Mobile Crisis Intervention

Service Model Presentation

January 11, 2024

MaineCare

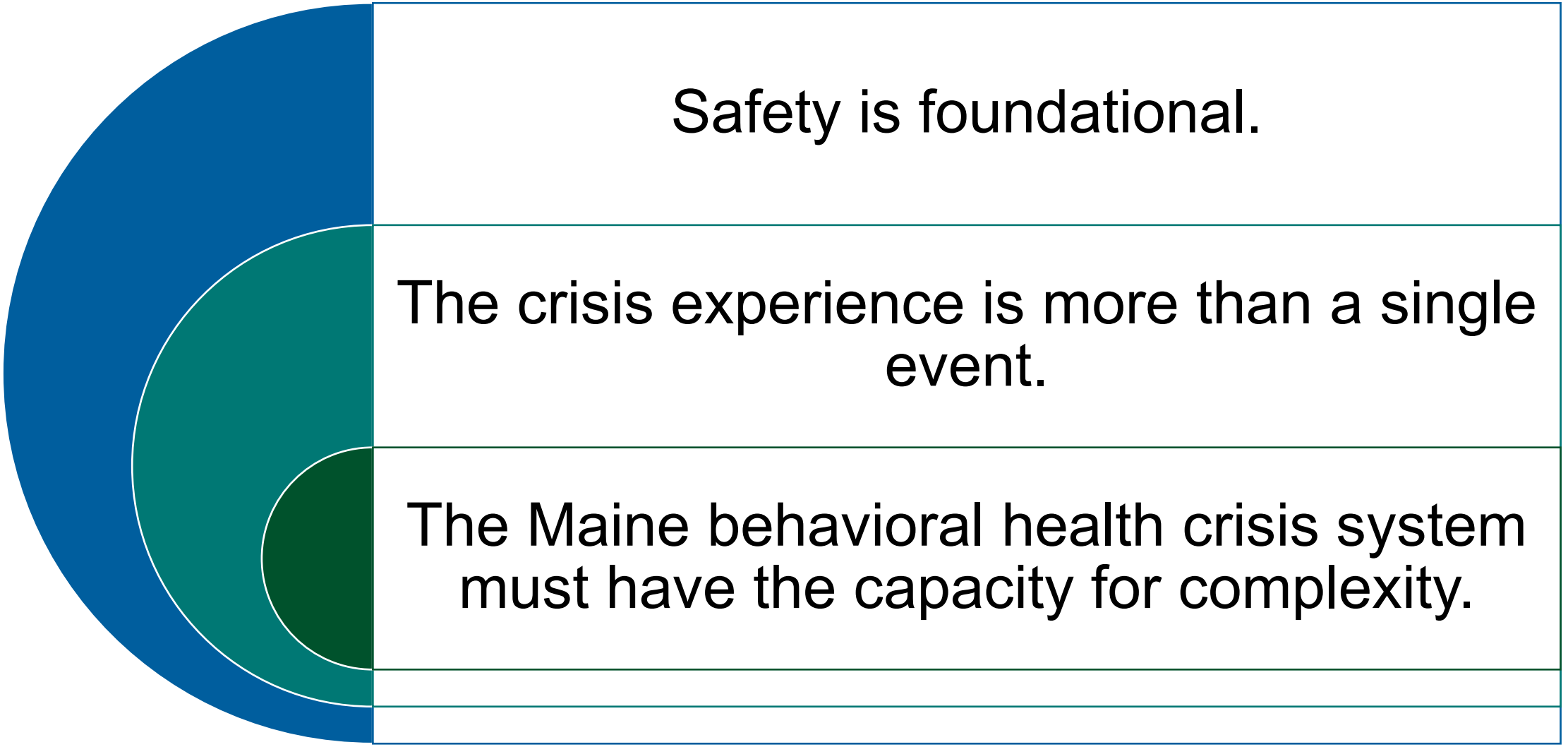
Crisis System Reform Efforts

Maine Crisis System

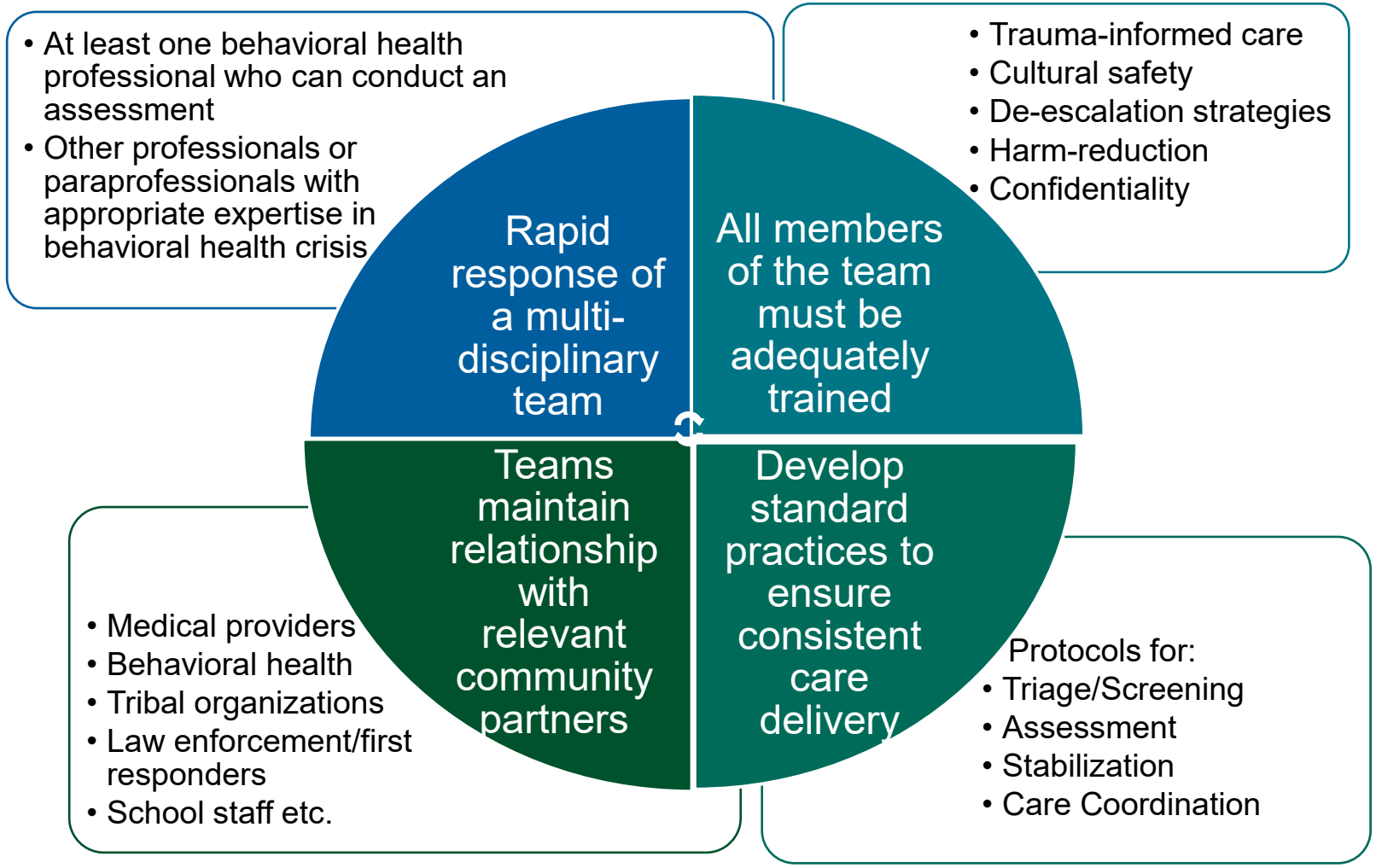
Mission:

To ensure immediate equitable access to welcoming, hopeful, trauma-informed, recovery-oriented behavioral health crisis services in the most supportive, least restrictive setting. Ensure every person gets the right response every time prioritizing safety and promoting future well-being.

