
NASMHPD

The document sets out to help MH & SUD providers (“providers”)

- Articulate the need for operational readiness for 988
- Prepare for the 988 transition (not a specific mandate for them)
- Explain how to make progress on the criteria that are central to 988 readiness
- Identify best practices and examples seen in the field today

. The document is written for executive leadership (e.g., CEO and/or Chief Clinical Officer) of a community behavioral health provider (e.g., Certified Community Behavioral Health Clinics (CCBHCs), Community Mental Health Centers (CMHCs), or similar) that provide MH and/or SUD services and treatments. These organizations may provide a range of services including mobile crisis services, crisis receiving and stabilization services,

Criteria

Criteria	Beginning	Emerging	Solidified
Linkages to Lifeline co ntact ce nters (“centers”): Does the organization have relationships with nearby centers?			

Criteria	Beginning	Emerging	Solidified
To what extent does the organization share individual data and information (e.g., electronic health records) with other providers?	Limited to no sending or receiving of electronic health records on individuals	Some sending or receiving of individual electronic health records but not via a standardized or consistent processes	Consistent sending and receiving of individual electronic health records via standardized and consistent processes, including full records in an interoperable format consistent with Office of the National Coordinator for Health Information Technology (ONC) requirements; this includes information about current crisis episode, prior history (incl. previous crisis episodes and contacts), any safety related information, and any medications previously dispensed)
To what extent does the organization have defined policies or procedures to follow up on individuals in crisis after the crisis episode, as appropriate?	Generally, no follow-up provided or coordinated	Follow-up provided or coordinated for some individuals in crisis	Follow-up provided and coordinated for all individuals in crisis
3. Crisis care practices: Do the organization's crisis			

Criteria	Beginning	Emerging	Solidified
	Limited engagement and collaboration with individuals to align actions to their preferences Limited engagement and collaboration with families to align actions to their preferences	Some engagement and collaboration with individuals, but care is not fully recovery-oriented Some engagement and collaboration with families, but care is not fully recovery-oriented	Care is fully recovery-oriented, with individuals and families engaging and collaborating in their care as well as care plans that fully align with their needs and preferences
What is the commitment to the Zero Suicide framework or a similar universal suicide assessment framework?[2]	Elements of the framework are not met, and there is no formal commitment Suicide risk screening, assessment, and planning processes are not standard practice	Elements of the framework are met to some degree and there is some commitment Suicide risk screening, assessment, and planning processes may take place but are not standard practice	Elements of the framework are met, and there is full commitment to it Suicide risk screening, assessment, and planning processes are standard practice
What role do peers (such as Peer Support Specialists, Recovery Coaches, and/o r Youth and Family Peer Support Specialists) with lived experience play in crisis response across service delivery, training, and evaluation of services?	Limited to no peers with lived experience engaged in services	Some peers with lived experience engaged in services, but they are not consistently integrated in crisis response	Many peers with lived experience are on staff and/or routinely engaged in services. Peers play a vital part in crisis response, as appropriate
How are social determinants of health (SDOH) considered as part of an individual's screening (e.g., evaluating an individual's environment and living conditions)?[3]	Limited to no screening for SDOH or referral of individuals to social services, as appropriate	Inconsistent screening for SDOH and referral of individuals to social services, as appropriate	Consistent screening for SDOH and referral of individuals to social services, as appropriate

2 Zero Suicide is a continuous quality improvement framework that shows health and behavioral health care systems how to transform care for individuals at risk for suicide. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving safety of individuals in crisis, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. Source: "Zero Suicide Framework," Zero Suicide, Education Development Center Zero Suicide Institute, accessed Jan 31, 2022, https://zerosuicide.edc.org/about/framework.

3The social determinants of health (SDOH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Source: "Social determinants of health," World Health Organization (WHO) Health Topics, accessed Jan 31, 2022, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

Criteria	Beginning	Emerging	Solidified
5. Capacity: Can the organization accommodate a potential increase in demand for services?			
To what extent can the organization accommodate an increase in demand for Mobile Crisis (MCT) services for all individuals in crisis (i.e., respond to requests with urgent need in one hour in urban areas or two hours in rural areas), if relevant for the organization?	Limited to no ability to increase capacity with no defined plan to provide and accommodate potential increases in future demand	Limited ability to increase capacity currently, but with plan in place to provide these services in the future and accommodate potential increases in demand	Ability to handle an increased demand for services for all individuals (including adults, youth, and parents / caregivers with children)
To what extent can the organization accommodate an increase in demand for c			

As an organization, building and/or strengthening relationships with nearby Lifeline contact centers is a key element of readiness for 988. Lifeline contact centers answer calls for the Lifeline as well as other local helplines and offer other resources such as text, chat, and mobile services. Building relationships with these Lifeline contact centers is an important step toward being able to accept transfers from contact centers as needed.

Some CCBHCs may currently have no relationship with their local Lifeline contact centers, while others may be informally engaged with Lifeline contact centers but lack formal agreements. Some CCBHCs themselves may also function as Lifeline contact centers. Based on the maturity of existing relationships with Lifeline contact centers, priorities for developing linkages to Lifeline contact centers will vary.

This section describes:

- Approaches to establishing relationships with Lifeline contact centers
- Resources to build / integrate mobile dispatch technology

A provider of crisis services in Tulsa for the past 22 years, F&CS is a Lifeline contact center and CCBHC that offers integrated crisis services that range from crisis calls to crisis beds. F&CS prioritizes:

- x : To serve the Tulsa Community and individuals in crisis, F&CS provides integrated crisis services for individuals in crisis across acuity levels that include:
  - Crisis contact services
  - Mobile crisis response (24/7/365)
  - Triage, screening, and assessment unit (24/7)
  - Crisis urgent recovery center (chairs, up to 24 hours)
  - Crisis stabilization unit (beds, three to five days)
  - Community response team, a collaboration with the Fire Department, Policy Department, and Mental Health Association) to respond to 911 calls with an eye towards MH support

- x To bes

documentation that suits the special requirements of crisis contact centers. It fully supports billing encounters, unlike many other systems currently used by other providers.

Examples of Solari's customized technology solutions include:

- Solari's telephony system sends live call data to the electronic medical record system. This increases data integrity by minimizing the number of fields staff manually complete. The system creates a list of calls that were taken and must be documented, therefore providing a reminder list for documentation
- By using a clearinghouse to automate client eligibility lookups, Solari ensures accuracy of data and allows staff to focus on crisis calls without needing to ask for insurance or funder information
- The forms are dynamic and adapt based on the call type and what occurs throughout the call. This helps guide staff through the call to ensure complete and appropriate

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Solari developed two methods of electronically communicating client- and crisis-based data points to mobile teams.

