COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

Colorado Crisis Service Mobile Crisis Response Definition

Effective: July 1, 2023

Introduction

The Colorado Crisis Service (CCS) Mobile Crisis Response (MCR) is intended to offer de-escalation and stabilization to individuals in a self-defined behavioral health crisis to decrease the use of the emergency department, inpatient care, and unnecessary arrest for individuals whose needs can be met in the community. MCR under the CCS program is available:

- to all people in Colorado 24 hours a day, 7 days a week, 365 days a year,
- regardless of insurance status, age, residency, or previous service utilization, and
- to be delivered by a multidisciplinary MCR team with requisite training and expertise.[1]

MCR is not a replacement for ongoing mental health and/or substance use disorder treatment as scheduled services are critical to both address a client's behavioral health needs and to prevent crises. MCR is used to address an emergent and unforeseen crisis. In the hours and days after an immediate crisis has been addressed, MCR teams provide or arrange for appropriate transportation to a facility if needed, coordinate follow up care, facilitate behavioral health referrals as clinically indicated, and may provide home-based or telemedicine follow up visits.

Purpose of the MCR Service Definition:
This service definition outlines key components that comprise the new MCR benefit and is intended for use by MCR teams that are eligible for Behavioral Health Administration (BHA) endorsement and enrollment as a Colorado Medicaid provider. MCR teams will deliver services to all people in Colorado in crisis regardless of insurance status. This service definition reflects national best practices and Colorado's unique needs for service delivery and provider performance. The definition details the following elements of the new MCR benefit:

- Engagement with Community
- Service Activities
- Provider/Agency Requirements, Enrollment, and Billing
- Staffing Requirements
- 24/7/365 Availability, Timeliness, and Location of Service Standards, and
- Use of Telehealth and Other Technology.

[1] Section 1947 of Title XIX of the Social Security Act as amended by the American Rescue Plan Act of 2021 (ARPA). See: PUBL002.PS (congress.gov)

Engagement with Community Partners

MCR providers are responsible for working with their geographically appropriate Administrative Service Organizations (ASOs) on formal and informal community engagement, coordination, and system navigation with key partners, including the CCS statewide crisis line/988, criminal justice agencies, emergency departments, hospitals, primary care facilities, peer-run recovery support organizations, behavioral health entities, walk-in centers, and other crisis service facilities as necessary. Engagement efforts are in addition to the marketing effort coordinated by the BHA and should supplement and not supplant those strategies. Engagement efforts should focus on building the necessary relationships with potential referral sources for MCR services. Each MCR provider shall work with their ASO to design and implement an engagement strategy for the communities served by the MCR provider. The goals of community engagement efforts are to:

- Provide information regarding CCS/988 for dispatching MCR teams
- Formalize relationships with partners in the region served by the MCR provider
- Build close relationships between first responders, dispatch centers, statewide crisis line/988 and the MCR provider
- Facilitate interdisciplinary approach to behavioral health crisis interventions in the community for the purpose of promoting continuity of care and diversion from the criminal justice system

Along with community engagement activities, the MCR provider shall also make outreach materials in collaboration with their ASO. The materials should be disseminated to all potentially involved parties, including but not limited to members and community, 988, behavioral health providers, Regional Accountable Entities (RAEs), law enforcement, schools, social services, recreational establishments, hospitals, recovery support organizations, emergency departments, faith-based organizations, and other local establishments. These outreach efforts should include distribution of materials regarding the provider's MCR program, presentations and other additional outreach activities that the MCR provider believes to be appropriate.

Initial Crisis Response Activities

Each MCR team shall provide community-based crisis intervention, screening, assessment, de-escalation and stabilization, safety planning, and coordination with and referrals to appropriate resources, including health, social, and other services and supports.

1. ***MCR Dispatch***

   Providers of MCR services shall receive requests from various sources including the statewide crisis line, 988, local crisis lines or other defined referral sources (e.g., schools, law enforcement). These requests should be immediately triaged by the receiving provider dispatch to the MCR team and must be answered by a live staff

person within the MCR agency. An answering service is not permitted to function as a MCR dispatch, including those that automatically forward calls to 911 or to another emergency service.

