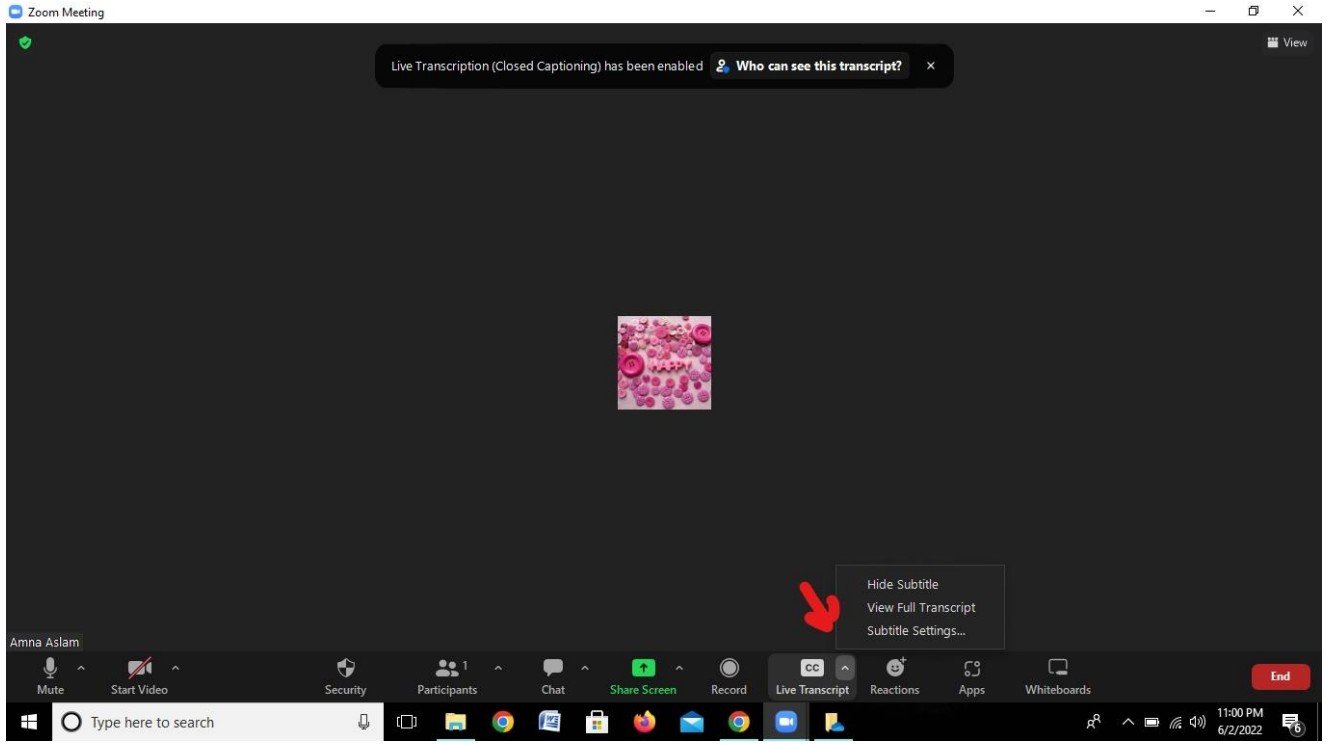

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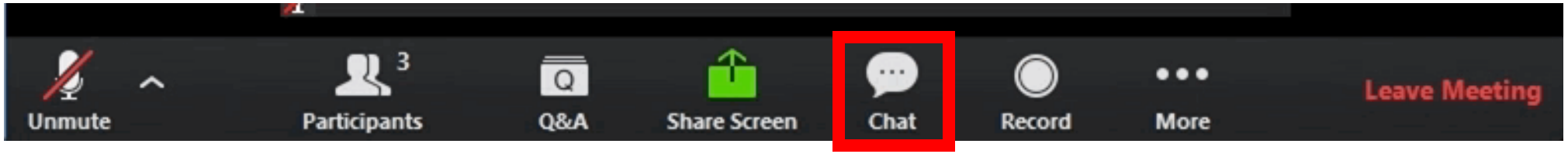
How to Ask a Question



Please share questions throughout today's session using the **Chat Feature** on your Zoom toolbar.
We'll answer as many questions as we can throughout today's session.

