Hudson Valley DSRIP Cross PPS
Behavioral Health Crisis Stabilization Report

January 2017

Introduction: The DSRIP Performing Provider Systems (PPS) in the Hudson Valley include--Montefiore Hudson Valley Collaborative (MHVC), Refuah Community Health Collaborative (Refuah) and WMCHealth PPS (WMC). The three PPSs serve all or several of seven counties in the Hudson Valley—Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester. The results of cross-PPS needs assessment in 2014 led to the three PPSs selecting Project 3.a.ii Behavioral Health (BH) Crisis Stabilization, that supports planning and implementation, in conjunction with Local Governmental Units, providers and consumers, to develop comprehensive crisis services throughout the Lower Hudson Valley region. This project is critical to the overarching DSRIP Project objective to reduce avoidable emergency room visits and inpatient admissions by building comprehensive community crisis systems that offer alternatives to hospital care. In 2015, the PPSs agreed to work together to plan and implement the Project in partnership with county governments, community providers, hospitals and residents. This work has resulted in broad-based planning activities and consensus on:

- Documentation of system gaps in various communities;
- Identification of relevant local and national best practices;
- Clarification of roles and responsibilities of key community services necessary for an effective community BH crisis system;
- Documentation of the impact that community culture regarding risk, safety and accountability play in an effective community BH crisis system; and
- Development of treatment protocols and care pathways designed to improve the service user’s access to and quality of crisis care, while also reducing avoidable emergency and inpatient service use.

Background: The three PPS initiated broad-based planning activities that involved a wide spectrum of community providers and county government representatives. Participants in the planning activities concurred that people experiencing a BH crisis had contact with a broad range of community gate-keepers—schools, libraries, police, families. Without other alternatives, often the only reasonable response is to call 911 or drive the individual in crisis to a hospital emergency room. The attached work reflects a belief that many types of providers and community organizations have a role to play in progress towards achieving the Triple Aim-- improving the consumer experience of care, improving population health and reducing the per capita cost of health care. Initial work focused on:

- Understanding the many ways in which people access crisis care and the complexity of their needs;
- Collecting key-informant ideas for how community BH crisis care functions today and promising ideas for community-focused improvements;
- Informing our work by studying the literature to learn about practices and protocols that have been shown to be effective based on peer-reviewed research studies and/or sound data collection; and
• Looking at county innovations and best practices, as well as strengths and system gaps in communities throughout the seven counties.

The three PPSs found that across the region there are a wide-range of crisis service options and capacity, much of it targeted to distinct subpopulations and geographic areas. Counties had been focused on improving their local BH crisis system for years pre-DSRIP and were interested and willing to take significant additional steps to strengthen their local systems. NYS Medicaid Redesign generally and DSRIP have brought a new level of attention and a collective hope that progress can be made to address persistent challenges in BH crisis services, including insufficient funding, disparate regulation and a lack of support for scaling up successful innovation pilots. Below is a summary of the planning work accomplished to date.

Collaboration with County BH Systems: The three PPSs have supported county “mapping” of its BH crisis system to better understand the strengths, gaps and differences among the seven-county region. These sessions are hands-on opportunities for individual County Government and the three PPSs to collaborate in Project work to date and to further apply the work to create action. In the summer of 2016, the three PPSs started with Orange County. Over 50 participants from 20 stakeholder agencies took part in an all-day planning session. The output of this session gave us keen insight into the important roles that provider tolerance for risk and safety, limited service capacity and siloed funding play in community-based crisis systems. These sessions will continue, based on interest from our partners in county government. In February 2017, the PPSs will support sessions in Westchester County for adults and children. These sessions will build from significant crisis service mapping completed by Westchester County and incorporate the work contained in this document to advance consensus and action on community strengths and gaps in crisis capacity.

Understanding Key Service Components of an Effective Crisis Stabilization System: Planning participants quickly highlighted the need for a BH crisis system to address the myriad of clinical and other circumstances that contributes to a person presenting to the Emergency Room (ER), such as lack of insurance coverage or by a waiting list for a needed BH service or a “community gate-keeper” (bus driver, librarian or teacher, etc.) calling 911 instead of having community resource options. Providers on the front lines, including peer organizations, emphasized that individuals experiencing a BH crisis can benefit from a multiplicity of interventions and supports, including

• Engagement in care management, treatment and/or peer and family supports;
• Improvement in the quality and availability of BH crisis services; and
• Education and training of BH professionals and community front-line sectors (e.g. police, teachers, social workers) to recognize symptoms of mental illness and help connect residents to essential services in the community.

Workgroups: The three PPSs decided to create work groups to explore five key components of an effective BH Crisis Stabilization System in more depth. The five components—Triage, Mobile Crisis, Respite, Intensive Services and Follow-up Services—were identified through review of evidence-based studies, local experience, DSRIP Project 3.a.ii requirements and the Orange County mapping session. Each workgroup looked at the following six issues: Service Area Description, Workflow, Quality Standards, Outcomes, Opportunities for Collaboration and Sustainability. The workgroups were facilitated by Refuah, MHVC and WMCH Health PPS staff or consultants. Workgroups met by phone and in person 3 to 4 times over November-December 2016.
Overview of Workgroup Reports:

- **Preventable ER visits and hospital admissions** across the region are undoubtedly linked to significant local gaps in Intensive Crisis and Follow-Up Services.

- **The service menu and capacity** of behavioral health (BH) crisis services varies across the 7-county region.

- Crisis services work optimally when the community culture and norms provide sufficient clarity on roles and responsibilities, promoting measurable accountability.

- **Local health systems need** both an intentional design (ability to determine and implement a “right” mix, location and capacity of Intensive Crisis and Follow-Up Services) and the resources and/or reimbursement pathway to support it.

- **Mobile and respite services** in NYS are regulated and funded by different state and county agencies for a variety of sub-populations. They have not had stable, cost-based reimbursement since their inception. It is therefore not surprising that we currently have a patchwork mobile/respite system with widely differing operating standards, narrow admission criteria (i.e. clinic client, county resident, waiver enrollee) and insufficient scale. Funding streams (ex. HCBS for respite) are inadequate to support operations, and capital funding to create the facilities are almost non-existent.

- **Intensive Crisis and Follow-Up Services** are a broad area encompassing natural supports and services that
  
  o Prevent crises from escalating,
  o Proactively identify and address signs of an emerging crisis, and/or
  o Offer an intensive crisis intervention and support.

  Communication, workflows and a single plan of care contribute to success given the fact that most consumers choose and may need more than one community service or support. These services can be residential or not, and are characterized by engagement that may span weeks or months, multi-disciplinary service teams, and evidence-informed program design tailored to address a variety of specific needs and issues.

- **Lack of interoperability in IT systems and continued challenges with HIPAA and 42 CFR (confidentiality)** have created chasms for providers trying to send and receive real-time information, share care plans and maintain bi-directional alerts and action flags.

- **Siloed regulations have been a deterrent to the implementation of uniform quality standards, alignment of incentives and sustainability** for providers to promote the Triple Aim.

**Development of Protocols and Care Pathways:** Starting in 2015, the 3 PPSs discussed the joint development of protocols and pathways. Each of the PPSs held BH crisis meetings with the provider partners. Committees were established to identify gaps in services and supports, and to research and review relevant national and local best practices and protocols to guide work on crisis protocols and pathways. This work was pursued and completed with extensive collaboration from counties, partners and community representatives. Throughout the planning period, counties and PPS partners have asked for collaborative processes and protocols in respect to BH crisis work. We hold a collective belief that the greatest and most efficient impact can occur if we advance a unified set of crisis protocols across the Hudson Valley. Thus, two clinical protocols and pathways developed by the WMCHealth PPS Committee were adopted by MHVC and Refuah.
(1) Care transitions from BH inpatient to community care to improve community stability and reduce readmissions, and

(2) Community-based BH crisis and urgent care for people experiencing BH crises as an alternative to hospital emergency services.

In brief, the protocols and care pathways call for implementation of several quality standards in delivering BH care transition and crisis/urgent care that the participants recommended to improve quality and outcomes, while reducing preventable emergency service presentations, as well as admissions and readmissions.

1. All individuals discharged from BH inpatient care should have comprehensive “transition plans”, not discharge plans, that address a range of factors that may contribute to a successful transition and involve all community providers identified as key to their success especially the individual and their family.

2. Every person discharged from a BH inpatient setting should receive post-discharge coordination of services recommended in their transition plan. Depending on system resources and the individual’s identified needs, everyone should receive either a call or visit or both within 48 hours of BH inpatient discharge. (Health Homes will be the preferred provider if feasible)

3. Community-based provider(s) should be identified in the transition plan as responsible for providing 30-day post discharge services to specific individuals, with care intensity and auspice varying depending on individual needs.

4. In every community, BH crisis and urgent care should be available based on self-referral and referral from a variety of community providers and organizations.

5. Many BH community providers (e.g. supportive housing, clubhouses, peer organizations, children’s family support) can be trained and supported to serve as points of access to crisis and urgent care, arranging for and coordinating care they do not offer, while providing key supports and services in the moment to de-escalate crises.

6. A key service with potential to provide an alternative to hospital-based emergency services is BH clinical urgent care that is simply not available widely in the region today.

To implement the protocols, regulatory and reimbursement modifications are needed to support provider activities and interventions that traditionally have not been reimbursed by Medicaid, or may be reimbursed at levels that will not support additional provider responsibilities for BH care transitions and community crisis/urgent care services. Moreover, effective use of redesigned and more accessible community-based BH care transition, crisis & urgent care services, instead of ERs, will depend on extensive training of all stakeholders.

**Conclusion:** Through activities completed to date, the following best practices and key priorities should guide our coordinated implementation of a BH Crisis Stabilization services in the 7-county region.

- **Having impact at scale** in the seven counties necessitates the three PPSs, in collaboration with their county, hospital and community partners, synthesize their planning work products into “an intelligent design” for a BH crisis service system that can be adapted based on local needs, conditions and preferences to offer both early identification of BH urgent needs and timely effective interventions to reduce avoidable use of ER and BH inpatient services.

- **Building a strong community culture and capacity for crisis intervention** is an essential and intentional component of an effective BH crisis system. Given limited resources, the most practical and timely to implement approach is to develop crisis intervention skills in
likely “community gatekeepers” (e.g. first responders, community providers, teachers, etc.) using evidence-based training such as Mental Health First Aid and CIT. This approach is rooted in the reality that, without the presence of a strong culture and capacity, it is very difficult to “predetermine” where, or how a person experiencing a BH crisis will seek help. A diverse and inclusive array of community members play a role in helping to triage people experiencing a crisis due to substance use and/or mental health challenges. These health-system “extenders” can be of significant value if they have professional support, coupled with training on how to identify BH issues, and where to reliably access help.

- **Individuals experiencing a BH crisis benefit from myriad access points to care** that enable them to receive the right services at the right time in the right amounts.

**Action Plan:** The story does not stop at the challenges. Everyone involved with the PPS planning initiative seeks to contribute to and see progress in our BH crisis system. Specifically, the three PPSs expect to take the following actions in 2017:

1. Offer training and implementation support on the Protocols for Care Transition and Community Crisis & Urgent Care.
2. Build on the power of PSYCKES to provide key data to drive care coordination, accountability and planning data.
3. Support County Crisis Planning Sessions to facilitate implementation of the Protocols and continue Crisis Stabilization culture.
4. Develop strategic regulatory waiver requests to advance the three PPSs and Partners work.
5. Make community crisis and urgent care more accessible
6. Educate Medicaid managed care organizations (MCOs) on gaps in funding key functions and services highlighted by the three PPS work on BH Crisis Stabilization to develop sustainable funding to support a stronger BH crisis system.
7. Advocate for start-up support for community-based care models with target and capacity to reduce avoidable ER use.