When the MCR provider receives a call from statewide crisis line/988 they shall immediately dispatch the MCR team. For other referrals to MCR providers, the provider must use the dispatch criteria approved by the BHA.

Once the MCR team is dispatched, the MCR team shall respond and arrive on-site within the timeliness and location standards. The MCR team shall meet the individual in crisis in the location where the crisis occurs unless the individual requests to be met in an alternative community-based location.

2. ***Crisis Response Activities***

a. Initial Face-to-Face Risk Assessment

Each MCR team shall conduct an initial face-to-face brief, person-centered screening of risk, mental status, medical stability and the need for further assessments or other behavioral health services. This risk assessment must include all aspects of the BHA provided risk assessment, which is based on national guidelines, and must be administered immediately upon initial contact with the individual in crisis.

The MCR initial Face-to-Face Risk Assessment shall include but not be limited to:

- Causes leading to the crisis event, including psychiatric, co-occurring disabilities, social, familial, legal factors, and substance use
- Safety and risk for the individual and others involved; including the need for an explicit assessment of suicide and risk of violence or harm to self or others using a validated tool determined by BHA
- Strengths and resources of the person experiencing the crisis, their family members, and other natural supports
- Recent inpatient hospitalizations and/or any current relationship with a mental health provider
- Medications prescribed, medications taken recently, current prescriber and information on the individual's ongoing medication regimen,
- Current or recent medical history (including pregnancy) that may impact the crisis response, and
- A rapid determination as to whether the crisis in question warrants medical or police response.

The administration of the initial risk assessment should be culturally sensitive to the needs of American Indian/Alaska Natives (AIAN), LGBTQ+ (Lesbian, Gay,

Bisexual, Transgender, Queer) youth and adults, individuals with disabilities including co-occurring conditions, intellectual and developmental disabilities (I/DD), serious mental illness (SMI), serious emotional disturbances (SED), substance use disorders (SUD), traumatic brain injuries (TBI), individuals who are Deaf/Hard of Hearing or Deaf-Blind (DHOHDB), other cognitive needs/neurodiversity, those who do not speak English or less than very well, individuals from racially and ethnically diverse backgrounds, and others with specialized trauma informed needs.

Initial assessments must be documented for each MCR response in the Electronic Health Record (EHR).

b. De-Escalation, Brief Intervention, and Stabilization

Mobile crisis teams shall provide trauma informed brief screening, de-escalation and stabilization, harm reduction, and coordination with other supports to reduce the need for higher level of care referrals and arrests to maintain an individual's stability in the community. MCR teams accomplish this by providing clinically indicated appropriate services, including, but not limited to:

- On-site interventions, including solution-focused crisis counseling, for immediate de-escalation of presenting behavioral health issues,
- Brief screening and intervention
- Stabilization services including:
    - Provide harm reduction interventions, including the administration of naloxone to reverse an overdose, when needed
    - Skill development, psychosocial education and initial identification of resources needed to stabilize the presenting situation
    - Provision of prevention strategies and resources to cope with presenting emotional symptoms, behaviors and existing circumstances and avoid future crises
    - Coordination with other providers involved in the individual's or family's care, and
    - Immediate coordination with other crisis providers when needed (e.g., Walk-In Centers, Crisis Stabilization Units and Respite, Psychiatric Emergency Services).

c. Crisis and Safety Planning

The MCR team, in collaboration with the individual, their family members and/or other social supports (e.g., friends, roommates), is required to develop and document a crisis and/or safety plan to help manage the individual's

current needs and prevent or reduce the frequency of future crises. The crisis safety plan shall not be used as a safety contract. MCR teams work with individuals to identify existing treatment plans or crisis safety plans; if available, any previously documented treatment or crisis plans should be utilized by the MCR team when it is appropriate to the presenting situation. When a crisis safety plan does not exist, the MCR team shall use the safety plan template provided by the BHA which identifies immediate strategies (e.g., contacting the statewide crisis line/988) and engages the individual and caregiver (when appropriate) in developing a crisis plan.

The crisis plan may include but is not limited to:

- Short term strategies that are key activities for immediate stabilization
- Longer-term activities that foster a return to the pre-crisis level of functioning
- Connections to and recommendations for the services, supports or other community resources identified by the MCR team, and
- When appropriate, the crisis safety plan should include psychiatric advance directives.