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Your Learning Community NTTAC Team

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Today's Presenter

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Dr. Minkoff is a community psychiatrist and addiction psychiatrist who is recognized as a national expert on recovery oriented integrated systems, including crisis systems. He is one of the lead authors of the NCMW published report: Roadmap to the Ideal Crisis System: Essential Elements, Measurable Indicators, and Best Practices (2021), and a consultant to the CCBHC-E NTTA Center.

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Today's Agenda

1. CCBHC Crisis System
2. Someone to Respond: Criteria for Establishing Effective Mobile Crisis Teams
3. A Safe Place to Be: Criteria for Urgent Care and Crisis Stabilization Services

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Poll

1. Is your CCBHC planning to deliver mobile crisis directly, or through a collaboration (DCO)?
    a. Directly
    b. Collaboration (DCO)
    c. A combination
2. How do your mobile crisis team services serve children and youth?
    a.Separate adult and child teams
    b.Combined team serving adults and children
    c.We don't serve children at present
3. What hours do you provide walk-in urgent care for your community?
    a.Mon-Fri business hours only
    b.Mon-Fri days/evenings (till 8 PM) only
    c.Mon-Fri days/evenings (till 8 PM) and weekends
    d.7 days week, 16-24 hours per day.

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CCBHC Vision of Crisis Services

- The purpose of CCBHC is to transform community behavioral health systems to provide timely, high-quality comprehensive, coordinated behavioral healthcare.
- CCBHC grantees use grant funds to transform their organizations in accordance with the CCBHC criteria.
- •This includes engaging with community partners in the development of a high-quality behavioral health services and system, **including a crisis system,** to serve the community.
- **•Mobile crisis services, urgent care, and crisis stabilization services should be designed to support this vision**

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What is the Crisis System Vision?

Crisis System Vision: An excellent Behavioral Health Crisis System is an essential community service, just like police, fire, emergency medical services (EMS).

Every individual/family in every community in the U.S. will have access to a continuum of best practice BH crisis services that are welcoming, person-centered, recovery-oriented, and continuous.

A crisis system is more than just a list of services. A crisis system is an interconnected network of services that are coordinated to provide the most effective responses, including pre-crisis and post-crisis intervention, to the whole community.

Essential Reading

- SAMHSA (2020): National Guidelines for Behavioral Health Crisis Care
- National Council for Mental Wellbeing (2021): Roadmap to the Ideal Crisis System
- CMS (2021): Medicaid Guidance on Scope of and Payments For Qualifying Community-Based Mobile Crisis Intervention Services

