COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

Colorado Crisis Service Mobile Crisis Response Definition

DRAFT for Public Comment

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Introduction

The Colorado Crisis Service (CCS)-Mobile Crisis Response (MCR) is intended to offer relief and stabilization to individuals in crisis and to decrease the unnecessary use of the emergency department and inpatient care for Medicaid members whose needs can be met in the community. MCR under the CCS program is available at all times, 24 hours a day, 7 days a week and 365 days a year, and delivered by a multi-disciplinary mobile crisis response team with requisite training and expertise in accordance with federal requirements under the American Rescue Plan Act of 2021.[1]

MCR is not a replacement for ongoing mental health and substance use disorder treatment services, which are critical to address a member's behavioral health needs after the resolution of a crisis and should instead be used to address emergent and unforeseen crises. In the hours and days after an immediate crisis has been addressed, MCR providers are required to coordinate follow up care and facilitate referrals to behavioral health treatment services and/or other community-based supports as clinically indicated, and may provide home-based follow up visits as needed. For individuals who need to be transported to a facility for additional physical or behavioral health services, the mobile crisis provider provides or arranges for appropriate secure and non-secure transportation.

Purpose of the MCR Service Definition:

This service definition outlines key components that comprise the new MCR benefit and is intended for use by mobile crisis response teams that are eligible for reimbursement for services to Medicaid members. 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:

- Service Activities
- Provider/Agency Requirements
- Staffing Requirements
- 24/7/365 Availability, Timeliness, and Place of Service Standards
- Use of Telehealth

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

Service Activities

A. Engagement with Community Partners

MCR providers are responsible for formal and informal community engagement, coordination, and system navigation with key partners, including Colorado Crisis Services (CCS), 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 Behavioral Health Administration (BHA). Engagement efforts should focus on building the necessary relationships with potential referral sources for MCR services. Engagement strategies should support and not supplant marketing strategies implemented by the BHA. Each MCR provider shall work with their Administrative Service Organization (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, Colorado's crisis line and the MCR provider.
- Coordinate behavioral health crisis interventions in the community as early as possible to promote continuity of care and diversion from the criminal justice system.

Along with community engagement activities, the MCR provider in cooperation with their ASO is to make outreach materials for MCR services and related crisis services available to families, CCS, 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.

B. 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 to the MCR team and must be answered by a live staff person within the MCR agency. An answering service is not permitted, including those that direct callers to 911 or to a hospital emergency department. When the MCR provider receives a call from CCS/988 they shall immediately dispatch the MCR team. For other referrals to MCR providers, the provider must use a standardized screening tool and process approved by BHA to determine when dispatch is needed. Once the MCR team is dispatched, the MCR team shall respond and arrive on-site within the standards required by the BHA. The mobile crisis team is to meet the individual in the location where the crisis occurs, unless the individual requests to be met in an alternative location in the community.

C. Mobile Crisis Response Activities

Each MCR team shall provide community-based crisis intervention, screening, assessment, stabilization and de-escalation, safety planning, and coordination with and referrals to appropriate resources, including health, social, and other services and supports, as needed. The staffing requirements for the MCR Team are on page 7.

When a MCR team is dispatched, they are required to meet the individual where they are in the community (most commonly at home or at a location in the community requested by the caller) and perform all immediate crisis response activities defined below including an in-person crisis risk assessment, activities that de-escalate the crisis, and the development of a crisis/safety plan which may include transportation to a provider. MCR services cannot be provided in institutions or facilities as defined later in this service definition. Specific activities and requirements that MCR teams must provide at different points during the initial response and follow-up are defined below.

1. *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 is different from that in other types of assessment with respect to goals, process, relation to treatment, and type of information gathered. Recognition of these differences is essential for team members who are involved in providing crisis intervention. Team members must often be prepared to provide crisis intervention services immediately upon initial contact. At a minimum, MCR teams include the following components in their initial risk assessment aligned with SAMHSA's National Guidelines for Behavioral Health Crisis Care evidence-based best practices[2]:

   - 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 and HCPF.
   - Strengths and resources of the person experiencing the crisis, as well as those of 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 as well as information on the individual's ongoing medication regimen.
   - Current or recent medical history (including pregnancy) that may impact the crisis response.

[2] SAMHSA. National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, 2020.

- A rapid determination as to whether the crisis in question warrants medical or police response.

The initial risk assessment should be culturally sensitive to the needs of American Indians/Alaska Natives, LGBTQ+ youth and adults, individuals with disabilities including co-occurring disabilities, I/DD, SMI, TBI, individuals who are deaf or hard of hearing, and individuals from culturally diverse backgrounds.

