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CCBHC-E National Training and Technical Assistance Center CCBHC Criteria Series

Scope of Services:
Opportunities for an Ideal Crisis System

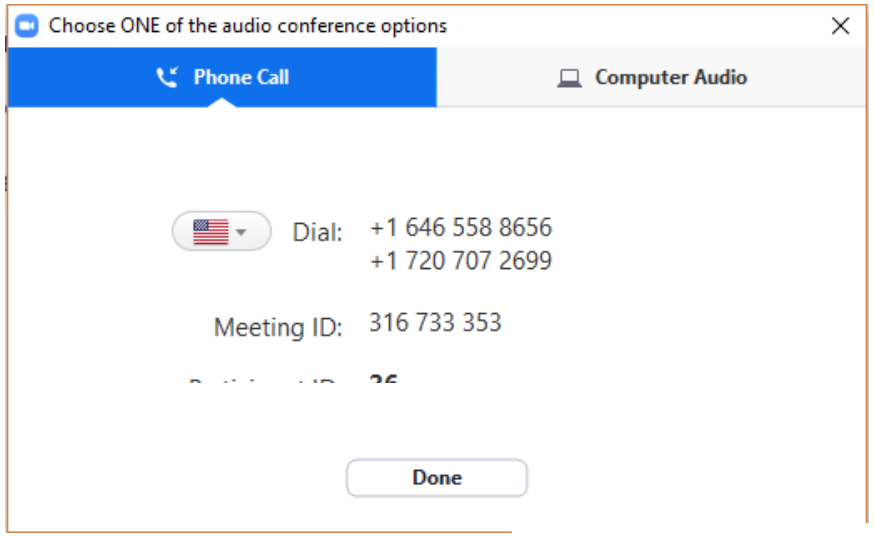
April 26, 2022

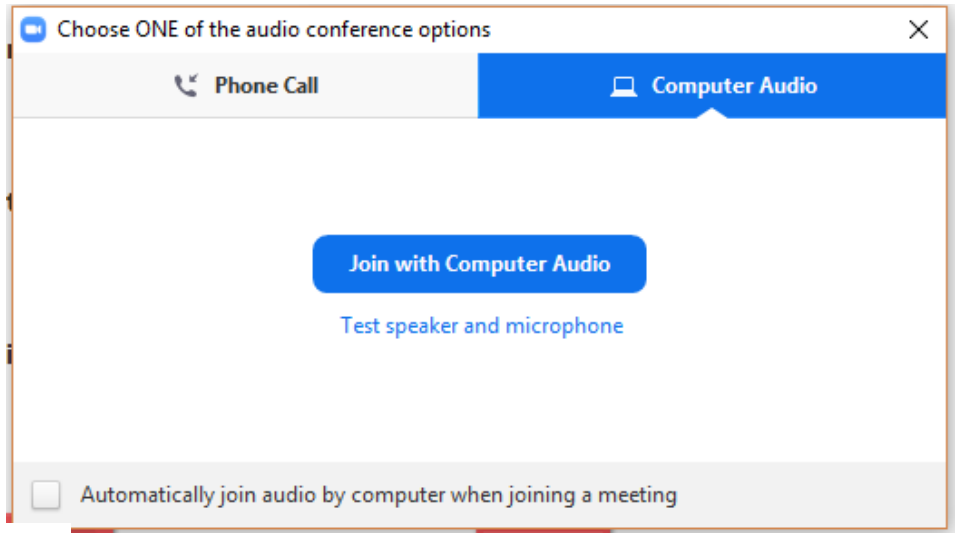
CCBHC-E National Training and Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Zoom Logistics

- Call in on your telephone, or use your computer audio option
- If you are on the phone, remember to enter your Audio PIN so your audio and computer logins are linked





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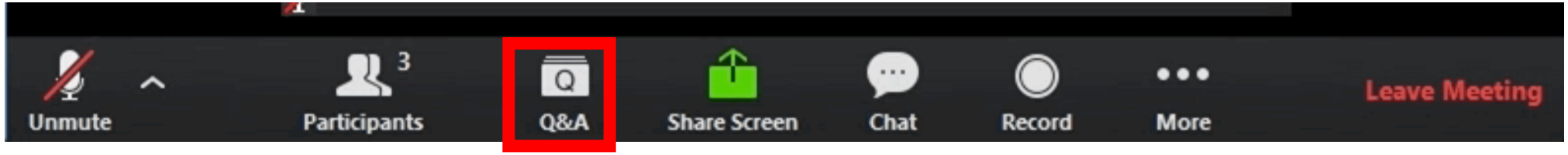
How to Ask a Question



Share questions throughout today's session using the **Q&A Feature** on your Zoom toolbar. **We'll answer as many questions as we can throughout today's session.**

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Acknowledgements and Disclaimer

This publication was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

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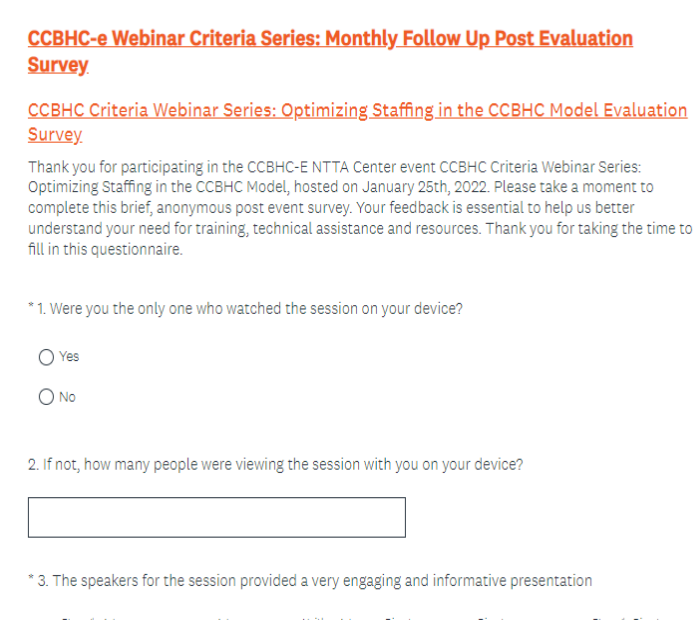
Post Evaluation Survey

CCBHC-E National TTA Center



CCBHC-e Webinar Criteria Series: Monthly Follow Up Post Evaluation Survey

CCBHC Criteria Webinar Series: Optimizing Staffing in the CCBHC Model Evaluation Survey

Thank you for participating in the CCBHC-E NTTA Center event CCBHC Criteria Webinar Series: Optimizing Staffing in the CCBHC Model, hosted on January 25th, 2022. Please take a moment to complete this brief, anonymous post event survey. Your feedback is essential to help us better understand your need for training, technical assistance and resources. Thank you for taking the time to fill in this questionnaire.