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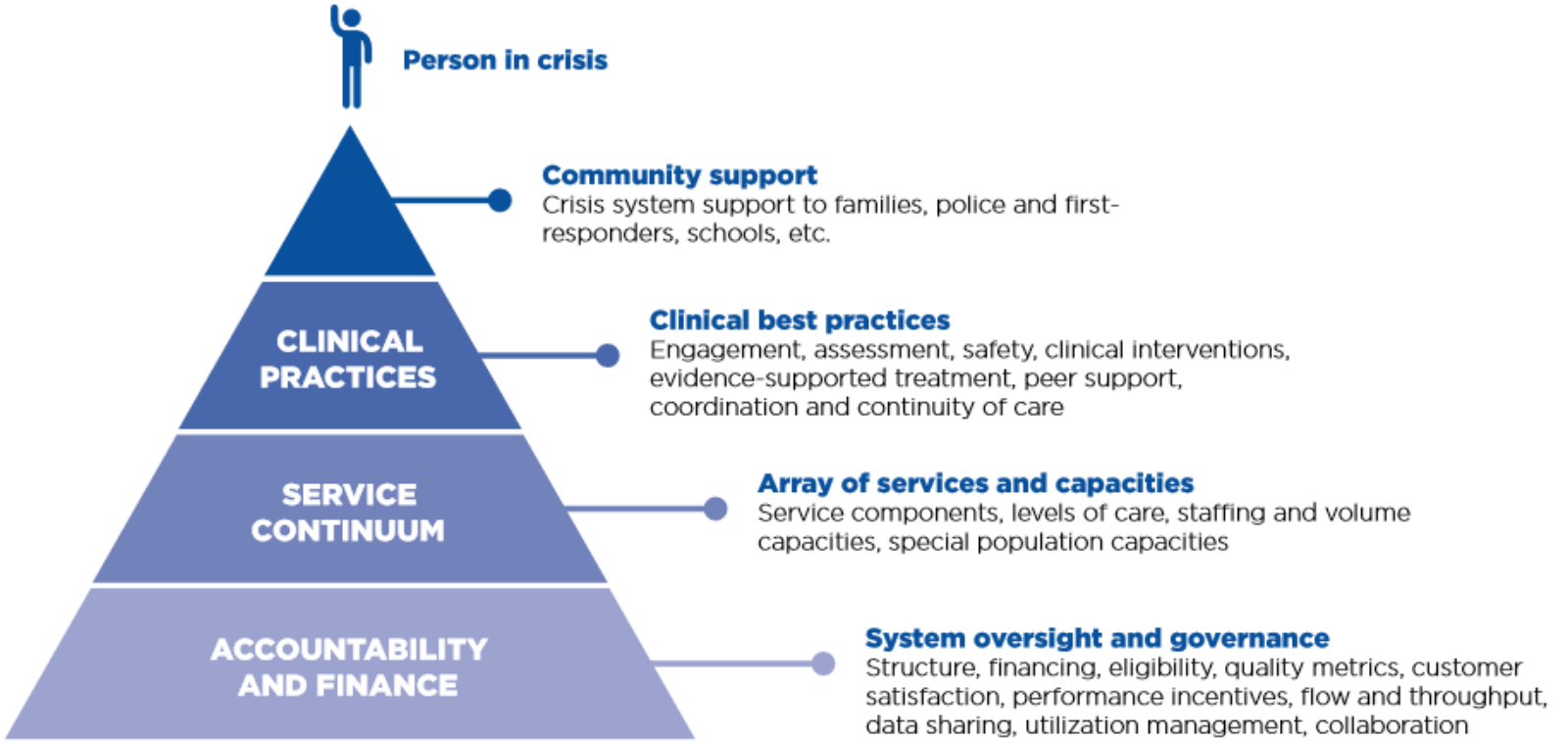
Roadmap to the Ideal Crisis System



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CCBHC Crisis Requirements: Six Essential Elements with Today's Areas of Focus in Bold

- Crisis System Needs Assessment
- Crisis System Collaboration and Partnership Development
- Crisis Services Implementation –
  - Someone to Call: Emergency Crisis Intervention: Call Centers, Triage, Care Traffic Control, and Quality Coordination
  - **Someone to Respond (Mobile Crisis)**
  - **Safe Place to Be (Walk-in Urgent Care and Crisis Stabilization)**
- Crisis Services Best Practice Implementation

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CCBHC Grantee Crisis System Needs Assessment

Defining Your Role

- All **required** services are delivered by the CCBHC or a Designated Collaborating Organization
- When considering what you provide directly vs. where you partner, ask:
  - Which services are already in place? How do we partner with and support those services?
  - Which services are missing or need expansion? What is the best role for our agency in filling those gaps?
  - What is our best contribution as a CCBHC to creating a full continuum for our community?
  - How do we share data, support "Care Traffic Control", and manage quality?
- MOTTO: **COLLABORATION NOT COMPETITION**

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CCBHC Grantee Crisis System Collaborations

- Crisis system collaborations are **required** as part of both client-specific and systemwide care coordination

Priority crisis-related collaborations: 988 and other call centers; 911 PSAPs, law enforcement and first responders, EMS, emergency departments, hospitals, and other crisis providers for adults/children, MH/SUD/IDD.

Other recommended crisis-related collaborations: schools, child and adult protective services, juvenile and adult probation, homeless services, supported housing providers, domestic violence providers.