The three PPSs will reach out to all stakeholders--their county partners, the new Regional Planning Consortium, the NYS Department of Health, Office of Mental Health and OASAS, and MCOs--to develop a solution framework with a 2 to 3-year timeframe to address regulatory, reimbursement and service gap barriers to implementation.
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Supporting Documents

I. Crisis Protocols and Workflows

II. Crisis Service Workgroups
   i) Participants
   ii) Reports
      (1) Triage
      (2) Mobile
      (3) Respite
      (4) Intensive
      (5) Follow-up

III. Visual Library
   i) Cross-PPS BH Crisis Stabilization Project
   ii) Crisis Service Components (Developed by Crisis Service Workgroups)
      (1) Triage
      (2) Mobile
      (3) Respite
      (4) Intensive
      (5) Follow-up
I. Cross PPS Behavioral Health Crisis Protocols and Workflows  
(Developed by WMC Health PPS – Adopted by WMC Health, MHVC and Refuah)

I. Purpose, Background, System Challenges and Goals

Purpose:
Frames & Guides Local BH Care Transition, Crisis & Urgent Care Interventions - The protocols are intended to be a best practice framework and guidelines for the delivery of BH inpatient to community care transition interventions and BH community crisis and urgent care services. It is expected that these protocols will be adapted by communities based on their system resources, local needs, resources & preferred approaches. Twenty-five agencies participated in the development of these protocols.

Background and System Challenges:
1) Reflects Best Practices - The following protocols reflect the knowledge gleaned from reviewing local, state and national best practices and protocols.

2) Rigidity of Medicaid Reimbursement is a Barrier to Implementation - The PPSs acknowledge that the protocols call for provider activities and interventions that traditionally have not been reimbursed by Medicaid, or may be reimbursed at levels that will not support additional provider responsibilities for BH care transitions and community crisis/urgent care services.

3) Recruitment Challenges for BH Clinicians May Impede Service Delivery - Expansion of community-based treatment services for BH care transitions and crisis/urgent care to serve more people, 7 days a week, including in non-traditional settings such as their home, may prove to be unfeasible in some communities due to workforce recruitment of clinicians.

Goals:
System Transformation to Shift the Locus of Care for BH Crisis Services to Community Settings from Hospitals Depends on Training of First Responders and BH Workforce, as well as Community Education - Effective use of redesigned and more accessible community-based BH care transition, crisis and urgent care services, instead of ERs, will depend on extensive training of all stakeholders including community organizations and residents, as well as BH and medical providers.
II. BH Inpatient to Community 30 day Care Transition Protocol

Step 1: BH Inpatient to Community Care Transition (CT) Protocols

1. Every person discharged from a psychiatric and substance use treatment inpatient unit (target population) will have a 30-day transition (formerly discharge) plan upon discharge that will
   a. Be a collaboration of individual, hospital, Health Home (HH) and other care coordinators (if any), Care Transition (CT) service providers (if any), current/future community providers and their caregivers (as appropriate);
   b. Be formulated in a planning process that commences upon admission and involves all relevant parties in-person or by phone, with the hospital leading the process and gathering relevant history from PSYCKES & other sources;
   c. Designate a point of responsibility for coordination of CT services based on individual access to services (e.g. Health Home, ACT), community resources and/or local system roles/responsibilities;
   d. Link eligible individuals with a Health Home if not already enrolled;
   e. Identify appropriate outpatient behavioral health (BH) treatment resources and include a scheduled appointment within 7 calendar days of the discharge date, with the goal of ensuring continuity of care unless the individual prefers a new provider;
   f. Provide or arrange for provision of a call or visit or both within 48 hours of BH inpatient discharge, as well as follow-up to ensure that the individual attends their scheduled 7 and 30 day provider appointment(s);
   g. Address strategies for medication adherence (ex. injectable medications, accompaniment to pharmacy);
   h. Identify appropriate medical resources in the community if the individual has a co-occurring medical disorder(s) and is not being treated or followed in the community, including a scheduled appointment within 7-14 calendar days of the discharge date depending on urgency, with the goal of ensuring continuity of care unless the individual prefers a new provider;
   i. Include an assessment of housing stability, economic security and natural supports, and address identified recovery, social service, housing and support needs with timeframes and roles/responsibilities of community providers (e.g. Health Homes, supportive housing, Peer Bridger, etc.); and
   j. Identify individuals who need more intensive transition services (e.g. respite/step down bed, residential or ambulatory detox, ACT, Care Transition team, mobile team, BH crisis stabilization center, etc.) and arrange for such services before or upon discharge if available in the community. If not available, the hospital will report the gap between need and availability to the PPS and county.

Step 2: BH Inpatient to Community Care Transition (CT) Protocols

2. Every person discharged from a BH inpatient setting will receive post-discharge coordination of services recommended in their transition plan.
   a. Depending on system resources and the individual’s identified needs, everyone will receive either a call or visit or both within 48 hours of BH inpatient discharge.
b. Point of responsibility for CT service coordination will vary by community with Health Homes (HH) taking on this role for enrolled members. If the individual is not enrolled in a HH at the time of discharge, then a supportive housing provider or BH clinic, as appropriate, will be identified in the Plan to provide a call and/or home visit for non-Health Home clients.
c. CT service coordination will be available on weekdays and on weekends for individuals discharged at the end of the week. At a minimum, the following services will be provided as needed:
   i. Follow-up to ensure that the individual attends their scheduled 7 and 30 day provider appointment(s), rescheduling if they are missed, and providing accompaniment or arranging transport to initial appointments as needed (everyone);
   ii. Accompany client home from hospital as needed and permitted by available staff resources;
   iii. Provide and/or arrange for medication reconciliation as needed;
   iv. Implement (or arrange to implement) treatment adherence strategies in transition plan;
   v. Coordination of other services specified in the CT plan (with timely reporting to the PPS and County if needed services are unavailable); and
   vi. Aid or arrange for assistance with any economic challenges faced by the individual post-discharge that might impair their stability (as needed).
d. Document gaps in system capacity to provide care transition services to all individuals discharged from BH inpatient care, and in fulfilling protocol roles.

Step 3: BH Inpatient to Community Care Transition (CT) Protocols

3. Community-based provider(s) will be identified in the transition plan as responsible for providing 30-day post discharge services to specific individuals, with care intensity and auspice varying depending on individual needs.
   f. Transition plans will specify whether an individual requires one of three service tiers:
      • BH community services,
      • BH intensive community services, or
      • BH intensive care transition (CT) services.

Individuals may require services from two or more of the service tiers. As resources permit, CT services will be made available 7 days a week.

b. Community services will include but not be limited to BH clinics, clubhouses, supportive housing, peer bridger services and/or community peer supports. Each community will vary in its availability of one or more community services.

c. Community BH clinic(s) or a comparable clinical provider will be identified in an individual’s transition plan based on past relationship, proximity to an individual’s residence, availability of services needed, individual preference and other factors. Clinics will implement, as feasible, new services available under Medicaid that support home and community-based treatment, including but not limited to, mobile crisis, licensed behavioral health practitioner (LBHP) and HCBS community psychiatric support and treatment (CPST).
d. BH intensive community services will include, but not be limited to, PROS, ACT, medically managed withdrawal (ambulatory detox), OMH licensed community residence, OASAS transitional residential services, peer bridger and county mobile teams. Each community will vary in its availability of one or more BH community intensive services, and capacity may not meet all needs.

e. BH intensive Care Transition (CT) services will include but not be limited to CT teams, mobile teams, BH stabilization centers, ACT, respite/step-down beds, and OASAS residential medically supervised and monitored services. Each community will vary in its availability of one or more BH intensive CT services, and capacity may not meet all needs. Priority for this tier should be given to individuals with moderate to low-high risk factors and a successful history of prior community engagement where intensive CT services has the most potential to ensure community stability.

f. CT services will be delivered using evidence based practices as applicable, including critical time intervention and motivational interviewing, which have both been demonstrated to be effective in addressing service needs and behaviors that correlate with successful care transitions.
BH Care Transition (CT) Protocol Workflow

**Step 1: Pre-discharge Planning Conference**
- Health Home, HH At Risk &/or TCMs
- Mobile Teams (if know client & can contribute to plan)
- Community BH treatment program-- clinic, PROS, ACT, SUD treatment prog
- Peer Bridger Program
- patient
- Family/Other supports
- Residential Provider
- CT Team (higher risk)
  *Community providers can attend by phone*

**Step 2: Post-discharge Coordination (HH preferred):**
- Health Home or HH At Risk
- CT Team or Mobile Team (if service provided/can provide)
- BH clinic, PROS, ACT &/or Supportive Housing

**Post-Discharge Coordination Activities for All:**
- 24-48 hour follow-up call &/or visit
- Monitor 7-day community BH visit and 30 day follow-up
- Accompany client home as needed & within resources to assess/address concrete needs
- Arrange for medication reconciliation as needed
- Accompany-arrange transport as needed to BH provider
- Document system gaps

**Step 3: CT Services**

*Community Services:*
- BH clinics + Licensed Behavioral Health Practitioner home-based treatment
- Clubhouses
- Supportive Housing
- Peer Bridger services
- Peer & family supports

*Intensive Community Services:*
- PROS
- ACT
- Ambulatory Detox
- CRs & OASAS transit, Residential beds
- Peer Bridger
- Mobile Team
- BH Stabilization Center
- Article 31 urgent care

*Intensive CT Services:*
- CT team (ex. RPC)
- Mobile team
- BH Stabilization Center
- ACT
- Step-down beds
- OASAS inpatient
- Medically Managed and Medically Supervised Treatment, OASAS Residential

**Inpatient Unit Role**
- Staff identify current/recent community providers/natural supports and assess housing status/financial situation
- Involve Health Home (HH) immediately if known (check PSYCKES)
- Initiate transition planning conference with key community providers starting on Day 1 of admission
- Identify post-discharge coordinator (HH preferred; refer if eligible but not enrolled)
- Implement transition plan with HH or other coordinator
- Document system gaps
- Provide or arrange for 24-48 hour follow-up call &/or visit, as well as 7-day community BH visit and 30 day follow-up

**Patient admitted to Psychiatric & SUD Units**
III. **BH Community Crisis & Urgent Care (BH-CCUC) Protocol**

**OVERVIEW**

1. **Background:**
   a. The region is comprised of 7 counties, with diverse urban, suburban and rural communities.
   b. Each county has a legacy BH system with differing crisis/urgent care resources and system roles/responsibilities.
   c. There is no dedicated funding source(s) for a single 24/7 point of access (POA) for the region or for each county.

2. **Objectives:**
   a. Implement a systemic change in the locus of care for behavioral health (BH) crisis and urgent care services from hospital emergency rooms (ERs) to community settings;
   b. Reduce the numbers of avoidable BH ER presentations and inpatient episodes; and
   c. Improve access to coordinated evidence-based clinical treatment and supportive services that can enable individuals with BH disorders to address urgent and crisis BH issues safely in community settings.

3. **Goals:** Better address the needs of local residents for BH crisis and urgent care in community settings by
   a. Creating a functional framework for organizing existing community resources;
   b. Defining the roles and responsibilities of BH service sectors;
   c. Identifying and addressing critical gaps in local service systems that may result from reimbursement and/or regulatory barriers; and
   d. Providing a tiered service approach aligned with the individual’s assessed risk factors.

4. **Target Population:** The BH-CCUC protocol is designed to address the needs of two cohort groups who are now poorly served by the current system of care:
   a. People with BH disorders who would prefer, and are assessed to be able to safely use, BH urgent/crisis care from community providers instead of hospital-based emergency rooms (ER); and
   b. People with BH disorders presenting at a hospital ER who are assessed, after triage, to be able to safely use a community alternative.

5. **Referral to Care:** The protocol is designed to mobilize a broad-based community referral system to utilize alternatives to ERs through training (ex. Mental Health First Aid), community education and outreach. Success depends on involvement of the following major referral sources:
   a. Self-referrals
   b. Family/caregiver
   c. First responders
   d. Local hotlines, warmlines and information lines
   e. Emergency Room (ER) personnel
   f. School personnel
   g. BH community agencies including supportive housing
h. Social service agencies

6. **Training:**
   a. Individuals with BH disorders, as well as their family members/caregivers, will learn about and be assisted to use BH community crisis and urgent care through PPS-initiated educational activities.
   b. A broad range of community members (e.g. first responders, teachers, social workers, community organizations, etc.) will be trained through PPS-initiated educational activities to identify mental health issues, as well as know about available community resources and how to refer individuals to their community’s points of access (POA) for CCUC services.
   c. ER staff will be trained on referral to community alternatives for individuals who are assessed to be able to safely use one.