The Dispatch Management System (DMS) enables the following in real-time:

- x – Once a mobile team is dispatched, the team receives the information related to that dispatch through a mobile application in real-time
- x – DMS employs vehicle-mounted hardware that sends GPS location information to track teams in real-time on a map
- x – DMS also allows mobile teams to log en-route, on-scene and cleared times in the app, minimizing the need for manual data entry of key reporting data points. These data points are fed back into the EHR and the data warehouse to allow for reporting on the end-to-end experience of the crisis caller

Solari technical teams collaborate with mobile team provider agencies to pass client- and crisis service-based data points (t)-6.634 38isis service

	variety of hours, shorter shifts, weekends, and/or nights. Having a deep bench of flexible staff allows the providers to be more responsive to peak times
x	Providers are encouraged to identify ways to have fast, if not immediate, access to psychiatric consultations available to individuals served by mobile crisis teams. At the state level, CT provides funding to the mobile crisis services to pay for psychiatric consultations

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There is no wrong door in an ideal crisis system. To best serve individuals in crisis and as part of an integrated crisis system, it is ideal for providers to accept referrals from any source. If the provider is unable to provide appropriate care for the individual, that provider can connect the individual to a provider that can deliver the most appropriate care based on available options.

This section describes:

- Referral processes and practices
- Resources to set up same day access

As part of accepting referrals and providing appropriate care and connection to care to individuals in crisis, providers can evaluate all potential sources of referrals and consider whether or not the provider can accept individuals from or connect individuals to the sites of care.

These sites of care include but are not limited to:

- Mobile crisis services
- Crisis receiving and stabilization services
- Crisis respite facilities
- Urgent care facilities
- Hospitals (EDs, inpatient, and outpatient settings)
- Primary

- Level of Care Utilization System (LOCUS) for adults
- Child and Adolescent Level of Care Utilization System (CALOCUS) for children and adolescents
- (Early Childhood Service Intensity Instrument for children aged 0-5
- American Society of Addiction Medicine (ASAM) criteria for SUD crises and treatment needs

x Individualized assessment for suicide risk, violence risk, and medical risk should be completed for each referral

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- Referrals should be consistent with the individual's crisis plan or advance directive if available
- Referrals should be consistent with the use of open dialogue with the person in crisis regarding their own wishes and preferences

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- Initial evaluation in one business day, if urgent (can be telephonic)
- Initial evaluation within 10 business days, if routine
- Comprehensive diagnostic and treatment planning evaluation to be completed within 60 calendar days

To set up SDA, provider organizations can assess their current access-to-care process flows and identify barriers to effective access. As outlined by the National Council, provider organizations can consider:

- "The number of processes, staff, and client time requirements; documentation requirements, including data collection redundancy; and the costing for each access-to-care flow process
- Use of objective flow charts, costing, and data mapping outcomes to increase awareness of change in access-to-treatment processes and practices that can improve access to services
- A standardized access-to-care process flow, including costing awareness"

Results-oriented change techniques include:

- Reduce documentation requirements by focusing on the removal of data elements that are captured repeatedly or not required by funding or accreditation organizations and by changing the answer formats used to capture

step training process and, initially, increased staffing as well as enhanced IT infrastructure and workflows.

Compass has now implemented SDA across all 47 locations, doubling the number of first-time clients served and eliminating no-shows. It also increased licensed staff and implemented telehealth capabilities for initial assessments.

	24.5%	100%
	79.8 days	

The 988 transition underscores the importance of ensuring crisis systems are able to respond to community needs. SAMHSA's National Guidelines for Behavioral Health Crisis Care lay out a comprehensive view of core services and guidelines for crisis care. This section provides an overview of the key elements covered in SAMHSA's National Guidelines, highlights some specific steps that providers can take to implement key elements into their practice, and offers additional information on how some of these elements have been incorporated by crisis care providers.

Best practice crisis care incorporates a set of core principles throughout the entire crisis service delivery system. These principles offer elements that must be systematically "baked in" to excellent crisis systems as well as the core structural elements that are essential for modern crisis systems.

The SAMHSA National Guidelines principles and practices (the descriptions below contain excerpts from these) include:

relationships between providers, SMHA, and Missouri Department of Public Health built trust, flexibility, and agility into processes.

The partnership between Compass Health, peer community health centers, and SMHA was largely successful because of:

- Comprehensive information-sharing
- Alignment of goals from different organizations
- Consideration of long-term horizons (e.g., one-year later)

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Zero Suicide is a continuous quality improvement framework that shows health and behavioral health care systems how to transform care for individuals at risk for suicide. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving the safety of individuals in crisis, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care.

People experiencing suicidal thoughts and urges often fall through the cracks. Zero Suicide takes a system-wide approach to improve outcomes and close gaps. For health and behavioral health care systems, Zero Suicide represents a commitment to the safety of individuals in crisis, as well as safety and a just culture of support for care providers.

The Zero Suicide model operationalizes the core components necessary for health care systems to transform suicide care into seven elements:

- : Leadership support and involvement in Zero Suicide represents a commitment that goes beyond one staff, one supervisor, or one department. Leadership must both help staff see and believe that suicide can be prevented and provide tangible support in a safe and blame-free environment—what is known as a just culture. Zero Suicide calls on leaders to use opportunities to improve care driven by data, research and best practices, and feedback from staff, individuals in crisis, and experts alike. This system-wide commitment is vital for the framework to take root and lead to sustainable systems-level changes and better-quality care.

- : It is essential that all staff members have the necessary skills, which in turn will help staff feel more confident in their ability to provide caring and effective assistance to individuals in crisis with suicide risk. Staff receive training commensurate with their roles in providing safer suicide care. Providers need to ensure that the training contains the following elements:

  1. The fundamentals of the organization's Zero Suicide philosophy

  2. Policies and protocols relevant to the staff member's role and responsibilities

  3. Basic, research-informed training on suicide identification for all staff

  4. Additional training to ensure all clinical staff possess a basic level of skill in assessing, managing, and treatment planning for individuals at risk of suicide, including safety planning and reduction of access to lethal means

Barb Gay, Manager of the Zero Suicide Institute at the Education Development Council.

5. Advanced training to deepen skills and increase confidence and effectiveness

x : A policy of screening all individuals at intake needs to be established as well as a routine frequency for screening established individuals. Providers should ensure that a comprehensive suicide risk formulation is completed during the same visit whenever a patient screens positive for suicide risk

x : Every individual who is identified as being at risk for suicide must be closely supported. By developing a suicide care management plan for individuals so they are engaged and re-engaged at every encounter (no matter the reason for the visit), staff working with these individuals can use these opportunities to instill hope of recovery. The result of active engagement in suicide care is that the individual feels heard, cared for, and empowered to make safe decisions

x : Clients with suicide risk must be treated in the least restrictive setting possible. Evidence-based approaches to treating suicidality include interventions and treatment that are designed to target suicide risk directly, which has demonstrated effectiveness in reducing suicidal thoughts and behaviors

x : Providers also need to implement follow-up protocols and supportive contacts for individuals in their suicide care management plans. The burden lies on the provider, rather than solely on the individual and family members, to develop methods to ensure that individuals make and keep appointments, and to help them

MHCGM implemented initiatives to train staff, assess suicide risk in 100 percent of their active cases, and enhance the provision of evidence-based practice. They saw a 44 percent decrease in suicide deaths following their first year of implementation.