CCBHC Mobile Crisis Teams

CCBHC Required Services (Directly and/or via DCO) Someone to Respond

24-hour Mobile Crisis Teams (CCBHC 2023 Criteria, page 27)

- CCBHC provides 24/7 mobile crisis intervention (MCI) teams for all ages, for MH/SUD, anywhere in the service area, including home, work, or "anywhere else".
- Can DCO with state-sanctioned systems/services and obtain a waiver if those systems have lower standards.
- Arrival in-person within one hour (2 hours in rural/frontier); never more than 3 hrs.
- Telehealth may be used to connect to "qualified" providers during travel time. Also, for very remote distances, but in-person must be available if needed for safety.
- Recommended to align with "*CMS Guidance on….Qualifying MCI Services" (2021)*
- *More detail on each element of this requirement in the following slides*

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CCBHC Mobile Crisis Requirements: *Staffing*

- **The CCBHC Criteria (2023) do not prescribe specific staffing models**. Require adhering to any state standards and recommend following ***CMS Guidance*** "if… in a state that includes this option in their Medicaid state plan." If billing Medicaid under that option, then CMS requirements must be met.
- ***CMS Medicaid Guidance on Scope of and Payments For Qualifying Community-Based MCI Services (p. 7)***: "*The team **MUST** include at least one BH professional who is qualified to provide an assessment within their authorized practice under state law*" and "***SHOULD** also include other professionals or paraprofessionals*" with crisis expertise.
  - May include nurses, social workers, peers, and others (case managers, family support workers) "as identified by the state in its state plan."
  - **States have flexibility.** Adult and Child/family teams may be staffed separately or operate together.
- **Including crisis-trained peers, with adequate supervision and support, is always recommended**.
- ***CMS Guidance (pp. 2-3)*** includes flexible language: "*Most programs utilize teams that include both professional and paraprofessional staff. For example, a master's or bachelor's level clinician may be paired with a trained peer (MH and/or SUD) and the back-up of psychiatrists, psychologists, or other Master's level clinicians on-call (or via telehealth) as needed*." "*When not on scene, licensed clinicians should be available on call (or via telehealth) to provide consultation and higher-level interventions*." Note that although 2-person teams on site are common, and sometimes needed for safety, it is not required that all interventions involve 2 person teams on site.

CCBHC Mobile Crisis Requirements: *Access*

- **Access:** Available to all. Anywhere in the service area. Any fees must be able to be reduced or waived (CCBHC Criteria, 2023)
- **Access:** No restrictions on location (as: "only in the ED"). Mobile teams can provide services in EDs and jails but should go anywhere. For youth, services in homes, schools, juvenile justice settings are important.
- **Access:** GPS enabled dispatch from call centers is recommended. Investing in technology is supported, including mobile platforms for mobile crisis workers and first responders.
- **Access:** Provision for limited English-proficiency and ASL is recommended (CMS p. 7)
- **Access:** Telehealth may be used "at the outset" as part of screening/assessment, or in "near-term follow up" regarding care coordination and continuity. (CMS, p. 7).
- **Access:** Mobile crisis should NOT require law enforcement presence, but rather there should be collaborative protocols determining when law enforcement is needed (alone or with MCT) for potential safety risk (CCBHC p. 28), and when EMS is needed for medical risk. Co-responder models can add value but aren't the standard of care for MCI.

CCBHC Mobile Crisis Requirements: *Services*

- **Services:** Trauma-informed, developmentally appropriate, sensitive de-escalation supports (CCBHC Criteria, 2023, p. 28)
- **Services:** Suicide risk assessment, prevention, and intervention (p. 28)
- **Services:** Both MH and SUD crises, including risk of opioid and alcohol overdose, and support following non-fatal overdose. Must include ensuring access to naloxone for individuals at risk and their supports(p. 28). May also include carrying fentanyl test strips.
- **Services:** Consider access to clinical or psych prescriber consultation and supervision
- **Services:** Goal is for crisis to be resolved in the field wherever possible but must be able to provide transportation to crisis centers and EDs, avoiding unnecessary ED visits or hospitalizations. Medicaid can be used to fund medically needed transport, in state plan.
- **Services:** Follow-up services to ensure continuity is required, and assigning staff to proactively provide follow-up contacts and visits is recommended.
- **Services:** Best practice approaches to mobile crisis for children/youth/families such as MRSS (Mobile Response and Stabilization Services) are recommended. See ***National Guidelines for Child and Youth BH Crisis Care (samhsa.gov).***