7. **Vision—People with BH disorders will be able to access services in the community at many Points of Access (POA):**
   a. A wide range of community providers, including residential programs, clubhouses and peer services, will have the opportunity of participating as a POA and receive ongoing training and technical assistance.
   b. The point(s) of access (POA) to crisis/urgent care services will shift from hospital emergency rooms (ERs) to community loci of care where intake, triage and services would be available daily, including evening hours for walk-ins and same/next day opportunities for clinical assessment.
   c. Everyone with a BH disorder who seeks help will receive concrete assistance; no one will be turned away because their needs are “urgent” but not an imminent crisis.
Step 1- BH Community Crisis & Urgent Care (BH-CCUC) Protocol: Intake

Points of Access (POA) will follow a framework of five key intake activities:

1. **Assessment:** The individual is assessed in a safe, calming environment (if possible) with timely clinical assessment.
   a. If the POA provider does not have the resources to do a clinical assessment the provider will connect the individual with their current BH clinical provider or a local “crisis/urgent care” clinical provider.
   a. Communities will identify local providers where individuals can be clinically assessed with the goal of assessments occurring 7 days a week within several hours of referral.
   b. People who need a higher level of care will be transported immediately to the ER by accessing 911 emergency ambulances.

2. **Involve Health Home:** If the individual is enrolled in a Health Home (HH), the POA will notify the Care Coordinator (CC) immediately and, if not enrolled, will facilitate enrollment.

3. **Understand Crisis:** The POA will be responsible for gathering current and historical information from the individual, collaterals, Health Home and/or current providers, and sharing the information with CCUC providers with the individual’s consent. Barriers to information sharing will be reported to the PPS and county, and will be addressed systemically.

4. **Safety/Crisis Plan:** The individual, their family member(s)/caregiver(s), CC and POA personnel collaborate on safety/crisis planning (ex. WRAP).

5. **Implement Plan:** Care pathway is informed by assessment, information gathered, housing stability and natural supports. The implementation lead will shift from POA to the Health Home if individual enrolled. POA will respond to individual needs and facilitate connection to CCUC services.

Step 2- BH-CCUC Protocol: Care Pathways

Based on the individual’s assessment, natural supports, housing stability, preferences and other factors, the POA (in conjunction with the Health Home care coordinator and the urgent care clinical provider if any) will recommend one of the following four care pathways:

1. **Community Provider Pathway:**
   a. **Target population** are individuals assessed to have stable housing, natural supports and community services.
   b. **Anchor provider sector** for this pathway are BH clinical providers with open access, extended hours and ideally home-based clinical services such as Licensed Behavioral Health Practitioner (LBHP) and/or HCBS Community Psychiatric Support and Treatment (CPST).
   c. **Other key community BH services/programs** (e.g. Health Homes, clubhouses, supportive housing, peers) collaborate with clinical providers to address the individual’s crisis and urgent care needs. Roles and responsibilities will be clearly specified in the crisis/safety plan.
d. **Functional Role** is for one or several providers to collaborate on addressing an individual’s time-limited crisis/urgent needs through an individualized service plan that addresses treatment, support and concrete (social determinants of health) issues, as well as offering supports (as available) to caregivers and others that form the individual’s natural support system.

e. **Transition from crisis/urgent care** occurs when the crisis/urgent issue has resolved, and the individual can transition to regular care. If enrolled in a Health Home, the care manager will take the lead in developing a Transition Plan. If not enrolled in HH, enrollment is facilitated.

2. **Community Crisis Care Pathway**:

a. **Target Population** are individuals assessed to be experiencing housing instability, natural supports unraveling, and community services are inadequate to meet needs.

b. **Anchor Provider Services** for this pathway are Mobile Crisis Teams and Crisis/Urgent Care Centers. (ex. Access mobile teams in Orange and Ulster Counties, Dutchess BH Crisis Stabilization Center and IFH Center for Counseling at Kingston)

c. **Other key community BH services/programs** (e.g. Health Homes, clubhouses, supportive housing, peers) collaborate with clinical providers to address the individual’s crisis and urgent care needs. Roles and responsibilities will be clearly specified in the crisis/safety plan.

d. **Functional Role** is to holistically address the individual’s support/safety needs with the goal of stabilizing their housing and natural supports.

   i. It will bridge the period until reengagement with current outpatient (OPD) provider or engagement with a new provider.

   ii. Within available resources, the individual is accompanied to OPD appointments as needed.

   iii. Family/caregiver/housing provider receives time-limited supports to stabilize housing & natural supports.

e. **Transition from community crisis care** occurs when the crisis/urgent issue has resolved, and the individual can transition to regular care.

   i. If enrolled in a Health Home, the care manager will take the lead in developing a Transition Plan.

   ii. If not enrolled in HH, enrollment is facilitated.

3. **Intensive Crisis Services Pathway**

a. **Target Population** are individuals assessed to need intensive community care for clinical and/or safety reasons, and can be safe treated in the community with intensive community services if available.

b. **Anchor Provider Services** for this pathway are time-limited residential services (e.g. crisis respite, OASAS medically supervised or monitored residential services). Peer staffing is critical to effectively engage and support individuals at this level of care.

c. **Functional Role** is to provide a safe alternative to BH inpatient admission by addressing the individual’s treatment, support and other needs, with the goal of stepping down to a lower level of care as soon as assessed to be safe and appropriate.

d. **Transition from Intensive Crisis Services** will be coordinated by the Health Home (HH), or Intensive Service Provider if no HH (“Transition Provider”).
i. The Transition Provider will arrange for treatment and/or support services for at least 30 days from Community or Crisis Community providers prior to leaving Intensive Crisis Services.

ii. If not enrolled in HH, enrollment is facilitated.

4. **Hospital:**

   a. **Target Population** are individuals who
      - Cannot be safely served in the community determined through an assessment with a BH-CCUC Point of Access (POA), or
      - Prefer to go to a local hospital emergency room (ER), or
      - Are taken to the ER by first responders without an initial crisis assessment in the community.

   b. **Anchor Provider Services** will be provided by the hospital BH inpatient units and the emergency department.

   c. **Transition from BH Inpatient to BH-CCUC**
      - If admitted for inpatient treatment, the BH Care Transition Protocol will be followed.
      - Care transition services will be arranged upon discharge per the protocol.

   d. **Transition from ER to BH-CCUC** services will occur if the ER assesses that an inpatient admission is not necessary.
      - The ER will be responsible for collaborating with the POA provider (if any) that referred to ER and the HH (if any) to arrange a Community, Community Crisis or Intensive Crisis Care Pathway.
      - The POA provider (if any) and the ER will notify the HH care manager (if any) respectively that hospital referral has been made and that the individual has presented for emergency services.
      - If not enrolled in HH, enrollment is facilitated.
BH Community Crisis & Urgent Care (BH-CCUC) Protocol Workflow

1) Community Services:
- BH urgent care clinics will be identified in each community for timely clinical/risk assessment if POA does not have the capacity.
- Client may be referred to another care path (e.g. Community or Intensive Crisis or Hospital) or receive community services (e.g. Art 31 clinic with Licensed BH Practitioner/ICBS CPST home-based services).
- If not enrolled in HH, enrollment is facilitated.
- CC takes lead in arranging needed clinical and supportive services.
GOAL: SUPPORT IN COMMUNITY IF SAFE

2) Community Crisis Services (e.g. Mobile Team or BH Crisis/Urgent Care Center if available):
- Addresses client’s support/safety needs.
- Bridges period until reengagement with current OPD provider or engagement with a new provider.
- May accompany to appointments.
- Provides support to family/caregiver/housing provider to stabilize housing & natural supports.
- If not enrolled in HH, enrollment is facilitated.
GOAL: SUPPORT IN COMMUNITY IF SAFE

3) Intensive Crisis Service (e.g. crisis respite, detox, OASAS residential):
- Time limited services in residential setting.
- Peer staffing critical to engagement and support.
- HH or Intensive Service program transitions client after stay & continues support services for 30 days.
- If not enrolled in HH, enrollment facilitated.
GOAL: PROVIDE CARE IN COMMUNITY, NOT ER

4) Hospital:
(i) BH-CCUC POA &/or urgent care provider finds person cannot be safely served in community.
(ii) Person prefers to go to ER.
(iii) 911 or police take person.
   - If ER assesses that admission not needed, than ER coordinates with BH-CCUC, POA and CC (if any) for other services.
   - If admitted, care transition services available upon discharge per protocol.
*CC is notified immediately.
GOAL: OFFER OPTION TO ER IF SAFE

Service Pathways:
Individual is generally referred to one of 4 pathways, and POA continues to coordinate care until transition to HH CC or another coordinating provider (e.g. PROS, ACT, clinics funded to do crisis/urgent follow-up).

Intake Activities:
- Individual is assessed in a safe, calming environment (if possible) with clinical assessment (if available).
- If client is HH, POA notifies care coordinator (CC) & collaborates on safety/crisis planning.
- Information is gathered from individual, family/caregiver(s), providers and HH.
- Safety/crisis intervention plans are developed &/or implemented.

Referral Sources:
- County hotlines/help lines
- MCO(s)
- Health Home (HH)
- First responders
- Community providers
- Residential providers
- Hospital ERs
- Family/Care Giver
- Self
IV. Implementation Issues to be Addressed for Both Protocols

1. Services needed for Care Transition (CT) and Behavioral Health Community Crisis and Urgent Care (BH CCUC) systems are similar. Communities can establish dedicated CT and BH-CCUC service tracks or one integrated community system. Protocols are designed to be “open architecture”, identifying components of CT and CCUC that can be combined or operated discretely. Training in evidence based practices, such as Critical Time Intervention, Motivational Interviewing and Mental Health First Aid, will enhance service efficacy.

2. PPS partners can benefit from training on emerging managed care funding opportunities to support CT and BH-CCUC. Even with new opportunities, available funding likely does not adequately address system gaps (e.g. stepdown and respite capacity, mobile treatment services). The PPS will facilitate communication with NYS and Plans about the systemic regulatory and funding issues that need to be addressed.

3. There are service gaps to implementation. New Medicaid crisis care funding will not come close to meeting regional needs without Medicaid funding specifically becoming available for new services/functions. One solution may be innovative bundled service models funded by Plans using case rates based on intensity of need (Ex. 30 day CT follow-up services that may involve 1 provider/3 services or 3 providers/1 service each).

4. Certain provider sectors (e.g. NYS-licensed clinics, supportive housing providers, etc.) will need to take on additional responsibilities. Strengthening the capacity of community providers to provide CT, crisis and urgent care is the most cost-effective way to implement system transformation. Funding must support these changes (ex. Article 31/32 clinics & housing providers participating in CT planning conference).

5. Information sharing will be a challenge until RHIO is fully operational. Interim solutions need to be explored and supported by MCOs and PPS.

V. Activities to Support Protocol Implementation

1. Rapid Cycle Evaluation-The PPS will support rapid cycle evaluation of early implementators to ensure that barriers are flagged and addressed.

2. Document Service System Gaps-Stakeholders will provide real time data to PPS and counties about system gaps that impede protocol implementation.

3. More Robust Reimbursement-PPS will assist community provider systems document the need for more flexible and adequate funding of BH care transition, crisis and urgent care services and the potential Medicaid cost savings.

4. Systemic Approach to Barriers is Essential with DSRIP Timeline-The PPS, counties and community provider networks (hopefully aided by managed care plans) will address the identified community service access barriers systemically so transition plans can be implemented.