* 1. Were you the only one who watched the session on your device?

- ◯ Yes
- ◯ No

2. If not, how many people were viewing the session with you on your device?

* 3. The speakers for the session provided a very engaging and informative presentation

Please note that we will be sending out **post-evaluation survey** within the next month to gather your feedback!

Agenda

- Welcome
- Today's Presenters
- ZiaPartners
- Clinic Perspectives – Integral Care Team and Best Self
- Q&A Period

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Today's Presenters

Samantha Holcombe
Senior Director Practice Improvement Consulting
National Council for Mental Wellbeing

Ken Minkoff
Senior System Consultant, ZiaPartners

Sherry Blyth
Director, Crisis Services, Specialty Substance Use Treatment and Justice Initiatives

Rita Cuda
Senior Vice President of Children and Family Clinic Services, BestSelf Behavioral Health

Crisis Behavioral Health Services (4.C)

- Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services, the CCBHC will directly provide robust and timely crisis behavioral health services, which must include:
  - 24-hour mobile crisis teams,
  - Emergency crisis intervention services, and
  - Crisis stabilization
- Services provided must include suicide crisis response and services capable of addressing crises related to substance use and intoxication, including ambulatory and medical detoxification.

Today's Highlights

- Thinking globally – considering the ideal crisis system
- Acting locally – the role and opportunity of CCBHCs in the crisis system

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ZiaPartners

Ken Minkoff

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Guiding Principles and Values of an Ideal Crisis System

Ideal BH Crisis Systems are

- *Based on a shared set of values.*

  Welcoming and engaging, customer-centered, hopeful, safe, compassionate, empowering, recovery-oriented, trauma informed, and culturally appropriate.

- *Accountable for all people and populations*

- *Designed for the expectation of complexity*

  MH and SUD, plus I/DD, health, housing, criminal justice, child/adult protection, etc.

- *Designed to be clinically effective and cost effective*

- *Able to use value-based involuntary intervention - only when necessary*

- *Organized to share and use data for continuous improvement*

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Vision

- Every individual/family in every community in the U.S. will have access to a continuum of best practice BH crisis services that are welcoming, person-centered, recovery-oriented, and continuous.
- An excellent Behavioral Health Crisis System is an essential community service, just like police, fire and emergency medical services (EMS).
- Every community should expect a highly effective BH crisis response system to meet the needs of its population.
- A BH crisis system is more than a single crisis program.

It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent BH crisis needs in a defined population or community, effectively and efficiently.

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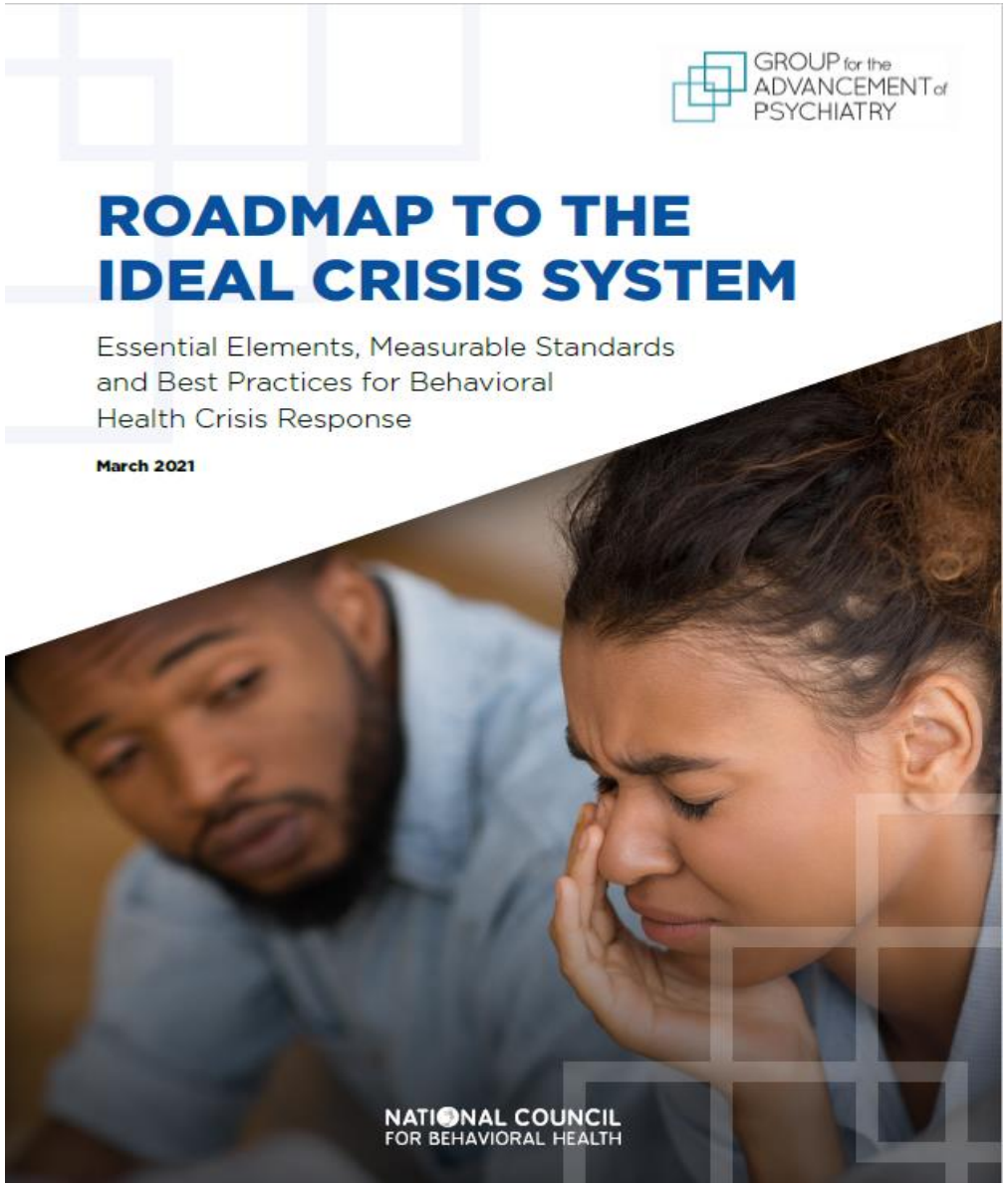

A report of the Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry

Jacqueline Maus Feldman MD co-chair
Ken Minkoff, MD co-chair

GROUP for the ADVANCEMENT of PSYCHIATRY

Published by the National Council for Mental Wellbeing

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Elements of an Ideal Crisis System

Community support
Crisis system support to families, police and first-responders, schools, etc.