CCBHC Mobile Team: Care Coordination and Collaboration

- Must connect to any “care traffic control” system and have a relationship with 988 or other call center that connect for dispatch.
- Required to have formal collaborations with law enforcement, EMS, and other first responders
- Required to have relationships with agency sites that may be important service users such as schools, MH and SUD service providers, homeless shelters.
- Required to develop highly effective collaborations with other partners in the crisis continuum, such as urgent care, EDs, crisis stabilization programs, intensive community- based crisis intervention follow up providers and so on.
- Participates in care coordination to ensure that individuals do not get lost to care. Some programs provide proactive outreach post discharge from hospital or crisis center.
- Participates with other partners in quality improvement collaborations to determine effectiveness based on quality metrics like avoidance of harmful events, avoidance of unnecessary arrest or ED visit, successful transition to continuing community care, etc.

CCBHC Crisis Urgent Care & Stabilization Services

CCBHC Required Services (directly and/or via DCO) *Safe Place to Be*

"Crisis Receiving/Stabilization" (CCBHC 2023 Criteria, page 28)

Walk-in urgent care plus access to 24/7 "crisis stabilization" services.

- **Minimum requirement: Urgent care after hours walk in** for voluntary individuals with MH and/or SU crises.
- The CCBHC **need not manage the highest acuity** individuals in this ambulatory setting.
- "Crisis stabilization" services **ideally SHOULD be available 24/7** for any type of presentation. This can be provided through DCO(s).
- "Encouraged" to provide "crisis receiving/stabilization" in accordance with ***SAMHSA National Guidelines for BH Crisis Care (2020) pp. 22-24.*** and (for youth) ***A Safe Place to Be: Crisis Stabilization Services for Children and Youth (samhsa.gov).***
- ***Note: Residential services longer than 23-hour observation cannot be paid for with CCBHC funds.***
- ***More detail on each element of this requirement in the following slides***

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CCBHC Walk-in Urgent Care Requirements

- **The CCBHC Criteria (2023) do not prescribe specific staffing models**. It is recommended to include access to a multidisciplinary team, including trained peers, and to include on site or virtual access to prescribers who can provide immediate medications as well as bridge prescriptions.
- **Including crisis-trained peers, with adequate supervision and support, is always recommended**.
- **Hours:** Walk-in hours are informed by community needs assessment and include publicly posted evening hours. The CCBHC should have the goal of expanding these hours (including for weekends) as much as possible, to minimize unnecessary use of emergency departments.
- **Medical clearance:** Routine medical clearance should not be required. There should be capacity for medical triage, and referral to EDs only when medically necessary. On site intervention or support for minor medical issues, if needed in the moment, possibly with telehealth consultation from a medical urgent care provider, is recommended.
- **Access:** These services are designed for **voluntary** presentations. Individuals may present on their own, or be accompanied by family members, professionals, first responders, or natural supports.
- **Follow-up:** Provision for follow-up continuity of crisis intervention, including next day access to CCBHC services, is a requirement, as well as organized protocols for individuals who need immediate access to a higher level of care.

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CCBHC "Crisis Receiving/Stabilization" Requirements

- Crisis "Receiving/Stabilization" includes a range of service categories that provide 24/7 services, and the CCBHC requirements do not clearly delineate a precise model.
- One service category includes crisis centers that may have up to 23-hour observation capabilities and may include capacity for both voluntary and involuntary clients. **These types of services most closely approximate what is in the SAMHSA Guidelines.**
- Another service category includes residential crisis services that allow for longer stays (usually no longer than 14 days). In some states, there are regulations that define service models that can have extended involuntary stays (3-5 day holds), and in other states these services are exclusively voluntary. If the settings allow for 24/7 access, they can arguably meet the criteria for "receiving/stabilization". **However, residential services beyond 23-hr observation cannot be paid for with CCBHC funds.**
- Some settings have both 23-hour observation programs and extended residential programs in separate spaces in the same facility.
- Can (in addition) offer directly or coordinate with peer-operated crisis respite programs.
- Children (18 and younger) and adults must be in separate spaces, though can have shared staff.