5. Workforce and Community Education-Changing behavior patterns to utilize newly available care transition, crisis and urgent care resources will only occur with well-timed and effective educational/training initiatives that the PPS will support.
## II. Crisis Service Workgroups

### i) Participants

Cross PPS BH Crisis Service Workgroups (November – December 2016)

#### Triage Workgroup

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Darcie Miller</td>
<td>Commissioner</td>
<td>Orange County DSS/MH</td>
</tr>
<tr>
<td>Beth Alter</td>
<td>Director, Diversion Services and Community Consultation</td>
<td>Dutchess County MH</td>
</tr>
<tr>
<td>Tracie Florida</td>
<td>Administrative Coordinator</td>
<td>Rockland BHRT</td>
</tr>
<tr>
<td>Bernadette Kingham-Bez</td>
<td>Executive Director</td>
<td>St. Vincents</td>
</tr>
<tr>
<td>Nadia Allen</td>
<td>Executive Director</td>
<td>MHA Orange</td>
</tr>
<tr>
<td>Joshua Gran</td>
<td>Executive Director</td>
<td>PEOPLE, Inc.</td>
</tr>
<tr>
<td>Charlotte Ostman</td>
<td>Chief Strategy Officer</td>
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</tr>
<tr>
<td>Mark Giuliano, MSW</td>
<td>Program Director Community Support Adult Mental Health Services</td>
<td>Westchester County Department of Community Mental Health</td>
</tr>
<tr>
<td>Stephanie Madison</td>
<td>President, CEO</td>
<td>MHA Rockland</td>
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#### Intensive Service Workgroup

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Raymond M. Rodriguez</td>
<td>Regional Director of Peer Services</td>
<td>Independent Living, Inc.</td>
</tr>
<tr>
<td>John Francis</td>
<td>Administrative Director of Care Management</td>
<td>St. Vincent’s Hospital</td>
</tr>
<tr>
<td>Andrew O’Grady</td>
<td>Executive Director</td>
<td>MHA Dutchess &amp; CBHS</td>
</tr>
<tr>
<td>Jane Mullin</td>
<td>Division Director, Strategic Integration</td>
<td>Jawonio Inc.</td>
</tr>
<tr>
<td>Kathleen F. Morgan</td>
<td>COO</td>
<td>HONORehg Inc.</td>
</tr>
<tr>
<td>Eric D’Entrone</td>
<td>Assoc. Director of Regional Services</td>
<td>Arms Acres and Conifer Park</td>
</tr>
<tr>
<td>Tammy Rhein</td>
<td>Director of Chemical Dependency / Adult Mental Health</td>
<td>Orange County Department of Mental Health</td>
</tr>
<tr>
<td>Cathy Ciavarello</td>
<td>Sr. Director Outpatient BH Services</td>
<td>WMCHealth</td>
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#### Mobile Crisis Workgroup

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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Beth Alter</td>
<td>Director, Diversion Services and Community Consultation</td>
<td>Dutchess Department of Mental Health</td>
</tr>
<tr>
<td>Amy Anderson-Winchell</td>
<td>President &amp; CEO</td>
<td>Access</td>
</tr>
<tr>
<td>Suzanne Cannella</td>
<td>Manager - Care Management</td>
<td>St. Luke’s Cornwall</td>
</tr>
<tr>
<td>Sally Eaton</td>
<td>Program Director</td>
<td>St. Vincent’s</td>
</tr>
<tr>
<td>Edward Herman</td>
<td>Director Managed Care</td>
<td>Rockland Psychiatric Center Office of Mental Health</td>
</tr>
<tr>
<td>Polly Kerrigan</td>
<td>SVP Program Operations</td>
<td>Family Services of Westchester</td>
</tr>
<tr>
<td>Joann Zucker</td>
<td>Clinical Director</td>
<td>Rockland Paramedics</td>
</tr>
<tr>
<td>Doug Hovey</td>
<td>CEO</td>
<td>Independent Living Inc</td>
</tr>
<tr>
<td>Dr. Abby Wasserman</td>
<td>Clinical Director</td>
<td>St. Vincents Crisis Response &amp; Prevention Team</td>
</tr>
<tr>
<td>Jane Mullin</td>
<td>Division Director of Strategic Integration</td>
<td>Jawonio</td>
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### Respite Workgroup

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<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Steve Miccio</td>
<td>CEO</td>
<td>PEOPLE, Inc.</td>
</tr>
<tr>
<td>Jeffrey Fox</td>
<td>CEO</td>
<td>Abilities First, Inc.</td>
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<tr>
<td>Rita Liegner</td>
<td>Deputy Director for Rehabilitative Services</td>
<td>Guidance Center of Westchester Inc.</td>
</tr>
<tr>
<td>Andrea Koscis</td>
<td>Executive Director</td>
<td>HDSW; CBHS</td>
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<tr>
<td>Aron Reiner</td>
<td>Executive Director</td>
<td>Bikur Cholim Inc.</td>
</tr>
<tr>
<td>Brian Kaley</td>
<td>VP Behavioral Health Services</td>
<td>St. Johns Riverside Hospital</td>
</tr>
<tr>
<td>Katarina Hoaas</td>
<td>Senior Vice President of Clinical Services</td>
<td>Access: Supports for Living Inc.</td>
</tr>
<tr>
<td>Billy Jolly</td>
<td>Director of MH Recovery &amp; Family Services</td>
<td>Access: Supports for Living Inc.</td>
</tr>
<tr>
<td>Amy Anderson-Winchell</td>
<td>President &amp; CEO</td>
<td>Access: Supports for Living Inc.</td>
</tr>
<tr>
<td>Ashley Brody</td>
<td>CEO</td>
<td>Search for Change, Inc.</td>
</tr>
<tr>
<td>Ruthanne Becker</td>
<td>Vice-President of Rehabilitation Services</td>
<td>The Mental Health Association of Westchester (CBHS)</td>
</tr>
<tr>
<td>Mark Sassvary</td>
<td>Director of Clinical Services</td>
<td>Hudson Valley Mental Health, Inc.(CBHS)</td>
</tr>
<tr>
<td>Peter Thomas</td>
<td>Assistant Director for Residential Services</td>
<td>Mental Health Association of Rockland County</td>
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### Follow-Up Workgroup

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Susan K. Miller</td>
<td>Managing Director</td>
<td>RSS – Orange Sullivan Division</td>
</tr>
<tr>
<td>Mary Babcock</td>
<td>Clinical Unit Administrator/HELPLINE</td>
<td>Dutchess County</td>
</tr>
<tr>
<td>Stephanie Madison</td>
<td>President, CEO</td>
<td>MHA Rockland</td>
</tr>
<tr>
<td>Michelle McKeon</td>
<td>COO</td>
<td>RECAP</td>
</tr>
<tr>
<td>Doug Hovey</td>
<td>CEO</td>
<td>Independent Living, Inc.</td>
</tr>
<tr>
<td>Amie Parikh</td>
<td>Executive Director</td>
<td>Hudson Valley Care Coordination</td>
</tr>
<tr>
<td>Nancy Magliocca</td>
<td>Program Director, Inpatient BH&amp; Recovery Center</td>
<td>Nyack Hospital</td>
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### WMCHHealth PPS BH Crisis Subcommittee Planning Meetings (June 2015-Dec 2016)

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<th>Organization</th>
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<tr>
<td>Access: Support for Living</td>
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<td>Arms Acres</td>
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<td>Bon Secours Charity Health Systems</td>
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<td>Catholic Charities Community</td>
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<tr>
<td>Orange County</td>
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<tr>
<td>Rockland County</td>
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<tr>
<td>Dutchess County Dept. of BH &amp; Community Health</td>
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<td>Guidance Center of Westchester</td>
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<td>Health Alliance</td>
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<td>HONOR ehg Inc.</td>
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<td>Human Development Services of Westchester</td>
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<tr>
<td>Independent Living</td>
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<td>Institute for Family Health</td>
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<tr>
<td>Jewish Board of Family &amp; Children's Services</td>
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<td>Lexington Center for Recovery</td>
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<tr>
<td>Mental Health Association of Westchester</td>
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<td>People Projects to Empower &amp; Organize</td>
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<tr>
<td>Putnam Family &amp; Community Services</td>
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<td>Rehabilitation Support Services.</td>
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<tr>
<td>Rockland Psychiatric Center</td>
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<tr>
<td>Search for Change</td>
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<tr>
<td>St. Christopher's Inn Inc.</td>
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<tr>
<td>Sullivan County Dept. of Community Services</td>
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<td>Westchester County Dept. of Community Mental Health</td>
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<td>Westchester Medical Center</td>
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ii) Crisis Service Workgroup Reports

Workgroup #1a:
Community Culture and Capacity for Crisis Triage

Service Area Description

Triage often begins well before a call is placed to 911, a Helpline. A missing link in building effective behavioral and IDD crisis capacity starts with building a community culture and capacity to support people in distress. Intentionally developing skills in likely "community gatekeepers" is an intelligent design for earlier identification and action resulting in fewer ER presentations and use of inpatient services. This approach is rooted in the reality, that without the presence of a strong culture and capacity it is very difficult to "predetermine" where, when or how a person in crisis stemming from an issue with behavioral health, substance use or intellectual/developmental disability will seek help. Further, behavioral health/IDD crisis are often manifested through somatic complaints such as chest pain, gastrointestinal concerns or migraines. It is through triage where we have opportunity to identify a root cause that may be behavioral or IDD in origin.

In addition to individual choice in selecting a crisis care path, there are systemic behaviors that also can be improved through the development of community culture and capacity for crisis triage. Clinicians in private practice or licensed programs with answering machine messaging offering a singular after-hours solution of “call 911” or “go the ER” are intended to address liability concerns, but unintentionally are responsible for countless preventable emergency room visits.

A diverse and inclusive array of community members play a role in helping to “triage” people experiencing a crisis due to substance use, behavioral health or IDD challenges. Examples include librarians, clergy, store owners, bus and taxi drivers, police, schools, probation officers, therapists, emergency departments, mobile crisis, clinics, peer services, professional associations (NYSAPA, NASW, Nursing, etc.), health aides, meals-on-wheels and care managers.

Community crisis triage culture and capacity are foundational elements in a strong health care system. An intention design, training, linkage and capacity building:

- makes it easier for gatekeepers to connect individuals with the right service at the right time.
- promotes greater consistency in the response to individuals seeking services as well as their caregivers and referring agents.
- helps to ensure that initial service responses are culturally and linguistically competent, and appropriate to the individual’s needs and risk.
- helps individual connect with the right service at the right time to resolve crisis.
- ensures optimal health literacy by assessing the individual’s capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions, and to ensure required follow up actions take place timely and consistently
- provides real alternatives to Emergency Rooms. Establish shared accountabilities, awareness of community resources (clinical/ CBO) and real-time knowledge of community resources.
- addresses social determinants of health
- over time can reduce the number of crisis by identifying needs earlier and linking people with solutions
Uniform Quality Standards

1. An overarching vision, message and culture for accessing behavioral health services is in place. (WELCOME Orange, System of Care, etc.)
   - Community gatekeepers is a term to refer to likely first contact points for individuals in need of behavioral health or IDD services or those in crisis. This term refers to librarians, clergy, store owners, bus and taxi drivers, police, schools, probation officers, therapists, emergency departments, mobile crisis, clinics, peer services, etc.
   - Common language, tools and processes for community gatekeepers are in place. Community gatekeepers have the knowledge and referral paths to act to prevent, identify and/or intervene with people in crisis.
   - Community gatekeepers are trained on an ongoing basis. Training is rooted in evidence and/or promising practices. Areas for inclusion: crisis intervention and de-escalation, trauma informed care for the layperson, Behavioral health, Mental Health First Aid, suicide prevention. (CIT, ASIST, ACE Interface, CompassEZ, WELCOME Orange, System of Care, etc.)
   - A formal and informal communication plan is in place to continuously message the vision, opportunities and resources of the community.

