Building a Crisis System of Care in Idaho

November 12, 2019

Special Thanks and Contributions

Beacon Health Options (Beacon) is excited to present the following report, "Building a Crisis System of Care in Idaho" to the Idaho Department of Health and Welfare, Division of Behavioral Health. It has been our great honor to work with the Division as you engage in a monumental effort to transform the crisis system. We applaud you on your foresight to commission this project, your courage to look to innovative designs, and your tenacity to implement a community-informed crisis system of care that is recovery focused, person centered, preventative, and available to all Idahoans.

Specifically, we would like to thank the Division of Behavioral Health project sponsors and managers: Ross Edmunds, Director; Candace Falsetti, Quality Assurance Program Manager; and Shane Duty, Quality Assurance Program Supervisor. Each person offered a clear vision, charge, and passion towards the project and, more importantly, for discovering the solution to meet the needs of those Idahoans utilizing crisis services. We would also like to thank the Division of Behavioral Health Program Managers who eagerly engaged with our team to work within their respective regions to gather community stakeholder participation. With your help, we were able to successfully capture the communities' innovations in crisis care, needs, and opportunities to ultimately co-create real-time recommendations to enhance communities' responses to those in crisis.

Similarly, we are grateful to the Idaho Federation of Families for Children's Mental Health for their help in identification of parents/caregivers to ensure the voice of persons with lived experience was heard in every regional conversation. This participation, which added a deeply personal element, also emphasized the urgency in transforming the system.

Finally, to all those who participated in this project via focus group participation, tours, and/or individual conversations, we thank you. Your insights have been invaluable and will truly assist the Division in moving forward with a system of care that is impactful for all Idahoans.

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Introduction

Idaho's health care delivery system continues to transform as Idahoans push for ongoing investments, innovations, and collaboration to better serve the health needs of the population. Pivotal system changes affecting both youth and adults in Idaho are driving this transformation. These changes include Medicaid expansion, the Jeff D. settlement agreement, and subsequent implementation of the Youth Empowerment Services (YES) Project, reprocurement of the behavioral health management contract, adopting national parity standards, and the expansion of evidence-based behavioral health practices.

The demand for comprehensive crisis systems seen in Idaho is also center stage nationally. Driving factors and influences include the opioid epidemic, increasing rates of suicide, stigma that continues to be associated with seeking behavioral health care, and ultimately access challenges to evidence-based care when the need for behavioral health is identified. Increasingly, law enforcement, first responders, and emergency departments are also joining in discussions of crisis and demanding alternative care pathways be found as the rate and time associated with crisis response is outpacing the availability of resources required.

With these converging influences, Idaho's Division of Behavioral Health (DBH) has rightly recognized this as an opportunity to purposefully take a step back and evaluate current system design and outcomes to help inform a forward-looking vision supported by design. There is commitment to drive a recovery-focused, whole-person approach to behavioral health care and, specifically, the crisis system delivery.

Recognizing the critical role a strong crisis response system plays in the overall health of any community, DBH is seeking strategic clarity on the optimal design and financing models available to support such a system. DBH's acknowledgment of under-developed crisis prevention, early intervention, and post-crisis recovery and reintegration services has led the agency to contract with Beacon Health Options (Beacon) to conduct a comprehensive crisis system assessment. The goal of the engagement is to identify region-specific current practices including needs, gaps, and opportunities along with national best practices to ultimately create a comprehensive statewide report of findings, inclusive of recommendations aimed to advance standardization in crisis delivery and experience while balancing flexibility needed to support geographic and cultural considerations.

Through meetings with stakeholders, providers, advocates, and DBH, it was clear that Idaho envisions a crisis system guided by standards that ensure each crisis intervention is delivered in a manner that is consistent with principles of recovery and resilience. Further, it is essential that the crisis system replaces the existing incomplete, and often ineffective, cyclical approach to a crisis with a system of crisis care that is person-centered, available to all citizens, strengths-based, and reduces the likelihood of future emergencies.

Although there are numerous examples of promising practices, there is an acknowledgment that Idaho does not have a comprehensive statewide crisis system of care today—the investment that Idaho is making to bring greater standardization to crisis response is a new and exciting endeavor.