The crisis safety plan shall be in writing and copies of the plan should be provided to the individual, caregiver (when appropriate) and when authorized by the individual and/or caregiver provided to, social supports and key resources, such as schools, behavioral health providers or other organizations. A crisis safety plan should be updated or developed prior to referral to another behavioral health provider by a MCR staff member.

d. Secure Transportation

MCR teams shall provide or coordinate clinically appropriate and accessible transportation to an appropriate level of care as needed, following an MCR. MCR providers may only provide transport if they are appropriately licensed and have appropriate vehicle permits as defined by Behavioral Health Secure Transportation[2].

e. Early Resolution of Mobile Crisis Response

If the member is accepted to a higher level of care, such as an inpatient hospital, the MCR ends. The provider must ensure continuity of care in any transition and may continue to provide a service as indicated but not as a MCR reimbursement. This can include speaking with inpatient, residential, or withdrawal management or outpatient care facilities, as well as sharing relevant patient information about the episode, and sharing documentation of the MCR.

[2] Behavioral Health Secure Transportation - Colorado Department of Health Care Policy & Financing

If an individual requires care coordination or further assistance with stabilization after the initial crisis episode beyond seven calendar days, the MCR provider is responsible for coordinating with the individual's ASO, RAE and/or BH provider to ensure continuity of care.

A MCR that results in an arrest is not reimbursable but must be recorded. If a MCR is provided on the same day as an arrest, documentation showing that the events are unique should be available upon request.

Follow Up Service Activities

1. Immediate Follow-Up Activities

MCR teams shall ensure follow up to the individual, authorized caregiver and/or family member(s) within twenty-four (24) hours as appropriate and agreed upon by the individual, and for up to five days to ensure continued stability post crisis, unless the individual is accessing higher levels of care or another crisis service. These activities should include but are not limited to:

- Telephonic or face-to-face follow-up based on a clinical individualized need
  - *Face-to-Face:* After the initial MCR, an additional face-to-face follow-up visit from MCR team member(s) may occur if clinically indicated and agreed upon by the individual and/or caregiver for the purpose of maintaining individual's stability, to identify the need for post-crisis services, and discuss referral options for ongoing stability. Additional activities could include meeting with a caregiver or other community supports who are immediately involved with the individual and who can assist with the implementation of the crisis safety plan. Telehealth with a video option may be utilized at the discretion of the MCR team when appropriate.
  - *Telephone Only:* A telephone-only follow-up may be utilized when agreed to by the individual and/or caregiver to commence activities that would stabilize the individual, identify the need for post-crisis services and discuss referral options post stabilization. Additional activities could include calls and/or telehealth visits with a caregiver or others who are immediately involved with the individual and who can assist with the implementation of the crisis safety plan.

Additional calls/visits to the individual or relevant supports following the crisis may be made as indicated to stabilize the crisis. If the individual indicates no further

communication is desired, it must be documented in the individual's health record.

2. Coordination with and Referrals to Other Services and Supports

MCR teams should identify all necessary referrals and linkages to behavioral health services and supports and facilitate referrals and access to those services. The MCR team also must work with the individual's RAE to arrange for dispositions to all levels of care, including 24- hour services, diversionary services, intensive outpatient services, secure transportation, and ongoing care coordination. Resources provided shall always include the Statewide Crisis Line.

Referral partners include, but are not limited to:

- Behavioral health outpatient providers (including Intensive Outpatient Services for Substance Use Disorder (SUD))
- Providers serving individuals with I/DDs, TBIs, SMIs, SEDs, SUDs, etc.
- Agencies offering intensive home and community-based services to youth and their families (e.g., intensive care coordinator and in-home therapies)
- Other crisis providers such as walk-in centers, crisis respite or crisis stabilization units
- Natural community supports (e.g., places of worship, recreation centers, Alcoholics Anonymous), and
- Other health related/care continuum e.g., primary care,

All disposition information including referrals shall be documented in the individual's electronic health record and dispatch portal.