2. Each consumer should have a single crisis plan, shared with all services or supports. The single crisis plan should be in a format that is usable and “in-the-hands” of the consumer. If current regulations or IT systems do not support a single crisis plan, providers should demonstrate movement towards functional approximation of a single crisis plan. In the future, real-time information sharing through shared EHR, or Apps (WRAP App or Mood App) will make having a single crisis plan easier.

3. Examples of shared community crisis culture and capacity accountabilities include:
   - Do no harm.
   - Intervene in person centered ways (see the person first, not the disability)
   - Share crisis resolution responsibility with the person
   - Address trauma
   - Establish feeling of safety
   - Strength-based and solution-focused
   - Ensure the person feels affirmed and validated.
   - See the person as a credible source and a whole person
   - Build natural supports
   - Community gatekeepers, behavioral health providers, peer services and hospitals are mutually accountable to each other

4. Professional re-licensure for physicians, nurses, psychologists, social workers, mental health counselors and marriage and family counselors and re-certification for CASAC’s should include a 30-minute on-line module for suicide assessment and behavioral health crisis system referral options.

5. New York State should issue guidance on the content for recorded after-hours messages for licensed behavioral health programs and private practitioners. This should include options other than calling 911 or presenting to the emergency room. Communities should incorporate this guidance into their community culture and capacity for crisis triage. Supporting providers to incorporate local numbers and/or service names and holding providers accountable for their afterhours messaging.
6. The following community culture and capacity standards for crisis triage are applicable to community members with clinical or peer roles:

- Capacity to develop and work toward each consumer having one WRAP or crisis plan which are communicated within the individual’s circle of support.
- Timely screening and assessment 24/7.
- Effective risk assessment
- Strong engagement and activation skills
- Services provided in the least restrictive manner
- Capacity to achieve warm handoffs with other crisis services, Health Home and service providers
- Evidence-Based Practices are used consistently and are age, culture and service appropriate. (Motivational Interviewing, Solution-based Casework, WRAP, CTI, CBT, DBT, etc.)
- Honor community norms and workflows targeted to improving crisis response.
- Basic needs should be assessed continuously and action taken to avoid disruption (safety, TRANSPORTATION, food, shelter, etc.)
- There is fluid and adaptive monitoring of progress – if individual is not engaged or target outcome not achieved, alternative interventions must be promptly implemented.

**Outcomes**

1. Reduce the number of avoidable ER visits
   - Measure # of ER visits for individuals with a BH/IDD diagnosis who present at the ER for either a medical and behavioral health issue.
   - Measure # of ER visits for individuals who present at the ER for a behavioral health issue.
2. Reduce avoidable inpatient behavioral health hospitalizations
3. Reduce hospital readmissions within 30 days
   - Measure # of 30 day readmissions for medical issue
   - Measure # of 30 day readmissions for behavioral health issue
4. Increase Health Home enrollment for eligible individuals
   - Increase care management role clarity and integration within the community care team

**Opportunities for Collaboration**

1. Implementation of a community culture and capacity for crisis triage **CAN happen IF** a commitment is made by the State, Counties and provider communities to work together to design it, reallocate current funds to support it and **INVEST** in building care-seeking pathways that will build to better care, improved patient experience and less overall health care cost. We are not starting at ground zero, there are exemplar aspects in use in the Hudson Valley, innovations in development and national strategies to build from.
2. Advancing work and achieving results:

I. DSRIP can be a catalyst to begin the conversation, educate policymakers and diverse stakeholders, incentivize pilot applications and help to build a sustainability plan.

II. County Mental Health and Social Services Departments are essential partners to lead and implement community culture and crisis capacity.

III. The Hudson Valley PPS’s could join to pilot the intervention across the region. Partners in provider community, law enforcement, advocacy and legislative representatives, among others, should be at the table helping to shape, implement and sustain the model. The charter should include development of progressive, yet step-wise approaches to building capacity to address the service needs and demand that will be created for lower-cost community services through this initiative.

IV. Communities, counties and regions could share the following elements with local tailoring and application:

- Behavioral Health/IDD community crisis culture and capacity messaging and vision
- Training capacity and cost (e.g. CIT, ASIST, ACE Interface, CompassEZ, WELCOME Orange, Behavioral health First Aid)
- Navigation can be standardized to get person back to their community provider
- Regional protocol for sharing client information with their consent
- BH crisis providers jointly “market” in their community to referral sources, individuals and their families.
- There is an interactive directory or app (ex. WMCHHealth has made Healthify available to its partners) to find out about available services.
- Uniform protocol for timely accessing the appropriate level of care for individuals assessed to be high risk

Sustainability
Long-term success in reducing avoidable emergency room and inpatient admissions is grounded in the culture and capacity of local health care systems. Attending to this culture is a public health issue. We know HOW to develop and sustain a culture that promotes effective crisis service patterns. It is not as elusive as other aspects of the social determinants of health. The Hudson Valley is uniquely positioned to demonstrate the impact of community culture and crisis capacity given the strength of County Mental Health and Social Services leaders, the collaboration of the three regional PPSs, the capability of the providers, involvement of law enforcement and the interest of local State Legislative representatives in supporting improvements in health care delivery.

Current financial support is available for specific elements of a community culture and capacity for crisis triage. For example, there is State funding for suicide prevention training or mental health first aid and County Mental Health Departments have long served as conveners, trainers, system planners and innovators.
Through a detailed and viable plan under the Crisis Stabilization 3.a.ii, DSRIP can be a catalyst to
dramatic reform by seeding the change process, advancing regulatory and practice reforms and
building care-seeking pathways that will build to better care, improved patient experience and less
overall health care cost. Allocation of current State and County funding should be adjusted to
support the new model. Cost studies to ascertain likely health care expenditure savings could also
be part of a pilot. The outcome of which could inform impact and investment from Medicaid
Managed Care Plans or State/County sources.

Given the direct relationship between preventable ER visits and answering service messages
offering singular guidance to call 911 or go the nearest emergency room, funders can also support
movement towards the vision through issuing policies and/or best practice guidance on
communication.

**Workgroup #1b:**
911/Crisis Hotline (Helpline)

**Service Area Description**
Individuals experiencing behavioral health or IDD crisis may have contact with 911 or a community
crisis hotline. These telephone systems are a centralized access point to assure people in crisis are
connected to emergency, intensive or follow-up services, and to minimally reduce and ultimately
eliminate risk of harm. Communities often have either a warm line or Helpline.

1. **A Warm Line** is a confidential 7 days/week telephone support service staffed by trained
   consumers who provides support, a listening ear and can provide information about available
   services.

2. **A Helpline** is available 24/7/365, offering telephone support service provided by trained
   Helpline listeners who provide crisis telephone counseling, support, information/referral for all
   ability groups, initiate mobile crisis team referrals and/or emergency response.

At a national level, **Lifeline** is a free and confidential service for anyone in emotional distress or
suicidal crisis that operates 24/7/365. By dialing 1-800-273-TALK (8255), callers are routed to the
nearest crisis center in a national network of 160+ crisis centers that provides counseling and mental
health referrals. The Lifeline also provides life-saving crisis services through **Lifeline Crisis Chat,**
which is available 24/7/365. In 2013, the Lifeline answered its 5th millionth call. The Lifeline
launched in 2005 and is funded by the Substance Abuse and Mental Health Services Administration.
The National Suicide Prevention Lifeline are intensely and continuously promoted and advertised via
billboards, radio ads, social media, etc.

**Uniform Quality Standards**
1. Each community should have a single line identified to receive behavioral health/IDD crisis
calls.

2. Caller engagement is characterized by
   - caring contacts: genuine and positive greeting; acceptance of the person as they are/
     where they are at; demonstration of recovery principles and person-centered services
• warm handoffs: Level A – a direct, personal introduction to the new service or support. Level B – An appointment is set up, directions and/or transportation arrangements are in place and all necessary information is transmitted to the new service in advance.

• real-time access to needed services or interim supports

3. Behavioral Health Telephone Triage Service operators are experienced clinicians who are appropriately trained in conducting standardized telephone behavioral health triage, have a working knowledge of the operating protocols of the service and have knowledge of intellectual, developmental disabilities (I/DD), mental illness, and substance use disorders.

4. Access to the history and recent status of current and past consumers of the BH service and access to resources about referral points. In the interim and as a minimum, staffs working with the consumer are to have access to a record of consumer’s previous contact with the crisis triage.

5. Each triage center is governed by detailed local policies and operational protocols which can be reliably interpreted.

6. Each triage center systematically monitors the accuracy of the telephone triage decision.

7. Each triage center is integrated with local services and permitted to mobilize emergency assistance, and local MH assessments within the specified urgency of response timeframe.

8. Each triage center:
   • Provides advice and information relating to the availability of public or private behavioral health/IDD services.
   • Provides direction to callers who raise non-BH concerns

8. Each triage center conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities are made publicly available.

The triage clinician must collect and document sufficient demographic, social and clinical information to determine whether there is a need, or potential need, for further intervention by the Behavioral Health/IDD Service, particularly face to face follow up, or whether referral to another service should be considered. The aim of the triage process is to obtain sufficient information from the person making the referral (including self-referral) to:

• Determine whether the person requires a behavioral health/IDD service intervention;
• Identify symptoms;
• Identify possible suicidal behavior or thoughts;
• Determine the level of risk of harm to self or others;
• Determine the level of risk of harm to children including pregnancy;
• Initiate emergency response where extreme and high urgency is identified;
• When a behavioral health service intervention is not required, identify the service most likely to meet the needs of the person (e.g. housing, food, domestic violence shelter);
• Identify local community health services and other relevant services;
• Give the individual clear and concise information about the services available and options for further assessment or treatment including to call back should the situation escalate;
• Refer the person to the service likely to meet the identified need for further assessment or treatment;
• Ensure optimal health literacy by assessing the individual's capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions, and to ensure required follow up actions (medication monitoring is key!!!) take place timely and consistently.
• Ensure that services are delivered in a culturally and linguistically competent manner.

Outcomes
Current Outcome Measures:
• # Units of Service
• # People Served
• # Volunteer Hours
• # Trained Volunteers
• # Call logs submitted
• # People satisfied with call
• # Follow up calls to individuals who agreed to disclose their contact information
• % Of people that were satisfied with call

The following section reflects STRETCH outcomes for future 911/Crisis Hotline services. Achieving these outcomes would require additional funding for expanded technology and staff.

• Grade of service: Average time to answer calls on average over a calendar month [example: 70% of Calls, answered within 30 seconds, when averaged over a calendar month].
• Maximum Speed to Answer (MSA): Not more than 1% of calls wait more than 2 minutes prior to being answered by a clinician. The 1% standard will be consistently achieved regardless of time of day or day of week. (The time to answer a call is measured from the time the call starts ringing to when it is answered by a clinician; not from the time a call is answered by a voice recording or placed in a queue).
• Call Abandonment rate: Not more than 5% of calls are abandoned. A call is “abandoned” if the caller terminates the call having waited at least 10 seconds from the completion of an announcement message.
• Stretch Outcomes
  o # callers who present to an emergency room within 24 hours of a call
  o # callers referred to outpatient or community service who receive service
Opportunity for Collaboration

Relationship with Hospital Emergency Departments. Crisis services programs will strive to develop collaborative relationships with EDs in their service area:

- Mutually Responsive Relationships.
- ED Requests for Help. Crisis services staff will be available to come to the ED and deliver assessment services for a person in crisis, as established in a memorandum of understanding.
- Crisis Services Refers Person to ED. When crisis services staff refers a person in crisis to an ED, they will call to notify the ED of the person’s arrival and the nature of the crisis (e.g., security may be needed, serious overdose situation, etc.).

Rapid Response Protocol.

Memorandum of Understanding. Crisis services providers will strive to develop MOUs to support an effective a working relationship with the EDs in their area. MOUs should address such issues as:

- Clarifying admission criteria for the crisis services providers and the EDs;
- Changes in the staffing capacity of the crisis services providers and the EDs;
- Performance goals for the crisis services providers and the EDs; and
- Holding quarterly meetings to discuss these and other issues of concern.

