Washington State Behavioral Health Administrative Services Organization (BH-ASO)

Pierce County Crisis System Protocols

2024

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INTRODUCTION

The Crisis System Protocols are guidelines to describe how various providers will work together to serve individuals and provide timely resolution and treatment. The Protocols clarify processes, roles and responsibilities. The Pierce County Crisis System values a supportive and solution-focused environment for reaching the best resolution across all five phases.

Carelon Behavioral Health is a health improvement company that serves more than 40 million individuals across all 50 states. On behalf of employers, health plans and government agencies, Carelon manages innovative programs and solutions that directly address the challenges the behavioral health care system faces today. Carelon is a national leader in the fields of mental and emotional wellbeing, addiction, recovery and resilience, employee assistance, and wellness. Carelon supports people in making difficult life changes needed to be healthier and more productive. Collaborating with a network of providers nationwide, Carelon helps individuals live their lives to their fullest potential. In Washington State, Carelon serves a number of large employers, and manages crisis services in several regions.

OVERVIEW OF GOALS AND CRISIS SYSTEM

The purpose of the crisis system is to respond rapidly, assess effectively, and deliver a person-centered course of treatment intended to promote trauma-informed recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with an individual in crisis, providers are expected to deliver a core service, including crisis assessment, intervention, and stabilization.

While it is expected that all crisis encounters minimally include the three basic components of crisis assessment, intervention, and stabilization, crisis services require flexibility in the focus and duration of the initial intervention, the inclusion/participation of the individual's preferred family members/ natural supports in the intervention, and the number and type of follow-up services. It is essential that individuals in crisis have timely access to the most appropriate behavioral health services across the crisis continuum. More specifically, it is essential to ensure access to urgent outpatient services as a crisis emerges in order to prevent over-reliance on acute crisis services. Similarly, it is necessary to improve access to inpatient and diversionary levels of care in order to streamline the crisis system's discharge and referral process.

The definition of a crisis is a time of intense difficulty, trouble, or danger as experienced by the individual. Any individual in Pierce County is eligible to receive crisis services regardless of insurance status. There are no medical conditions that exclude someone from receiving crisis services.

Goal: Individuals in Pierce County (Medicaid and non-Medicaid) will receive timely crisis services at the appropriate level of care at the time they need it, with every effort made to keep individuals connected to their communities and natural supports. Services will promote recovery and resiliency and seek to keep individuals at the least restrictive level of care.

CRISIS SYSTEMS OF CARE ORGANIZING FRAMEWORK

Behavioral health crises do not fit neatly into a box. Crisis services are not an Essential Health Benefit nor a required service under Medicaid. Thus, funding comes from a combination of federal, state, and local dollars.

The management and treatment of mental health and substance use related crises is a systems-level and public health need which requires commensurate response. No single entity or system owns full responsibility for crises, and a single entity or system

is not, on its own, sufficiently leveraged to address systems-level complexities necessary for a healthy system. While some individuals do have serious and persistent mental and substance use conditions, often crises are exacerbated by poverty, unstable housing/homelessness, job disruption, school performance, trauma (including exposure to home and community violence), unmet primary health care needs, stressed households, lack of community support, and social isolation.

Using a Crisis Systems of Care Framework can help a community:

1. Identify and address gaps in the safety net
2. Expand knowledge and skillset of laypersons
3. Increase efficient use of resources
4. Reduce handoffs and duplication
5. Provide services that are most meaningful and useful to individuals in crisis and their families
6. Promote development of local solutions
7. Reduce use of coercive interventions
8. Reduce civil and criminal court involvement
9. Reduce need for emergency and inpatient services
10. Reinforce a coordinated, systemic (rather than agency-centric) approach to planning, delivery, policy, and outcome management.

Crisis systems are incredibly complex and idiosyncratic- no two are alike. There are numerous components within any crisis system. Effective crisis systems of care do not naturally exist. They are built. Unless purposely arranged, they do not operate in a coordinated and systematized fashion. An organizing framework gives a community a visual structure in which to map/assess/strengthen what currently exists, and to strategically enhance, strengthen and add new elements.

The graphic below provides one organizing and planning framework that offers nine points of opportunity for building depth and breadth into a crisis system. There are five crisis phases for community development and investment:

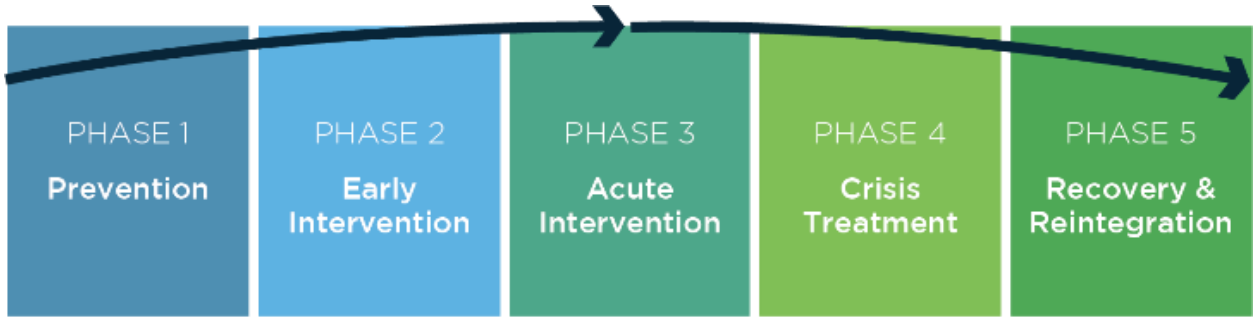
1. Phase I – Crisis Prevention
2. Phase II – Early Intervention
3. Phase III – Acute Intervention
4. Phase IV – Crisis Treatment
5. Phase V – Recovery/Reintegration

There are five categories of “components” that need to work together effectively:

1. Lived Experience
2. Players
3. Logistics
4. Competencies
5. Parts

Within the organizing and planning framework, there is some overlap. Some communities invest narrowly in phases III (Acute Intervention) and IV (Crisis Treatment) and miss building resources to prevent or intervene early in crisis and/or there can be the tendency to invest in "parts" without attending to the other three components.

Crisis System Organization and Planning Framework Example



LIVED EXPERIENCE: In program development, oversight and service delivery

PLAYERS: Strong, cross-sector collaborations

LOGISTICS: Processes to facilitate movement of people and data

COMPETENCIES: Skills that promote resolution and reduce harm

PARTS: Services used as intended and producing results

Crisis system framework developed by Kappy Madenwald of Madenwald Consulting

DEFINITIONS

- 988 is the new, nationwide, three-digit dialing code for the Suicide and Crisis Lifeline. The 988-dialing code connects people via call, text, or chat, to the existing National Suicide Prevention Lifeline (NSPL) where compassionate, accessible care and support are available for anyone experiencing mental health-related distress. 988 is the newest addition to the state's network of crisis center providers and will not replace any crisis call centers in Washington.

- Adult Mobile Crisis Intervention (AMCI) is a short-term service that provides a mobile face-to-face response to an adult (age 18 years and older) experiencing a behavioral health crisis. Access to this service is through the regional crisis line (800-576-7764). In the Pierce County region, the Mobile Outreach Crisis Team (MOCT) operates as an AMCI team.

- BH-ASO means Behavioral Health Administrative Services Organization (BH-ASO). In Pierce County, this entity is Carelon Behavioral Health (Carelon), charged with the responsibility of improving the experiences

of individuals in crisis and the efficiency/efficacy of the crisis system that serves them. Carelon is also responsible for additional non-crisis services for low-income individuals who lack insurance coverage. The BH-ASO structure is part of the Washington Health Care Authority's Fully Integrated Managed Care (FIMC) model, which seeks to bring whole-person, integrated care to Washington's Medicaid population.

- Community Re-entry Program (CRP) assists individuals who have a high number of repeat Jail bookings, often due to complex mental health challenges. Supported by a team of clinicians, peers and a nurse who work with them to find housing and build community supports, increasing their chances of avoiding future arrests.

- Crisis Services (Behavioral Health) means providing evaluation and short-term treatment and other services to Individuals with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the Individual's health or safety. Crisis services will be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services include, but are not limited to the Telephone Crisis Triage, Intervention, and Mobile Crisis Outreach.

- Designated Crisis Responder (DCR) means a mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in RCW 71.05 and 71.34

- Detention vs Commitment a detention or "detain" means the lawful confinement of a person by a DCR for up to 120 hours excluding weekends and holidays under the provisions of RCW 71.05 and 71. 34.. A commitment means the determination by a court that a person should be detained for a period of either evaluation or treatment, or both, in an inpatient or a less restrictive setting.

- Felony Forensic Assertive Community Treatment (FFACT) in collaboration with the Pierce County Superior Court, individuals with a mental health or substance-use disorder who have committed a non-violent felony can participate in a rigorous program to avoid prosecution.

- Gravely Disabled means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

- Involuntary Treatment Act (ITA) allows for individuals to be committed by court order to a psychiatric hospital, Evaluation and Treatment Facility or Secure Withdrawal Management and Stabilization Facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled, pose a danger to themselves or others or needs assisted outpatient behavioral health treatment, and who refuse or are unable to enter treatment on their own behalf. An initial commitment may last up to 120 hours not including weekends and holidays, and, if necessary, the court may order additional commitment of up to 14, 90, and 180 calendar days Involuntary Treatment Act Services includes all services and administrative functions required for the evaluation for involuntary detention and treatment of individuals in accordance

with RCW 71.05 71.24. 300 and 71.34. The decision-making authority of the DCR must be independent of the Contractor's administration. ITA services continue until the end of the involuntary commitment.

- MCO means Managed Care Organization. In the Pierce County region, they are Molina Healthcare, Coordinated Care (CCW), United Healthcare, Amerigroup, and Community Health Plans of Washington (CHPW). The MCOs cover Medicaid lives and are part of Washington Health Care Authority's Fully Integrated Managed Care (FIMC) model, which seeks to bring whole-person, integrated care to Washington's Medicaid population.

- Mobile Crisis Intervention (MCI) services are designed to optimize clinical interventions by meeting individuals in home or community settings where they are more comfortable, where strengths and cultural differences are more apparent and where natural supports are more available. Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing individuals to bypass the stigma, trauma and disruption of a hospital or out of home setting.

- Mobile Outreach Crisis Team (MOCT) part of MultiCare Behavioral Health provides face-to-face crisis outreach intervention services to assist individuals in community settings, such as an individual's home, an emergency room, a nursing facility, or other private or public location.

- Program of Assertive Community Treatment (PACT) are community-based, multi-disciplinary teams which provides the treatment, rehabilitation and support services needed to enable adults with severe and persistent mental illness to engage in an individual process of recovery. The three teams consists of a psychiatrist, nurses, master's level clinicians, vocational specialists, addiction specialists, a housing specialist, and a case manager. One team is managed by MultiCare the second is managed by Greater Lakes Mental Health, the final team is managed by Comprehensive Life Resources. These self-contained teams, organizes and provides all services in partnership with the participant. Most services are delivered in the individual's home.

- Re-Referral is the process of re-referring an individual back to the DCR or AMCI team who was previously referred for crisis intervention services.

- Single bed certification is a process to provide additional treatment capacity for a person suffering from a mental health disorder for whom an evaluation and treatment bed is not available. The DCR submits an application for a single bed certification for treatment at a facility that is willing and able to provide timely and appropriate mental health treatment. Single Bed Certification can be initiated by the DCR for the initial 120-hour detention and can be continued throughout the commitment process and must be renewed every 30 days.