Guiding Principles



Background of new "Mobile Crisis Intervention Response Services"



Eligibility for new “Mobile Crisis Intervention Response Services”

Provider Eligibility:

Federal authority allows for DHHS to waive “any willing and qualified provider” requirements for this service through a State Plan Amendment. DHHS proposes for these services to be eligible only to competitively selected OBH/OCFS contracted crisis providers to ensure all Maine people may be served by regional providers regardless of insurance status.

Note: DHHS is retaining Crisis Resolution services for crisis response outside of the mobile teams.

Member Eligibility:

Only after the individual is stabilized, is the provider is responsible for verifying a member's eligibility for MaineCare.

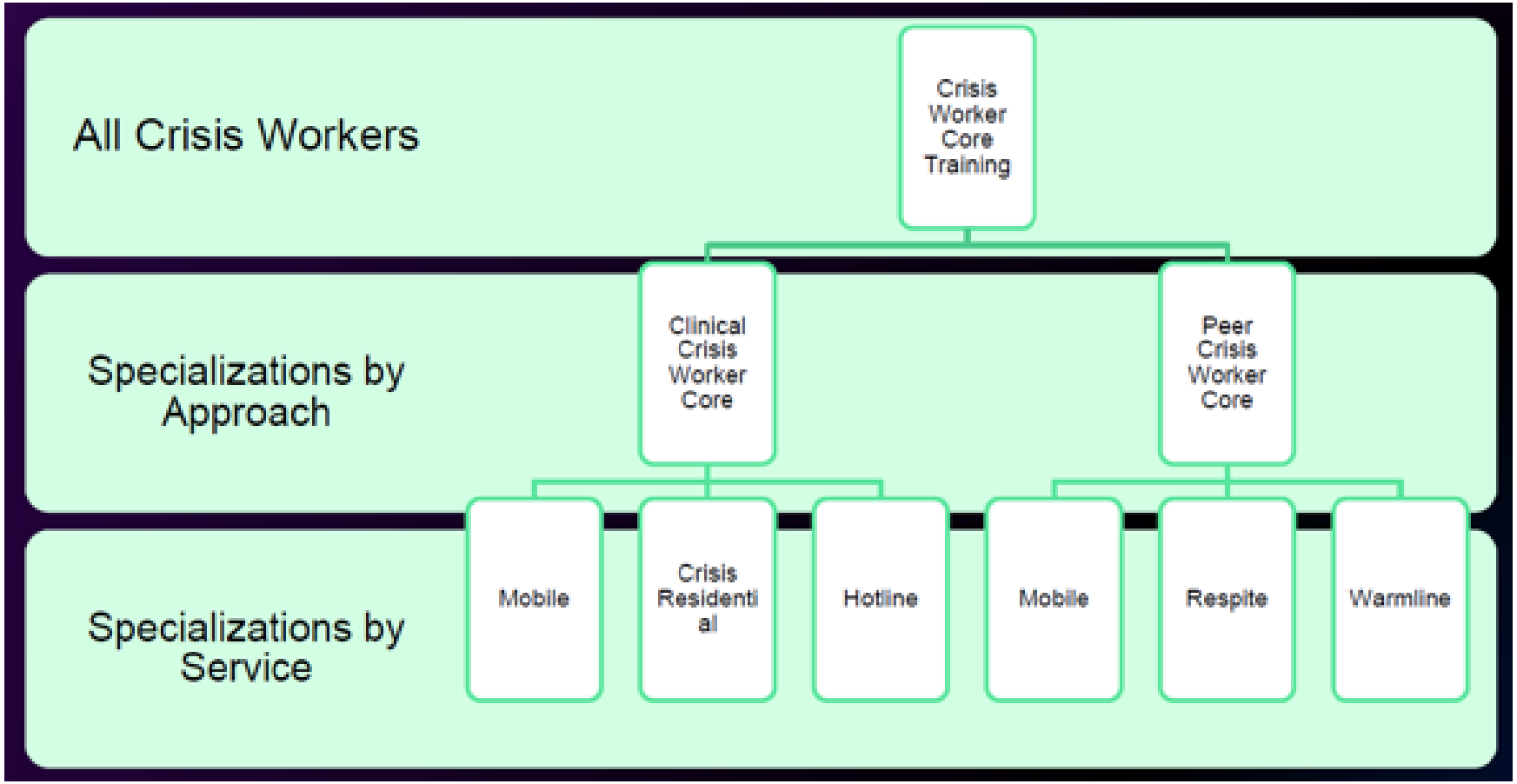
This service will respond to both mental health and substance use crises and does not require a formal diagnosis.