Relationships with Law Enforcement Agencies/County Jails. Cooperation and collaboration between the crisis-services program and law enforcement agencies/county jails are essential for ensuring the safety of persons in crisis and the staff who help them:

- Violence Occurring or Imminent.
- Other Situations.
- After all significant communication and/or interventions involving law enforcement or county jails, crisis staff will follow-up as needed and appropriate with the local law enforcement agency or county jail and with the person's clinical provider, Care Manager, and/or other treatment provider.
- Memorandum of Understanding. Crisis services providers will strive to develop MOUs with law enforcement agencies and county jails in their service area to support an effective a working relationship.
- Coordination and Collaboration with Others. Unless clinically contraindicated and or not possible, given the time of the day or other factors, crisis services programs will coordinate services with others who are involved with persons in crisis, such as clinical provider, Care Manager, and/or other treatment providers, psychiatric inpatient facilities, and others in their service areas. If due to the time of day, or other circumstances, the others involved in services to the individual could not be immediately accessed, the Crisis services program will apprise them of the crisis and the response as soon as possible. Crisis services programs will:
  - Communicate with all involved providers about plans, assessments, alerts, and interventions; and
  - MOUs. Strive to develop MOUs with providers that describe each other’s role in providing crisis services to mutual consumers. Issues considered should include:
○ Availability of psychiatric consultation and clinical staff;
○ Live telephone response;
○ Screening and classification to determine priority needs (triage);
○ Sharing of information and clear channels of communication;
○ Linkages with resources appropriate to identified needs; and
○ Coverage for crisis services during both the workday and after hours.

**Sustainability**

Developing the capacity of 911 and hotline services to be efficient and effective in connecting with and guiding people in behavioral health/IDD distress is a fundamental hallmark of an effective crisis system. Having the capacity to collect and analyze demographics, clinical characteristics, social determinants of health and outcomes of 911/hotline services has high value to health care systems. This information is highly reflective of the functioning of 911/hotlines, crisis services and health/behavioral health/IDD providers.

Current financial support is available for 911/Hotlines through State and County sources. The funding, however, is not sufficient to establish a baseline standard level across counties nor to support movement to service capability and outcome reporting to support the Triple Aim goals.

Through a detailed and viable plan under the Crisis Stabilization 3.a.ii, DSRIP can be a catalyst to dramatic reform by seeding the change process, advancing regulatory and practice reforms and building care-seeking pathways that will build to better care, improved patient experience and less overall health care cost. Allocation of current State and County funding should be adjusted to support the new model. Cost studies to ascertain likely health care expenditure savings could also be part of a pilot. The outcome of which could inform impact and investment from Medicaid Managed Care Plans or State/County sources.

**Workgroup #1c: Emerging Triage Models**

**Service Area Description**

A Stabilization Center embodies an emerging model of interest in national literature and in the Hudson Valley. The Stabilization Center addresses situational behavioral health crises as an urgent response enabling the guest to cope with a crisis, while maintaining their functioning in the community. The behavioral health need is usually an unplanned event that results in the guest’s immediate need for a behavioral health service and is limited to the stabilization of that presenting crisis. The services will:

- ensure healthcare integration (take into consideration the whole health needs of the guest)
- address the presenting need in a culturally and linguistically competent manner
- promote and ensure optimal health literacy
- address social determinants of health to achieve greater health equity

Appropriate linkages for on-going services will be made prior to the guest leaving the Center. Follow up services will be monitored to ensure timeliness, consistency and effectiveness.
San Antonio, Texas has advanced the model of a community center further into a broader, non-crisis oriented extension referred to as a Restoration Center.

Triage is a first step in the Stabilization Center.

**Uniform Quality Standards**

**Ideal Standards:**

1. Delivers quality minor medical triage and care
2. Has stabilization capacity (consumer can stay for a specified period)
3. Evidence-based clinical crisis counseling, substance use sobering unit and peer services
4. Co-located care management, resources & social services
5. Shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels, including requirements for service approval and transport, shared protocols for medical clearance algorithms, and data on speed of accessibility (average minutes until disposition). The program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. Some systems display names on a pending linkage status board, highlighted in green, white, yellow, or red, depending on how long they have been waiting.
6. 24/7 Outpatient Scheduling. Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the state while providing data on speed of accessibility (average business days until appointment).
7. Shared Bed Inventory Tracking. An intensive services bed census is required, showing the availability of beds in a variety of community and hospital settings with interactive two-way exchange (individual referral editor, inventory/through-put status board).
8. High-tech, GPS-enabled Mobile Crisis Dispatch. Mobile crisis teams should use GPS-enabled tablets or smart phones to quickly and efficiently determine the closest available teams, track response times, and ensure clinician safety (time at site, real-time communication, safe driving, etc.)
9. Real-time Performance Outcomes Dashboards. These are outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates, and service accessibility performance. When implemented in real time, the public transparency provides an extra layer of urgency and accountability.

**Outcomes**

1. Reduce the number of avoidable ER visits
   - Measure # of ER visits for individuals with a BH/IDD diagnosis who present at the ER for either a medical and behavioral health issue.
   - Measure # of ER visits for individuals who present at the ER for a behavioral health issue.
2. Reduce avoidable inpatient behavioral health hospitalizations
3. Reduce hospital readmissions within 30 days
   - Measure # of 30 day readmissions for medical issue
4. Increase Health Home enrollment for eligible individuals

Opportunity for Collaboration

Relationship with Hospital Emergency Departments. Crisis services programs will strive to develop collaborative relationships with EDs in their service area:

1. Mutually Responsive Relationships.
2. ED Requests for Help. Crisis services staff will be available to come to the ED and deliver assessment services for a person in crisis, as established in a memorandum of understanding.
3. Crisis Services Refers Person to ED. When crisis services staff refers a person in crisis to an ED, they will call to notify the ED of the person’s arrival and the nature of the crisis (e.g. security may be needed, serious overdose situation, etc.).
5. Memorandum of Understanding. Crisis services providers will strive to develop MOUs to support an effective working relationship with the EDs in their area. MOUs should address such issues as:
   - Clarifying admission criteria for the crisis services providers and the EDs;
   - Changes in the staffing capacity of the crisis services providers and the EDs;
   - Performance goals for the crisis services providers and the EDs; and
   - Holding quarterly meetings to discuss these and other issues of concern.

Relationships with Law Enforcement Agencies/County Jails. Cooperation and collaboration between the crisis services program and law enforcement agencies/county jails are essential for ensuring the safety of persons in crisis and the staff who help them:

1. Violence Occurring or Imminent.
2. Other Situations.
3. After all significant communication and/or interventions involving law enforcement or county jails, crisis staff will follow-up as needed and appropriate with the local law enforcement agency or county jail and with the person’s clinical provider, Care Manager, and/or other treatment provider.
4. Memorandum of Understanding. Crisis services providers will strive to develop MOUs with law enforcement agencies and county jails in their service area to support an effective working relationship.
5. Coordination and Collaboration with Others. Unless clinically contraindicated and or not possible, given the time of the day or other factors, crisis services programs will coordinate services with others who are involved with persons in crisis, such as clinical provider, Care Manager, and/or other treatment providers, psychiatric inpatient facilities, and others in their service areas. If due to the time of day, or other circumstances, the others involved in services to the individual could not be immediately accessed, the Crisis services program will apprise them of the crisis and the response as soon as possible. Crisis services programs will:

6. Communicate with all involved providers about plans, assessments, alerts, and interventions; and
7. MOUs. Strive to develop MOUs with providers that describe each other’s role in providing crisis services to mutual consumers. Issues considered should include:
• Availability of psychiatric consultation and clinical staff;
• Live telephone response;
• Screening and classification to determine priority needs (triage);
• Sharing of information and clear channels of communication;
• Linkages with resources appropriate to identified needs; and

Sustainability
While there is broad interest across the lower Hudson Valley in incorporating Crisis Stabilization Centers into the local health care system, Dutchess County is the first in the cue to operationalize this new delivery approach. Supporting the roll-out of the Dutchess County Center is important to inform future design, outcome measures and replication.

Sustainability and the pursuit of Crisis Stabilization Centers requires the establishment of regulation, Medicaid reimbursement and supplemental funding resulting in the ability to replicate and sustain Crisis Stabilization Centers at a scale in New York State. The creation of the program in New York State should build towards the future of value-based payments and create a platform for Medicaid managed care support as well as commercial insurance.

Workgroup #2:
Mobile Crisis

Service Definition
A program which provides a means of mobile mental health assessment, peer services, facilitation and offering of hope, crisis management, crisis de-escalation with immediate support. These services will also offer resolution and connection to appropriate services.

Service Users may include, but are not limited to
• Self-referral
• School
• Providers (Mental Health, Primary Care, Social Services)
• Hospitals and ERs
• Case management/ care coordination
• Family/acquaintance/community member
• Law enforcement Service
• Begins – Positive community awareness of service availability and knowledge of how to access.
• Ends – Individual has followed through on any referral/ treatment plans or has disengaged in services by their own choice

Uniform Quality Standards
Identify uniform standards for the service. Uniform standards are subset of best practices and ideal characteristics.

1. Risk Assessment and Intervention Protocols are in place to:
   • Identify individual at risk and potential risk to other
   • Market services available to providers, within community, and to individuals at risk
• Perform assessment of risk while using clinical judgment and incorporating preferred best-practice based tools
• Respond to/manage risk
• Develop crisis plans for all “at risk” individual

2. Care Engagement and Transitions
• Staff have been trained in activation and/or engagement techniques (e.g. motivational interviewing) as well in the key principles of providing culturally competent and trauma-informed care (e.g. patient empowerment, provider cultural humility, structural competency)
• Protocols are in place to:
  • Develop an agreed upon plan with individual, based on evidence-based practice whenever possible
  • Share crisis plans with Individual’s Mental Health provider/ PCP/care management team/ other applicable parties, with individual’s consent, unless clinical judgment deems it critical to communicate without consent
  • Ensure follow-up takes place as soon as possible and within 7 days of engagement to confirm individual has followed through on any referrals and/or treatment plans

3. Evidence-based Guidelines/ Promising Best Practice-based Treatment
Protocol citations below
• Evidence based treatment protocols are maintained and regularly updated
• Process is in place to monitor and ensure that the above protocols are being practiced, with remediation as necessary

4. Coordination with external departments and agencies
• Mechanism in place for 911 calls to link to Mobile Crisis team when appropriate and regulations permit
• Communications/marketing strategy ensures that referral sources are aware of the service and engage in ongoing feedback
• Required participation in community forums, education fairs, etc. to facilitate communication with schools, primary care facilities, group homes, clergy, other providers, and community brokers
• Mobile Crisis team has representation on local government task forces to align strategies and create efficiencies

5. Administrative Protocols
Protocol is in place to ensure/set forth:
• Outreach team includes at least one licensed mental health professional or other qualified mental health professional under Mental Hygiene Law 9.58 at all times for purposes of effectuating transportation, if needed
• Recommendation that team includes at least one staff member with lived-experience and one staff member who has been trained in serving the specific needs of those with IDD
• All triage and follow-up staff has been trained in risk identification protocols
• Staff available 24/7/365
• Staff has access to supervision by a medical mental health provider (psychiatrist, psych NP)
• Tracking of utilization patterns and response times
• Adequate staffing patterns are maintained to ensure average time from referral to face-to-face outreach is at the earliest available time, at max one hour
• Telephone outreach linkage will be established immediately

Outcomes
1. User experience/satisfaction scores
2. Rate of Emergency Department utilization by individuals within 7 and 30 days of Mobile Crisis Engagement
   a. Measuring clinical individual outcomes
   b. Documentation of follow-up within 7 days of engagement eliciting feedback of service received and clinical stability
   c. Tracking of Emergency Department utilization by individual within 7 and 30 days of original Mobile Crisis Engagement
   d. Documentation of follow-up for those who engaged Mobile crisis service and following failure of engagement utilized Emergency depart within 24 hours
   e. Measuring Provider/Individual/ community satisfaction

Sustainability
Workgroup members will follow pending OMH guidance regarding reimbursement for mobile crisis services and financial sustainability.