- Trueblood Mobile Crisis Enhancement Team is an enhancement to the capabilities of the mobile crisis team through MultiCare's MOCT team and does not duplicate services. This expansion allows for more coverage so that the mobile crisis team may provide a prompt response throughout the county as well as follow up after the initial crisis intervention to ensure connection to community resources. These additional team members consist of two full time Care Coordinators, one Crisis intervention staff, one Peer Specialist, one DCR, one part time supervisor, and one part time ARNP.

- Voluntary treatment implies the individual is capable of providing informed consent as defined in RCW 7.70.060 and can express a sincere willingness (free of coercion) to engage in treatment and procedures

as prescribed by the treatment provider and treatment team at the facility where the individual has given consent.

- Wraparound with Intensive Services (WISe) is an intensive mental health services to assist youth and families in achieving wellness, safety, and to strengthen communities. WISe uses a team-based approach to providing services, and is available to youth under age 21 who are eligible for the Medicaid program. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid costly and disruptive out-of-home placements. WISe teams are staffed by a Care Coordinator, Therapist, Family Partner, and/or Youth Partner.

- Youth Mobile Crisis Intervention (YMCI) is a short-term service that is a mobile, on-site, face-to-face therapeutic response to an individual (under age 18) experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the individual or others. Catholic Community Services (CCS) and Seneca Family of Agencies (Seneca) both operate a Youth Mobile Crisis Intervention Team in the Pierce County region.

- Systems of Care Grant This federal grant funding is provided for the enhancement of existing Mobile Crisis Response (MCR) services already contracted through Carelon BH-ASO to help align current systems with the Mobile Response and Stabilization Services (MRSS) model.

- Foster Care Pilot the BH-ASO is working to enhance access to the crisis system for youth in the foster care system. The YMCI teams will be working with DCYF directly to provide these services.

CRISIS DURING BUSINESS HOURS

During regular business hours, outpatient providers provide crisis response to individuals enrolled in their services and are the first level of response when an individual is in the presence of the provider. Responses can include de-escalation, crisis counseling, crisis planning and reintegration for any individual involved in their care. In situations where the provider needs additional support, all internal agency avenues should be explored first before seeking support from the county crisis teams while maintaining safety for the individual and staff.

CRISIS FOR PROGRAMS WITH 24/7 COVERAGE

For intensive programs that have 24/7 crisis response built into the program model (e.g. PACT, WISe, FFACT, CRP), the on-call coverage should be activated to respond to the individual's crisis, utilizing individualized crisis response plans developed by the treatment team and documented within the program. If additional support is needed, the crisis team can be accessed for consult or ITA evaluation if warranted. All efforts are made to prevent hospitalization or out of home care. If a known PACT, WISe, FFACT, and CRP enrolled individual calls the regional crisis line (Crisis Connections, or 988) directly, the crisis line clinician will follow procedure sets to link the individual back to their team.

The MCOs (Amerigroup, Coordinated Care, Molina, United, and Community Health Plan of Washington) send Carelon rosters for their members enrolled in PACT, WISe, FFACT, and CRP in order for Carelon to create alerts in the regional crisis line system on a monthly basis.

Below is the regional crisis line procedure set for programs with 24/7/365 coverage

Special Programs – PACT/WISe/FFACT/CRP

Overview

Community Mental Health Agencies will often have special programs serving their respective populations with specific procedures and requirements.

Information

Pierce County has the following programs:

- PACT (Program for Assertive Community Treatment) for adults
- WISe (Wraparound with Intensive Services) for children
- FFACT (Felony Forensic Assertive Community Treatment) for adults
- CRP (Community Re-entry Program) for adults

Numbers

Crisis Line Numbers:

- The PACT program is run by three organizations, MultiCare - PACT: 253-301-5220, Greater Lakes PACT 253-620-5036 and Comprehensive Life Resources PACT 253-395-5016
- The WISe program is run by Catholic Community Services: ***There are unique numbers based on the crisis team associated with the individual. See procedures below
- The FFACT program is run by Greater Lakes Mental Health - FFACT: 253-581-7020
- The CRP program is run by Greater Lakes Mental Health - CRP: 253-581-7020

If call is from a…	Then…
Current WISe member	1. Cross reference them in the Person Alert System to locate their Crisis Response team. 2. Remind the caller that they have a WISe support team consisting of the individuals below and to contact them directly: Clinician Coordinator Peer Support Family Support Specialist 3. If the caller does not want to contact their support team, follow Intervention Options Prospective WISe member: Direct the caller to contact 253-759-9544 and leave a message with their request. Alternatively, have the family call the Crisis line (Crisis Connections can reach out to CCS to connect with the family.)

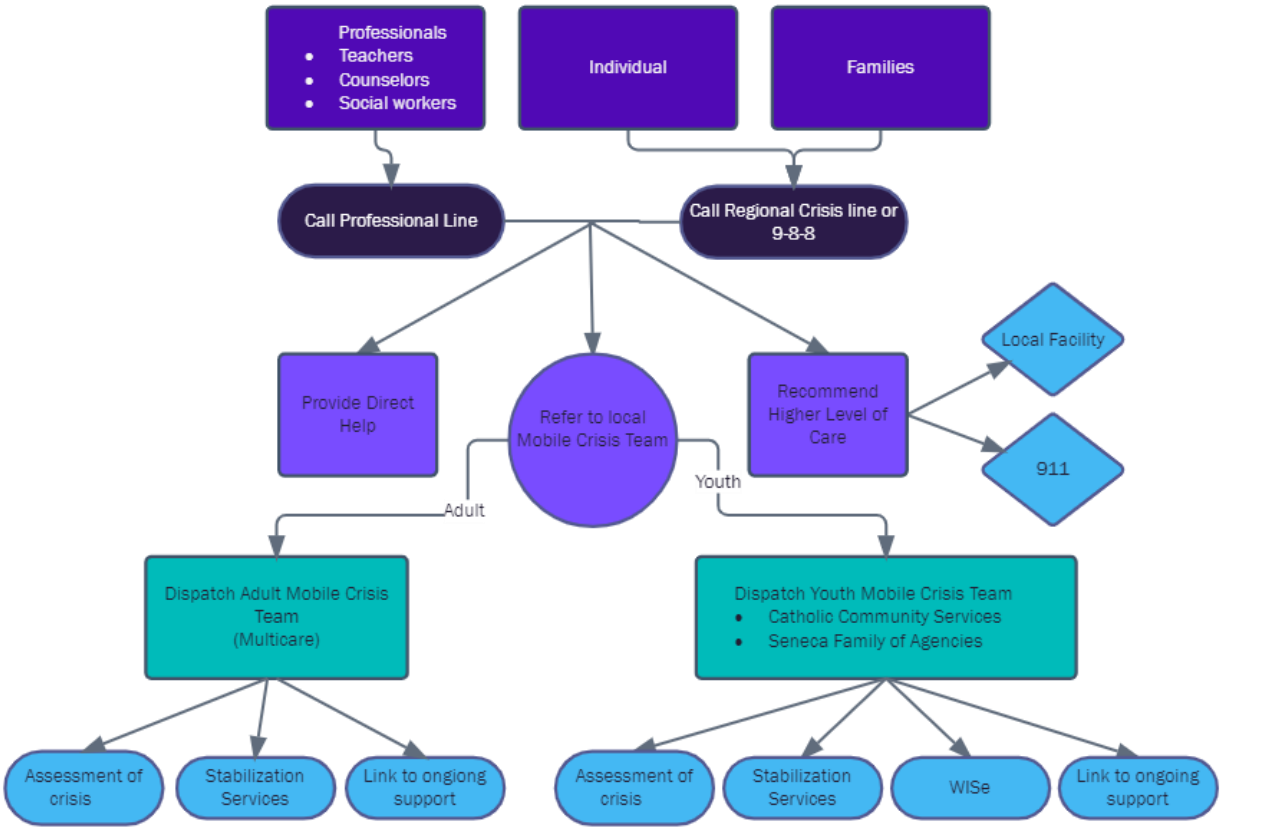
<table>
<tr>
<td>Current
PACT member</td>
<td>
1. Ask which program caller is with and cross-reference them in the Person Alert System to locate their Crisis Response team.
2. Conduct Level of Care (LOC) assessment
<table>
<tr><th>If the LOC is…</th><th>Then…</th></tr>
<tr><td>Routine/Urgent</td><td>Offer to warm transfer them to the proper crisis line listed above and encourage them to call their case manager the next day.
This is a voicemail system, and the caller is called back within 45 minutes to an hour.</td></tr>
<tr><td>Emergent</td><td>If the caller does not want to participate in be transferred, handle per intervention options. Follow Hospitalization or Emergency Procedures.</td></tr>
</table>
If the caller has a case management need:
Direct the caller to their case manager the next business day.

Prospective PACT: Proceed as you would with a counseling PACT request and provide a referral to Multi-Care, Greater Lakes or Comprehensive Life Resources.
</td>
</tr>
</table>

CRISIS SERVICES

Crisis services available in the region include a 24/7/365 regional crisis hotline, mobile crisis response for adults and youth and evaluation for involuntary treatment from a Designated Crisis Responder (DCR). The diagram below illustrates the crisis services flow from initial entry point, through the crisis regional crisis hotline, dispatch of mobile crisis team, and individualized treatment at the optimal level of care.

Crisis Services Workflow



- Any of the mobile crisis teams can call a Designated Crisis Responder (DCR) if there is a danger to self, others, and/or a risk of harm due to grave disability
- 911/Police can dispatch Co-responder response teams which consist of law enforcement and behavioral health professionals who engage with individuals experiencing crises that do not require incarceration.
- Regional Crisis Line: 800-576-7764
- If you are a professional and need the Professional Line number, please contact: Darlene.Davies@Carelon.com

REGIONAL CRISIS LINE: Crisis Connections

Crisis Connections operates the 24/7/365 regional crisis hotline for Pierce County. For all callers, the crisis hotline will triage, screen, and assess needs and intervention preferences; and as indicated, will offer resolution-focused telephonic crisis support, support caller's use of their crisis plan, coordinate with the caller's local treatment providers, and facilitate linkage to timely and appropriate interventions and resources if needed.

When calling the regional crisis line, the following steps will occur:

- The call will be answered by a Call Screener and Coordination Specialist who will first gather the name and contact number for the caller and the name and contact of the person of concern as well as their county of residence or current location. At this point, they will be passed to the appropriate line depending upon need. Crisis Connections maintains a crisis line for individuals in crisis or needing emotional support, and a professional line for quick linkage between service providers and crisis programs.
- The caller and the person of concerns names will be cross-referenced for an active person alert and previous call history.
- Based on the caller's need, the trained phone worker will follow a series of procedures and survey questions to support proper call handling. Calls can come from any community member as well as community providers such as law enforcement, 911 Dispatch, County Jails, Hospital Emergency Departments, residential or outpatient providers, school staff or third parties.
- For callers needing support for themselves or someone else, a trained phone worker will provide the person of concern with a level of care determination based on the safety concerns explored.
- If the caller is seeking emotional, telephonic support (empathetic listening, problem solving, advice), the trained phone worker will provide this directly with the caller.

If further support or evaluation is needed, the trained phone worker will collaborate with the caller to facilitate either a referral, direct connection to the DCR teams, AMCI or YMCI team, or take active rescue to ensure that person either gets to a hospital or has law enforcement intervention.