The MCR provider is responsible for linking individuals to the necessary post-crisis resources that are identified by the individual, caregiver (when appropriate), and MCR team. These efforts must include scheduling follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care. Appointments should attempt to be scheduled within seven days of referral by the MCR provider. This includes the following activities:

- Making the initial contact or working directly with the individual or caregiver (when appropriate) within 24 hours of the face-to-face crisis intervention with referral source to schedule an intake or appointment.
- Providing information to the individual and caregiver (if appropriate) regarding:
    - Name of the agency or practitioner
    - Contact information for the practitioner or agency (telephone number and email address)

- Date and time of the appointment
- Location of the appointment, and
- Back-up provider referral if needed.

If an individual requires care coordination or further assistance with stabilization after the initial crisis episode beyond seven calendar days, the MCR provider is responsible for coordinating with the individual's ASO, RAE and/or BH provider to ensure continuity of care.

If the member is accepted to a higher level of care, the MCR ends. The provider may continue to provide a service as indicated but not as a part of the MCR and reimbursement.

3. Maintaining Relationships with Community Partners

MCR providers work cooperatively with their ASO, for network adequacy, and RAE, for Medicaid participation, to develop and maintain relationships with referral sources to and from the MCR provider. These may include, but are not limited to:

- Schools
- Law Enforcement
- Service Providers for Other Populations (E.G., Individuals With I/DD, TBI)
- Inpatient Hospitals
- Withdrawal management Providers, and
- Other Crisis Service Providers and Specialty Facilities Such as Psychiatric Residential Treatment Facilities and Qualified Residential Treatment Programs.

Provider/Agency Requirements, Enrollment and Billing

MCR providers must meet all requirements outlined in this service definition to be authorized as a MCR team. The process beginning July 1, 2023 is as follows:

- Obtain a Behavioral Health Entity License, if applicable and available. Work with your ASO and RAE to determine applicability,
- Pass an initial readiness review by the BHA prior to providing MCR services,
- Applying for a BHA Mobile Crisis Endorsement no later than June 2024. Applications may be accepted by the BHA as early as November 2023, and
- Enroll as an approved Health First Colorado provider of Behavioral Health Crisis Services Provider Type 95; Specialty type Mobile Crisis Response, Code 772.

Providers must be an approved provider type to be eligible to contract under the ASO system. Providers must be additionally contracted with a RAE and be enrolled as a Health

First Colorado provider to receive Medicaid reimbursements. To enroll prior to formal BHA endorsement availability, providers must obtain the BHA letter of approval which is required for the Health First Colorado application.

Health First Colorado providers may use codes 90839 for the first hour of service with modifier ET in the second position, and H2011 for the remainder of the crisis response and follow up also using modifier ET in the second position.

Staffing Requirements

1. Team Requirements

Each MCR team shall include multidisciplinary professionals and paraprofessionals with appropriate skills and expertise to respond to any individual in need of MCR. An initial MCR shall be a paired response from any two members of the MCR team, both of whom are defined as a Crisis Professional having undergone the curriculum on the BHA Learning Management System. Follow-up visits to continue stabilization efforts, coordinate care and make referrals can be performed by any member of the MCR team.

Paired response by both team members in-person is strongly preferred, however, if this is not possible one individual must provide the initial response on-site and the other team member may participate using telemedicine. Both audio and visual are required for the response, and when initiating an involuntary psychiatric hold (also known as an "M1" or "27-65" hold in accordance with CRS 27-65-103 et al.) via telemedicine.

MCR teams must still meet all requirements, including a paired Crisis Professional response team, when additional emergency services professionals respond in addition to the MCR clinical and eligible team.

2. Team Members

The following professionals and paraprofessionals may be included on a MCR team and are eligible for the BHA Crisis Professional LMS training:

- Clinical Social Worker/Professional Counselor/Marriage and Family Therapist/ Psychologist (Ph.D./Psy.D.)/Addiction Counselor (LAC) who are licensed by the State of Colorado
- Unlicensed Master's Level /Ph.D./Psy.D.
- Bachelors level clinician or case manager
- Registered Nurse (RN)/ Licensed Vocational Nurse (LVN)/ Licensed Practical Nurse (LPN)

- Advance Practice Registered Nurse (APRN)/Advance Practice Registered Nurse with Full Prescriptive Authority (RxN)
- Emergency Medical Technicians, including Paramedics with Community Paramedic endorsement (EMT-P CP)
- Adult or transition age youth peer support professional or family advocate,
- Mobile crisis case manager, and
- Other trained crisis response staff members, as identified by the contract.