Workgroup #3:
Respite Services

Service Area Description
Respite services are community-based residential crisis care that, as part of a behavioral health (BH) community crisis stabilization system, can divert individuals with BH disorders (including people with co-morbid intellectual and developmental disabilities as appropriate to setting) from unnecessary hospitalizations and ensure the least restrictive support option is available to people experiencing BH crises. SAMSHA identifies two types of residential services and supports:

• intensive time-limited residential services (SAMSHA calls it 23-hour crisis stabilization (CS)/observation beds & DSRIP project says up to 48 hours); and
• short term crisis residential services.

1. Intensive CS/Observation residential services are defined as follows: A direct time-limited residential service with appropriate medical and/or psychiatric services available on-site at all hours from respite program staff and/or collaborating partners (e.g. mobile team, BH Crisis Stabilization Center, Article 31 clinic offering new off-site clinical services) that provides individuals in severe distress with brief supervised care to assist with deescalating the severity of their crisis and/or need for urgent care. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care. The main outcome of observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation. Hudson Region has no CPEP
observation beds. HCBS Intensive Respite Beds could fill this need for the HARP population, if and when developed.

2. **Short term crisis residential services** are defined as follows: A direct time-limited residential service with access to clinical services off-site that assists with de-escalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental health disorder. Residential crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour engagement, stabilization and support services for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery. Core attributes of residential crisis services include providing housing during a crisis with services that are short term, serving individuals or small groups of clients, and are used to avoid hospitalization.” (Hudson Region has several these services listed below supported by various NYS and county funding).

a. RPC Alliance House: on State PC grounds, crisis residence with up to 30 day LOS (OMH reinvestment funding thru county)

b. OMH Crisis Respite/Stepdown Pilot Beds: ASFL in Orange uses Parachute Criteria for admission (adult SMI only, no homeless), others? (OMH contract funding)

c. Rose House: short-term peer-run crisis respite with approx. 7 day ALOS, accepts referrals or self-referrals who have SMI and/or SUD, multiple county locations. (County contract funded)

d. HCBS Short Term Crisis Respite: is a short-term care and intervention residential service for individuals with mental health or co-occurring disorders that cannot be managed in their home or community. The model provides on-site peer and other supports for up to 7 day LOS for HARP enrollees. Region has several providers designated to develop, but there are facility and operating funding sustainability challenges (managed care plan funded with Medicaid $s). Currently cannot be offered in CR facilities due to CMS settings rule.

e. HCBS Intensive Respite: has 24/7 nursing and daily medical/psychiatric services (Observation Bed model), with up to 7 day LOS for HARP enrollees. Region has several providers designated to develop, but there are facility and operating funding sustainability challenges (managed care plan funded with Medicaid $s). Currently cannot be offered in CR facilities due to CMS settings rule.

f. Westchester County Planned Respite/Stepdown Beds: Organized by MHA Westchester with many OMH residential providers making available vacant beds for people with crisis or urgent needs for up to 14 days in a calendar year, admission is pre-authorized by county, homelessness is exclusionary criteria, underused by hospitals and first responders (County contract funded).

g. OPWDD Respite Beds: ASFL operated 2 for region that are always full, often with individuals who can’t be easily placed in residential setting due to behavioral issues. (OPWDD contract funded). New Horizons operates beds in Dutchess. OPWDD-funded START will be developing 4 additional bed.
h. Children’s Crisis Respite will be addressed under the Children’s SPA/HCBS that will be implemented soon. Access is planning to seek dual licensure for its OCFS Emergency Group Residence/Diagnostic Center as a Children’s Intensive Crisis Respite

i. Misc. Legacy Beds: Since late 1990s, SFC has 1 bed in Putnam and 1 in Westchester located in OMH-licensed apartment treatment programs, used for respite, stepdown and crisis diversion. (County funds with OMH reinvestment).

j. Honor EHG operates 3 respite beds in Orange County adult shelter and up to 13 in youth shelter. Initial LOS is 72 hours with time extensions; average 4 days. (County funds with OMH reinvestment).

k. New Beds: St. John's Riverside and St. Vincent's are both in the planning stage to open crisis residences if financially viable (not sure of funding stream(s). CBHS is working with an MCO to utilize vacant CR beds and apartments for Plan-reimbursed respite. Supportive services will be offered by visiting staff.

3. Non-Residential Respite Services are defined as professional and/or supportive services that can be offered by BH professionals, including credentialed Peers, in community settings to address crisis needs of persons with BH disorders and do not have a residential component. Examples include in-home supportive services during a time-limited crisis (ex. PEOPLE Inc. provides with Peers) and day respite in a variety of settings (ex. PEOPLE Inc. offers Peer support at Rose House, MHA of Dutchess for homeless people in Dutchess with BH disorders, HDSW opening a Living Room program with on-site RN, LCSW & Peers with consulting psychiatrist).

Summary: Region has many types of beds supported by varying funding sources that require different operating standards and admission criteria (most for discrete populations & not for homeless). Most programs are targeted for county residents and do not serve the region or contiguous counties. Depending on county and funding auspice, the respite beds may be a component of a planned community crisis response system, or operate as a one-off service working hard for front door referrals and discharge options. Overall, there is a high level of regulation and population targeting regardless of funding source that makes it difficult to optimally address need in the region. Funding streams (ex. HCBS) are inadequate to support operations and capital funding to create the facilities are almost non-existent.

Recommendation: Current and future crisis respite services can most effectively and efficiently respond to community needs if the BH Crisis Stabilization system changed in the following ways: (1) Creates a quick acting intake and referral process in each community for all beds that allows providers to respond to referrals within hours; (2) Addresses the facility challenges for creating new beds by prioritizing local resources and capital, as well as advocating for NYS resources; (3) Adopts uniform quality standards regardless of funding streams; (4) Adds a “home respite” model to the service category to enable individuals to stay in their homes with time-limited crisis respite workers staying with them as needed, with a menu of crisis-based services available to meet individual needs. This in-home service could work with a community program or day respite program that the individual attends during the day; (5) Adds “day respite” programs such as Living Rooms and day respite for individuals who do not need residential services or who are using in-home respite services; and (6) Coordinates the development of children’s crisis respite services within the framework of the new SPA/HCBS to meet community needs.
Uniform Quality Standards

Functional Role in BH Crisis Stabilization System:

1. Connected to a variety of referral sources (e.g. hospitals, community providers, mobile teams, Health Homes, MC Plans, 911, self, family, police, etc.), as well as local central triage and/or hotline if any;
2. Has timely admission process (ideally daily within a few hours of referral), with clear standards as to who is eligible;
3. Have a significant service component provided by certified and trained peers as feasible;
4. Utilizes evidence-based practices (e.g. trauma-informed care, MI, CTI, etc.) and local promising practices;
5. Provides safe, calming, trauma-informed environment for individuals to literally get “respite” from outside stressors and a place to rest before they address other issues;
6. Appropriately trained staff who are supported in their work;
7. Is knowledgeable about and can connect respite clients with Health Home, intensive and/or follow-up services based on their needs and preferences;
8. Has a process for giving information to and getting information from other providers in the BH crisis stabilization system; and
9. Works with other BH community crisis stabilization services to achieve desired outcomes for participants (e.g. reductions in ER and inpatient use, reduction in incidence of crises; increasing early intervention to BH crises).

Outcomes

1. Positive user experience as measured by post discharge surveys
2. Improved community stability and engagement as measured by few ER visits/inpatient admissions) post discharge from crisis respite
3. Engagement in intensive or follow-up services post discharge from crisis respite
4. Positive impact on housing stability with family, supportive housing and/or community housing
5. Positive referral source experience as measured by post-referral surveys

Opportunity for Collaboration

State, county and MC Plan funding sources of crisis respite in the region should collaborate on

1. joint outreach activities to hospitals, information lines, mobile teams, police and other referral sources to facilitate optimal use of existing resources;
2. alignment of admission process/approvals to access service;
3. uniform referral processes to access intensive and/or follow-up services in timely way;
4. pooling new resources to support additional respite beds; and
5. create a new funding category for in-home respite supportive services.

Police and hospital systems in the region should collaborate with BH community crisis systems to divert people who can safely use community alternatives to crisis respite and other community services.
Sustainability
HCBS: Potentially significant new source of funding for Short-term and Intensive Crisis Respite but
• No funding for facilities and can’t be co-located in CRs because of CMS settings rule.
• Operating funding is FFS and will not support a 24/7 operation with varying levels of occupancy without payment guarantees by Plans (ex. Plan pre-reserves capacity for 4 beds for Plan members)
• Limited to HARP enrollees and that pool would have to grow for residences to be able to fill beds

No Medicaid funded Crisis Respite options for Mainstream Plan Beneficiaries and Duals and avoidable ER and inpatient use goals cannot likely be achieved without addressing this gap.

FFS Payments don’t work for respite services: Respite residential and day services have high fixed operating costs that cannot be sustained without reliable funding to support 7 day a week operations regardless of service demand.

Workgroup #4:
Intensive Services

Service Area Description
Intensive crisis services are not explicitly discussed in the literature as a category of crisis care, in contrast to triage, mobile crisis and short term residential respite services which are explicitly defined and discussed. Given that we could not find a definition in the literature, the workgroup offers the following: Intensive Crisis Services are those services that are (a) recovery-oriented, (b) time-limited, (c) offered in community settings, and (c) targeted for people with behavioral health (BH) disorders (e.g. mental health and/or substance use disorders including those with co-occurring intellectual/developmental disabilities) who need more than a brief intervention available from mobile crisis teams and/or short-term crisis respite but can safely be treated in a community setting. These services can be residential or not, but are characterized by engagement that may span weeks or months, multi-disciplinary service teams, and evidence-informed program design tailored to address a variety of specific needs and issues. In the region, the following programs have been identified as falling into this service area, though this list is not all inclusive:

1. Inpatient Medically Supervised Withdrawal and Stabilization Service (Detoxification) and Medically Monitored Withdrawal and Stabilization in a Residential Setting (regulated by OASAS and reimbursed by Medicaid, Managed Care, etc.). Ex. Arms Acres has Inpatient Medically Supervised Withdrawal and Stabilization.
2. Intensive Outpatient Services (regulated by OMH and OASAS, and funded by Medicaid). OASAS IOS is 3 days a week for 3 hours a day. Ex. Arms Acres (OASAS) and St. Vincent’s (OMH)
3. Partial hospital programs (regulated by OMH and funded by Medicaid). Ex. St. Vincent’s. Jawonio starting one for adults with SMI (Funding NYS legislative grant).
4. NY START Program that provides a range of community services to address BH crises and urgent issue in community settings, including in IRAs and other regulated settings (OPWDD contract program). (ex. One region-wide program)
5. Intensive Behavioral Support (IBS) that offers in-home intensive time-limited services for people with IDD and their families to address BH challenges (OPWDD home &
6. Crisis Stabilization Center that has elements of intensive services and connects individuals to intensive services (funded by Dutchess County & WMCHealth PPS)

7. Ambulatory Detox (regulated by OASAS and funded through Medicaid). None known to be operating in region.

8. Peer Hospital Diversion/Transition (county contracts for OMH reinvestment funds). Ex. Independent Living offers 30-90-day peer services based on need in Orange and Sullivan.

9. Residential crisis stabilization (regulated by OASAS and funded by Medicaid). Ex. HONOR.

Summary: The workgroup identified that there is no widespread network of intensive crisis services in the PPS region, leaving a gap between outpatient and inpatient care. The high rates of unnecessary hospital admissions and ER visits are directly linked in part, they concluded, to the paucity of intensive community alternatives.