2. *Brief Intervention, Stabilization, and De-Escalation*

Mobile crisis teams shall provide brief intervention, stabilization, and de-escalation intended to maintain stability in the community and reduce unnecessary higher level of care referrals, which may include, but are not limited to the following components aligned with national and other state guidelines for mobile crisis response:

- On-site interventions, including solution-focused crisis counseling, for immediate de-escalation of presenting behavioral health issues.
- Coordination with other providers involved in the individual's or family's care
- 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.
- Immediate coordination with other crisis providers when needed (e.g., Walk-In Centers, Crisis Stabilization Units and Respite, Psychiatric Emergency Services).
- Provide harm reduction interventions, including the administration of naloxone to reverse an overdose, if needed.

3. *Crisis and Safety Planning*

The MCR team in collaboration with the individual and their family members and/or other social supports (e.g. friends, roommates) is required to develop and document a crisis safety plan to help manage the individuals current needs and prevent, or reduce the frequency of future crises. MCR teams work with individuals to identify existing treatment or crisis plan; if available, these should be utilized by the MCR team when it is appropriate to the presenting situation. When a crisis plan does not exist, the MCR team identifies immediate strategies (e.g., contacting CCS/988) and engages the individual and caregiver (when appropriate) in developing a crisis plan. The crisis plan should include short term strategies (that are key activities for immediate stabilization) and longer-term activities that fosters a return to the pre-crisis level of functioning and connects or recommends the individual to the services, supports or other community resources identified by the MCR team. When appropriate, the crisis safety plan should include advanced directives. The crisis plan shall be in writing and copies of the plan should be provided to and signed by 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 plan should be updated or developed prior to referral to another behavioral health provider by a MCR staff member.

4. *Immediate Follow-Up Activities*

   MCR teams shall ensure follow up to the member and authorized member's caregiver and/or family member(s) within twenty-four (24) hours as appropriate and desired by the member and up to five days to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:

   - Telephonic or face-to-face follow-up based on a clinical individualized need; and
   - Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

5. *Follow-up Crisis Response:*

   - *Face-to-Face*
     After the initial mobile crisis response, an additional face-to-face follow-up visit from MCR team member(s) may occur if recommended and agreed to by the individual and/or caregiver to commence activities that would help to maintain the stability of an individual, identify the need for post-crisis services and discuss referral options for ongoing stability. Additional activities could include meeting with a caregiver or others 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 mobile crisis provider when appropriate.

   - *Telephone Only*
     A telephone-only follow-up is needed as recommended and 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.

6. *Coordination with and Referrals to Health, Social, and 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, transportation and ongoing care coordination. Resources provided shall always include the Statewide Crisis Line phone number but shall not list the National Text number or the National Lifeline number. Referral sources include, but are not limited to:

   - Behavioral health outpatient providers (including Intensive Outpatient Services for Substance Use Disorder (SUD))
   - Providers serving individuals with intellectual or developmental disabilities (I/DD)

- 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 center, crisis respite or crisis stabilization units
- Natural community supports (e.g., places of worship, recreation centers, Alcoholics Anonymous)

All referrals provided shall be documented in the individual's electronic record.

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 in order to support connection to ongoing care. Appointments should attempt to be scheduled within 7 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.
  - Back-up provider referral if needed.

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

7. *Maintaining Relationships with Community Partners*

MCR providers work cooperatively with their ASO and RAE 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, detoxification providers, other crisis service providers and specialty facilities such as Psychiatric Residential Treatment Facilities and Qualified Residential Treatment Programs.

8. *Secure Transportation*

MCR teams shall provide or coordinate clinically appropriate and accessible transportation between levels of care throughout the crisis episode. MCR providers must provide transport only if they are a Secure Transport Vendor and are appropriately licensed to provide secure transport. MCR providers that are not a licensed Secure Transport Vendor will have a MOU with a Secure Transport Vendor in their regions that outlines the roles and responsibilities of

each party. Secure Transportation Vendors may include emergency medical responders and the MCR provider must provide BHA with a copy of each MOU on an annual basis.

Provider/Agency Requirements

MCR providers must meet state licensure requirements, complete required training, and pass an initial readiness review by the BHA prior to providing mobile crisis response services. BHA and HCPF are in the process of finalizing the provider/agency requirements.

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 mobile crisis response. An initial mobile crisis response shall be a paired response from two members of the MCR team. Follow-up visits to continue stabilization efforts, coordinate care and make referrals can be performed by a single member of the MCR team.

   MCR providers may request an exception to the in-person paired response. If an exception is granted, one individual must provide the initial response on-site and the other team member must participate using telehealth (visual and audio).

2. *Team Members*

   The following professionals and paraprofessionals may be included on a MCR team:

   - 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..
   - 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 Technician (EMT)/Community Paramedic.
   - Adult or transition age youth peer support specialist or family advocate
   - Mobile crisis case manager.
   - Other trained crisis response staff member, as identified by the contract.