Clinical best practices
Engagement, assessment, safety, clinical interventions, evidence-supported treatment, peer support, coordination and continuity of care

Array of services and capacities
Service components, levels of care, staffing and volume capacities, special population capacities

System oversight and governance
Structure, financing, eligibility, quality metrics, customer satisfaction, performance incentives, flow and throughput, data sharing, utilization management, collaboration

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Section I: Accountability And Finance

- An ideal behavioral health crisis system must have both a mechanism to finance and implement a comprehensive continuum of crisis services and a mechanism to ensure oversight, accountability, and quality of the performance of that continuum.

- This section defines the concept of an **Accountable Entity**, which is a structure and a mechanism for allocating responsibility and accountability that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures.

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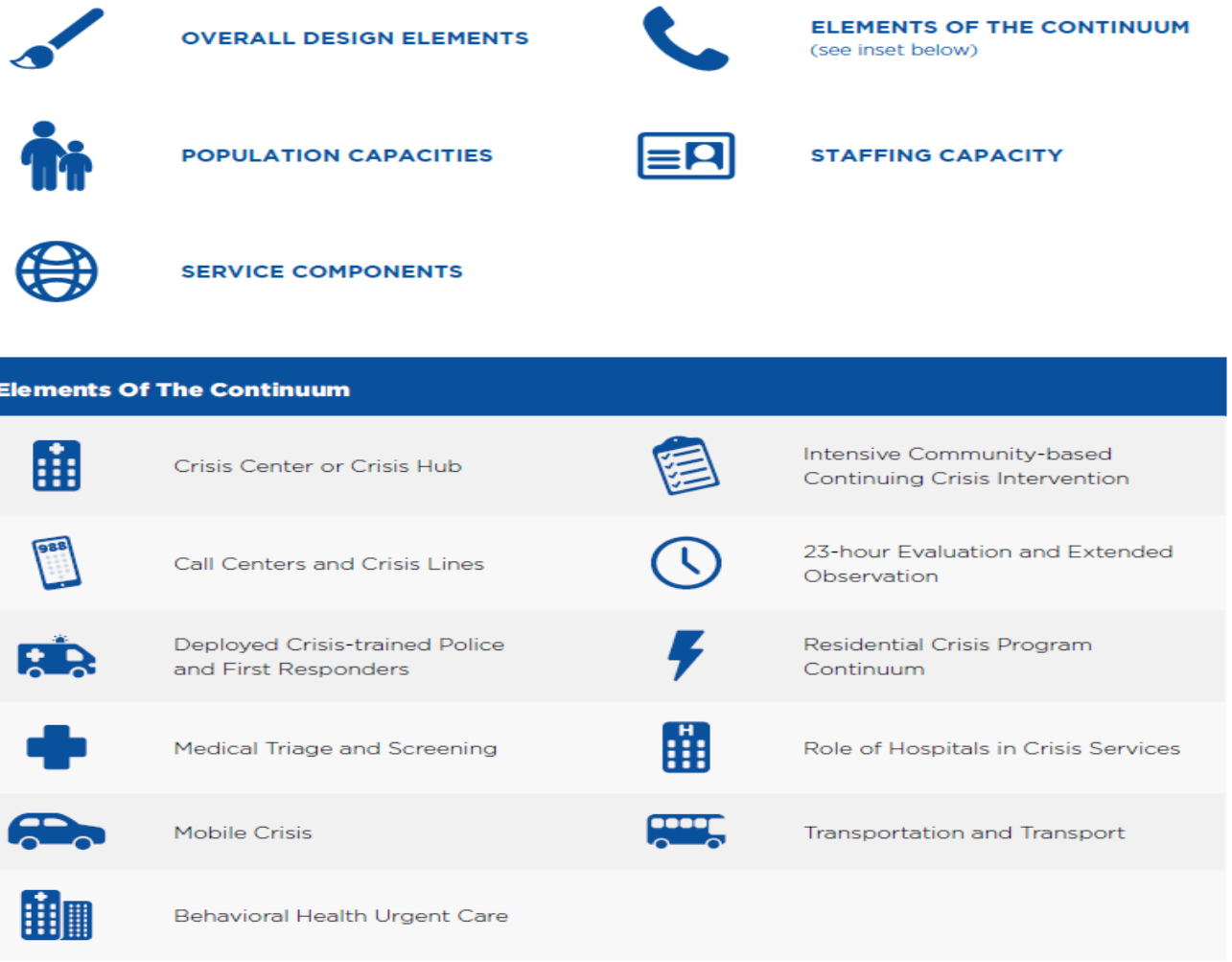
Section I: Accountability And Finance – Key Takeaways

- There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.
- There is a behavioral health crisis system coordinator and a formal community collaboration of funders, behavioral health providers, first responders, human service systems and service recipients.
- There is a stated goal that each person and family will receive an effective, satisfactory response every time.
- Geographic access is commensurate with that for EMS.
- Multiple payers collaborate so that there is universal eligibility and access.

Section I: Accountability And Finance – Key Takeaways

- There are multiple strategies for successfully financing community behavioral health crisis systems.
- Service capacity of all components is commensurate to population need.
- Individual services rates and overall funding are adequate to cover the cost of the services.
- There is a mechanism for tracking customers, customer experience and performance.
- There are shared data for performance improvement.
- Quality standards are identified, formalized, measured and continuously monitored.

Section II: Crisis Continuum: Basic Array Of Capacities And Services



An ideal behavioral health crisis system has:

- Comprehensive array of service capacities,
- A continuum of service components
- Adequate multi-disciplinary staffing to meet the needs of all segments of the population.

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Section II: Crisis Continuum: Basic Array Of Capacities And Services

- The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.
- Family members and other natural supports, first responders and community service providers are priority customers and partners.
- Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.
- There is capacity for sharing information, managing flow and keeping track of people through the continuum.
- There is a service continuum for all ages and people of all cultural backgrounds.
- All services respond to the expectation of comorbidity and complexity.
- Welcome all individuals with active substance use in all settings in the continuum.
- Medical screening is widely available and is not burdensome.
- There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.
- Telehealth is provided for needed services not available in the local community.
- Program components are adequately staffed by multidisciplinary teams, including peer support providers.
- There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.

Section III: Basic Clinical Practice

An ideal behavioral health crisis system has guidelines for utilization of the best clinical practices for crisis intervention with associated processes for practice improvement and developing workforce competency.