Provider Requirements:

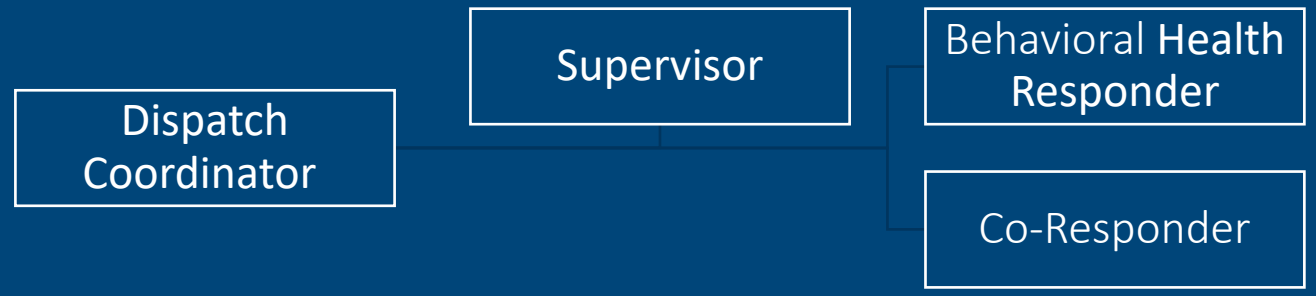
- Maintain a current and valid license for the provision of emergency mental health services issued by the Division of Licensing and Certification.
- Be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year.
- Provide trauma-informed responses to all people with unconditional positive regard and cultural humility.
- For children this includes ensuring frameworks, programs, and staff training are consistent with the principles of Positive Youth Development.
- Ensure that all staff are trained to recognize the signs and symptoms of overdose and administer Naloxone.
- Initiate and maintain relationships with a range of relevant community partners to support referrals and care coordination.

Department Approved Crisis Responder Training

Proposed Comprehensive Tiered Training - Jess Stohlmann-Rainey



Mobile Crisis Intervention Response services must be furnished by a multidisciplinary team.



Initial Encounter Follow Up

Engagement

Developing a therapeutic relationship with individuals in crisis within the context of family, culture, and community.

When clinically-indicated during a follow-up encounter, the service may end with this component.

De-Escalation

Steps to decrease the emotional, behavioral, and mental intensity of a situation to ensure autonomy, personal choice, and self-directed care whenever possible.

Crisis teams shall practice with a specific goal of diversion criminal justice and hospital systems.

Assessment & Planning

Immediate initiation of information gathering from available sources. Focus on addressing most acute issues helping the individual identify a strategy to respond.

Conducting a medical screening/clearance when appropriate.

Engage supports for near-term and building a solid follow-up plan.

Intervention

May include: Therapeutic screening including explicit screening for suicidality.

Safety planning including lethal means as required.

Transporting the member to receive additional care.