- Safety Assessment Items:
  - Presenting concern
  - Suicidal ideation
  - Homicidal or harm to others ideation
  - Intentional self-harm
  - Substance use
  - Interpersonal or domestic violence
  - Abuse to vulnerable populations
  - Psychiatric medication
  - Cognitive concerns

- Level of Care Determinations
  - Routine Criteria: Call is resolved with de-escalation if necessary and referral to local resources are provided. Caller initiates next steps.
    - Low risk of harm (suicide and homicide)
    - Low risk of substance use
    - Minimal-to-mild impairment in functional status
  - Urgent Criteria: Call requires de-escalation and referral to local resources. Possible referral to sobering/detox unit, outreach to DCR, MOCT/AMCI, or YMCI team.
    - Moderate-to-serious risk of harm (suicide or homicide)
    - Moderate-to-serious risk related to substance use

        - Moderate-to-serious impairment in functional status
    - Emergent Criteria: Call requires immediate emergency attention
        - Extreme-to-serious risk of harm (suicide or homicide)
        - Extreme-to-serious risk related to substance use
        - Extreme-to-serious impairment in functional status

- If the caller does not need an assessment, the staff member will follow the proper procedures to connect with either the DCR, AMCI, YMCI team, or provide community referrals.

For facility calls (professional line calls) requesting AMCI, or YMCI, the following actions will occur:

- The call will be answered by a Crisis Services Clinician or Crisis Intervention Specialist who will first gather the name and contact number for the caller and the name and contact of the person of concern as well as their county of residence or current location.
- The caller and the person of concerns names will be cross referenced for an active person alerts and previous call history.
- Once the facility caller indicates that they need either AMCI, YMCI, or Crisis, the crisis phone worker will transfer the caller to the on-call phone for follow-up.

988 National Suicide and Crisis Lifeline:

988 is the three-digit number to call for the National Suicide and Crisis Lifeline. When a person calls 988, they are connected to trained counselors that are part of the 988 Lifeline Network.

In Pierce County, Volunteers of America (VOA) is the 988 provider in Pierce County and Crisis Connections provides the Regional Crisis Line (RCL) Services to Pierce County.

Carelon, VOA and Crisis Connections have a memorandum of understanding in place to ensure that if a caller reaches out to 988 and they are in need of an outreach by a mobile crisis team, VOA can quickly transition the call to the RCL for crisis team dispatch.

MOBILE CRISIS TEAMS

Mobile crisis teams are generally available 24/7/365 in Pierce County for an in-person response to the community. The Mobile Crisis Teams are accessed through calling the regional crisis line operated by Crisis Connections, who will dispatch the crisis teams after conducting an assessment and determining that the person of concern has met an urgent level of care and the caller has agreed to mobile crisis intervention or mobile crisis intervention could assist the caller from decompensating.

YOUTH MOBILE CRISIS INTERVENTION (YMCI)

MRSS is a child and family specific crisis intervention model that recognizes the developmental needs of children, young adults, parents, and caregivers. A comprehensive crisis continuum acknowledges that youth can be screened upstream of a crisis event and stabilized and connected to resources and supports downstream.

MRSS teams perform robust outreach and engagement to inform regional, family, community, and system partners about the availability of MRSS crisis response. Teams should intentionally include parents, caregivers, natural supports, and relevant treatment providers to stabilize the person in crisis.

The responding team can assess risk and safety needs, provide developmentally appropriate de-escalation, deliver peer support, and help caregivers secure the home, or increase supervision depending on safety concerns. Safety planning is a collaborative process that includes the identified client, caregivers, natural supports, and existing providers.

The best practices in MRSS include an in-home stabilization phase, which is separate but must be connected to the mobile response phase. A stabilization phase provides up to 8 weeks of intensive in-home services. This phase can include identifying and addressing ongoing needs, reviewing safety plans, skill building, youth and/or family peer support, parent support and skill building, and care coordination to identify and connect families with community providers through family facing systems of care, and natural supports. Services are provided face to face in the youth's natural environment, home, school, and community settings as appropriate.

There are two YMCI teams in the county, operated by Catholic Community Services Family Behavioral Health (CCS) and Seneca Family of Agencies (Seneca). Services are available 24/7/365 and provided in accordance with the MRSS model of care. Referrals from the crisis line to YMCI are handled by the Access Team or supervisor on-call. Calls are answered live, 24 hours per day, by the Access Team or supervisor and responded to within 15 minutes. The Access Team clinician or supervisor gathers the following information from the referent:

Demographic information (name, DOB, address, caregiver's phone number etc.)

The information gathered is documented and relayed to the responding YMCI team consisting of one clinician and one peer (Youth or Parent peer), as indicated.

The YMCI team has clinician/peer co-responding teams available to dispatch upon receiving a referral. Departure and Arrival time depends on location and traffic conditions; however, the target arrival time is 120 minutes from the original call to the crisis line. YMCI goal is 60 minutes.

MOBILE OUTREACH CRISIS TEAM (MOCT)

The Mobile Outreach Crisis Team (MOCT) is operated by MultiCare and serves as the AMCI team in the Pierce County region. Services are available 24/7/365. MOCT staff receive referrals from the crisis line for crisis services.

Calls are answered live by MOCT staff or responded to within 15 minutes. The following information is gathered from the referent:

- Demographic information (name, DOB, address, phone number etc.)
- Clinical information, nature of the crisis, risk of harm, as well as potential risk of harm to MultiCare staff responding to the individual

The information gathered is documented and relayed to the responding MOCT team, which consists of designated crisis responders, crisis intervention therapists, care coordinators and peer specialists.

The MOCT team has one outreach crisis team that includes crisis workers, care coordinators, DCRs, and peers available to dispatch upon receiving a referral. Calls are triaged and responded to according to acuity and time of call with a priority on community referrals. Arrival time depends on location and traffic conditions; however, the target arrival time is 120 minutes from the original call to the crisis line.

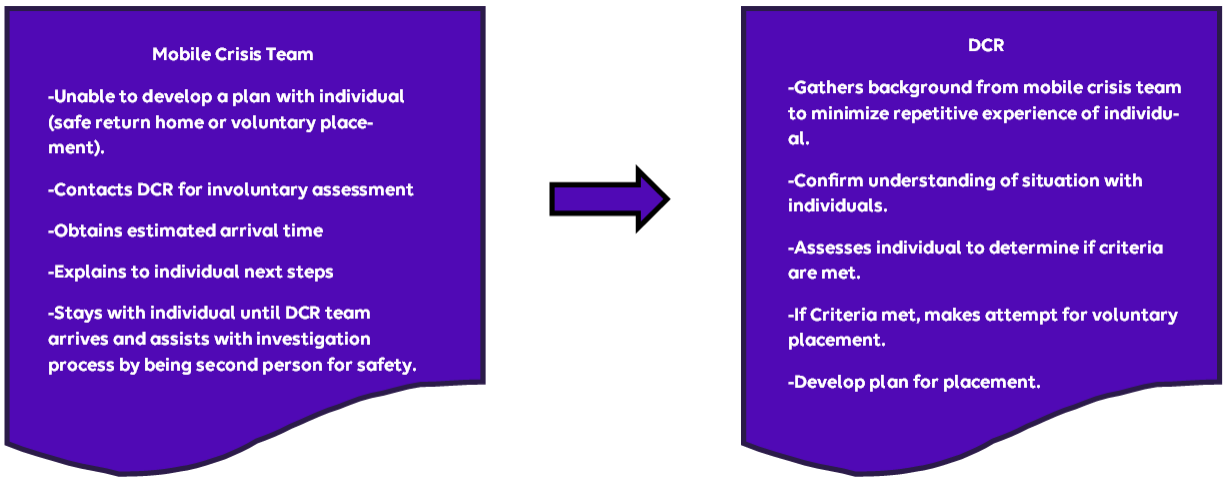
	MOCT	YMCI
Age	Available age 18 and up	Available up to age 18
Insurance	No insurance restrictions	No insurance restrictions
Episode duration	Up to seven days of follow up care-coordination	Up to seven days of follow up care coordination
Availability	Available 24/7/365 days per year	Available 24/7/365 days per year
Clinical referral criteria	Must be currently experiencing a behavioral health crisis	Must be currently experiencing a behavioral health crisis

DESIGNATED CRISIS RESPONDERS (DCRs)

DCRs respond to facilities and community locations throughout the community to assess for risk and to determine if an individual can be safely served in an outpatient or voluntary inpatient setting or if they require involuntary hospitalization in order to be stabilized. The DCRs are the only entity with the authority to detain an individual involuntarily and should only be accessed when all other voluntary and collaborative options have been exhausted. When needed, DCRs respond to first responders or family requests to evaluate individuals who are displaying behaviors that place them or those around them in imminent danger. Evaluations can take place in any community location. DCRs work with area first responders to arrange for endangered individuals to be transported to an emergency department for a complete involuntary treatment assessment and medical clearance.

Whenever possible, DCRs dispatch with the assistance of a Certified Peer Support Specialist. Peer Support Specialists provide further support and assist individuals in accessing community services.

Workflow between Mobile Crisis team and DCR



Lakewood Police Department (LPD), Tacoma Police Department (TPD), Puyallup Police Department (PPD), and Pierce County Sheriff's Department (PCSD) Co-Responder Programs

LPD has contracted through Greater Lakes Mental Health for 2 Co-Responders. The Co-Responders rides with LPD and respond to patrol calls that have a mental health component. They also provide follow ups that Law Enforcement has requested for individuals that are looking for services.

TPD has contracted through MultiCare Health System to have two Co-Responders/Designated Crisis Responders (DCR's) 4 days per week. The Co-Responders ride with TPD and respond to patrol calls that have a mental health component to the call. The Co-Responders also work with the Homeless Outreach team.

PPD is contracting through MultiCare Health System for 1 Co-Responder, 4 days per week. PPD Co-Responder is dispatched through South Sound 911 when requested by law enforcement (LE). The PPD Co-Responder is a resource for LE when there is a mental health component to the call.

The PCSD has contracted through MultiCare Health System to have 9 Co-Responders/DCR's available 7 days per week, from 6am-2am. The PCSD Co-Responder program is regional, and they respond to 17 different law enforcement agencies in Pierce County except for Tacoma and Lakewood (due to them having their own Co-Responder programs). The Co-Responders are a resource that law enforcement can utilize when they have calls with a mental health component. The Co-Responders are dispatched via 911 when law enforcement requests them.

Co-Responders provide crisis intervention and assessment with law enforcement to determine if involuntary commitment criteria are met with individuals experiencing a behavioral health crisis, according to RCW 71.05. They also assist in connecting individuals with appropriate services and help divert them from incarceration or unnecessary hospital emergency department visits.

Co-Responders can make contacts with individuals and families over the phone to assist with de-escalation or/and provide additional support to connect the individual or families to services. They also can arrange transport for individuals to go to a crisis stabilization facility, such as: Response Recovery Center (RRC) or Crisis Recovery Response center (CRC).

The Co-Responder programs are growing in Pierce County due to the success of the PCSD and TPD Co-Responder programs. MultiCare Health System is currently getting request from other Law Enforcement agencies, Fire, South Sound 911, such as: Puyallup PD, Sumner PD, and Bonney Lake PD to have their own Co-Responders or Mental Health Professionals.