Organizations that are not endorsed by the BHA for MCR, eligible for endorsement by the BHA, and eligible to be enrolled as a Health First Colorado Medicaid provider may not be MCR providers.

3. Roles of Select Team Members

Every MCR team must include a behavioral health clinician licensed by the State of Colorado ("licensed clinician"). The role of the licensed clinician on the MCR team is to provide oversight and clinician supervision to the MCR team, and to be available for immediate consultation during a crisis call via telemedicine or in person. In this capacity the licensed clinician may:

- Provide consultation to the team for determining and executing clinical de-escalation strategies
- Provide consultation to determine if a higher level of care (crisis stabilization or inpatient services) is needed for an individual who is in crisis
- Effect an M1 hold, or involuntary transportation hold for an individual who is deemed to be an imminent danger to the person's self or others, or meets criteria for grave disability, or requires involuntary transportation for immediate screening, and
- Provide supervision on a regular basis to MCR team members.

Each MCR team must include a peer support professional(s) who can take the lead on crisis responses and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis. This peer support professional can be included through direct employment or through a contract with another peer employing agency. Peer support professionals, including individual(s) or family members with lived experience, are eligible to become a trained and paid Crisis Professional to take the lead on the clinical interventions. They may engage with the caregiver of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support. Peer support professionals may not serve an administrative function.

Each MCR team must have a staff member that has specific competencies in serving children, youth and caregivers who experience crisis.

MCR staff must also be trained in responding to individuals with I/DD, TBI, SMI, SED, SUD, co-occurring disorders, and other cognitive needs/neurodiversity who are in crisis. MCR providers must also collaborate with their ASO and RAE to develop contractual relationships with local providers with expertise working with these populations. These providers must be engaged during or immediately after initial face-to-face intervention as needed to support individuals in crisis. Telehealth may be used to secure expertise for these individuals. MCR teams should connect individuals to their existing providers if these relationships already exist.

4. Training Requirements

Each MCR provider shall have all members of the team participate in required training to be endorsed as Crisis Professionals therefore eligible to provide MCR services. The MCR provider shall ensure that all staff complete their training requirements within the timeframes established by BHA, working with their ASO and RAE as needed to access training. MCR team members must complete annual training and shall receive documentation regarding their compliance with these training requirements from BHA. In the future, standardized training will be available on the BHA Learning Management System (BHA LMS) as the Crisis Professional Curriculum. These requirements will be finalized in BHA rule and available in the BHA LMS by2024.

Required training must cover the following topics, but training is not limited to:

Required Training on the MCR Service:

- Initial Telephonic Screening and Standardized Dispatch Protocol*
- Suicide Screening, Risk Assessment and Safety Planning
- Evidence-based and Promising Practices in Crisis Intervention, including De-escalation Strategies
- Crisis Plan Development and Use of Advanced Directives*
- Harm Reduction Strategies and Use of Naloxone and Other Supplies to Address Overdoses*
- Non-violent Crisis Intervention
- Psychiatric Medications and Side Effects
- Trauma-Informed Care including responding to victims of interpersonal and gender-based violence
- National Standards for Culturally and Linguistically Appropriate Services (CLAS), Including BHA CLAS Standards Policies and Communications Technology*
- Federal and State Requirements and Privacy and Confidentiality of Patient Information*
- Training for adult or transition age youth peer support professionals or

family advocate members and their supervisors to support paired response by clinical/peer teams*
- Using accessibility related tools including telehealth and communication devices or other language resources

Required Training to Ensure MCR Services are Tailored to Meet the Needs of Key Populations:

- Cultural Awareness and Responsiveness including responding to individuals from racially and ethnically diverse backgrounds
- American Indians/Alaska Natives*
- Child, Youth and Family Crisis Interventions
- Co-Occurring Disorders
- Deaf, Hard of Hearing, and Deaf/Blind care*
- Dementia and other age-related needs
- Gender-responsive Services
- Intellectual and Developmental Disabilities
- Lesbian, Gay, Bisexual, Transgender, Queer/questioning and other (LGBTQ+) * youth and adult related needs
- Mental Health Conditions (including Serious Mental Illness, Serious Emotional Disturbance) *
- Neurodivergence, including Autism Spectrum Disorders*
- Non-English speakers and those for whom English is not their first language
- Substance Use Disorders
- Traumatic Brain Injuries

Training modalities may include in-person or virtual training sessions and refresher sessions. Training will be available in the LMS, via the BHA, and via ASOs or RAEs.