SAMHSA "Crisis Receiving/Stabilization" Guidelines

- Function as a 24-hour "receiving/stabilization" facility. 23-hour observation is ideal, but any extended observation capacity is valuable. Some facilities may not be able to accept admissions 24/7.
- Accept all referrals without requiring medical clearance prior to admission. May divert obvious medical emergencies (overdose, delirium) but should address minor physical health challenges on site.
- Address MH and/or SU crises (See next slide for services.)
- Offer walk-in and first responder drop-off options, with a dedicated first responder drop off area. No rejection for first responders. 90% of referrals accepted from others.
- Multi-disciplinary team at all times with prescribers, nurses, licensed/credentialed clinicians, peers. Telehealth may be used.
- Access to residential crisis beds for individuals who need longer support to maintain flow at the "front door", and connection to existing "care traffic control" and/or "bed registry" systems to promote access to needed care.

CCBHC Crisis Stabilization Requirements: *Services*

- **Services:** Trauma-informed, culturally/linguistically accessible and fluent, developmentally appropriate, sensitive de-escalation supports (CCBHC Criteria, p. 28).
- **Services:** Suicide/violence risk assessment, prevention, and intervention (p. 28)
- **Services:** Both MH and SUD crises, including risk of opioid and alcohol overdose, and support following non-fatal overdose. Must include ensuring access to naloxone for individuals at risk and their supports(p. 28). Immediate access to MOUD is ideal.
- **Services:** Access to clinical or psych prescriber consultation and provision of medication when needed.
- **Services:** Goal is for crisis to be resolved in the setting whenever possible but must have provision for access to higher levels of care or longer crisis residential services when needed.
- **Services:** Follow-up services to ensure continuity is required, and assigning staff to proactively provide follow-up contacts is recommended.
- **Services:** Best practice approaches to crisis stabilization for children/youth/families are recommended. See ***National Guidelines for Child and Youth BH Crisis Care (samhsa.gov).***

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CCBHC Crisis Center: Care Coordination and Collaboration

- Must connect to any “care traffic control” system
- Required to have formal collaborations with law enforcement, EMS, and other first responders, as well as with referring human service providers.
- Required to develop highly effective collaborations with other partners in the crisis continuum, such as urgent care, EDs, mobile crisis programs, inpatient units, residential crisis services, intensive community- based crisis intervention follow up providers and so on.
- Participates in care coordination to ensure that individuals do not get lost to care. Some programs provide proactive telehealth outreach post discharge from crisis center.
- Participates with other partners in quality improvement collaborations to determine effectiveness based on quality metrics like avoidance of harmful events, avoidance of unnecessary arrest or ED visit, successful transition to continuing community care, etc.

Closing: Sharing and Preparing

- Brave Volunteers: We need 2-3 volunteers to lead off the discussion next time
- Next Session: March 28, 2024: 3pm ET
- Topic: **CCBHCs as Crisis System Partners and Leaders in Their Communities**
  - Prep work:
    - 1. Identify and be prepared to describe the way in which you and your community partners come together to collaborate and plan for your community's crisis system. If this is not happening, be prepared to describe what you would want.
    - 2. What is (or would be) your CCBHC's role in that partnership group? Leader/convener; participant; other? Who else is expected to participate?
    - 3. How do you work with your state BH authority and other state entities to define and develop your community's crisis system? Do you know your state's "BH crisis lead"? Does the state attend local meetings? Do you know the state's requirements for community planning? What crisis services are paid for by state and/or Medicaid?
  - All slides and recordings will be posted to our learning community website within 48 hours

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We offer CCBHC grantees…

Virtual Learning Communities, Webinars and Office Hours

Regular monthly offerings that are determined based on grantees expressed needs.

Opportunities for Collaboration with Other Grantees

Monthly Peer Cohort Calls for CCBHC Program Directors, Executives, Evaluators and Medical Directors.

Direct Consultation

Request individual support through our website requesting system and receive 1:1 consultation.

On-demand Resource Library

Includes toolkits, guidance documents, and on-demand learning modules.