Chickasaw Nation Departments of Health and Family Services began implementing in the ED

- The National Coalition for Mental Health Recovery (NCMHR) has a list of peer organizations members (https://www.ncmhr.org/members.htm)

x Develop support and supervision that aligns with the needs of a program's team members

x : Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This can include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members, and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility, crisis respite, and/or alternative sites of care. Many sites integrate peers into the full continuity of care, starting with the initial point of crisis and keeping the same peer support person as the point of contact.

- Provide at least 25 percent of treatment contacts in the community, including accompanying clients to appointments and events (including those actively hospitalized)
- Conduct mobile outreach to clients who unexpectedly disengage from clinic services
- Connect incarcerated persons with telemental health services they can access after release

Advocates, a community mental health center (CHMC), has a well-developed peer program that coordinates with the nearby CCBHC and runs a Living Room program, a Community Crisis Stabilization/Respite program, and Mobile Crisis Services.

- The Living Room was developed to be a completely peer-run crisis alternative for people from anywhere in the community who prefer peer support over other alternatives. It is especially utilized by individuals who have experienced previous trauma in other sites of care. The Living Room has 24/7 staffing by Peer Specialists and Recovery Coaches, and there are no clinical or administrative staff on site. Individuals can stay up to three nights consecutively, and transportation is provided to and from the site if needed. In a survey, 83 percent of respondents indicated that the Living Room had prevented them from having to go to the ED
- This program provides clinical support for individuals in crisis and includes social workers, nursing staff, direct support workers, and one full-time Peer Specialist
- Advocates offers mobile crisis services, known as the Emergency Services Program (ESP), for 31 towns in the region. One full-time Peer Specialist is partnered with an ESP clinician in each location to provide peer support to individuals when they ask for additional crisis support. In addition, two full-time Recovery Coaches—peer support oriented to the experience of substance misuse or addiction recovery—work in two local EDs to provide peer support to individuals in the ED

BCC houses four treatment programs, all under one roof, including the Rapid Access Unit (RAU), Adult Crisis Stabilization Unit (ACSU), Recovery Services–Social Detox Unit (SD), and Residential Substance Use Disorder (SUD) Program.

Burrell staffs the RAU with 24/7 peer coverage, meaning at least one peer will be assigned to each shift. Burrell defines the peer role as a “Certified Peer Support Specialist.” These specialists are people with a background in MH conditions or SUDs or both and a more recent history of successfully maintaining a lifestyle of recovery.

Certified Peer Support Specialists:

- Provide non-clinical, strengths-based support and are “experientially credentialed” by their own recovery
- Help to inspire hope that people can and do recover, walk with people on their recovery journeys, and dispel myths about what it means to have a MH condition or SUD
- Provide self-help education and link people to tools and resources
- Support people in identifying their goals, hopes, and dreams, and creating a roadmap for getting there

Peer support workers can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with other members of the treatment team. The peer support worker’s role is to assist people with finding and following their own recovery paths, without judgment, expectation, rules, or requirements.

In reflecting on the role of peers, BCC Director Bradley Powers said, “In my opinion peers have been a blessing in client engagement and connection, and an immediate impact that I have not seen in the 30+ years I’ve worked in the MH field. Just in the agency’s mission statement alone, there is a specific reference to the value of having PSSs [Peer Support Specialists] in our system “To form meaningful connection and inspire hope,” and I believe they are the key to that success. … The people we serve are diverse, and our ability to provide compassionate assistance to everyone who asks is critical to carrying out this mission. Peers’ ability to remain objective, non-judgmental, and self-aware is paramount to providing this care. People will enter our doors in a state of crisis, and it is our staff’s job to quickly assess their need (sometimes basic human needs) and create an environment and setting that is open, friendly, accessible, and that quickly responds. Crisis is a perceptual state, so the peers’ ability to break out of their own, versus biased perception and see through the eyes of each client is the hallmark of creating this [RAU] setting.”

on incorporating peers into crisis care can be found in the National Council’s Ideal Crisis System report (pages 127-128) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).

Screening for SDOH is a necessary part of the process of level of care determination for MH and SUD crisis. According to CMS, “SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.” Providers should screen for and consider the impact of social determinants because an individual’s acute crisis is often related to environmental factors in their lives, e.g., what are the aggregating factors such as violence in the home, housing insecurity, and food insecurity. These screening tools are used in addition to the standardized level of care determination tools like: LOCUS for adults, CALOCUS for children and adolescents, and Early Childhood Service Intensity Instrument for children aged 0-5.

Thorough screening for SDOH can contain the following:

Committee on Psychiatry, “Roadmap to the ideal crisis system,” pgs. 127-128, 2021.
Centers for Medicare & Medicaid Services, “Using Z codes: the social determinants of health (SDOH) data journey to better outcomes,” 2021, accessed February 23, 2022, https://www.cms.gov/files/document/zcodes-infographic.pdf.

x Standardized criteria that are used to conduct a screening for every client

- There is no single screening tool for SDOH, but several tools often used in primary care settings can be employed and customized as needed. Screening tools often contain questions related to homelessness, housing insecurity, food insecurity, inability to afford medications, transportation, education, and issues with utilities, caregiving, and employment, among other considerations. O'Gurek and Henke outline three screening tools for a primary care setting:

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	15 core Five supplemental	http://www.nachc.org/research-and-data/prapare/toolkit/
The American Academy of Family Physicians Social Needs Screening Tool	11 (short form) 15 (long form)	https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf
The Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool	10 core 13 supplemental	https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

x Standardized level-of

- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

A provider of MH and substance use programs, services, and resources, BHD piloted a SDOH screening during the intake of individuals in crisis. The aim of the screening during intake was to capture SDOH information early so it would follow the individual through their meetings with clinicians and be incorporated into treatment plans, rather than emerging over the course of many interactions.

Initially, completion rates for the one-page SDOH screening were high at intake, but during the COVID-19 pandemic, as care was more often virtual, BHD found fewer screenings were being filled in, potentially due to the increased time required to fill out the form for both clinicians and individuals.

BHD used Microsoft Forms to create a screening tool that allo-3.3a(i)2.6 (i)26.6 (.)-478 (5)37(edam)]TJ 5 (j)-7 (i)

    - that address cultural competence
- Review recruiting practices and prioritize recruiting team members that are representative of the community, understand the community's needs, and/or are able to provide tailored services that may not be addressed, to the degree possible
- Determine how to embed equity considerations into all planning and decision-making
    - Consider starting with a tool such as the Government Alliance on Race and Equity's (GARE's) racial equity toolkit and modifying it to address specific needs of providers
- Conduct analysis of population provider services and how community demographics and needs align with the population that is served
- Disaggregate data to understand access and outcomes

To make the promise of 988 a reality for the country, the crisis continuum should be comprehensive and customized for children, youth, and young adults. Some services may need to be tailored to meet their needs. In particular, children's crisis services may not be centered on transporting the individual in crisis to a crisis receiving or stabilization facility. Instead, the most appropriate approach may be de-escalation and stabilization within the home and community. Ideally, every effort should be made to maintain the child or youth in their current environment, when appropriate.