NOTE: New or updated training modules required under the MCR service definition are indicated with a *. In the future, standardized training will be available on the BHA LMS.

Availability, Timeliness and Location Standards

24/7/365 Availability

MCR services are available through a regional network of mobile crisis providers to ensure 24/7/365 availability statewide. Based on the demand for MCR services, the ASO must determine the number of mobile crisis teams needed to ensure 24/7/365 coverage in their region, as applicable, to achieve statewide coverage. RAEs must ensure adequate coverage for Health First Colorado and CHP+ Medicaid members. This will still ensure 24/7/365 coverage is available to each county but provides for regional

flexibility and responsiveness.

Timeliness

MCR teams shall arrive at the community-based location where a crisis occurs within one hour of a request for dispatch of mobile crisis services in urban areas, and within two hours in rural and frontier areas, as defined by the State.

Locations of Service

MCR services should be provided in the individual's or caregiver's home, or an appropriate alternative community setting, and not in facilities providing 24-hour care, prisons and jails, or outpatient settings that offer crisis services, such as Certified Community Behavioral Health Clinics or Community Mental Health Centers.

For instance, MCR teams may respond to crises in non-hospital or other facility settings, including but not limited to:

- Homes
- Workplaces
- Schools
- Libraries
- Group homes
- Assisted living facilities
- Outpatient medical providers' offices or clinics
- ASAM Level 1 and 2 Designated Facilities
- Community correctional facilities (i.e., Halfway houses), and
- Other settings where health centers or clinics do not offer behavioral health services.

MCR teams may not respond to crises in the following settings where behavioral health crisis services should be available, including but not limited to:

- Inpatient Hospital
- Inpatient Psychiatric Hospitals
- Emergency Departments
- Psychiatric Residential Treatment Facilities (PRTFs)
- Qualified Residential Treatment Programs (QRTPs)
- Inpatient Alcohol and Drug Rehabilitation Centers
- Withdrawal Management Facilities
- ASAM Level 3 and 4 Designated Facilities
- Prisons and Jails, and
- Outpatient settings that offer crisis services, such as Community Mental Health Centers (CMHCs) or Certified Community Behavioral Health Clinics (CCBHCs)s.

Facility-based providers that offer and are reimbursed for crisis services can provide those services in-house or continue to contract directly with a vendor for emergency psychiatric and crisis stabilization services but may not utilize community MCR for the purpose of state funding through the BHA or through Medicaid. Crisis stabilization services may be billed to Medicaid or other payers using other appropriate crisis codes, provider types, and places of service to receive reimbursement.

Use of Telehealth and Other Technology

Paired in-person responses should be prioritized, though telehealth may be leveraged in certain instances to connect with licensed clinicians who have additional crisis response skills and strategies for immediate actions needing to be considered by the MCR on-site team members.

Telehealth may also be used for involuntary psychiatric holds, also known as an "M1" or "27-65" hold in accordance with CRS 27-65-103 et al., so that an onsite responder may transport an individual to a withdrawal management facility or inpatient care on an involuntary basis, or to involve physicians who can write prescriptions that allow an individual in crisis to take their regularly prescribed medications in withdrawal management.

In addition, telehealth may be used to secure expertise for individuals who have a co-occurring condition(s) or disability(ies) during or immediately after a crisis response.

Other technology should also be accessible to providers when needed to ensure mobile crisis teams are able to communicate with all individuals in crisis, including individuals who speak another language than English or less than very well, are Deaf, Hard of Hearing, or Deaf-Blind. This may include Communication Access Realtime Translation (CART) services, closed captioning, videophone, amplified and captioned phones, smartphones and tablets, language lines and other Augmentative and Alternative Communication devices.

The use of telehealth is not restricted to reasons as outlined above. All telehealth policies and procedures used by MCR providers are to be approved by the BHA and HCPF.