Access our website to register for upcoming events, submit a consultation request or scan our on-demand resource library:
https://www.thenationalcouncil.org/program/ccbhc-e-national-training-and-technical-assistance-center/

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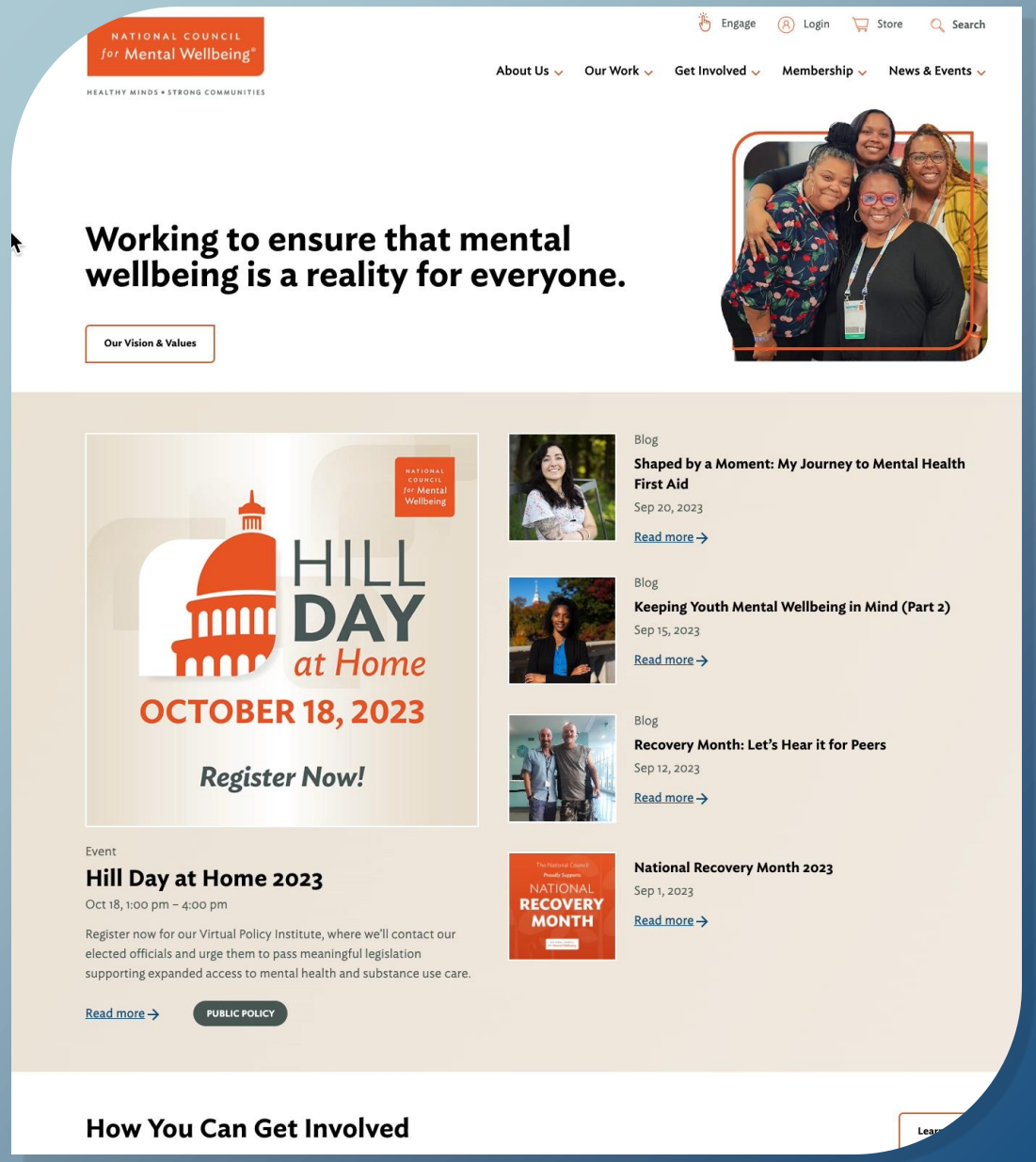

Questions or Looking for Support?

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