National Council's Ideal Crisis System report notes, "Individuals in crisis often move rapidly between services, so information must be effectively shared throughout the crisis continuum. The availability of historical information also contributes to the assessment and resolution of the crisis and is particularly valuable when the individual is unable or unwilling to provide such information to crisis providers. Finally, transmitting information to continuing care providers following the crisis facilitates effective transition planning and reduces the need for redundant and burdensome collection of information" (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).

Crisis system data should be gathered to:

1. Efficiently connect individuals in need to care
2. Provide feedback on provider performance
3. Inform crisis system design efforts. Ideally, systems are driven by technology that offers real-time "care traffic control" functioning with transparent sharing of that data throughout the system

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Julie Nelson and Lisa Brooks, "Racial equity toolkit: an opportunity to operationalize equity," Local and Regional Government Alliance on Race & Equity, September 2015, http://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf.

"988: America's suicide prevention and mental health crisis lifeline," Substance Abuse and Mental Health Services Administration, accessed Feb 22, 2022, https://www.samhsa.gov/find-help/suicide-prevention/988-lifeline.

Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 81.

Input from RI International, February 2022

Data collection targets can include:

Mobile Crisis Response	Response time Percentage resolved in the community Percentage escalated to a higher level of care (facility) Disposition (ED, inpatient, crisis facility, outpatient, home, etc.)
Crisis Facilities	Percentage of referrals accepted Number served Referral source (self, law enforcement, EMS, hospital ED, fire, family, outpatient provider) Length of stay Disposition (return to community or transfer to inpatient) Completion of seven-day and 30-day follow-up services
Crisis Call Centers	Number of calls answered Number of text message received and delivered Number of chats received and responded to Call answer time Call abandonment rate Duration of call Percentage of calls originated by law enforcement / first responders Percentage of calls received as 911 transfer Percentage of calls transferred to 911 Percentage of calls transferred to warm line (if applicable) Percentage of calls resolved by phone Reason for call

A sample of reported metrics from Mercy Care (operating as the Regional Behavioral Health Authority and a Medicaid MCO in Arizona) can be found in the Appendix.

To support individuals in EMC /9(h)10.6 (e R)239:3

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Behavioral Health Link's Crisis Now technology solutions that are implemented statewide in Georgia are able to orchestrate connections to care, including:

- x 24/7 outpatient scheduling
- x Live bed registry
- x One-click mobile crisis dispatch
- x Robust data analytics

This software solution significantly enhances system efficiency, largely automates care-coordination efforts, and creates transparent insights that support accountability as well as continuous quality improvement efforts.

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The Data Access and Collaboration on Treatment Alternatives program (DACOTA) is a data collection program that collects information in order to improve the way the department responds to people in crisis.

- x Treatment history
- x Care coordination
- x Violence risk
- x Recidivism
- x MH functioning
- x Referrals to treatment

DACOTA is intended to facilitate communication between criminal justice and MH agencies by:

- x Developing a shared information database where both criminal justice and MH agencies can each access data systems with summary dashboards and individual treatment histories
- x Implementing a co-responder model whereby licensed clinician (s)-2 (Qp2 ((dao5 (s)-2 ((i)2.61 (oc

SAMHSA launched an app called “My Mental Health Crisis Plan,” which allows individuals who have serious mental illness to create a plan to guide their treatment during a MH crisis. The app provides an easy, step-by-step process for individuals to create and share a psychiatric advance directive (PAD): a legal document that includes a list of instructions and preferences that the individual wishes to be followed in case of a MH crisis, should they not be able to make their own decisions.

My Mental Health Crisis Plan allows individuals with serious mental illness to:

- Clearly state treatment preferences, including treatments to use and those not to use, medications to use and those not to use, preferences for hospitals, and preferences for doctors and other MH professionals
- Decide who can act on their behalf by designating a trusted person (sometimes referred to as “healthcare agent,” “proxy,” or “health care power of attorney”) as a decision-maker for them. Some states require appointment of a decision-maker to carry out the PAD instructions
- Identify whom to notify in the event of a MH crisis
- Share the plan with others, including doctors, other members of the care team, and family and friends
- The app includes state-specific requirements for completing the PAD (such as signatures, witnesses, anaLbl /MCIrrrThe app ies1 Tu.6 (t)-6.bd937 0 Td[(s)1 148s0g[f&6

To make

- Providers should consider how policies such as opening

The 988 transition may result in an increase in the number of individuals seeking assistance, with additional contacts to Lifeline contact centers and behavioral health-related visits to many providers. This section describes ways providers can expand capacity, including medical capacity. It also includes resources about how to set up Mobile Crisis Services and Crisis Receiving and Stabilization services.

Before identifying opportunities to expand capacity, it will be important for providers to understand potential increases in demand associated with the 988 transition. To understand potential demand, they can consider:

- State-level demand projections—for additional information, see the States, Territories, and Tribes playbook
- An estimated population-level monthly need of assistance for 200-230 people in behavioral health crises per 100,000 persons in a community (data is from the Action Alliance) [74]

According to SAMHSA, telehealth is effective across the continuum of care for SMI and SUD, covering screening and assessment, treatments, pharmacotherapy, medication management, behavioral therapies, case management, recovery supports, and crisis services. Additional detail about processes and interventions can be found in SAMHSA's Telehealth report on pages 16-25, which describe health outcomes, telehealth-specific outcomes, populations that benefit from the treatment, providers who can offer intervention services, technologies used, intensity / duration / frequency, and lessons learned from transitioning from in-person care to telehealth (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf).

: Telehealth modalities provide an effective alternative to in-person suicide screening and assessment. The following suicide screening and assessment tools can be implemented through telehealth modalities:

- The Ask Suicide-Screening Question Toolkit (ASQ) from the National Institute of Mental Health (NIMH) is an evidence-based, 20-second, four-question suicide screening tool (https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials)
- The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based intervention to assess, treat, and manage clients with suicidal ideation in a range of clinical settings (https://cams-care.com/)
- Columbia-Suicide Severity Rating Scale (C-SSRS), also known as the Columbia Protocol, can be used to determine whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support the person needs (https://cssrs.columbia.edu/)

If a client is at risk of imminent harm:

1. Assess the immediate danger. If the client is in immediate danger and the provider is unable to detain them or physically intervene, the provider must contact emergency services.
2. Identify the client's location in case emergency services are necessary.
3. Work with other care providers (e.g., suicide prevention coordinators) when contacting emergency services. Remain connected with the client as the client connects with emergency services or while arranging hospitalization.
4. Support clients as they navigate the triage process at an

have emerged that offer virtual behavioral health services, including Eleanor Health, Brave Health, Included Health, Doctor on Demand, SonderMind, and Mindstrong, among others.