CORE COMPETENCIES FOR ENGAGEMENT, ASSESSMENT AND INTERVENTION

POPULATION-SPECIFIC CLINICAL BEST PRACTICES

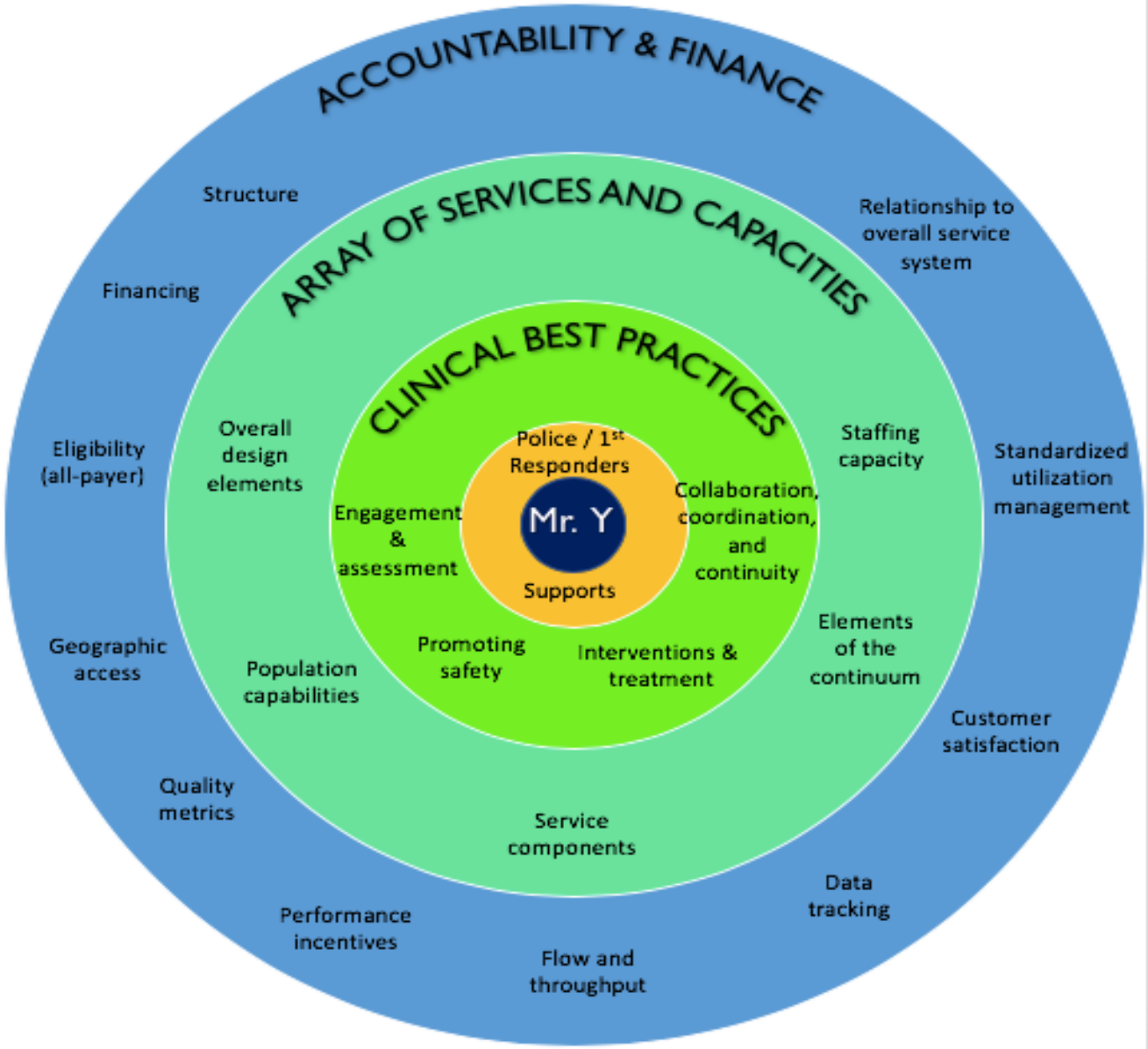
SCREENING AND INTERVENTION TO PROMOTE SAFETY

COLLABORATION, COORDINATION AND CONTINUITY OF CARE

PRACTICE GUIDELINES FOR INTERVENTION AND TREATMENT

Section III: Basic Clinical Practice

- The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.
- Engagement and information sharing with collaterals is an essential competency.
- Staff must know how to develop and utilize advance directives and crisis plans.
- Essential competencies include formal suicide and violence risk screening and intervention.
- “No force first” is a required standard of practice.
- Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate rather than inhibit access to behavioral health crisis care.
- Utilizing peer support in all crisis settings is a priority.
- Behavioral health crisis settings can initiate medication-assisted treatment (MAT) for SUD.
- Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues.
- Utilize best practices for crisis intervention, like critical time intervention, to promote successful continuity and transition planning.



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The Role and Opportunity of CCBHCs

CCBHCs are required to provide: crisis call line, 24/7 mobile crisis teams, crisis stabilization, and emergency crisis intervention

Many also provide:

- ER diversion
- Crisis Stabilization/Drop-in Centers
- Co-response with police/EMS
- Diversion of calls and mobile response instead of police

- **75%** of CCBHCs directly operate a crisis call line
- **21%** report they participate in the National Suicide Prevention Lifeline network
- **91%** are engaging in one or more identified **high-impact activities** in crisis response, including:
  - Coordinating with hospitals/emergency departments to support diversion from EDs and inpatient (79%);
  - Operating a crisis drop-in center or similar facility for crisis stabilization (33%)
  - Behavioral health provider co-responds with police/EMS (38%);
  - Mobile behavioral health team responds to relevant 911 calls instead of police/EMS (19%);
  - Partnering with 911 to have relevant calls routed to CCBHC (17%);
  - Providing telehealth support to law enforcement officers responding to mental health/SUD calls (20%)

CCBHC Impact Report: https://www.thenationalcouncil.org/wp-content/uploads/2021/08/2021-CCBHC-Impact-Report.pdf?daf=375ateTbd56

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CCBHCs' Role in the Crisis Continuum

Prevention	Crisis Response	Post-crisis care
• Early engagement in care • Crisis prevention planning • Outreach & support outside the clinic	• 24/7 mobile teams • Crisis stabilization • Suicide prevention • Detoxification • Coordination with law enforcement & hospitals	• Discharge/release planning, support & coordination • Comprehensive outpatient MH & SUD care

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Sherry Blyth

CCBHC-E National Training and Technical Assistance Center

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Integral Care supports adults and children living with:

- mental illness
- substance use disorder
- intellectual and developmental disabilities