MOBILE CRISIS RESPONSE IN THE COMMUNITY

RESPONSE TO INDIVIDUAL/FAMILY HOME – USING MOCT AND YMCI

Upon arrival at a community location (e.g., home), the MOCT staff assesses the immediate level of risk to the individual, child/youth, and others and works with the caregiver/natural support and/or individual to de-escalate the crisis. Initial de-escalation techniques may include:

- Ensuring the child/youth/individual has eaten (MOCT and YMCI teams provide a small snack) → this would not be a primary or even secondary strategy. Very rare (at least on the youth side.)
- Reducing noise and other sensory type items in the environment
- Separating family members when conflict interferes with getting resolution
- Making recommendations to caregivers/staff/natural support to remove any potentially dangerous items in the environment
- Exploring ways to increase supervision → *this is used in the safety planning phase* and reduce risk of harm
- Collaborating with the individual, youth and family to increase coping strategies mechanisms and reduce stress

The MOCT or YMCI clinician then collaborates with the child/youth/individual and family and other community supports (e.g., school staff, community mental health professionals etc.) to develop a safety plan and a plan for next steps. The team will also make recommendations for further behavioral health services and care-coordination between natural and professional supports. The MOCT or YMCI team will also notify the current behavioral health therapist and/or primary care physician (if one exists) as soon as possible during or after the intervention in which the child/youth/individual had contact with MOCT or YMCI. The possible outcomes of MOCT or YMCI intervention include:

1. Crisis resolved via phone, no in-person support needed, or in-person support was declined
2. Crisis resolved in person: no further follow up needed or individual/youth/family declined seven-day case management with MCI team
3. Crisis resolved and follow-up and care coordination needed with additional brief support MCI
4. Crisis unable to be stabilized

RESPONSE TO SCHOOLS

If the YMCI team determines an in-person response at a school location is warranted, the YMCI team will contact the youth's primary caregiver and meet them at the school for an on-site therapeutic response to the youth experiencing a behavioral health crisis. The YMCI team will coordinate care with Wraparound Intensive Services (WISe) if those services are already in place. YMCI will provide psychiatric consultation and urgent

psychopharmacology intervention as needed. If WISe is not in place, the YMCI team will assess the need for ongoing mental health support and help the family access additional resources. YMCI team members will meet with the youth to identify, assess, treat, and stabilize the situation, as well as work to reduce the immediate risk of harm to self or others.

RESPONSE TO FACILITIES

Hospitals and Inpatient Facilities

In Pierce County, there are six community hospitals and three local inpatient psychiatric facilities for adults and one adolescent behavioral health unit located at Mary Bridge Hospital.

- YMCI: The YMCI team responds in person to local hospital emergency departments when referent is located there at the time of crisis. Hospital staff requests after gaining the consent of the individual or accompanying adult. The goal is always to develop a plan with the family to safely return home and coordinate with the current mental health provider or make additional referral to a provider, as needed. Procedures for community response as outlined above are followed. The team coordinates all activities with hospital staff and the attending physician prior to discharge. Providers may call any time for consultation or questions!

- DCR: The DCR team responds to emergency departments and medical floors in the six hospitals and 2 free standing Emergency Departments. Requests for evaluations can be made by medical, behavioral health or social work staff. Hospital mental health staff members generally conduct an initial evaluation and work for consensus with the individual to obtain needed care. If an individual is deemed to be unsafe for discharge and refuses less restrictive alternatives, a DCR is called to conduct an evaluation to determine if the individual meets legal criteria to be detained to an evaluation and treatment center for involuntary treatment. If the individual does not meet criteria for detention, the DCR works with hospital staff and with the individual to develop a discharge plan, which may include a referral to peer services. A re-referral should not be used if the outcome of the DCR was not to the liking of the individual, facility or family member. A re-referral will only be accepted if there is “new evidence” from the last evaluation.

- AMCI: Only DCR’s go into hospitals or inpatient units. However, MOCT accepts referrals for follow-ups for individuals that have been assessed and discharged with a safety plan by the social worker in the Emergency dept.

The DCR team responds to the local behaviorally health inpatient facilities for ITA evaluation when an individual has been admitted on a voluntary basis, is asking to leave against medical advice and if a professional person as defined in RCW 71.05.020 does not believe that the individual can be safely discharged.

Jails

When an individual is booked into the Pierce County Jail on a criminal charge, they may be experiencing a mental health crisis or under the influence of drugs or alcohol. All intakes are assessed for medical and mental health issues by a medical professional, who works to complete a release of information in order to obtain medical and mental health records from a community provider to formulate an in-custody treatment plan.

Individuals who have special needs related to medical or mental health concerns are assessed weekly to coordinate in-custody care. This is a collaborative meeting involving classification, medical, mental health, operations, and re-entry. During this meeting, the following are reviewed: legal proceedings, institutional behavior, medical and mental health concerns, and the individual's needs. The jail re-entry team and medical unit may collaborate with community providers at the time of release including, but not limited to, PACT team notification, ITA evaluation, hospitalization, or other services.

Should the individual be found incompetent to stand trial for the charges that are pending against them, they will be considered a jail flip and taken to a local evaluation and treatment inpatient facility for restoration [RCW 10.77.068].

- YMCI: The YMCI team responds to local detention facilities to provide support to the youth, conduct an assessment and safety planning with the youth and facilities. After the initial intervention, the YMCI team will coordinate with the facility, probation officers and other court officials around safety planning and continued behavioral health treatment.
- AMCI: MOCT can respond to local jails (except the Pierce County Jail as they have in house mental health staff) if an adult is being discharged and it is determined they are still in crisis or may need support to avoid a crisis post discharge. The MOCT team can facilitate coordination with the current mental health provider or make a referral to a provider. Procedures for community response as outlined above are followed. The team coordinates all activities with jail staff prior to discharge.
- DCR: The DCR team performs court-ordered evaluations at all jails to determine if individuals are safe to be discharged with outpatient support or if they need to be hospitalized on a voluntary or involuntary basis. In addition, DCRs dispatch to the Pierce County Jail to perform ITA evaluations for individuals that have been assessed as meeting detention criteria and are scheduled for release.

Outpatient Provider Office

As noted above, during regular business hours, outpatient providers provide crisis response to individuals enrolled in their services and are the first level of response when in the presence of the provider. Responses can include de-escalation, crisis counseling, crisis planning, and reintegration for any individual involved in their care. In situations where the provider needs additional support, all internal agency avenues should be explored first before seeking support from the crisis teams while maintaining safety for the individual and staff.

- YMCI: The YMCI team responds in person to local outpatient provider offices when the provider determines that the youth is experiencing a current behavioral health crisis and would benefit from an in-person response from the YMCI team. The YMCI team can respond directly to the clinic or to the youth's home. After the initial intervention, the YMCI team will connect with the provider to ensure that they have updated information on the intervention as well as on-going needs the youth and family may have. If the YMCI team made referrals to additional services every attempt will be made to provide a warm hand-off to the new provider and information is also passed on to the provider.
- AMCI: The MOCT team responds in person to local outpatient provider offices when the provider determines that the individual is experiencing a current behavioral health crisis and would benefit from an in-person response from the MOCT team. The MOCT team can respond directly to the facility or to the individual's home. After the initial intervention, the MOCT team will connect with the provider to ensure that they have updated information on the intervention as well as on-going needs the individual may have. If the MOCT team made referrals to additional services that information is also passed on to the provider.

- DCR: The DCR team responds to area behavioral health and medical facilities to evaluate individuals that appear to meet detention criteria. DCRs assist these facilities in identifying and accessing needed support from expanded outpatient services to involuntary inpatient treatment.

	Hospital	Inpatient Facility	Jail	Outpatient Office
YMCI	Y	Y	Y	Y
MOCT	Y	Y	Y	Y
DCR	Y	Y	Y	Y

ASSESSMENT FOR INVOLUNTARY TREATMENT AND DCRS

CRITERIA FOR ASSESSMENT

Criteria for assessment under the Involuntary Treatment Act (ITA) by a DCR includes evidence of a behavioral health disorder resulting in likelihood of serious harm to self, others, other's property, or grave disability. The Pierce County DCR team can be accessed through the regional crisis line. DCR's will respond within timelines set forth in RCW 71.05.

VOLUNTARY TREATMENT

Whenever possible, Outpatient providers and MOCT and will help develop voluntary treatment in collaboration with the individual. They will also facilitate voluntary treatment ranging from outpatient therapy to voluntary inpatient hospitalization. Crisis services will facilitate treatment in the manner that is least restrictive, taking into consideration the iatrogenic risk and expected benefit of hospitalization (Appendix D). Individuals that are in need of outpatient services are encouraged to engage in those services with additional support provided by Crisis Services and Peer Support Specialists. Individuals who are found to be an imminent danger to self, others, or property or who are deemed to be gravely disabled are given the option to enter inpatient hospitalization on a voluntary basis before involuntary treatment is considered.

Note: To agree to voluntary treatment implies that the individual is able to provide informed consent as defined in RCW 7.70.060 and express a sincere willingness (free of coercion) to treatment and procedures as prescribed by the treatment provider and treatment team at the facility where the individual provided consent.

CRITERIA TO DETAIN

A DCR may take a person into emergency custody when the person presents and imminent likelihood of serious harm or is in imminent danger because he/she is gravely disabled as a result of a behavioral health disorder [RCW 71.05].

The DCR assesses available information to determine whether or not there is an imminent risk of harm and as a result of a behavioral health disorder the individual presents as a danger to self a danger to others, danger to property of others, or the individual is gravely disabled. "Likelihood of serious harm" means a substantial risk that:

- Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself

- Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm, or which places another person or persons in reasonable fear of sustaining such harm
- Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others
- The individual has threatened the physical safety of another and has a history of one or more violent acts [RCW 71.05.020RCW 71.34.020.

"Gravely disabled" means a condition resulting from a mental disorder, in which the person:

- Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020 and 71.34.020
- Manifests severe deterioration in routine functioning, as evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety [RCW 71.05.030 and 71.34.020].

TIMELINES

For adults:

- If an individual was brought to an emergency department voluntarily, the DCR must determine whether the individual meets detention criteria within six hours of the emergency department staff determining that a referral to the DCR is needed, not counting time periods prior to medical clearance [RCW 71.05].
- If an individual was taken to the emergency department by peace officers, a mental health professional must examine the person within three hours of his or her arrival, not counting the time periods prior to medical clearance, and the DCR must determine whether the person meets detention criteria within 12 hours of receiving the referral, not counting time periods prior to medical clearance [RCW 71.05].
- If an individual was voluntarily admitted for inpatient psychiatric treatment and requests discharge, but presents as a risk of harm or gravely disabled, the DCR must determine whether the individual meets detention criteria no later than end of the next judicial day [RCW 71.05].

For minors:

- If a minor, 13 years or older, is brought to an evaluation and treatment facility, secure withdrawal management and stabilization facility with available space, approved substance use disorder treatment program with available space or hospital emergency room for immediate behavioral health services, the professional person in charge of the facility shall evaluate the minor's mental condition, determine whether the minor suffers from a behavioral health disorder, and whether the minor is in need of immediate inpatient treatment. If the minor is unwilling to consent to treatment, the minor's family member may be able to enact Family Initiated Treatment and consent to treatment on behalf of the minor. If it is determined that the minor suffers from a behavioral health disorder, inpatient treatment is required, the minor is unwilling to consent to voluntary admission, the parent/guardian is not agreeable to Family-Initiated Treatment, and the professional person believes that the minor meets the criteria for initial detention set forth herein, the facility may detain or arrange for the detention of the minor for up to twelve hours in order to enable a DCR to evaluate the minor and commence initial detention proceedings under the provisions of this chapter [RCW 71.34.700].

- The DCR will evaluate the child at the emergency department and commence proceedings to determine whether the child meets criteria for detention within 12 hours of the referral.

NON-EMERGENCY REQUESTS

For non-emergency requests, the DCR team will provide consultation and assistance in developing and implementing a plan for securing and accessing needed support within the community. The DCR team is available to discuss treatment options, safety planning, and available community resources. The goal is to provide services in the most effective and least restrictive manner.