[82] is a comprehensive, evidence-based outpatient services platform for opioid and other SUDs. Eleanor Health treats addiction as a chronic disease, focusing on clinical and non-clinical factors and providing both human and high-tech support, including MAT.

is a virtual, national outpatient behavioral health practice.[83] Brave Health's team includes therapists, social workers, SUD specialists, advanced psychiatric nurse practitioners, and psychiatrists, all of whom deliver virtual care. Its patients' conditions range from low acuity to extremely complex. It uses both human-driven and tech-driven approaches to reach and engage prospective patients quickly and integrate them easily into the healthcare ecosystem. Brave Health also uses data and analysis to drive improvement.

To best serve individuals and improve outcomes in the healthcare system across the acuity spectrum, Brave Health prioritizes speed to care a closed-loop, data-driven approach. Its omni-channel patient engagement strategy has yielded: a 90 percent reach rate (often within 24 hours), a 65 percent opt-in rate, an 80-90 percent kept appointment rate, and seven days to first appointment offered. Brave Health tracks metrics on the individual and population levels and communicates these back to the relevant stakeholders. When it receives a referral from a health plan, PCP, or discharge personnel, it closes the loop with that source and others by providing status updates (reached, opted-in, kept appointment, etc.), thus ensuring no one falls off the radar.

Alluma, a CCBHC in Northwest Minnesota, uses telehealth to improve timely access to care, regardless of location or weather conditions, and support the maximization of workforce.

Alluma services six geographically large counties (roughly 6,800 square miles) Its CCBHC demonstration catchment area has a total population of 68,000, in addition to the surrounding communities, and it serves 4,200 unique individuals throughout the region annually. Alluma's main office is in Crookston, MN, which is the largest community (7,900 people). The furthest locations it serves are up to one-and-a-half to two hours away. Cold winter weather and the expansive geography make telehealth particularly helpful for clients and the organization.

Telehealth has been a vital part of providing access to timely services across the region. It is used for assessment, medications, therapy, rehabilitation, peer services, case management, crisis response, and other non-CCBHC services. Alluma's highly trained staff help the client evaluate their telehealth

"Compassionate support for your mental health or substance use," Eleanor Health, accessed) H E U X D U \ , https://www.eleanorhealth.com/.

Anna Lindow, CEO and Co-founder of Brave Health.
Input from National Council for Mental Wellbeing, February 2022

capacity and ensure they have access to technology. It can be at their home or, if they do not have the technology, staff can either send them a device or coordinate with community partners (primary care clinic, library, social services) for them to go to a secure location and connect for their appointments. This allows clients, many of whom experience poverty, the ability to engage in care without needing to travel.

- x Brutal winters have historically prevented access to care. With severe subzero temperatures, whiteout conditions, and road closures, staff were unable to safely get to clients' homes and/or clients were unable to travel safely to offices. Alluma recently had to close its office, but was still able to provide many services to clients through telehealth. Care was still offered, staff did not need to take time off, and community partners were still able to access crisis care when it was needed

- x Alluma's 24/7 crisis response team is able to connect with local EDs

in crisis settings that are based on the existing evidence-based guidelines that have been promulgated by AAEM and are regularly updated."

Best practices include:

- "Ensuring availability of psychiatric care providers, including nurse practitioners (NPs), physician assistants (PAs), Doctors of Osteopathic Medicine (DOs), and MDs. Either on-site or through telehealth to support every component of the crisis continuum with specific protocols for access and availability, commensurate with the level of acuity of the setting."
- "Establish protocols for psychiatric care provider-to-psychiatric care provider communication and collaboration between crisis settings, and between crisis and community settings. Ensure that community psychiatric care providers are routinely contacted to provide medication information to inform the crisis intervention. Ensure that medication plans are vetted and approved by receiving community psychiatric care providers in order to minimize discontinuity. Identify access to psychiatric care providers for continuity of all types of medications, including clozapine, intramuscular antipsychotics, intramuscular naltrexone, and suboxone."

Psychotropic medication practice guidelines can be found in the Ideal Crisis System report on pages 158-159 (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).

in crisis and trying to help all individuals. It believes the o

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- x Connections utilizes a standardized approach to assessment and intervention for medical conditions. One similar approach is the SMART Medical Clearance form (http://smartmedicalclearance.org/forms/). In fact, Michigan has launched a statewide rollout of SMART Clearance (https://mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/).
- x . Connections has a continuous quality improvement approach that includes:
  - Regularly evaluating data on individuals' referrals to EDs and reasons for their referral to identify patterns with types of cases that the organization could address instead of the ED
  - Maintaining good working relationships with EDs and relevant sites of care to evaluate the types of cases Connections could handle rather than a referral. In one example, it previously sent people with high blood sugar to the ED, but the ED thought Connections could handle those cases. It collaborated with the ED to develop a way to handle people with high blood sugar without referring them further
  - Considering ways to add appropriate capacity to handle more cases, when appropriate, including using telehealth and consultation partnerships with EDs, local primary care providers, and other medical professionals

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Coordinating capacity and gaps requires both: (a) the ability to comprehensively monitor the flow of individuals in crisis through the crisis system, and (b) considering how the organization should be interacting with the community at large and what the gaps are in the community (e.g., conducting a community needs assessment). To coordinate capacity and gaps to serve all individuals in crisis, organizations can consider collaborative, integrated processes and models (e.g., the Collaborative Care model (CoCM)).

As stated in the National Council's Ideal Crisis System Report:
"Processes must be in place to both respond in real-time to fluctuations in demand and barriers to flow and periodically review whether the system has the adequate capacity and

future crises, develop and implement strategies to effectively de-escalate potential future crises, and avert and divert from more restrictive levels of care (ED, residential treatment, etc.), out-home-placement, and unnecessary contact with law enforcement and juvenile justice.”

Buildin

Crisis receiving and stabilization services offer the community no-wrong-door access to MH and substance use care and operate much like a hospital ED that accepts all walk-ins, ambulance, fire, and police drop-offs. Requirements and best practices can be found in the SAMHSA National Guidelines on pages 22-24. Additionally, four different types of crisis receiving and stabilization services can be found in the National Council's Ideal Crisis System (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56). These include urgent behavioral health, intensive community-based continuing intervention, 23-hour evaluation and extended observation, and residential crisis. Several local examples are included in these sections.