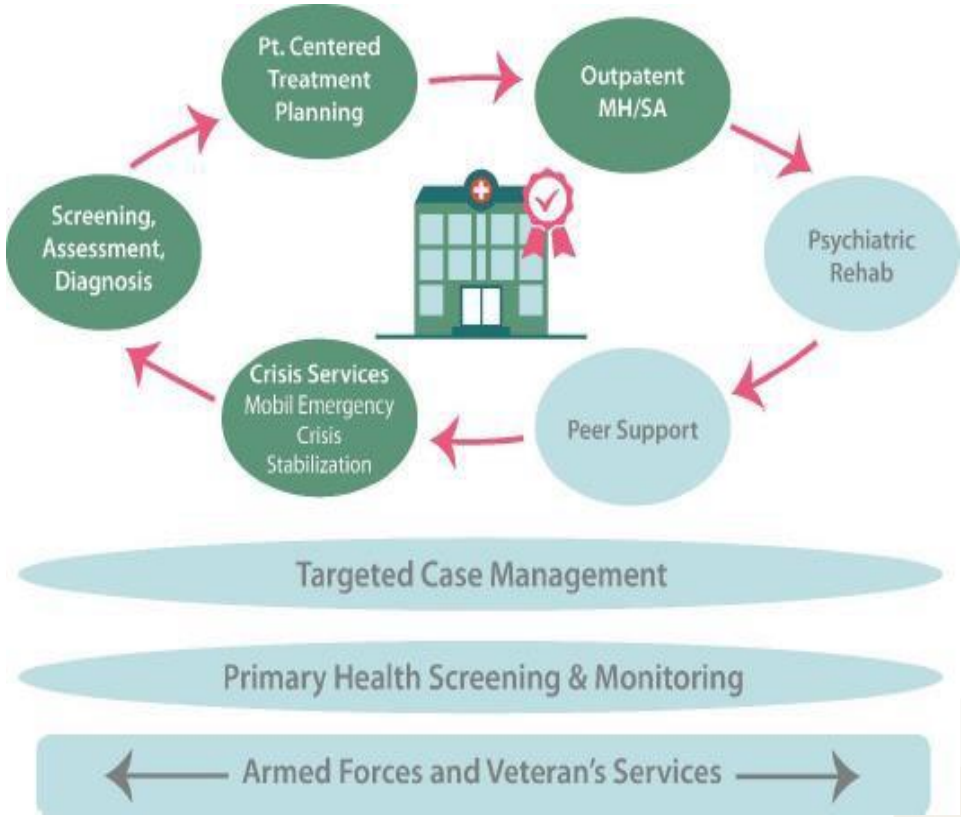
We help people build health and well-being so everyone has the foundation to reach their full potential.

Austin, Texas (Travis County) Snapshot

- Population 2021:
  - 1,328,720,
  - Rapid growth
  - Primarily Urban
- Demographics:
  - Race/Ethnicity: White 55%, Hispanic 33%, Multi-Race 16%, African 8%, Asian 8%
  - Median Age: 35 years
  - Median Income: $80,690
- Capital of Texas
- University of Texas- Student population over 50,000
- UT Dell Medical School
- Hosts several events
  - Film/Music Festivals
  - Professional/Collegiate Sporting events
  - Formula 1 Circuit of the Americas

CCBHC Operations in the Community

- 24/7 Helpline
- Care Coordination
- Healthcare Partners
- Homeless Outreach
- Schools
- Law Enforcement
- Hospitals
- Urgent Care



First Responder Collaborations

- Austin Police Department
  - Overview
  - Crisis Intervention Team
  - Integration in to the 911 Call Center
  - Mental Health Training
- Austin Travis County Emergency Medical Services
  - Overview
  - Community Health Paramedics
  - Mental Health Training

Crisis Services

Integral Care offers mental health crisis support 24 hours a day, 7 days a week – on the phone and in the community. Our crisis services help people recover from a mental health crisis and rebuild their well-being.

A helpline for anyone who needs immediate emotional support

Tools and resources to prevent suicide

Teams that go anywhere someone needs help

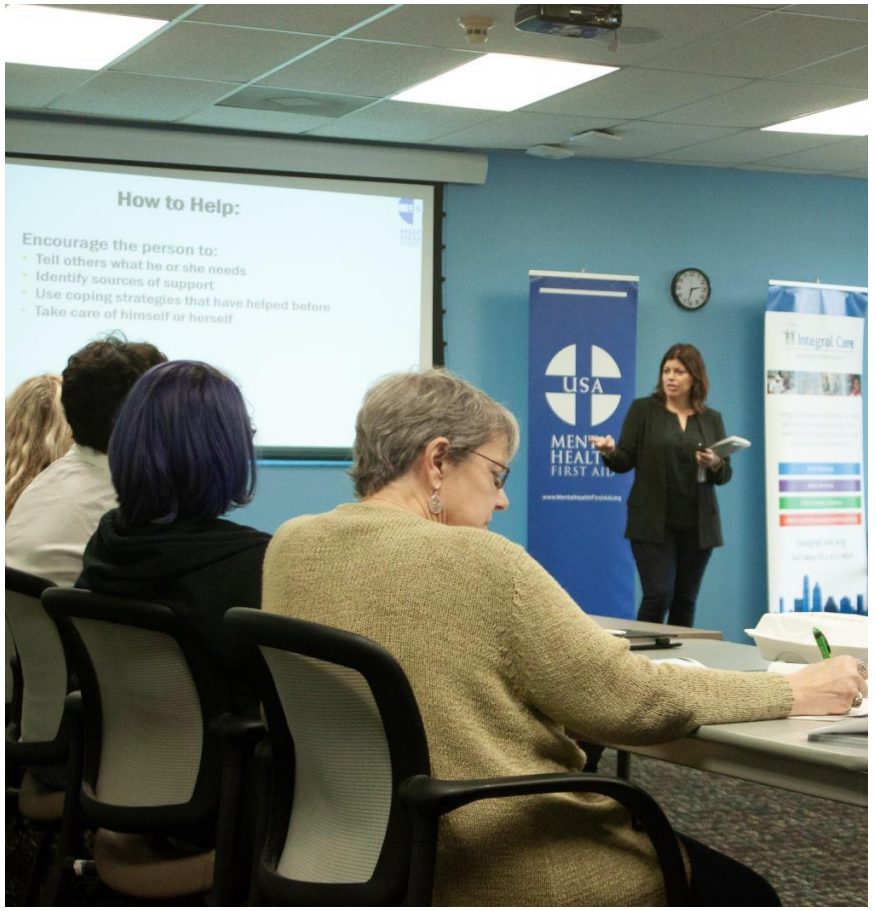
Mental Health Urgent Care

EMCOT Overview

- EMCOT provides specialized response to people in mental health emergencies anywhere someone is in crisis
- Goal of the team is to decrease/prevent arrests and emergency department visits, release first responders to other needs and connect people to the specialized care they need
- Provides follow-up care for up to 90 days
- Developed based on local community needs, drawing from best practice models across the U.S.
- EMCOT services are voluntary, never forced or required
- How it works:
  - Answer mental health calls to the 911 call center
  - Co-response with law enforcement and EMS to the scene
  - Dispatched by 911 to the scene or requested by Travis County Jail personnel
  - Provide telehealth to support law enforcement and EMS
  - Follow-up services to support ongoing stabilization and connection to care