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Identifying Best Practices through a National Lens

In a SAMHSA review, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, the authors noted the effectiveness of 24/7 crisis hotlines. 24/7 hotlines serve as the backbone in the most efficient of crisis systems. "A rigorous study of crisis hotline outcomes was reported in two parts—one devoted to non-suicidal callers and one to suicidal callers. These investigators studied 240 counselors who worked at telephone crisis services across the United States. Among non-suicidal callers, distress was significantly reduced from the beginning to the end of the call, and there was a significant reduction in callers' distress levels from the end of the call to follow up. Among suicidal callers, there was a significant reduction in suicide status from the beginning to the end of the call on intent to die, hopelessness, and psychological pain. There were also significant reductions in callers' psychological pain and hopelessness from the end of the call to follow up."[1]

Additionally, the National Association of State Mental Health Program Directors has conducted several assessments related to crisis services. One such assessment, *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*, identifies the essentials of a crisis system. These include regional or statewide crisis call centers, centrally deployed mobile crisis services available 24/7, and residential crisis stabilization programs. The authors of the assessment noted that effective call centers "incorporate readily accessible crisis call centers that are equipped to efficiently connect individuals in a mental health crisis to needed care. These programs use technology for real-time coordination across the system of care and leverage big data for performance improvement and accountability across systems every minute of every day."[2]

As identified in both these reports, most communities have historically relied on hospital emergency departments to care for those individuals experiencing a psychiatric or substance use crisis. According to the Agency for Healthcare Research and Quality, approximately one in eight emergency room visits involves a behavioral health issue.[3] Many times, these settings lack the expertise and resources to effectively address a member's needs. Additionally, individuals who are seen in the ED during a behavioral health crisis are more likely to be placed in an inpatient setting instead of being treated through effective diversionary care options in the community. In many states and communities, there is growing adoption of more effective crisis response services; services that stabilize and improve psychological symptoms of distress, and engage community members in the most appropriate and least restrictive course of treatment.

Effective crisis care has proven itself an effective strategy for suicide prevention, a national issue affecting more than 47,000 people every year according to the CDC's National Center for Health Statistics (NCHS).[4] A more robust crisis response system can reduce the overutilization of psychiatric

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[1] https://store.samhsa.gov/system/files/sma14-4848.pdf
[2] nasmhpd.org/sites/default/files/TACPaper5_ComprehensiveCrisisSystem_508C.pdf
[3] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf
[4] https://www.cdc.gov/nchs/products/databriefs/db241.htm

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beds or emergency departments and the overreliance on emergency responders, creating significant cost savings while increasing positive outcomes and improving the quality of care for members.[5]

Building on the Crisis System of Care Model and modeled after systemic reforms in states like California, Colorado, Georgia, and Washington, a best-in-class crisis model emerges. What follows are eight essential core system components that ensure an individual experiencing any behavioral health crisis will be able to access appropriate services for prevention, resolution, and recovery/ reintegration. These elements are:

1. **1-800 "Front Door":** 24/7 hotline able to provide phone-based crisis de-escalation and resolution: screening, initial assessment, triage, information and referral services; **front entry** into the crisis system, affording real-time monitoring, tracking and disposition of anyone touching the crisis system. Accommodation registries or proactive crisis plans can be housed within the 24/7 system for person centered care intervention.
2. **Mobile Crisis Units: Adult and child specialty teams, inclusive of peers,** who intervene **within the community**, facilitate crisis resolution, utilizing de-escalation techniques, and administer pre-screening assessments. Mobile teams provide an opportunity to **triage** and **coordinate** crisis follow-up care, including education and support to families
3. **Community-Based Locations: Crisis walk-in capability and law enforcement drop off** locations focused on providing crisis intervention outside of the ED. Community-based locations **stabilize** and **connect** individuals with sources of **ongoing** support and services.
4. **Integrated SUD/Medication-Assisted Treatment (MAT) Solutions: Engage, partner** with, and **train** key community stakeholders on effective ways to **identify** and **interact** with individuals in crisis with standalone addiction or concurrent needs; i**ntegrate** processes to ensure that access to addiction treatment is readily available within the crisis response system, including follow-up, that is **comprehensive** and **consistent,** and provide referrals when needed.
5. **23-Hour Receiving Centers or Peer Living Rooms:** Small, diversionary options that offer a **less restrictive**, more **recovery-focused** approach for people in acute crisis but do not require hospital care. For individuals with SUD/OUD needs, short-term sobriety support may be a secondary gain of a 23-hour center.
6. **Providers for all levels of care; Availability of Urgent Access:** An **array** of services that facilitate needed **throughput** to individuals in crisis. Levels of care vary in relation to an individual's **acuity** level, **support system**, and **immediate needs**.
7. **Crisis Collaborative:** Law enforcement, local community organizations, faith-based organizations, and other local stakeholders **working together** to develop and provide **integrated**, community-based intervention, care plans, and services that are comprehensive, culturally competent, strengths-based, and family-centered.
8. **System Management and Oversight:** Unifying organization serving several functions: **technology infrastructure** that facilitates access to needed services tracking availability of service availability, high risk member management, coordination throughout treatment episodes, provider contracting, network oversight; promotion of system wide data sharing and measurement of outcomes.