ASSISTED OUTPATIENT TREATMENT

Assisted Outpatient Treatment (AOT) program is an involuntary civil commitment. AOT provides therapeutic wrap around behavioral health services for individuals who have not been successful in traditional outpatient mental health or substance use disorder programs. Initiated by a clinical determination and based on the persons historical and current behavior, a petition for involuntary civil commitment can be filed when a person is unlikely to survive safely in the community without supervision and the person's condition is deteriorating, or services are needed to prevent a relapse or deterioration that would result in grave disability or harm to the self or others.

A history of lack of compliance is defined as: at least twice in the last 36 months a person was hospitalized as a result of their behavior, was a recipient of forensic assessment, or was admitted into a mental health unit in a correctional facility, required emergency medical care or hospitalization for behavioral health-related medical conditions, or within the last 48 months the behavioral health condition resulted in one or more acts of violence, threats or attempts to cause serious physical harm to the self or others.

The AOT team has the ability to wrap around a client before a petition is filed. If interested in referring to the program or would like more information, please contact the team at aot@p-c-a.org or 253-572-4750.

ADMISSION TO AN EVALUATION AND TREATMENT FACILITY

In Pierce County, there are six community hospitals and three local inpatient psychiatric facilities for adults and one adolescent behavioral health unit located at Tacoma General Hospital.

Evaluation and Treatment Centers offer a 16-bed secure psychiatric inpatient program for treatment of acute psychiatric symptoms that meet medical necessity criteria for acute inpatient level of care as demonstrated by a clear and reasonable inference of imminent serious harm to self or others, or as the result of a mental illness is unable to provide for their basic needs due to mental health symptoms and are not able to be addressed in a lower level of care, such as the community outpatient environment. All evaluation and treatment facilities accept both voluntary and involuntary clients who are at least 18 years of age and have a mental health diagnosis. Referrals received are screened for medical necessity and exclusionary criteria such as dementia and delirium. All evaluation and treatment facilities accept, except the Telecare Pierce County Supportive E&T, voluntary individual referrals directly from local hospitals. Voluntary individuals must be willing to engage in treatment offered, including taking medications as prescribed. Involuntary individuals are referred directly from MOCT.

The primary treatment focus is medication stabilization, along with basic supports, and connecting the individual to an outpatient provider in the community for ongoing support upon discharge. The average length of stay is three to seven days; however, the first stay can be 120 hours. All facilities work collaboratively with the individual, natural supports, ongoing service provider, and MCOs to return to the community at discharge, including to the previous residence or a new residence if appropriate.

Per current protocol of the receiving inpatient facility, medical clearance at a hospital emergency department is required before admission. The purpose of obtaining medical clearance is to establish that the individual is medically stable and to rule out a medical cause for the current symptoms. If a mental health professional determines that an individual requires inpatient psychiatric care, the individual is sent to an area emergency department for medical evaluation, including laboratory tests, urine drug screen and other diagnostic testing as indicated. Results are shared with the considering facility to determine if there are medical needs that could rule out acceptance at a particular inpatient facility. There are active efforts to change the requirement of medical clearance prior to acceptance for specific populations with facilities in Pierce County.

RECOVERY INNOVATIONS (RI) EVALUATION AND TREATMENT (E&T)

RI Evaluation and Treatment Center is a 16-bed facility that host single and double rooms, we believe that the journey to recovery begins from within. The support of our multidisciplinary team allows us to provide a person-centered approach that emphasizes choice, opportunity, and mutuality.

TELECARE EVALUATION AND TREATMENT (E&T)

Originally opened in 2009 the Telecare Pierce County Evaluation and Treatment (E&T) Center has recently modified programming services as

1) Supported Evaluation and Treatment: 8 beds for intensive mental health and psychiatric treatment services in a safe, welcoming respectful environment for adults with Intellectual and/or Developmental Disabilities experiencing a mental health emergency. These individuals are currently WA DD/ID enrolled and currently on an Involuntary Civil Commitment and must have services through one of the 5 contracted Managed Care Organizations (MCOs). These referrals do not utilize the ER or Jail referral systems as in the Crisis System of WA Counties. Referrals are made directly to the Clinical Leadership Team Director and are triaged and screened for acceptance by the attending providers. The program maintains a wait list please contact for details.
2) NEXT STEPS Long Term: 8 beds designated for sub-acute NEXT STEPS Long Term clients who have recently completed a stay within an acute psychiatric setting and require continued sub-acute care while individual needs are met and planned for. These individuals are currently on 90+ day Civil Commitments.

   Both programs utilize Telecare's Recovery-Centered Clinical System (RCCS), an innovative recovery-based framework that incorporates the latest research and evidence-based practices. We believe that recovery starts from within, and that people are best equipped to begin a recovery journey when supported in a comfortable, structured environment that emphasizes choice-making skills and harm-reduction techniques.

WELLFOUND BEHAVIORAL HEALTH HOSPITAL

Wellfound Behavioral Health Hospital, a joint venture between CHI Franciscan and MultiCare Health System provides voluntary and involuntary admissions and inpatient mental health treatment in Tacoma. The hospital has a focus on general adult psychiatric care for ages 18 and older with common psychiatric

conditions such as acute depression, suicidal tendencies, self-injury, mania, psychosis and anxiety, and co-occurring substance use disorders.

Wellfound's inpatient behavioral care unit accepts referrals from hospital emergency rooms, first responders, and crisis centers. Individuals and walk-ins are evaluated by a skilled assessment team to determine the level of care and treatment needed, and based on evaluation, may be admitted pending bed availability. The hospital is currently opening beds in phases with currently 72 beds open and adding more over time. When fully up and running, the freestanding, two-story hospital will offer 120 inpatient beds and serve approximately 5,000 patients annually.

TACOMA GENERAL ADOLESCENT BEHAVIORAL HEALTH UNIT

A 27-bed hospital-based unit with private rooms and open social areas located at Tacoma General. Adolescents aged 13 -17 years old are served on a voluntary, involuntary, and parent-initiated treatment basis with a provider referral. The collaborative care model offers a team of pediatric and mental health experts to include a medical director, psychiatrists, psychiatric advanced registered nurse practitioners, registered nurses, psychologists, educators, social workers, and mental health techs. Working together, they create a treatment plan tailored to needs based on diagnosis, background, and triggers. Typical diagnoses or potential diagnoses appropriate to refer to us include major depression, anxiety disorders, psychosis, schizophrenia, and bipolar disorder. All patients must receive medical clearance from the referring physician or the emergency department prior to admission to the unit. Patients are admitted on a voluntary basis by signing themselves in, admitted under the Involuntary Treatment Act, or admitted under Parent-Initiated Treatment.

CRISIS STABILIZATION

Recovery Innovations Recovery Response Center (RRC) is a 16-bed facility with single and double rooms for individuals in need of support when faced with a mental health and or substance use crisis. The support staff consists of a team of psychiatrists, nurses, mental health professionals, individuals that specialize in resource management and peer support specialists. The RRC serves as a crisis alternative for First Responders and emergency rooms in Pierce County.

Parkland Crisis Response Center (CRC) is a 16-bed facility with single and double rooms for individuals in need of support when faced with a mental health and or substance use crisis. The support staff consists of a team of psychiatrists, nurses, mental health professionals, individuals that specialize in resource management and peer support specialists. The CRC serves as a crisis alternative for First Responders and emergency rooms in Pierce County. The CRC opened its door August 2021.

WRAP AROUND SERVICES

Telecare – Community Alternatives Team (T-CAT)

The Telecare Community Alternatives Team (T-CAT) is intended to reduce demand for Evaluation & Treatment inpatient psychiatric services by providing Emergency Department diversion and transitional community support services for those adults who have been recently discharged from, and/or are at high risk of readmission to, acute psychiatric inpatient treatment.

T-CAT services are provided by a multidisciplinary team, intended to divert individuals from acute psychiatric inpatient services when it is safe to do so. T-CAT staff bridge participants from acute psychiatric inpatient settings to stable community housing and living arrangements whenever possible and connect individuals

with appropriate mental health wraparound support. The team includes Peers, Case Managers, Masters-level and licensed clinicians and a psychiatric prescriber. All services are provided through outreach to where the individual is located. T-CAT also serves as a critical frontline crisis diversion support for participants who might otherwise require admission or readmission to acute psychiatric inpatient treatment. The services are intended to be transitional, terminating once the participant is successfully connected with ongoing, longer-term community-based mental health services at the appropriate level of care.

Recovery Innovations – Peer Bridger

The Peer Bridger Program is a community/home-based outreach service which is designed to be short-term community support for Pierce County residents (over 18 years of age). This program provides services to individuals to support their recovery as they transition from inpatient services back into the community. All services are provided under the direction of an MHP (Mental Health Professional) and include certified Peer Recovery Coaches. The Peer Bridger Program services are based on recovery principles and focus on the values of hope, choice, empowerment, and wellness.

Comprehensive Life Resources- Mobile Community Intervention Response Team (MCIRT)

The Mobile Community Intervention Response Team (MCIRT) is designed to improve the lives of those affected by mental illness, substance abuse and/or unmet medical needs by providing therapeutic alternative in the community resulting in reduced contact with first responders.

The intent is to reduce the number of people with behavioral health (mental and substance use disorders) that use costly interventions such as jail, emergency rooms and hospitals. Reduce the utilization of calls to the Emergency Management System from individuals who are not getting their medical needs met due to lack of self-care, lack of community support and connection to resources.

The team primarily collaborates with EMS, MOCT and the Pierce County Sheriff's Department to determine local concentrations of people in the target population. Special attention will be given to focus on individuals who might otherwise be brought to a hospital emergency department or arrested for minor crimes and taken to jail.

Program of Assertive Community Treatment (PACT) available with Greater Lakes, MultiCare and Comprehensive Life Resources

PACT (Program of Assertive Community Treatment) provides community-based comprehensive, individualized services in an integrated, continuous fashion in collaboration with persons with severe and persistent mental illness who may not respond to traditional outpatient psychiatric case management.

PACT provides treatment for the primary symptoms and impairments of the illness itself. It provides Rehabilitation to help each person build strengths and cope with the effects of mental illness on adult activities (e.g., employment, home life and activities of daily living, and social and interpersonal relationships), emotional and practical support to help individuals sustain a good quality of life and negotiate complex social and health care symptoms. Assistance using PACT services instead of more intensive services such as hospitals and other emergency services.

PACT is a self-contained specialized service delivery system that provides the following services:

- mental health
- chemical dependency
- vocational rehabilitation
- psychiatric nursing

- medication prescribing
- 24 hours per day, every day of the year crisis response

PACT's Client-Centered Approach: PACT staff do not assume they know what is best for clients but strive to listen, really listen, to what clients say they need and want. All too often, even with the best intentions, mental health professionals may miss this important treatment component. In PACT, the client comes first; staff then assist in whatever ways might help. This is genuine client-centered treatment!

COORDINATION OF CARE FROM MCOs/BH-ASO

There are daily information exchanges between the regional crisis line, crisis teams, the five MCOs (Amerigroup, Coordinated Care, Molina, Community Health Plan of WA and United), and the BH-ASO, Carelon Behavioral Health is responsible for overseeing the crisis system in Pierce County. On a daily basis, Carelon receives clinical documentation from the crisis line and crisis teams. Carelon Care Coordinators process the information and the MCOs receive daily crisis notes related to their members accessing the crisis systems, whether calling or received in-person treatment from the Mobile Crisis team or DCR team. Clinical documentation for the non-Medicaid population is sent to the Carelon clinical case management team.

The case management staff at each organization reviews these notes, triages the clinical information, and may reach out to the individuals that have utilized the Crisis Line or the Mobile Outreach Crisis Team. During the initial contact, the Case Manager assesses the individual's engagement in appropriate outpatient services or if needed works with the individual to connect to the appropriate behavioral health provider and community resources, as needed. Case Managers reach out to crisis stabilization and inpatient treatment teams to coordinate care for those who are admitted to these settings.