EMCOT Services

- Individuals
  - De-escalation and stabilization on scene
  - Assessments
  - Screening and Triage
  - Navigation to intensive crisis support as needed
  - Crisis counseling
  - Case management
  - Medication Management
  - Psychosocial Rehabilitation
  - Rehabilitation Skills Training
- Agencies
  - Co-response
  - Training



EMCOT Timeline

FY 2013: Established as an 1115 Medicaid Waiver Project (21 FTE)

FY 2019: Funding shifted due to changes in federal program

- Travis County (40%)
- City of Austin (60%)

FY 2020: City of Austin provided additional funding (28.5 FTE)

- Provide Telehealth Services to first responders
- Integrate EMCOT clinicians into 911 Call Center with APD

FY 2021: City of Austin provided additional funding (41 FTE)

- Provide Telehealth Services
- Expand to 24/7 integration with 911 Call Center

FY 2022: Travis County invests in 911 integration (45 FTE)

Background

Where We Were	Inbound mental health call to 911	Police, Fire or EMS?	911 call taker dispatches officer	Officer responds to the scene	Responding officer can dispatch MHO and/or EMCOT
Where We Are Now	Inbound mental health call to 911	**Police, Fire, EMS or Mental Health Services?**	Non Mental Health: 911 call taker dispatches officer	Officer responds to the scene	Responding officer can dispatch MHO and/or EMCOT
			Mental Health: 911 call taker transfers to C3	C3 provides telephone counseling and de-escalation	EMCOT dispatched as appropriate for follow-up

Call Center Diversion (CCD)

- CCD focuses on diverting appropriate mental health related calls received by Austin Police Department's Emergency Communications Division to a Center Crisis Clinician (C3) imbedded on the Operations Floor.

- The goal is to engage the caller in addressing mental health issues in the mental health treatment system as opposed to the criminal justice system.

- The C3 position will serve as an add-on service to a 911 Operator answering a call with a suspected or confirmed behavioral health crisis component.

911 Calls Ineligible for C3 Transfer

- An individual in possession of firearms, knives, or any other weapons
- An individual under the influence of alcohol or drugs to the extent requiring medical intervention (overdose or detox) or exhibiting violent behavior
- An individual threatening or at imminent risk of hurting self or others/ of killing self or others
- When an individual has committed a crime (e.g. family violence)
- Hot Shot calls (calls where life and/or property are in imminent danger)
- Priority 1 calls, with the exception of Check Welfare Urgent calls ***if*** the call does not have other disqualifiers

C3 Support When First Responders Assigned

The C3 have many opportunities to assist the caller and APD without diverting the call.

C3s …

- Are a source of support for the caller during his/her immediate crisis
- Provide resources to better prepare the caller to handle future mental health related crisis. C3s provide referrals during the call or during follow up calls.
- De-escalate the crisis prior to APD arriving on scene, which creates a safer environment for the caller and first responders.
- Provide additional information to the 911 Operator, which would otherwise be unknown to first responders arriving on scene - Consult.

9-1-1 Calls Appropriate for C3 Transfer

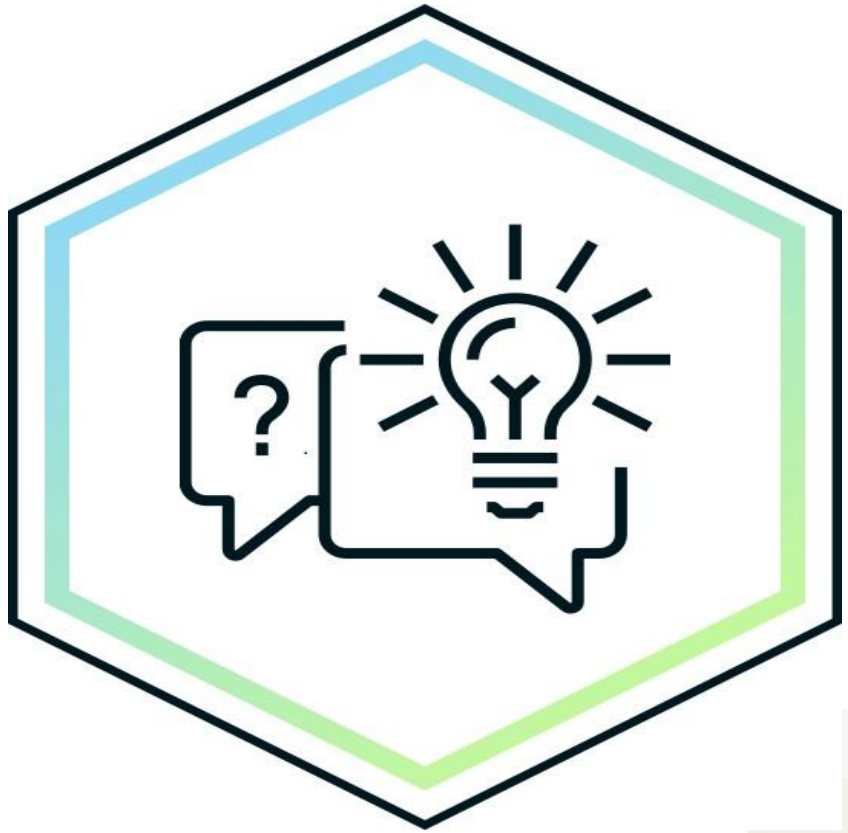
- Callers experiencing a mental health (MH) crisis and ***NOT*** actively attempting suicide or physically violent toward themselves or others
- Callers indicating there is a verbal dispute or disturbance ***only*** with a MH component
- Callers requesting police due to psychosis or an altered mental state
- Parents requesting police due to child behavioral issues
- Repeat callers with a known MH history
- A caller experiencing a mental health crisis and requesting a Mental Health Officer
- A caller experiencing an mental health crisis and the call does not meet the transfer criteria, if the 911 Operator believes the C3 could assist in de-escalation prior to the officers' arrival.
- Second party callers concerned about the welfare of someone who has a known or suspected mental health history