[5] https://theactionalliance.org/sites/default/files/crisisnow.pdf

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Crisis Systems of Care Framework

In meeting with state and local stakeholders, the consulting team used the Crisis System of Care framework as a tool to contextualize the conversation, and as a reference as groups considered the strengths, limitations, and gaps in how mental health and substance use-related crises are managed in Idaho today as well as opportunities for a redesign. The use of the framework is briefly described later in this section.

A Systemic Approach in Crisis Service Delivery—an Emerging, but Underdeveloped, Modality

Behavioral health crises come in many forms, and most do not fit neatly into a categorical service box. Comprehensive community-based crisis prevention, early intervention, and crisis services are not considered an Essential Health Benefit nor a required service under Medicaid. Payment for crisis services, when not delivered in an emergency department, generally comes from an insufficient mix of federal, state, and local dollars. If not intentional in design, crisis services can fall in the chasm between managed behavioral health services (e.g., outpatient treatment, ACT) and traditional medical benefits (e.g., emergency department visit, inpatient hospitalization), leaving little financial incentive for behavioral health systems to shift the location of crisis service delivery. Commercial payors often have a gap in benefit design between outpatient therapy and medication management and inpatient and residential care that contributes to high use of emergency department evaluations and inpatient hospitalization. Any dependency on these hospital services is particularly problematic in states like Idaho, where transporting individuals to emergency departments/inpatient units might require hours of travel.

The management and treatment of mental health and substance use-related crises is a complex, systems-level, public-health need, and necessitates a commensurate response. These challenges set crisis services apart from other types of behavioral health services. No single entity or system owns full responsibility for managing crises. A single entity or system is not, on its own, sufficiently leveraged to address the multi-factored complexities necessary to operate a healthy and effective crisis system of care. While some individuals seen by the crisis systems do have serious and persistent mental illness and/or substance use conditions that are at the crux of the crisis, many crises are more specifically related to or exacerbated by:

Crisis Systems of Care work is necessarily systemic—there is no getting around this. Individuals representing all populations and all insurance payor types will experience crises. The need is not limited to individuals with severe and persistent mental illness—any individual could experience a crisis given the right set of circumstances. For many individuals seen by crisis teams, it is their first contact with the mental health system.

- Trauma (including exposure to home and community violence)
- Unstable housing/homelessness
- Struggling in school
- Stressed households
- Poverty
- Job disruption
- Unmet primary health care needs
- Lack of community support
- Social isolation

Many individuals (as many as 30-50 percent, and varying by locale) served by crisis systems are previously unknown to the system or are not actively receiving treatment at the time they present for services.

Crisis systems are incredibly complex and idiosyncratic—no two are alike. There are numerous components and practices within any crisis system—some reflective of long-standing and even default habits and patterns of care that pre-date the build-out of community behavioral health systems.

Building a Crisis System of Care

Effective crisis systems of care do not naturally exist. They are built. Absent a built system; there is a heavy reliance on default, safety net services, namely 911, law enforcement, emergency departments, involuntary treatment processes, inpatient psychiatric beds, and jails/detention—and these approaches come with tremendous implications to a person's whole health and well-being. Unless purposely arranged, crisis systems do not operate in a coordinated and systematized fashion. An organizing framework gives a community a visual structure in which to map what currently exists and to strategically enhance, strengthen, and add new elements.

There are commonalities among exemplar crisis systems, and these elements are incorporated into the Crisis System of Care framework. The framework offers 10 points of opportunity for building depth and breadth into a Crisis System of Care. There are five crisis phase opportunities for community development and investment:

1. Crisis Prevention
2. Early Intervention
3. Acute Crisis
4. Crisis Treatment
5. Recovery/Reintegration

In addition, there are five crisis system key components:

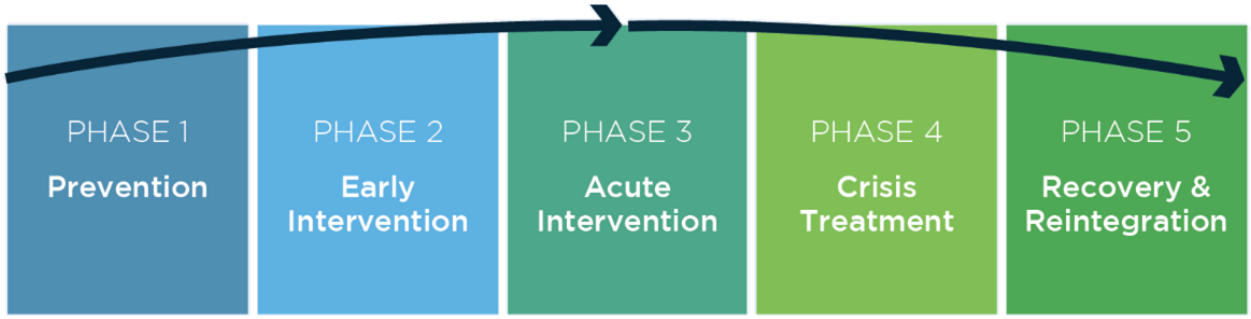
1. Lived experience
2. Players
3. Logistics
4. Competencies
5. Parts

As shown in the graphic on the following page, these 10 points need to operate in a synergistic fashion to produce optimum results.

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 the 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 the development of local solutions**
7. **Reduce the use of coercive interventions**
8. **Reduce civil and criminal court involvement**
9. **Reduce the 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 of Care Model



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

Source: Kappy Madenwald, Madenwald Consulting; Steve Day, Technical Assistance Collaborative

The framework was developed iteratively by watching crisis systems across the country to see how they operate. The highest performing systems, regardless of scale, overall costs, or service specifics, attend to all, or nearly all, of the 10 points of opportunity.

In under-developed crisis systems, it is common to find that most of the crisis system response involves acute, and often involuntary or otherwise coercive, intervention strategies (including heavy use of 911, law enforcement, and hospital emergency departments). Even when purposeful development has occurred, it is most common to find that a state or community is making significant investments in Phase 3 (e.g., mobile crisis units, walk-in acute crisis centers, involuntary evaluations) and Phase 4 (e.g., inpatient hospitalization and crisis stabilization units). While Phases 3 and 4 are advancing, it is also common to have minimal investment in "upstream" crisis prevention and early intervention, and "down-stream" crisis recovery and reintegration services. This is in part because the opportunity within Phases 1, 2, and 5 rests largely with primary outpatient treatment providers and other service systems rather than with specialized crisis services teams. On the whole, primary outpatient treatment providers are less likely to be invited to participate in crisis system of care initiatives and less likely to view themselves as essential players in the crisis system.

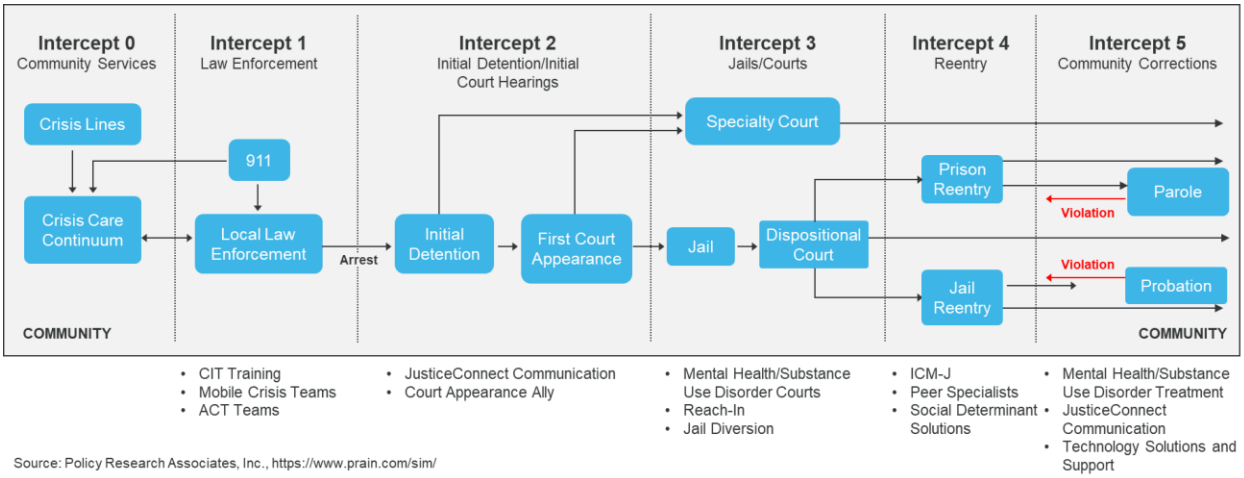
Of the five key components in the framework, it is common to find that states or communities narrowly invest in programmatic "parts" (e.g., mobile crisis teams, crisis stabilization units). Even more common, these investments are not aligned with a commensurate investment in the logistics, essential competencies, player partnerships, and infusion of lived experience. Investments in these four enablers are required to ensure that the "parts" perform as intended and deliver services that are well-received by the individuals who use them.