Utilization of the crisis line or mobile crisis services can also be seen as a positive outcome for individuals who otherwise may have used emergency room services. The crisis team may appropriately stabilize a crisis and link an individual to appropriate outpatient services. Crisis service utilization is very individualized, which is why it is so important for the case management teams to review and triage the daily crisis notes. Sometimes an individual has utilized services before and is already working with an MCO/BH-ASO Case Manager or a new case management candidate may be identified. Referrals may be completed to initiate case management and care coordination services. Care management programs are voluntary, person-centered, and collaboratively establish goals to work towards together. Care management services are available through behavioral health providers MCO/BH-ASO and Health Home Care Coordination Organizations. Referrals to a care management program are made based on where an individual is (or is not) receiving services. Case Managers may provide in-person and telephonic contact to an individual. Specific services that can be provided through care management can include, but are not limited to:

- Connecting an individual to service providers
- Addressing barriers to access to services
- Addressing resource needs, including assistance with submitting paperwork for benefits
- Appointment reminders
- Medication support including education, automated phone reminders, etc.
- Providing support to family members or natural supports (with proper releases)
- Coordination of services when an individual is working with multiple providers

Carelon aims to target case management services for individuals who frequently use crisis services, including those who are uninsured.

On a monthly basis, Carelon generates a high utilizers report and sends the MCO's a list of their members. The criteria are two or more in-person contacts with the crisis team in the last month and or two or more months over the last six months, where there are two or more face-to-face contacts with the crisis team. This allows for broader view of identifying individuals who are accessing crisis services and may be interested in case management services from the MCO/BH-ASO. Case Managers from the respective MCO or BH-ASO reach out to the individual to ensure connection to appropriate care.

On a broader scale, the MCOs participate in the monthly Pierce County Crisis Collaborative meetings to improve system wide access, streamline processes, review data, look at gaps in care, and identify other opportunities for improvement and collaboration across the system of care.

DISAGREEMENTS AND DISPUTE RESOLUTION

Disagreements and disputes are handled on a case-by-case basis between providers and the specific matter at-hand is resolved swiftly with the best interest of the individual in mind. At the monthly Crisis Collaborative meeting, process and system issues are a standard agenda item, as an optimal crisis system is constantly iterating and improving. Meeting attendees are encouraged to bring concerns to the table for discussion so the larger group can develop community consensus. Process issues can potentially be resolved in one meeting and for a more complex process or system issues, a workgroup may be developed to work offline and report back to the group. It is important to understand the root cause of issues and learn from situations that do not go as planned. Ad-hoc root cause analysis workgroups can be convened to further examine concerns and report to the larger group.

APPENDICES

APPENDIX A: PIERCE COUNTY CRISIS COLLABORATIVE CHARTER

Pierce County Crisis Collaborative purpose:

1. Cross sector, county-specific system collaborative group to focus on system-wide improvements and transformation
2. Identify gaps in the crisis system continuum of care (reference crisis system of care organizing framework) in prevention, early intervention, acute intervention, crisis treatment, and recovery and integration efforts as well as logistics, players, competencies, and parts involved in assisting crisis system users experience adequate relief and resolution

3. Identify strategies and solutions to address gaps in the crisis system continuum of care and pathways to implement best practices and technical assistance, including making recommendations to system providers and payers
4. Promote principles of recovery and resiliency by using Peer services and individual/family voices to inform and improve the crisis system continuum of care
5. Develop written protocols that describe roles and expectations in interactions between the players in the crisis system such as pragmatic, working memoranda of understandings between key entities starting with the crisis teams, regional crisis line and lead treatment agencies with specific attention to mutual expectations throughout a crisis episode, filing of crisis plans and alerts, on-call schedules and administrative support, post-crisis follow-up commitments, and lead persons for collaborating on improvements.
6. Develop a communications strategy to share written protocols with key community partners so they understand the crisis continuum of care and opportunities for upstream interventions.
7. Develop county specific Crisis System of Care (CSOC) protocol handbook for use and dissemination (such as at CIT trainings, Mental Health First Aid, staff orientation, use by other sectors, CVAB and NAMI), describe access, inform about involuntary processes, but have the primary focus be on voluntary alternatives.
8. Map out specific responsibilities and expected competencies in performance standards
9. Review medical clearance practices and make recommendations for improvements in user experience
10. Decide critical data for the community to track to assess crisis system performance and review the data routinely, such as real-time data sharing, cost analysis and target populations.
11. Track data and strategize how to:
    a. Reduce the use of involuntary interventions in crisis episodes
    b. Increase the use of peer or parent peer specialist involvement in crisis episodes
    c. Reduce out of area placements
    d. Report out to the community and key stakeholders

Members:

- Pierce County Crisis
- Managed Care Organizations (MCOs)
- Law enforcement
- Hospitals
- Behavioral health providers
- Individuals with lived experience
- Housing/homelessness providers
- Regional Crisis Line- Crisis Connections
- School districts
- Emergency Medical Services (EMS)

Role: As the BH-ASO, Carelon will be the organizer and entity responsible to ensure that work is completed between meetings to make forward progress, ensure people feel invested in the forum and the time is well spent.

Participants' minimum roles and responsibilities:

- Attend meetings monthly
- Provide input to issues, strategies, and direction
- Support the overall work of the crisis system

- Assist in recruiting additional stakeholders from targeted sectors
- Members shall receive no compensation for participation
- Follow through on agreed upon assignments

APPENDIX B: ADULT MOBILE CRISIS INTERVENTION TECHNICAL SPECIFICATIONS

Adult Mobile Crisis intervention services are designed to optimize clinical interventions by meeting clients in home or community settings where they are more comfortable, where strengths and cultural differences are more apparent and where natural supports are more available. Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing individuals to bypass the stigma, trauma and disruption of a hospital or out-of-home setting.

Adult Mobile Crisis services produce more holistic evaluations, solutions, and referrals. They are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments, reduce the likelihood of psychiatric hospitalization, and promote resolution of crisis in the least restrictive setting and in the least intrusive manner. Adult Mobile Crisis interventions are administered with the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the individual or others.

Adult Mobile Crisis Intervention will provide a short- term service that is a mobile, on-site, face-to-face therapeutic response to an individual (18 years old and older) experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the individual or others. The goal eventually is for this service to be provided 24 hours a day, 7 days a week. Initially, the service will be offered from 10 am to 10 pm, 365 days per year.

The service includes: A crisis assessment and engagement in a crisis planning process, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation, and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For individuals who are receiving PACT (Program of Assertive Community Treatment) or COMET (Co-occurring Methamphetamine Treatment), Adult Mobile Crisis Intervention staff will coordinate or partner with the individual's care coordinator throughout the delivery of the service. Adult Mobile Crisis Intervention also will coordinate with the individual's primary care physician, any other care management program or other behavioral health providers providing services to the individual throughout the delivery of the service.

Components of Service

1. Adult Mobile Crisis Intervention (AMCI) is the adult-serving component of the crisis continuum of care.
2. Adult Mobile Crisis Intervention is delivered by a provider with demonstrated infrastructure to support and ensure
    a. Quality Management / Assurance
    b. Utilization Management
    c. Electronic Data Collection / IT
    d. Clinical and Psychiatric Expertise
    e. Cultural and Linguistic Competence
3. Adult Mobile Crisis Intervention provides mobile, community-based crisis intervention services, which are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs), to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner.
4. Adult Mobile Crisis Intervention provides crisis assessment and crisis stabilization intervention services 24 hours a day, 7 days a week, and 365 days a year. Each encounter, including ongoing coordination

following the crisis assessment and stabilization intervention, may last up to 7 days.

5. Adult Mobile Crisis Intervention teams will respond in the following timeframes:
    a. Triage calls within 15 minutes of initial request
    b. Respond in person within 90 minutes.
6. Adult Mobile Crisis Intervention includes, but is not limited to:
    a. Conducting a mental status exam;
    b. Assessing crisis precipitants, including psychiatric, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current crisis (e.g., change in job or home; exposure to domestic or community violence; death of friend or relative; or recent change in medication);
    c. Assessing the individual's behavior and the responses of others to the behavior;
    d. Discussing and activating natural supports strengths and resources to identify how such strengths and resources impact their ability to respond to the individual's behavioral health needs;
    e. Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care;
    f. Assessing medication compliance and/or past medication trials;
    g. Assessing safety/risk issues for the individual and others involved;
    h. Taking a medical history/screening for medical issues;
    i. Assessing current functioning at home, work, and in the community;
    j. Identifying current providers, including state agency involvement;
    k. Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the individual and natural supports.
    l. Solution focused crisis counseling;
    m. Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support;
    n. Clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to 7 days;
    o. Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone from an on-call Child Psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist.
7. Adult Mobile Crisis Intervention assesses the safety needs of the individual and others involved in the crisis. Adult Mobile Crisis Intervention, with the consent of and in collaboration with the individual, guides the individual through the crisis planning process that is in line with the present stage of readiness for change. As the individual chooses, Adult Mobile Crisis Intervention engages existing service providers and/or other natural supports.
8. Adult Mobile Crisis Intervention identifies all necessary referrals and linkages to medically necessary behavioral health services and supports and facilitates referrals and access to those services. Adult Mobile Crisis Intervention also works with the individual's health plan to arrange for dispositions to all levels of care,

including inpatient and 24-hour services, diversionary services, and outpatient services.

9. Adult Mobile Crisis Intervention provides the following additional services up to 7 days after the initial response:
    a. Crisis counseling and consultation to the individual and natural supports (if appropriate);
    b. Emergency medication management and consultation;
    c. Telephonic support to the individual and natural supports (if appropriate); and
    d. Coordination with other behavioral health providers.

10. For individuals who are receiving PACT or COMET, Adult Mobile Crisis Intervention coordinates with the individual's care coordinator throughout the delivery of the service. For individuals not in PACT or COMET, Adult Mobile Crisis Intervention will coordinate with the individual's primary care physician, any other care management program or other behavioral health providers who provide services to the individual throughout the delivery of the service.

11. The Adult Mobile Crisis Intervention provider has policies and procedures relating to all components of this service. The Adult Mobile Crisis Intervention provider ensures all new and existing staff members are trained on these policies and procedures.

Staffing Requirements

1. Adult Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and Peers with lived experience and maintains staffing levels as warranted by data trends.
2. Adult Mobile Crisis Intervention is staffed with master's and bachelor's level clinicians trained in working with adults and families, with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, co-occurring populations, and de- escalation techniques.
3. Adult Mobile Crisis Intervention is also staffed with a Peer experienced or trained in providing ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system that support brief interventions that address behavior and safety.
4. A member of the Psychiatric team is available for phone consultation to Adult Mobile Crisis Intervention staff 24-hours a day, 7 days a week to provide clinical insight, support clinical diagnosis, medication and immediate safety planning needs in crisis planning.
5. All Adult Mobile Crisis Intervention staff receive crisis specific training through the agency that employs them. Prior to serving the community independently, Adult Mobile Crisis Intervention staff also complete 12 hours of on-the-job training in Managing assaultive behaviors training (MOAB) or equivalent program. A master's level clinician with at least two years of crisis intervention experience supervises this training. This training is documented.
6. All Adult Mobile Crisis Intervention staff are trained in the following: performance specifications, clinical criteria, *Systems of Care* philosophy and the *Wraparound process*; medications and side effects; First Aid/CPR; adult serving agencies and processes; family systems; conflict resolution; risk management; partnering with natural supports; motivational interviewing; human development; cultural competency; Confidentiality and HIPPA; suicide prevention; Trauma informed care and related core clinical issues/topics. This training is documented.
7. Adult Mobile Crisis Intervention staff members are knowledgeable about available community mental health and substance use disorder services within their geographical service area, the levels of care, and relevant laws and regulations. They also have knowledge about other medical, legal, emergency, and community services

available to adults.