Key Strategies

- Site Visits
- Observations (Call Takers/MCOT)
- Build relationships with first responder partners
- Interlocal, Memorandum of Understanding
- Integrate Emergency Communication Centers (benefits to same location)
- Data Collection

Lessons Learned

- Technology
- Training
- Recruitment for positions

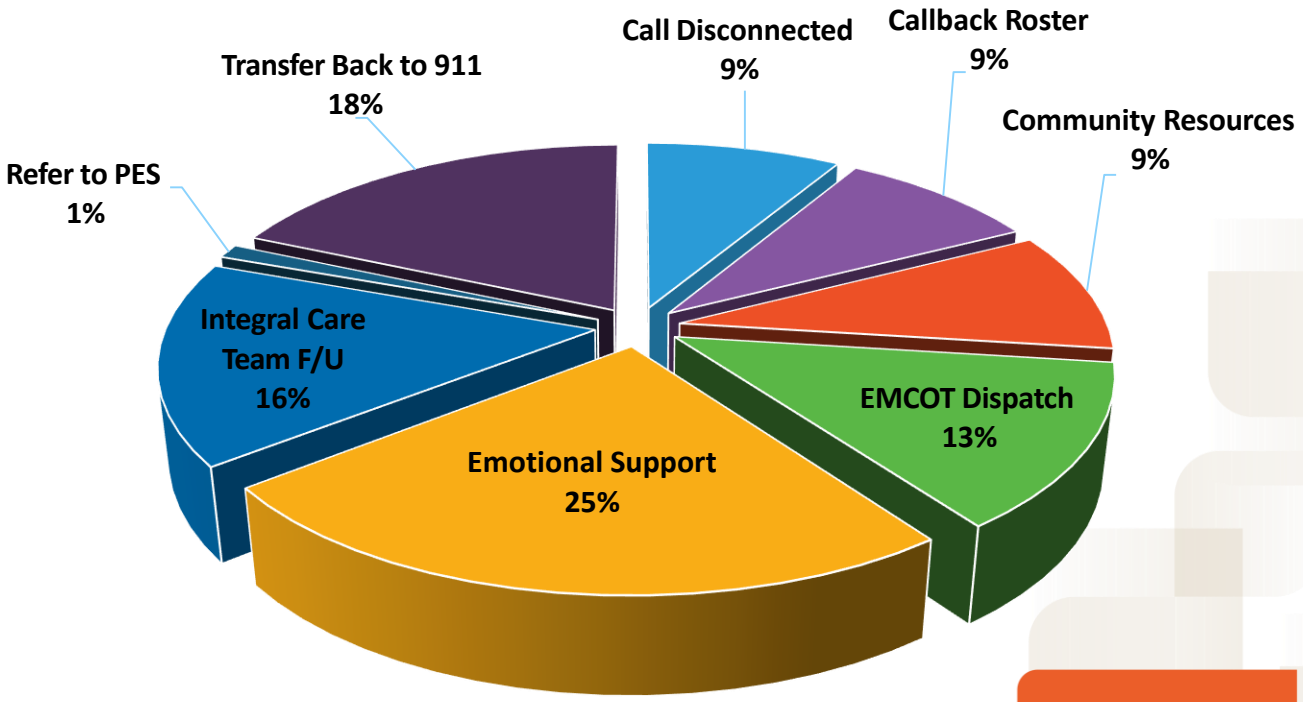


FY 2021 Data

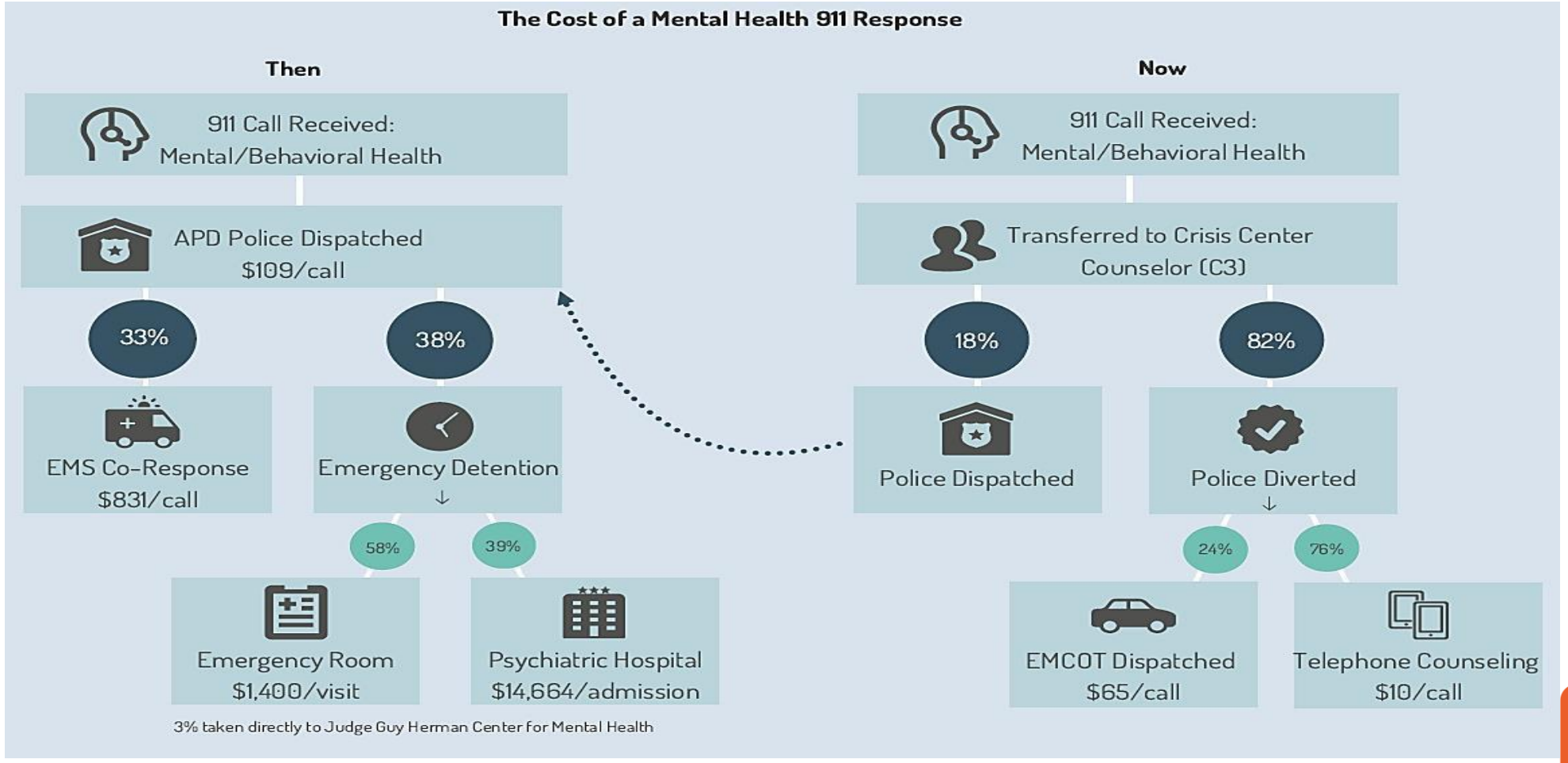
FY2021 (10/1/2020-9/30/21)