Uniform Quality Standards

Functional Role in BH Crisis Stabilization System:

1. Connected to a variety of referral sources (e.g. hospitals, residential respite, community providers, mobile teams, Health Homes, managed care plans, law enforcement, family/caregivers), as well as 911, local central triage and/or hotline if any;

2. Has clear objective standards as to who is eligible for the program and appropriate for the program’s level of care;

3. Has a timely admission process that can respond to referrals within 24 hours for residential programs and within 1 business day for ambulatory programs;

4. Offers effective time-limited interventions that incorporate evidence-based practices (e.g. trauma-informed care, MI, CTI, CBT, DBT, etc.) to address BH treatment, recovery and support needs post inpatient/ER discharge or as a community alternative to inpatient treatment;

5. Preferable to have a certified peer service component as available;

6. Works with the individual to develop a safety plan;

7. Is knowledgeable about and can connect intensive services clients with follow-up services based on their needs;

8. Has a process for giving information to and getting information from other providers in the BH crisis stabilization system; and

9. Works with other BH community crisis stabilization services to achieve desired outcomes for participants (e.g. reductions in ER and inpatient use, reduction in incidence of crises; increasing early intervention in crises, improved rates of housing and financial stability).

Outcomes

1. Positive user experience as measured by post discharge surveys

2. Improved community stability and engagement as measured by fewer ER visits/inpatient admissions/911 calls post discharge from crisis respite, as well as improved financial stability (e.g. benefits, income) and enrollment in Health Home if eligible.

3. Engagement in follow-up services post discharge from intensive crisis services
4. Positive impact on housing stability with family, supportive housing and/or community housing
5. Positive referral source experience as measured by post-referral surveys

Opportunity for Collaboration

Identify opportunities for collaboration between providers, counties and across the region. Incorporate relevant Regional Planning Consortium recommendations.

How can intensive services be used most effectively in meeting Medicaid transformation goals? How can intensive services be better aligned to contribute to their local BH crisis system?

1. Funders can align intake protocols and quality metrics
2. Navigation can be standardized to get person back to their community provider
3. All providers collaborate on transition plan from Intensive Services
4. Regional protocol for sharing client information with their consent
5. BH crisis providers jointly “market” in their community to referral sources, individuals and their families.
6. There is an interactive directory or app (ex. WMCHealth has made Healthify available to its partners) to find out about available services and program capacity to accept referrals.
7. Uniform protocol for timely accessing the appropriate level of care for individuals assessed to be high risk.
8. Counties and PPS should work with BH crisis providers to document and examine systemic causes that precipitate avoidable use of ER and inpatient services by individuals with BH disorders (e.g. lack of housing, economic insecurity) and provide an economic analysis to NYS and MCOs about potential savings from better addressing these issues.
9. Counties and PPS should also work with BH crisis providers around identifying specific service gaps that can reduce avoidable hospital use and engage funder partners (e.g. NYS, MCOs) to timely fill gaps (e.g. supports in shelters, small caseload Health Home care managers for high risk individuals).

Sustainability

Identify current reimbursement sources for services, those being planned for by the State/Community and those needed in the future.

1. New funding streams for community-based BH Intensive Services become available from managed care plans, NYS and counties to fill gaps in communities throughout the region.
2. Current funding is adequate to cover the costs of operating Intensive Service programs
3. NYS earmarks new funds to expand existing effective programs as need for community services increases with Medicaid system transformation.
**Workgroup #5:**
**Follow Up Services**

**Service Area Description**
Follow-up is a broad area encompassing natural supports and services that prevent crisis, proactively identify and address signs of an emerging crisis or contribute to helping a consumer resolve a crisis. Follow-up is characterized by the right service, at the right time in the right amount. Communication, workflows and a single plan of care contribute to success given the fact that most consumers choose and may need more than one follow-up service or support.

Examples of follow-up include but are not limited to:
- Health Home & Care Management
- ACT
- Peer Services (Adult Peer, Youth Peer & Family Peer)
- Behavioral Health Services
- Medical Treatment
- Vocational, Educational &/or Recovery Supports
- Home & Community Based Waiver Services (Adult/Youth)
- Housing
- Mobile Crisis
- Community Based Organizations

**Uniform Quality Standards**
1. Engagement is characterized by
   a. caring contacts: genuine and positive welcome to the service/support; acceptance of the person as they are/where they are at; demonstration of recovery principles and person-centered service
   b. warm handoffs: Level A – a direct, personal introduction to the new service or support. Level B – An appointment is set up, directions and/or transportation arrangements are in place and all necessary information is transmitted to the new service in advance.
   c. real-time access: Services/Supports are provided within 24 hours or a phone call is made within 24 hours to the consumer to acknowledge their need and to inform them of next steps and timeframes

2. The roles and responsibilities of follow up services should be mapped in community specific workflows. The use of workflows creates shared expectations, definitions and examples of what a “warm handoff” is and the interdependency of services, supports and the consumer. Workflows help communities to build in evidence based practice and community-wide norms (i.e. Welcome Orange; Dutchess Stabilization Center)

3. Success targets should be established for each service. This supports shared understanding of what we are working towards to move to self-sufficiency and/or graduation from more intensive services to less intensive services (Services do not necessarily have to be forever)

4. Consumers are supported through a single crisis plan, driven by the consumer, inclusive of natural supports and assessing/addressing the consumer’s basic needs (housing, food, safety, etc.)
5. Evidence-Based Practices are used consistently and are age, culture and service appropriate. (Motivational Interviewing, Solution-based Casework, WRAP, CTI, CBT, DBT, etc.)

6. Consumer engagement and achievement of target goals should be discussed at the time a care plan is developed or updated. In completing a care plan, the consumer and provider should discuss and agree on the frequency within which the care plan will be reviewed. The care plan should also include a plan to re-engage the consumer if needed. e.g. John prefers an in-person visit at his home if he has not been in contact as planned. Celebrating successes, making adaptations and trying something different if engagement is not strong or outcomes are not achieved.

7. National Standards for Care Transitions should be pursued by individual providers and community systems. Working with the Care Transition Standards helps communities advocate for specific changes in regulation, incentives and operations. Held as “stretch goals” these standards may be needed to be modified to reflect current, local best practice based on capacity, timing, technology, etc.
   a. During a crisis, the consumer, intensive service, Health Home/Care Manager, natural supports and follow-up services are communicating, coordinating and educating.
   b. Shared accountability for success. The sending and receiving service are both accountable for a successful transition.
   c. The transition plan is specific, achievable and incorporates strategies to avoid repeating past failures or known risks. Including suicide risk and problems in meeting basic needs of housing, food, safety, etc.
   d. Shared forms, assessments and a single plan of care are in place and can be accessed in real-time.
   e. Community training in the importance of care transition and in common practices that support collaboration are in place.
   f. Access to follow-up occurs in a timely fashion. Markers could be identified using benchmarks such as outpatient behavioral health visit within 7 days of discharge or adapted at a community level to reflect local standards.
   g. No-shows are flagged and actions are taken to locate the person, ensure their safety, and reschedule the appointment or link them to a higher level of care if necessary.
   h. If a consumer returns to the ER or Inpatient Unit within 30 days of discharge, the care team gains an understanding of why and incorporates learning into future care plans.

Outcomes

1. Reduce the number of avoidable ER visits
   • Measure # of ER visits for individuals who present at the ER for a behavioral health issue.

2. Reduce hospital readmissions within 30 days
   • Measure # of 30 day readmissions for behavioral health issue

3. Increased early access to service within 7 days of discharge from a hospital
   • Measure behavioral health appointments kept within 7 days of hospital discharge
   • Measure medical appointment kept within 7 days of hospital discharge
   • Measure community support service connections kept within 7 days of hospital discharge
4. Reduce avoidable inpatient behavioral health hospitalizations TBD
5. Measure service connectivity across agencies. TBD

**Opportunity for Collaboration**

Follow-up works optimally when the community culture and norms provide sufficient clarity on roles and responsibilities to allow for genuine accountability. Additionally, the following factors heavily influence success:

- Real-time information
- Alerts and action flags
- Quality Standards
- Aligned Incentives for Providers

As we enter the era of value-based payment solutions to sharing information are critical. Health Homes, PPSs, LGUs and DOH must collaborate to ensure that members' PHI sharing amongst providers adheres to HIPAA and other specified regulations, without adding burden to the providers.

The maturation of IPAs offer an important structure through which services, incentives, information and quality can be aligned. Providers need these structures that focus on quality, cost and outcomes rather than regulatory compliance and volume to innovate and be successful.

In the Hudson Valley, we could (if it is not in place currently) create this culture through County-Based Dialogues

- Use data (Inform and Ongoing Accountability)
- Establish norms
- Build workflows (I know where I fit and what to do)
- Identify priorities for rapid process improvement (create solutions or work-arounds; hands on experience activates)
- Prioritize State/Federal Issues

**Sustainability**

Through DSRIP, the PPSs, LGUs and Partners need to work to create roadmaps and templates to support follow-up services in meeting the stated objective of ensuring access to natural supports and services that prevent crisis, proactively identify and address signs of an emerging crisis or contribute to helping a consumer resolve a crisis. There is hope and promise that the move to value and an introduction of improved technology can not only sustain but grow follow-up capacity in the lower Hudson Valley. DSRIP has capacity that can support this important mapping effort and subsequently in the establishment of funding mechanisms through contracts, reimbursement and government funding. The road map should expressly address actions to create a more universal access to follow-up services through activation of the Parity laws.
III. Visual Library
   i) Crisis Service Components (Developed by Crisis Service Workgroups)

   (1) Triage
(2) Mobile

MOBILE CRISIS PROGRAM WORK VISUAL

REFERRAL
(individual, community member, school, provider, case management, 911, law enforcement, Hospital/ER)

Consent obtained

Mobile Crisis ENGAGEMENT

Telephone outreach

Face-to-face outreach

No contact made with individual

Community-Based services/Hospital Diversion

Referral to Emergency Department

Case Closure

Admission

Discharge with referral to services

Warm hand-off to case management

Mobile Crisis Follow-up
(3) Respite
Joint PPS Crisis Service Work Groups
Crisis Respite Workflow Visual

Referral Sources  Interacting Services  Referral Services

- Mobile Crisis, BH Crisis Stab Center, OPD mobile, HH

Crisis Respite
Functions
- Support engagement & stabilization
- Offer option for risk assessment
- Coach self management/determination skills
- Assess wellness, housing, economic & social domains (e.g. SAMSHA 8 dimensions of wellness)
- Develop/Implement transition plan

(4) Intensive
Joint PPS Crisis Service Work Groups
Intensive Services Workflow Visual

Referral Sources
- Information Lines
- Triage Services
- Hospitals: ERs & Inpatient
- Mobile Teams
- BH Crisis Center
- Community Providers
- Police/EMS
- Self Referrals
- Family

Intensive Crisis Services
- OASAS residential medically supervised & medically monitored services
- OMH Partial Hospital
- OPWDD START/Intensive Behavioral Support
- Dutchess BH Crisis Stabilization Center

Functions
- Bridge between high & low levels of care
- Recovery-focused & Trauma Informed
- Stabilization & rehabilitation
- Treatment of clinical and other factors that triggered crisis
- Implement crisis plan from referral source
- Develop transition plan to lower level of care & implement

Lower Level of Care
- Referral Source
- Recovery Services (Clubhouses, Peer Supports, Recovery Coaches, PROS)
- Supportive Housing
- ACT
- BH Clinics
- Health Homes
- OPD Medication Assisted Treatment
- Family/Informal Supports
(5) Follow-up

Follow-Up is...

ongoing care to prevent or respond to a crisis

meeting the individual where they are

Community Support

Care Management

BH/Medical Treatment

a team sport (we are elevated by our stars and weakened by those who do not perform well)

ER

Hospital

doing care transitions well
BUILDING COMMUNITY CULTURE AND CAPACITY

BEHAVIORAL HEALTH CRISIS STABILIZATION

- Many Access Points
- Person Centered
- Knowledge of Community Gatekeepers
- Accounting
- Skill in Engagement
- Funding Siloes
- Limited Access
- Overuse of ER
- Variable Quality
- Regulatory Siloes
- Differing risk tolerance

Pulling Together to Define Behavioral Health Culture and Capacity

3 DSRIP PPS’s
MHVC
Refuah
WMC

Regional Planning Consortium/LGUs