8. Adult Mobile Crisis Intervention supervises all staff, commensurate with licensure level and consistent with credentialing criteria.

Service, Community, and Collateral Linkages

1. As the adult-serving component of the crisis continuum of care, Adult Mobile Crisis Intervention takes a strategic, leadership role in improving the crisis system infrastructure, building collaborations, improving efficiencies and effectiveness of crisis services.
2. Adult Mobile Crisis Intervention upon completion of a crisis assessment, works with the individual to provide needed crisis stabilization services and, if necessary, with the individual's insurance carrier to obtain authorization for medically necessary level of care for the individual.
3. Adult Mobile Crisis Intervention will ensure smooth access to behavioral health services in the area by maintaining regular communication and interagency relationships (e.g., MOU).
4. Adult Mobile Crisis Intervention coordinates all behavioral health crisis response with the individual's existing providers, including PACT/COMET, In-Home Therapy Services, and outpatient providers (e.g., mentors, therapists), other care management programs and primary care provider (PCP). Adult Mobile Crisis Intervention facilitates referrals for, and provides information on, both Medicaid and non-Medicaid services (e.g., PACT/COMET, voluntary services, therapy).
5. Adult Mobile Crisis Intervention, with required consent, makes referral to PACT/COMET, Therapy Services, or other services as needed.
6. Adult Mobile Crisis Intervention supports linkages with the natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g., Parental support groups, AA, etc.).
7. For individuals with PACT/COMET/In-Home Therapy Services that provide 24-hour response, Adult Mobile Crisis Intervention staff contacts the provider for care coordination and disposition planning. The PACT/COMET/In-home Therapy Services staff and Adult Mobile Crisis Intervention staff communicate and collaborate on the individual's treatment throughout the Adult Mobile Crisis intervention or crisis stabilization to develop a disposition plan that is consistent with the individual's treatment plan.
8. For individuals engaged in services that do not provide 24-hour response, Adult Mobile Crisis Intervention staff contacts the provider for the purpose of care coordination and disposition planning. Adult Mobile Crisis Intervention staff communicates with the provider and collaborates on the individual's treatment to develop a disposition plan that is consistent with the individual's treatment plan.
9. Adult Mobile Crisis Intervention establishes formal relationships (e.g., MOU) including collaborative education and training with local police, emergency medical technicians (EMTs), adult protective services, and local healthcare professionals to promote effective and safe practices related to the management of emergency services for individuals with behavioral health issues and their natural supports.
10. With obtained consent, crisis assessments occur in the individual's home setting or appropriate alternative community setting. Crisis assessments only occur in a hospital emergency department (ED) if the individual presents an imminent risk of harm to self or others; if the individual refuses required consent for service in home or alternative community settings; or if request for Adult Mobile Crisis Intervention services originates from a hospital emergency department.
11. In instances when an individual is sent to a hospital emergency department (ED), Adult Mobile Crisis Intervention

mobilizes to the ED. The number of hospital-based interventions will be closely monitored to ensure that Adult Mobile Crisis Intervention services are delivered primarily in community settings.

Quality Management (QM)

1. Adult Mobile Crisis Intervention participates in all network management, utilization management, and quality management initiatives and meetings.

Process Specifications

Treatment Planning and Documentation	1. Adult Mobile Crisis Intervention immediately works to de-escalate the situation and intervenes to ensure the safety of all individuals in the environment, utilizing the interventions and services listed under the "components of service" section above. 2. Adult Mobile Crisis Intervention completes a comprehensive crisis assessment, including the elements listed under the "components of service" section above and engages in delivering crisis stabilization services. 3. To complete the crisis assessment and crisis intervention, Adult Mobile Crisis Intervention seeks consent to speak with collateral contacts (e.g. PACT/COMET care coordinator, therapist, psychiatrist, social worker, etc.) and natural supports (e.g. friends, neighbors, extended family, etc.) to enlist their support in stabilizing the situation and developing an aftercare plan. 4. For individuals enrolled in PACT/COMET, Adult Mobile Crisis Intervention staff collaborates with the PACT/COMET provider to ensure coordination of care. Adult Mobile Crisis Intervention coordinates with the PACT/COMET provider throughout the intervention. 5. A member of the Psychiatric team is available for phone consultation to Adult Mobile Crisis Intervention staff 24-hours a day, 7 days a week to provide clinical insight, support clinical diagnosis, medication and immediate safety planning needs in crisis planning. 6. If the crisis assessment indicates that placement outside of the home in an acute 24-hour behavioral health level of care (e.g., Crisis Stabilization setting, acute inpatient hospital) is medically necessary, Adult Mobile Crisis Intervention will make every effort to facilitate a voluntary placement in collaboration with the individual. If an assessment for an involuntary placement is deemed necessary after voluntary placement options are attempted, AMCI staff consults with the Designated Crisis Responder (DCR) team and arranges for an assessment. If the individual meets criteria for a higher level of care (for either voluntary or involuntary placement), Adult Mobile Crisis Intervention consults with the receiving provider to assist the receiving provider to develop a plan for stabilizing the crisis that was addressed by the Adult Mobile Crisis Intervention 7. If the crisis assessment indicates that the individual is stable to remain in the community or current placement, Adult Mobile Crisis Intervention obtains authorization for medically necessary community-based services and coordinates with the individual and natural supports and the community-based service provides to ensure that the individual is receiving medically necessary services.

	8. If the individual is not already enrolled in behavioral health services, Adult Mobile Crisis Intervention may arrange a follow-up appointment with a behavioral health provider in the individual's service area and coordinates with the behavioral health provider for the following 7 days to ensure that the individual is receiving medically necessary services.
Discharge Planning and Documentation	1. For individuals who remain in the community, Adult Mobile Crisis Intervention will be in contact with the individual and natural supports for a period of up to 7 days following discharge from Adult Mobile Crisis intervention, to ensure that the aftercare plan developed during the intervention has been implemented and will offer assistance as necessary in order to ensure that the plan is implemented. 2. For individuals with PACT/COMET, Adult Mobile Crisis Intervention plans and coordinates *all* referrals for aftercare services with the PACT/COMET care coordinator. Adult Mobile Crisis Intervention conducts at least one phone call or face-to- face meeting with the PACT/COMET provider and the individual to facilitate the transition. 3. For individuals receiving therapy, (or who Adult Mobile Crisis Intervention has referred for Therapy Services), Adult Mobile Crisis Intervention conducts at least one phone call or face-to-face meetings with the provider and the individual to facilitate the transition. 4. Adult Mobile Crisis Intervention remains involved with the individual and his/her natural supports until aftercare services are established and work has begun with the identified aftercare provider(s). Simply making a referral for an aftercare service does not meet the criteria for ensuring that the individual and his/her natural supports have established a connection with a provider. If the individual declines aftercare supports and services, this must be clearly documented in the individual's medical record. 5. With required consent, the Adult Mobile Crisis Intervention provider sends copies of the crisis assessment to all necessary providers as identified by the individual, including natural supports, state agency, behavioral health providers, etc.
Admission and Discharge Criteria	
Definition of crisis, admission criteria, discharge criteria	The definition of a crisis is: 1) A behavioral health crisis that is unable to be resolved to the caller's satisfaction by phone triage 2) where immediate intervention is needed to attempt to stabilize an individual's condition safely in situations that do not require an immediate public safety response and 3) the individual demonstrates an impairment in mood, thought and/or behavior that substantially interferes with functioning. <u>Admission criteria:</u> All of these criteria must be met: ○ Behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage by the regional crisis line; ○ Immediate intervention is needed to attempt to stabilize the individual's condition safely in situations that do not require an immediate public safety response;

	○ The individual demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community. In addition to the above, at least one of these criteria must be met: ○ The individual demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others. ○ The individual is experiencing escalating behavior(s) and, without immediate intervention, he/she is likely to require a higher intensity of services. ○ The individual is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community. Exceptions to providing face to face intervention: ○ There are significant safety issues identified, documented, and reported ○ It is agreed by the caller and Adult Mobile Crisis team that a face-to-face intervention is not required <u>Discharge criteria:</u> ○ The crisis assessment and other relevant information indicate that the individual needs a more (or less) intensive level of care and a transfer has been facilitated to the next treatment setting and ensured that the risk management/safety plan has been communicated to the treatment team at that setting. ○ The individual's physical condition necessitates transfer to an inpatient medical facility and the risk management/safety plan has been communicated to the receiving provider. ○ Consent for treatment is withdrawn and there is no court order requiring such treatment.

APPENDIX C: YOUTH MOBILE CRISIS INTERVENTION (YMCI) TECHNICAL SPECIFICATIONS

YMCI services are designed to optimize clinical interventions by meeting clients in home or community settings where they are more comfortable, where strengths and cultural differences are more apparent and where natural supports are more available. Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing individuals to bypass the stigma, trauma and disruption of a hospital or out-of-home setting.

YMCI services produce more holistic evaluations, solutions, and referrals. They are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments, reduce the likelihood of psychiatric hospitalization, and promote resolution of crisis in the least restrictive setting and in the least intrusive manner. Youth Mobile Crisis interventions are administered with the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the individual or others.

YMCI will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth (under age 18) experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others.

The service may include: A crisis assessment and engagement in a crisis planning process, up to seven days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent (limited) psychopharmacology intervention, as needed, and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care. Some concrete supports such as door alarms and lockboxes can be utilized in instances where needed.

For youth who are receiving Wraparound with Intensive Services (WISe), YMCI staff will coordinate or partner with the youth's WISe team throughout the delivery of the service. Youth Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Components of Service

1. YMCI is the youth-serving component of the crisis continuum of care.
2. YMCI is delivered by a provider with demonstrated infrastructure to support and ensure a. Quality Management/Assurance
   a) Utilization Management
   b) Electronic Data Collection/IT
   c) Clinical and Psychiatric Expertise
   d) Cultural and Linguistic Competence
3. YMCI provides mobile, community-based crisis intervention services, which are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner.
4. YMCI provides crisis assessment and crisis stabilization intervention services 24 hours per day, seven days a week, and 365 days a year. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to seven days.

5. YMCI teams will respond in the following timeframes:
   a) Triage calls within 15 minutes of initial request
   b) Respond in person within 120 minutes.
6. YMCI includes, but is not limited to:
   a) Conducting a mental status exam
   b) Assessing crisis precipitants, including psychiatric, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication)
   c) Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior
   d) Discussing and activating parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the youth's behavioral health needs
   e) Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care
   f) Assessing medication compliance and/or past medication trials
   g) Assessing safety/risk issues for the youth and parent/guardian/caregiver(s)
   h) Taking a medical history/screening for medical issues
   i) Assessing current functioning at home, school, and in the community
   j) Identifying current providers, including state agency involvement
   k) Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parent/guardian/caregiver(s)
   l) Solution focused crisis counseling
   m) Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support
   n) Clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to seven days
   o) Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone from an on-call child psychiatric or psychiatric nurse mental health clinical specialist.
7. YMCI assesses the safety needs of the youth and family. With the consent of an in collaboration with the youth and family, YMCI guides the family through the crisis planning process that is in line with the family's present stage readiness for change. As the family chooses, YMCI engages existing service providers and/or other natural supports.
8. YMCI identifies all necessary referrals and linkages to medically necessary behavioral health services and supports and facilitates referrals and access to those services. YMCI also works with the youth's health plan to arrange for dispositions to all levels of care, including inpatient and 24-hour services, diversionary services, outpatient services, and WISe.
9. YMCI provides the following additional services up to seven days after the initial response:
   a) Crisis counseling and consultation to the family
   b) Emergency medication management and consultation
   c) Telephonic support to the youth and family
   d) Coordination with other crisis stabilization providers
10. For youth who are receiving WISe, YMCI coordinates with the youth's clinical team throughout the delivery of the service. For youth not in WISe, YMCI will coordinate with the youth's primary care

physician, any other care management program or other behavioral health providers who provide services to the youth throughout the delivery of the service.