- Number of Calls Transferred to EMCOT C3: 4,497
- Percent of Calls Diverted from Police Response: 81%

Primary Outcomes: 10/1/20-9/30/21



Cost Savings and Cost Avoidance



Integral Care

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Projected Program Impact

Projected Total Cost Avoidance for Calls Diverted to C3 - Annual			
Encounter Type	Cost per Unit	Diverted Calls	Cost Avoidance
Austin Police Department Mental Health Response	$ 109.00	4,210	$ 458,890.00
Typical response involving ambulance and/or fire truck	$ 831.00	1,389*	$ 1,154,259.00
Emergency Detention	-----	1,600*	-----
Emergency Detention – Emergency Room Admission	$ 1,400.00	928*	$ 1,299,200.00
Emergency Detention – Private Psychiatric Hospital Admission	$ 14,663.60	624*	$ 9,150,086.40
Projected Total Cost Avoidance – 12 Months Scaled			$ 12,062,435.40
Projected Average Cost Avoidance per Diverted Call – 12 Months Scaled			$ 2,865.19

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Bestself Behavioral Health

Rita Cuda

CCBHC-E National Training and Technical Assistance Center

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Questions?

Reminder: Sign up for Office Hours

Thursday, April 28st, 2022 – 1:00-2:00pm ET

Register here

Looking for more time to dive deeper with our presenters,

get your questions answered or exchange ideas?

Join our follow-up office hours session!

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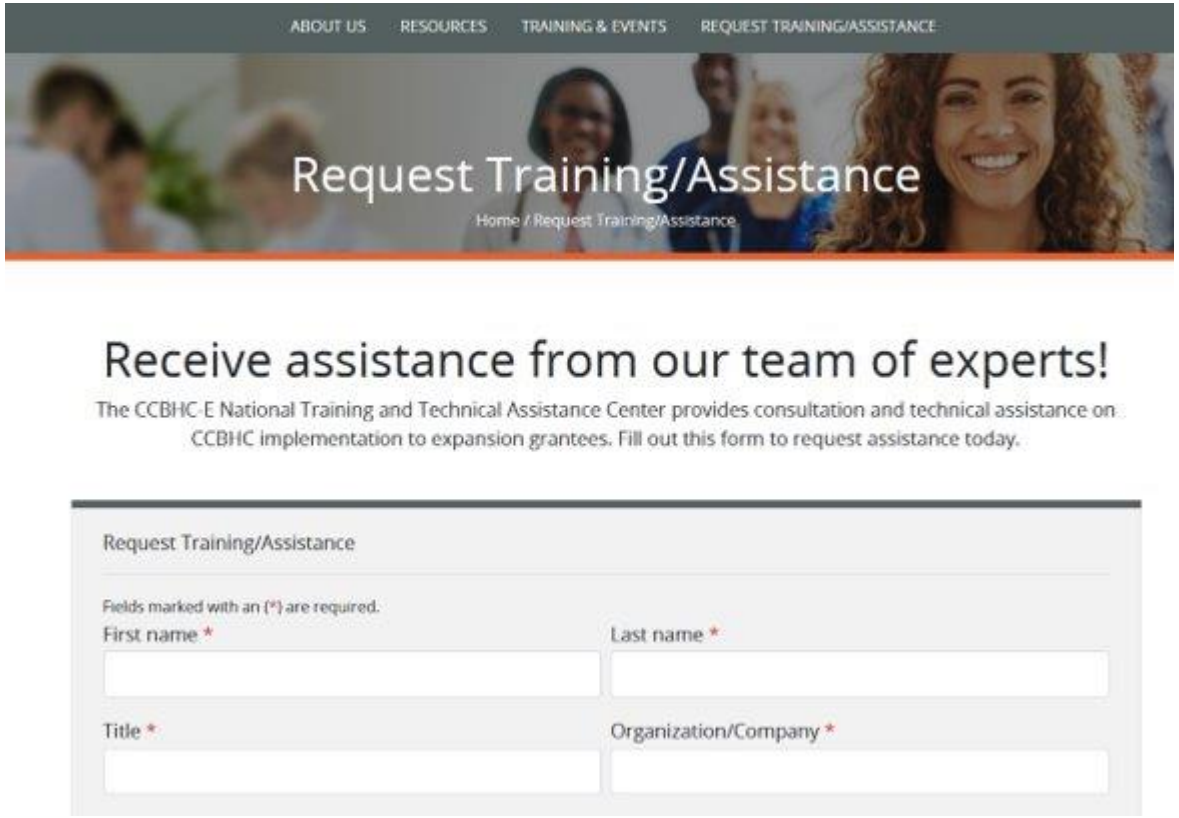
Questions or Looking for Support?



Visit our website and complete the **Request Technical Assistance** form

https://www.thenationalcouncil.org/ccbhc-e-nttac/

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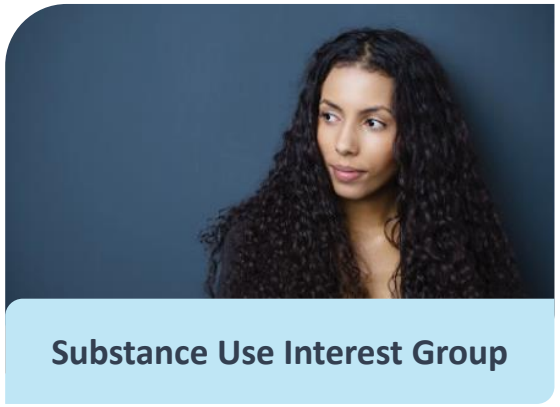
Explore National Council Interest Groups

TheNationalCouncil.org/national-council-interest-groups

Crisis Response

Connect and learn more about how to contribute to the ongoing evolution of the crisis response continuum, including the once-in-a-generation opportunities related to 988.

Substance Use



Pulling from the fields of research, advocacy, policy and practice, this interest group will explore the latest innovation and guidance from across the field and throughout the full continuum of substance use prevention, treatment and recovery.

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Thank You

Please take a moment to share your feedback in the **post-webinar survey**.

It will pop up once the webinar is closed.

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