In setting up their mobile crisis and receiving facilities, RiverValley

- Focused on coordination to prevent relapses and hospitalizations

Connecticut’s mobile crisis services (CT) prioritize the following best practices:

- CT purchases rapid face-to-face service as the typical response and does not do a telephonic triage to determine mobility. The crisis is defined by the caller with the expectations that the face-to-face assessment will begin within 45 min of the call. Prior to the pandemic, the average statewide face-to-face response time for mobile crisis services was 29 minutes (2019) with 93 percent of all calls receiving a mobile face-to-face assessment and 87 percent of all mobile responses made within 45 minutes of the call

- After the initial acute crisis is stabilized, the episode of care can continue (with permission of the parents or caregiver) for up to 45 days, providing follow-up support and connecting the client to appropriate longer-term outpatient or other services

- Individuals with lived experience can be part of the mobile crisis response and some providers in the state have found having individuals with lived experience can build connections and empathy with individuals in crisis. Parents who in the past have had children who needed behavioral health services and used / needed youth mobile crisis services can build particularly strong connections with parents and caregivers who are currently in a behavioral health

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Additional resources for MH and SUD providers are listed below:

Email: _____
First name: _____
Last name: _____

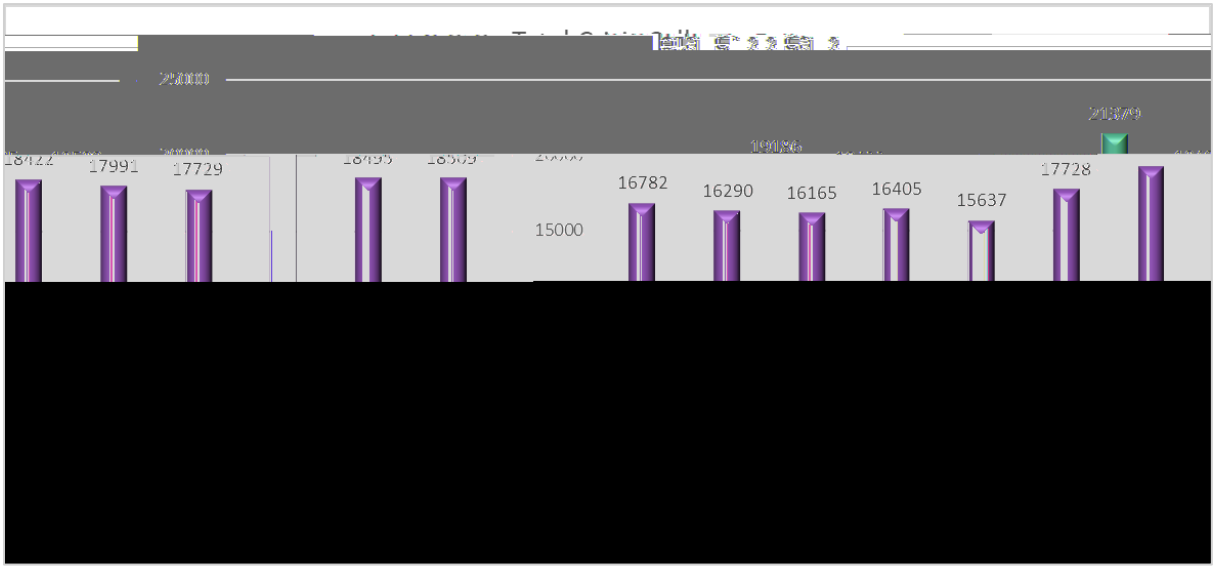
1. Are you worried that in the next 12 months, you may not have stable housing?
    - o Yes
    - o No
2. In the last 12 months, has the electric, gas, oil or water company threatened to shut off your service in your home?
    - o Yes
    - o No
3. Within the past 12 months, did you worry that your food would run out before you got money to buy more?
    - o Yes
    - o No
4. Do you have trouble finding or paying for a ride (or any form of transportation)?
    - o Yes
    - o No
5. In the last 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
    - o Yes
    - o No
6. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
    - o Yes
    - o No
7. Do you often feel that you lack companionship?
    - o Yes
    - o No
8. Think about the place you live. Do you have problems with any of the following? (Check all that apply)
    - o Pest such as bugs, ants, or mice
    - o Mold
    - o Lead paint or pipes
    - o Lack of heat
    - o Oven or stove not working
    - o Smoke detectors missing or not working
    - o Water leaks
    - o None of the above

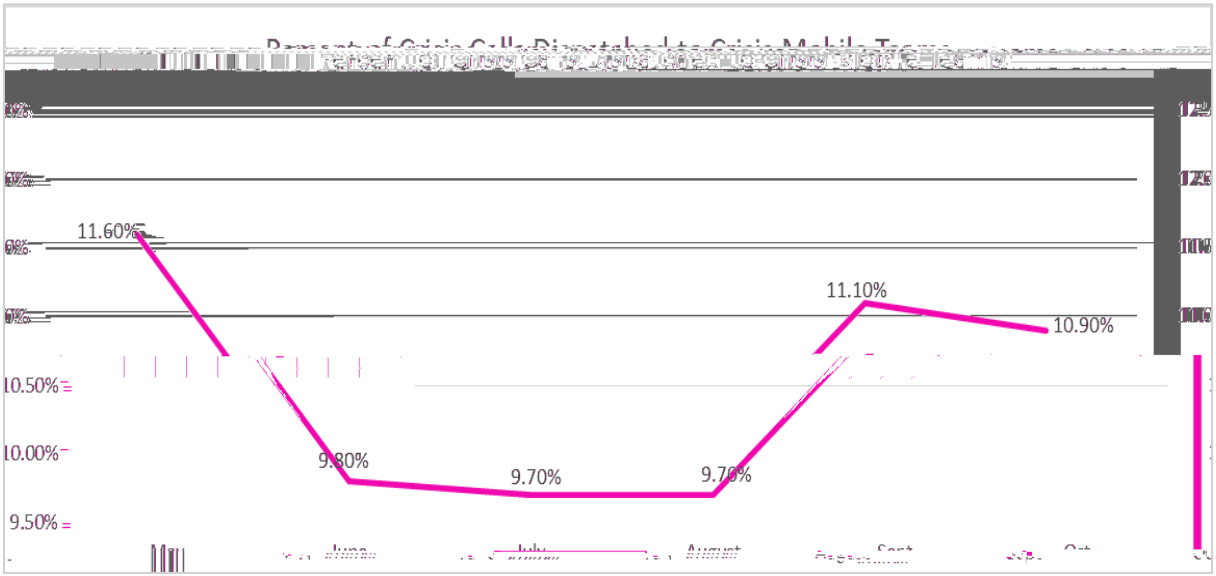
Oliver Russell, Assistant Chief, Behavioral Healthcare at Arlington County, Arlington Department of Human Services.

9. In the past year have you or any of your family members been unable to get any of the following when it was really needed (Check all that apply):
    - o Food
    - o Clothing
    - o Utilities
    - o Childcare
    - o Medicine or any health care (medical, dental, mental health, or vision)
    - o Do not have problems meeting my needs
    - o Other:
10. Are any of your needs urgent? For example, I do not have food for tonight, I am afraid I will get hurt if I go home today.