3. *Roles of Select Team Members*

   Every MCR team must include a behavioral health clinician licensed by the State of Colorado ("licensed clinician") or must have a licensed clinician immediately available by phone or telehealth. The role of the licensed clinician on the MCR team is to provide oversight and clinician supervision to the MCR team. 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 a 72 hour-hold (M-1 process) for an individual who is deemed to be an imminent danger to others or to himself or herself or meets criteria for grave disability.
- Conduct any necessary physical health examinations or tests within the scope of their practice.
- Provide supervision on a regular basis to MCR team members.

Each MCR team shall have access to a peer support specialist (a trained and paid individual or family member with lived experience) who can often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis. Peer support specialists can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of behavioral health professionals but instead should establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis. They may also engage with the caregiver of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support. Peers should not serve an administrative function.

Each MCR team is required to have a staff member that has specific competencies in serving youth and caregivers who experience crisis. As indicated below, these staff should be trained and have experience in responding to youth and caregivers in crisis.

MCR teams may utilize Emergency Medical Technician- Paramedics with a Community Paramedic Endorsement (EMT P-CP) in alignment with a Community Integrated Health Care Service (CIHCS) agency that is working with the MCR team.

4. *Training Requirements*

Each MCR provider shall have all members of the team participate in required training. The MCR provider shall ensure that all staff complete their training requirements within the timeframes established by HCPF or their designee. MCR team members must complete annual trainings and shall receive documentation regarding their compliance with these training requirements from BHA or their designee. Required training must cover the following topics, but training is not limited to:

- Trauma-informed Care
- Cultural Awareness and Responsiveness
- Evidence-based and Promising Practices in Crisis Intervention, including De-escalation Strategies and Harm Reduction
- Child, Adolescent and Family Crisis Interventions
- Crisis Plan Development and Use of Advanced Directives
- Suicide Screening, Risk Assessment and Safety Planning

- Mental Health Conditions (including SMI, SED)
- Substance Use Disorders
- Harm Reduction Strategies and Use of Naloxone and Other Supplies to Address Overdoses
- Co-occurring Disorders
- Intellectual and Developmental Disabilities
- Traumatic Brain Injuries
- Dementia
- Deaf, Hard of Hearing, and Deaf/Blind
- Screening and Risk Assessment
- Psychiatric Medications and Side Effects
- Non-violent Crisis Intervention
- Gender-responsive Services
- 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 modalities may include in-person or virtual training sessions and refresher training sessions.

Standards

24/7/365 Availability

MCR services are available through a regional network of mobile crisis providers to ensure 24/7/365 availability. Based on the demand for MCR services, the ASO must determine the number of mobile crisis teams needed to ensure 24/7/365 coverage by region and sub-region, as applicable.

1. *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. If the ASO contracts with providers to support inter-regional coverage across rural and frontier areas, BHA may approve longer response times.

2. *Place of Service*

   Mobile crisis response services should occur in the individual's or caregiver's home or an appropriate alternative community setting. For instance, MCR teams may respond to crises in non-hospital or other facility settings, including homes, workplaces, schools, libraries, group homes, assisted living facilities, outpatient hospitals, outpatient medical providers' offices or clinics, community correctional facilities, and health centers or clinics that do not offer behavioral health crisis services.

   MCR teams may **not** respond to crises in the following settings:

- Inpatient Hospital,
- Inpatient Psychiatric Hospitals,
- Emergency Departments
- Psychiatric Residential Treatment Facilities (PRTFs),
- Inpatient Alcohol and Drug Rehabilitation Centers,
- Nursing Homes,
- Prisons,
- Jails, unless part of a diversion effort, and
- In settings that offer crisis services, such as Certified Community Behavioral Health Clinics (CBHCs) or comprehensive behavioral health providers.

Use of Telehealth and Other Technology

Telehealth may be leveraged in certain instances such as connecting with clinicians capable of performing an assessment of the crisis situation and additional de-escalation strategies or immediate actions needing to be considered by the MCR on-site team members. Telehealth for the initial response may only be provided when there is one member of the MCR team in-person and the MCR provider requests and received permission from their ASO to provide telehealth. Telehealth may also be used for M1 psychiatric holds so an onsite responder may transport an individual to detox 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 detox. In addition, telehealth may be used to secure expertise for individuals served by the MCR team who have an I/DD or who may need ASL or other translation services. 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 or their designee.

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 are deaf, hard of hearing, or deaf-blind, such as Communication Access Realtime Translation (CART) services, closed captioning, videophone, amplified and captioned phones, smartphones and tablets, and other Augmentative and Alternative Communication devices.