11. The YMCI provider has policies and procedures relating to all components of this service. The YMCI provider ensures all new and existing staff members are trained on these policies and procedures.

Staffing Requirements

1. YMCI utilizes a multidisciplinary model, with both professional and Peers with lived experience (Family Partner) and maintains staffing levels as warranted by data trends.
2. YMCI is staffed with master's and bachelor's level clinicians trained in working with youth and families, with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de- escalation techniques.
3. YMCI is also staffed with a Peer (Family Partner) experienced or trained in providing Mobile ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system that support brief interventions that address behavior and safety.
4. A member of the psychiatric team is available for phone consultation to YMCI staff 24-hours a day, seven days a week to provide clinical insight, support clinical diagnosis, medication and immediate safety planning needs in crisis planning.
5. All YMCI staff receive crisis specific training through the agency that employs them. Prior to serving families independently, YMCI staff also complete 12 hours of on-the-job training in Crisis Prevention Institute Training (CPI) or equivalent program. A master's level clinician with at least two years of crisis intervention experience supervises this training. This training is documented.
6. All YMCI staff are trained in the following: performance specifications, clinical criteria, systems of care philosophy and the wraparound process; medications and side effects; First Aid/CPR; youth-serving agencies and processes; family systems; conflict resolution; risk management; partnering with parents/guardians/caregivers; youth development; cultural competency; and related core clinical issues/topics. This training is documented.
7. YMCI staff members are knowledgeable about available community mental health and substance use disorder services within their geographical service area, the levels of care, and relevant laws and regulations. They also have knowledge about other medical, legal, emergency, and community services available to the youth.
8. YMCI supervises all staff, commensurate with licensure level and consistent with credentialing criteria.

Service, Community, and Collateral Linkages

1. As the youth-serving component of the crisis continuum of care, YMCI takes a strategic, leadership role in improving the crisis system infrastructure, building collaborations, improving efficiencies and effectiveness of crisis services.
2. YMCI upon completion of a crisis assessment, works with the parent/guardian/caregiver(s) to provide needed crisis stabilization services and, if necessary, with the youth's insurance carrier to obtain authorization for medically necessary level of care for the youth.
3. YMCI will ensure smooth access to behavioral health services in the area by maintaining regular communication and interagency relationships (e.g. MOU).
4. YMCI coordinates all behavioral health crisis response with the youth's existing providers, including WISe, In-Home Therapy Services and outpatient providers (e.g.. mentors, therapists), other care management programs and primary care provider (PCP). YMCI facilitates referrals for, and provides information on, both Medicaid and non-Medicaid services (e.g. WISe, voluntary services, therapy).
5. YMCI, with required consent, makes referral to WISe, Therapy Services or other services as needed.
6. YMCI supports linkages with the family's natural support system, including friends, family, faith community, cultural communities, and self-help groups (e.g. Parental support groups, AA, etc.).
7. For youth with WISe/In-Home Therapy Services that provide 24-hour response, YMCI staff contacts the provider for care coordination and disposition planning. The WISe/In-Home Therapy Services staff and YMCI staff communicate and collaborate on a youth's treatment throughout the mobile crisis intervention or crisis stabilization to develop a disposition plan that is consistent with the youth's treatment plan.
8. For youth engaged in services that do not provide 24-hour response, YMCI staff contacts the provider for the purpose of care coordination and disposition planning. YMCI staff communicates with the provider and collaborate on a youth's treatment to develop a disposition plan that is consistent with the youth's treatment plan.
9. YMCI establishes formal relationships including collaborative education and training with local police, emergency medical technicians (EMTs), schools, child welfare, local healthcare professionals and juvenile justice to promote effective and safe practices related to the management of emergency services for youth with mental health issues and their parent/guardian/caregiver(s).
10. With obtained consent, crisis assessments only occur in the youth's home or appropriate alternative community setting. Crisis assessments only occur in a hospital emergency department if the youth presents an imminent risk of harm to self or others; if youth and/or parent/caregiver refuses required consent for service in home or alternative community settings; or if request for YMCI services originates from a hospital emergency department.
11. If instances when a youth is sent to a hospital emergency department, YMCI mobilizes to the emergency department. The number of hospital-based interventions will be closely monitored to ensure that YMCI services are delivered primarily in community settings.

Quality Management

1. YMCI participates in all network management, utilization management, and quality management initiatives and meetings.

Process Specifications

Treatment Planning and Documentation	1. YMCI immediately works to de-escalate the situation and intervenes to ensure the safety of all individuals in the environment, utilizing the interventions and services listed under the “components of service” section above. 2. YMCI completes a comprehensive crisis assessment, including the elements listed under the “components of service” section above and engages in delivering crisis stabilization services. 3. To complete the crisis assessment and crisis intervention, YMCI seeks consent to speak with collateral contacts (e.g. WISe care coordinator, therapist, psychiatrist, social worker, etc.) and natural supports (e.g. friends, neighbors, extended family, etc.) to enlist their support in stabilizing the situation and developing an aftercare plan. 4. For youth enrolled in WISe, YMCI staff collaborates with the WISe provider to ensure coordination of care. YMCI coordinates with the WISe provider throughout the intervention as well as Care Coordination staff of the youth’s assigned MCO plan. 5. A member of the psychiatric team is available for phone consultation to YMCI staff 24-hours a day, seven days a week to provide clinical insight, support clinical diagnosis, medication and immediate safety planning needs in crisis planning. 6. If the crisis assessment indicates that placement outside of the home in an acute 24-hour behavioral health level of care (e.g. Crisis Stabilization setting, acute inpatient hospital) is medically necessary, YMCI will make every effort to facilitate a voluntary placement in collaboration with the individual and family. If an assessment for an involuntary placement is deemed necessary after voluntary placement options are attempted, YMCI staff consults with the Designated Crisis Responder (DCR) team and arranges for an assessment. If the youth meets criteria for a higher level of care (for either voluntary or involuntary placement), YMCI consults with the receiving provider to assist the receiving provider to develop a plan for stabilizing the crisis that was addressed by the YMCI. Youth Crisis services will follow the youth to inpatient and partner to transition them back home at discharge from the facility. 7. If the crisis assessment indicates that the youth is stable to remain in the community or current placement, YMCI obtains authorization for medically necessary community-based services and coordinates with the youth and family and the community-based service provider to ensure that the youth is receiving medically necessary services. 8. If the youth is not already enrolled in WISe, YMCI may arrange a follow-up appointment with the WISe provider in the youth’s service area and coordinates with the WISe provider for the following seven days to ensure that the youth is receiving medically necessary services. 9. On a daily basis, a service log is emailed to Carelon via secure email with a summary of services delivered and contacts made.

Discharge Planning and Documentation	1. For youth who remain in the community, YMCI will be in contact with the family for a period of up to several days following discharge from a mobile crisis intervention, to ensure that the aftercare plan developed during the intervention has been implemented and will offer assistance as necessary in order to ensure that the plan is implemented. 2. For youth with WISe, YMCI plans and coordinates all referrals for aftercare services with the WISe care coordinator. YMCI at least one phone call or face-to- face meeting with the WISe provider and the family to facilitate the transition. 3. For youth receiving therapy, (or who YMCI has referred for Therapy Services), YMCI conducts at least one phone call or face-to-face meetings with the provider and the family to facilitate the transition. 4. YMCI facilitates access to Crisis Stabilization Services (FAST), WISe, Therapy Services, or other levels of care/covered services as medically necessary and ensures that families have established a connection with the services and supports identified through YMCI assessment and intervention. YMCI remains involved with the youth and his/her parent/guardian/caregiver(s) until aftercare services are established and work has begun with the identified aftercare provider(s). Simply making a referral for an aftercare service does not meet the criteria for ensuring that the youth and his/her Parent/guardian/caregiver have established a connection with a provider. If the parent or guardian declines aftercare supports and services, this must be clearly documented in the youth's medical record. 5. With required consent, the YMCI provider sends copies of the crisis assessment to all necessary providers as identified by the youth and Parent/guardian/caregiver, including state agency, school, and juvenile justice personnel.

Admission and Discharge Criteria	
Definition of Crisis	The definition of a crisis is: 1. A behavioral health crisis that is unable to be resolved to the caller's satisfaction by phone triage 2. Where immediate intervention is needed to attempt to stabilize an individual's condition safely in situations that do not require an immediate public safety response and 3. The individual demonstrates an impairment in mood, thought and/or behavior that substantially interferes with functioning.

Admission Criteria	All of these criteria must be met for admission: • Behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage by the regional crisis line; • Immediate intervention is needed to attempt to stabilize the individual's condition safely in situations that do not require an immediate public safety response; • The individual demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community. In addition to the above, at least one of these criteria must be met: • The individual demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others. • The individual is experiencing escalating behavior(s) and, without immediate intervention, he/she is likely to require a higher intensity of services. • The individual is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community. Exceptions to providing face to face intervention: • There are significant safety issues identified, documented, and reported • It is agreed by the caller and YMCI team that a face-to-face intervention is not required

Discharge Criteria	• The crisis assessment and other relevant information indicate that the individual needs a more (or less) intensive level of care and a transfer has been facilitated to the next treatment setting and ensured that the risk management/safety plan has been communicated to the treatment team at that setting. • The individual's physical condition necessitates transfer to an inpatient medical facility and the risk management/safety plan has been communicated to the receiving provider. • Consent for treatment is withdrawn and there is no court order requiring such treatment.
Coordination with CCS Program	

Screening, referral and ensuring continuity of care for community crisis stabilization FAST services (CCS) program	YMCI manages the front door of referrals into the Child Community Crisis Stabilization (CCS) program. Following completion of a YMCI, if the MCI clinician determines that CCS may be medically necessary in accordance with applicable medical necessity criteria, then the following steps shall be followed: 1. Screening and referral: • Describe to the youth and parent the purpose of additional service, which shall be available to youth based on medical necessity and shall be short-term, home-based services and no more than 90 days. Plan for daily contact with the youth, parents, and community providers until discharge from the YMCI service. • Obtain informed consent to refer to the CCS service • Confirm that the youth will return to his/her previous living setting or that an alternate placement is firm and immediately available at discharge 2. Ensures continuity of care The YMCI clinician shall: • Develop with the youth and family a brief and focused treatment plan (with actions identified for the youth, parent, and providers, as indicated) that shall guide the course of treatment in the child CCS program • Convey a copy of the behavioral health assessment and the brief, focused treatment plan to the child CCS program provider so that targeted services can begin immediately. • Work with the parent or guardian to ensure that any prescribed medications are in their original container, are labeled with instructions and the prescribing physician's name/phone number. • With consent, alert all providers who shall be expected to attend a treatment meeting with CCS. 3. Notification to Carelon and the MCO for referrals accepted by CCS program • Notify Carelon and the assigned MCO when a referral made to the CCS program is accepted and services are planned to initiate.

APPENDIX D: QUADRANT MODEL FOR RETHINKING HOSPITALIZATION