In central Arizona, Mercy Care (operating as the Regional Behavioral Health Authority and a Medicaid MCO) shares system and provider performance on a regular basis. A sample of their reported metrics can be seen below:

- Total crisis calls
- Percent of crisis calls dispatched to mobile crisis teams
- Average time it takes to dispatch mobile teams
- Total mobile teams dispatched
- Mobile team community stabilization percentage
- Mobile crisis team response time to policy & community
- Number of people treated by an emergency psychiatric center
- Policy drop-offs to all crisis facilities





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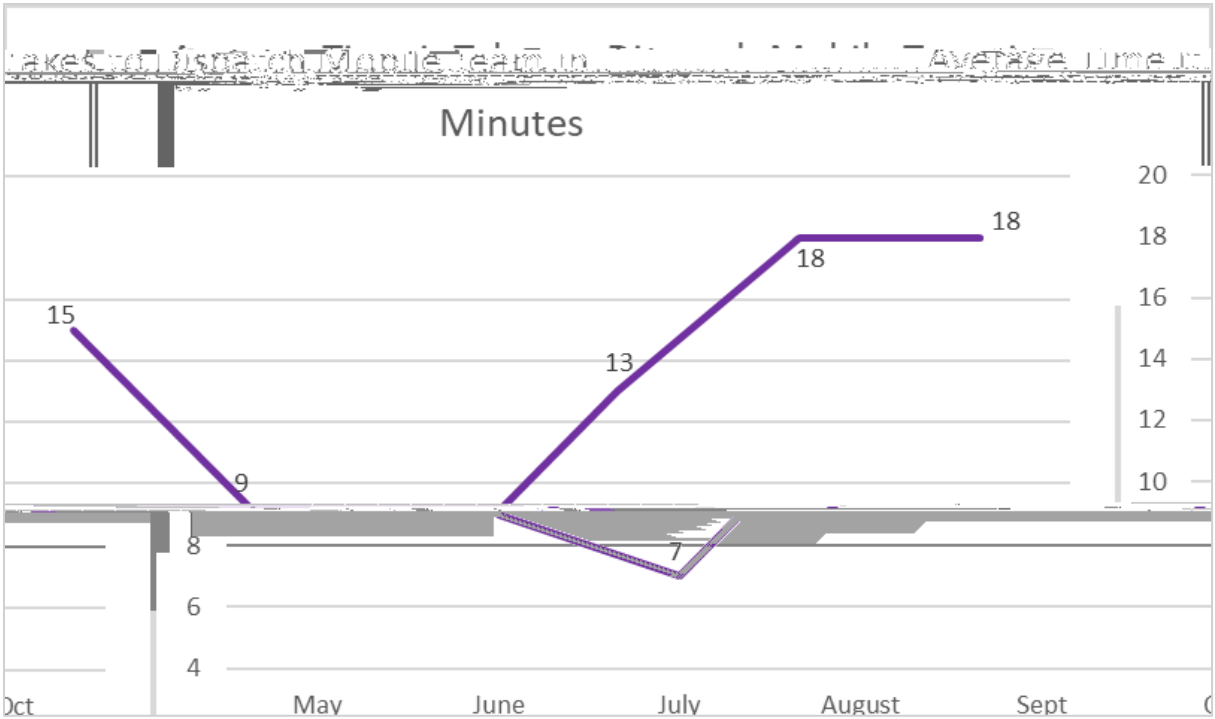
Minutes
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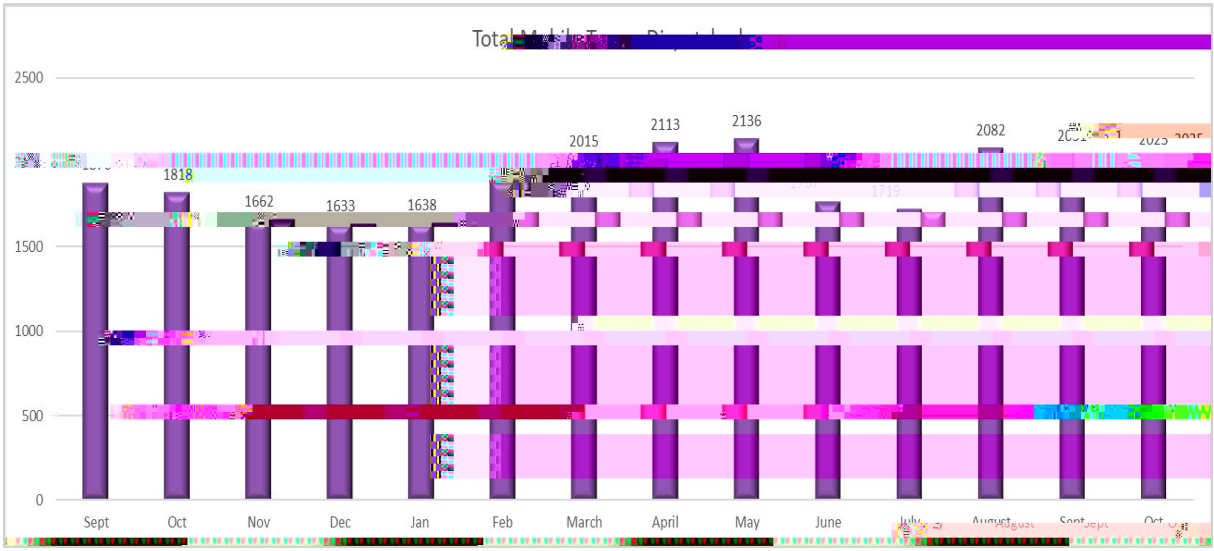
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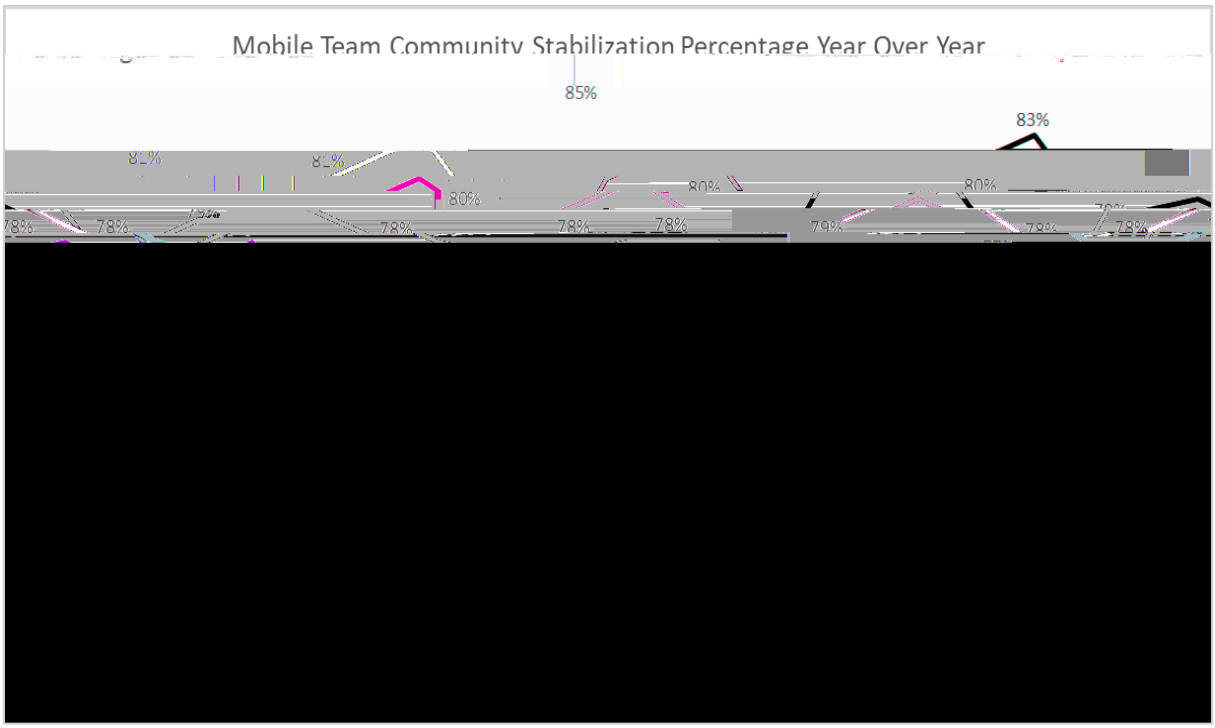
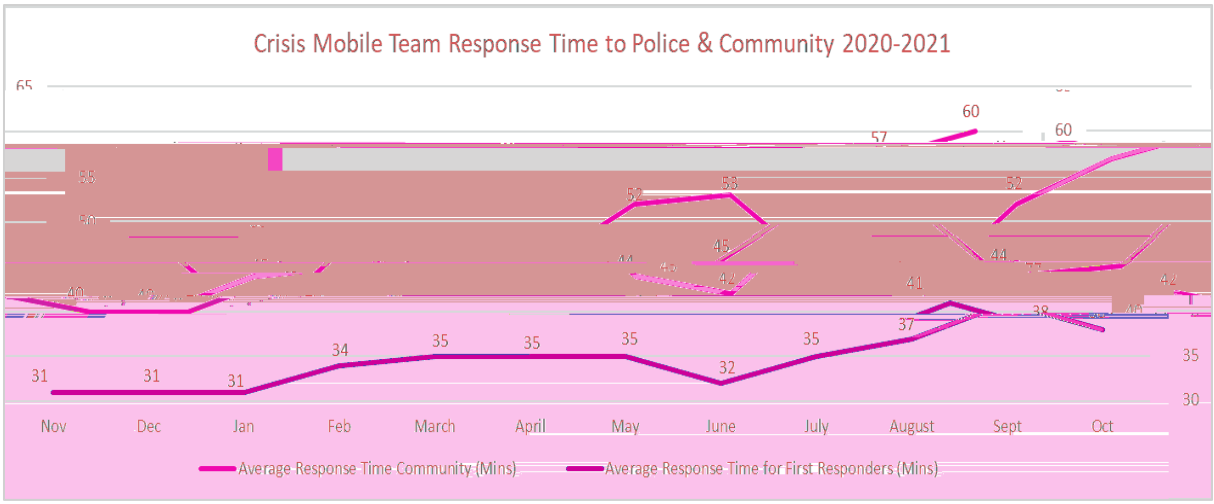