Aftercare

In-home crisis-related supports and/or care coordination following an acute crisis event post discharge from a more restrictive care environment, or as a preventative measure until the individual is successfully connected to routine community-based services.

Providing the member with the opportunity to ask questions, clarify, or correct information about their care.

National Best Practice Performance Measures

	Value	Meaning	Examples
A	*Accessible/ Affordable*	I am welcomed wherever I go. I am not turned away.	• Percentage of help-seekers who receive appropriate care vs. all who have sought care. • Percentage of persons seeking care who are turned away due to lack of coverage vs declined due to not being able to afford care.
C	*Collaborative*	Helpers work in partnership with me, my family, my caregivers, and other responders.	• The programs assess consumer/family satisfaction surveys and/or net promoter scores.
C	*Comprehensive*	I get help for all my issues that are part of the crisis.	• Access to medical screening. • Able to treat co-occurring substance use disorder (SUD), intellectual/developmental disorder (I/DD), etc.
E	*Equitable*	The quality of services I receive are not affected by my race, ethnicity, gender, sexual orientation, etc.	• Stratify outcome metrics (e.g., return to crisis centers, access to care) by race/ethnicity and other key demographics (e.g., ZIP code). What percentage of poor outcomes are disproportionately influenced by performance in underrepresented populations?
S	*Safe*	My experience of help is safe and not harmful. I am never traumatized by asking for help.	• What percentage of individuals presenting in crisis end up injured, hurt or killed while doing so?
S	*Successful*	The care I receive meets my needs.	• Readmission rates. • Symptom reduction.
T	*Timely*	I get help quickly enough to meet my needs.	• Time to intervention (e.g., call answer times, mobile dispatch times, facility door-to-doctor times). • Abandonment rate (e.g., call abandonment, left without being seen, etc.). • Lag time between seeking care and receiving care.
O	*Ongoing*	I receive help to move from my crisis situation to ongoing support that wrap around me to help me thrive.	• Successful linkage to continuing care at adequate intensity: 3-, 7-, 30-, 60-, 90-day follow up.
H	*Hopeful*	I am helped to feel more hopeful, and I make better decisions as a result.	• Decrease in suicide, violence, self-harm. • Personal Outcome Measures (POMS).
E	*Engaging*	I am treated as a valuable customer, with respect and dignity.	• Complaints, adverse incidents, escalation.
L	*Least Intrusive*	I receive help in a place that is designed to meet my needs.	• Avoidance of inappropriate emergency department use or arrest diversion, voluntary conversion.
P	*Publicized*	I know who to call and/or where to go.	• Information about call lines and walk in centers, increased use of 988 vs. 911.

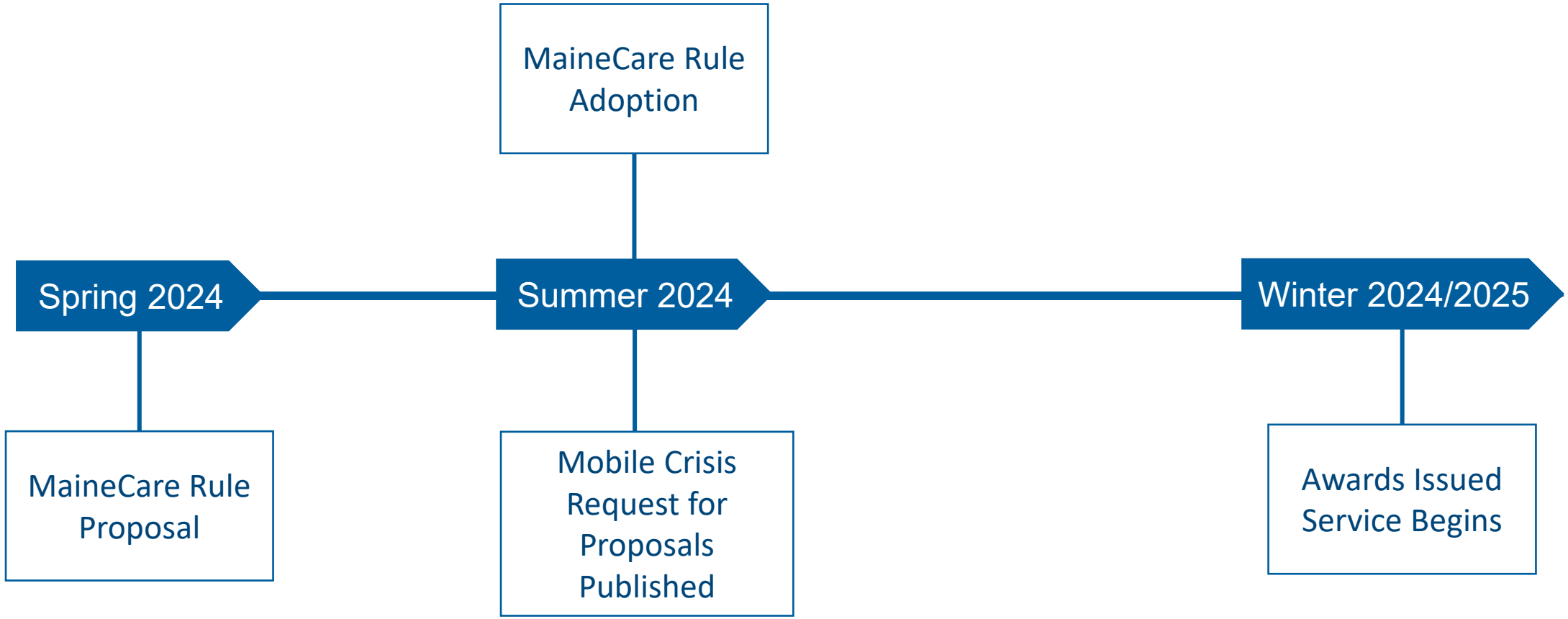
Potential Mobile Crisis Performance Measures

Proposed Performance Measure	Exceptions for Inclusion	What is this measuring?	What does it incentivize?
Response rate The number of referrals accepted by mobile crisis that did not result in the following interactions: -Wellness checks -Community education -Crisis intervention (in-person/telehealth) -Drop-in interaction at agency or other setting	Not accepted referrals (e.g., OADS Crisis Known CPS case)	The number of people seeking care that did not receive support by mobile crisis: including the count of people who did not receive care, had a documented refusal, or were referred to 911, ED, or law enforcement	Greater focus on response to all referrals More face-face community-based interactions Adequate staffing to meet the need Misrepresentation of abandoned referrals by mobile crisis entity
Linkage to Supports Successful linkage to community-based support within 60 days of initial resolution	People who refused care People who were transferred to a higher intensity service	Amount of time to connect a person to community-based healthcare services (if needed) Pull claims and/or administrative data of connected community-based healthcare services (Medicaid covered) This measure would not include anyone that needed a higher acuity of care based on assessment	Crisis stabilization services and warm handoffs to care
Timeliness to Response Time from mobile crisis referral accepted to documented face-face intervention (as defined by mobile crisis policy) with person/family		Length of time between when someone reaches out for help and when they are seen by mobile crisis	Shorten time between initial outreach and primary response Adequate staffing to meet the need This does not include referrals to service or wellness checks

Value-Based Payment

- Once rule is adopted, measures are finalized, and benchmarks are established:
  - 4% of encounter rate withheld to ensure providers meet “minimum standards” on select performance metrics.
  - An additional bonus payment (est. 1% of encounter rate) for providers that meet “excellence” benchmark(s), subject to appropriation.
- Expected to “kick-in’ no sooner that 6 months after service begins.
- DHHS will look to national standards and in-state experience to set benchmarks.
- Providers will receive ample notice and regular performance reports on selected metrics.

Proposed Timeline



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