Mobile Team Community Stabilization Percentage Year Over Year
85%
83%
81%
81%
80%
80%
80%
78%
78%
78%
78%
78%
79%
78%
78%


Crisis Mobile Team Response Time to Police & Community 2020-2021
65
60
60
57
55
53
52
52
45
44
42
41
40
38
37
35
35
35
35
34
32
31
31
31
30
Nov
Dec
Jan
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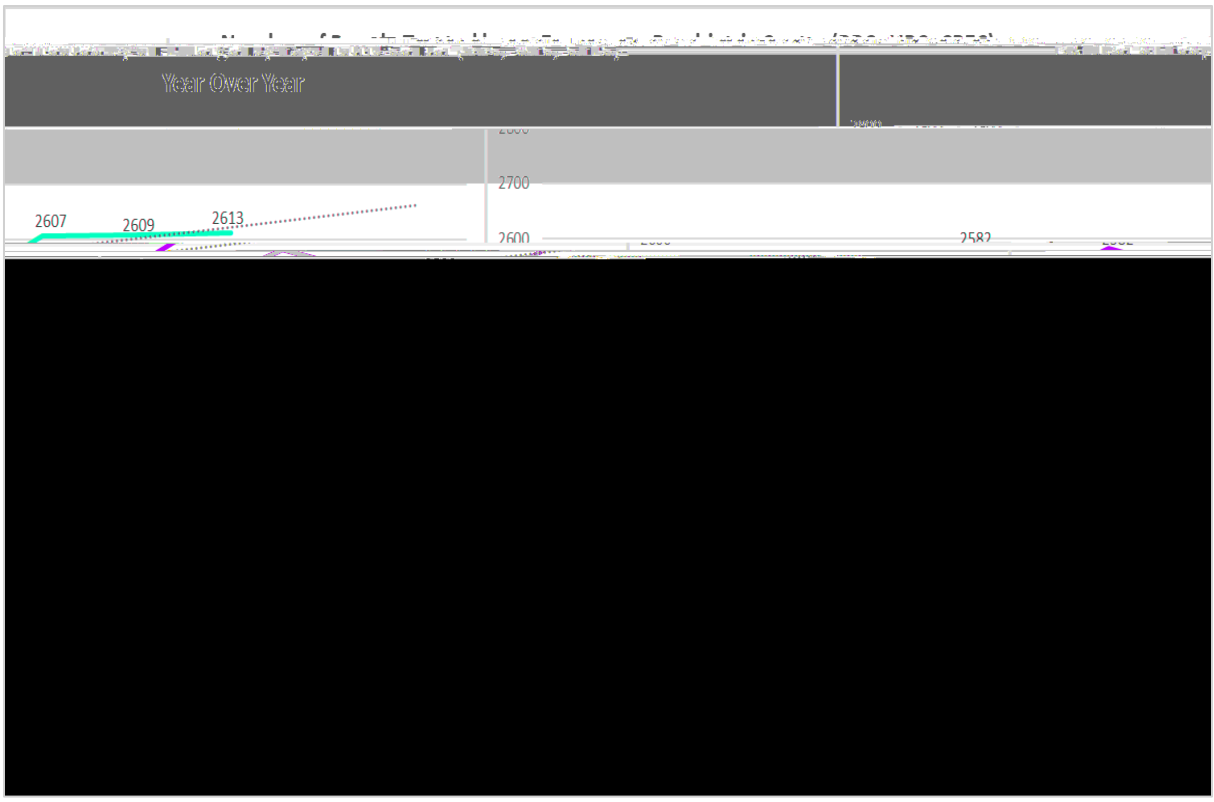
March
April
May
June
July
August
Sept
Oct
Average Response Time Community (Mins)
Average Response Time for First Responders (Mins)


Year Over Year
2700
2607
2609
2613
2600
2582