Comparator Models

As Idaho envisions how the Crisis System of Care framework might be beneficial, it may be useful to consider and borrow from some other models developed to manage complex cross-sector work:

- **Public Health Model:** Public health initiatives are organized, multi-faceted, multi-system-involved, and attended to varying stages, including prevention and harm reduction. Public health is defined as "the art and science of preventing disease, prolonging life, and promoting health through the organized efforts of society.[6]
- **Disaster Management:** Modern-day disaster management harnesses the capabilities of federal, state, and local governments, volunteer organizations (including, but not limited to American Red Cross), and the private sector to minimize the impact of disasters on the American public. Much work is done to prepare for disaster response so that when an incident occurs, roles of each of the varying players are clear and each can activate rapidly. The four phases of disaster management are mitigation, preparedness, response, and recovery. (FEMA.gov)
- **Sequential Intercept Model:** In 2006, Mark Munitz, MD, and Patricia Griffin, Ph.D., first published an article on the Sequential Intercept Model for reducing the number of individuals with mental health and substance use conditions who end up in the criminal justice system with an emphasis on the use of early "intercepts." This model has produced rather extraordinary results. In the intervening years, this model has propelled many states forward on the formation of partnerships between law enforcement agencies, behavioral health crisis systems of care, and the behavioral health system at large. For example, while the Memphis Model of law enforcement, CIT (Crisis Intervention Team), was developed in 1988, it was helped along greatly by sequential intercept model advancements,with CIT used as very effective Intercept 1 strategy. CIT is now practiced in 2,700 jurisdictions across the country. It is important to note that Intercept Zero was not part of the initial model, but is best understood as non-police involved, community-based crisis service array, including, but not limited to, mobile crisis response.

The Sequential Intercept Model



[6] https://www.cdc.gov/publichealth101/public-health.html#anchor_available_materials

It is important to note the necessary commonalities between these three models (i.e., Public Health, Disaster Management, and Sequential Intercept) and the Crisis Systems of Care Framework. All four models:

- Require cross-sector partnerships
- Maintain both a macro and micro focus
- Build strategies for multiple stages of intervention (with emphasis on intervention upstream prevention/harm mitigation)
- Rely on strong logistical capability
- Built to address the public health nature of the problem being addressed—these are not payor-specific situations
- Employ wide-ranging competency development across multiple sectors

Part of what makes crisis systems development so complex is that these very factors are not nearly as necessary in the delivery of other behavioral health treatment services—it is an anomaly, and programs at state, local, and agency level are not historically set up to manage this type of model.

Methodology used in Idaho Evaluation

To obtain a robust, 360-degree view of the current Idaho system of care, Beacon engaged strategic stakeholders, including those with lived experience. These stakeholders included: parents/caregivers of persons who have used crisis services, providers of crisis care, mental health professionals, first responders, hospital representatives, advocates, law enforcement, payors of behavioral health services, regional DBH staff, and staff within the Idaho Division of Health and Welfare. Recognizing that a single, statewide system of care does not exist in Idaho, a methodology was developed to make observations of crisis care in each of the seven geographic regions and gather feedback regarding crisis care needs, gaps, promising practices, and opportunities to improve the system of care within communities across the state. The process for the creation of the method of engagement follows.

DBH Planning Meetings

Beacon held a series of meetings with DBH sponsors, HUB Administrators, and DBH Regional Program Managers. These planning meetings allowed for the identification and review of available data and reports. Additionally, through these planning meetings, the engagement and vision for comprehensive crisis systems were created, and a methodology was developed to gather feedback from stakeholders regarding the current system of care and desired future state of care.

Regional Visits/Tours/Listening Session
As previously noted, to obtain a comprehensive view of the current state of crisis care across Idaho's diverse communities and to gather community recommendations in which to build a robust crisis system of care, the consulting team collaborated with DBH Program Managers to establish community focus groups in each of the seven regions. Deliberate efforts were made to ensure community representation from all stakeholders (of both children and adult) of the crisis system of care. Each focus group was attended by between 20-30 stakeholders including parents of children who have used the crisis system, law enforcement, advocates, mental health providers, first responders, judicial system representatives, and emergency room/hospital representatives (see **Appendix A** for Focus Group Agenda). Community focus groups were two hours in length and posed the following in questions to attendees:

- How do those in crisis experience crisis response in the community?
- How do their families experience it?
- For whom does the crisis system work best?
- For whom is it least productive?
- What is the crisis system experience like for treatment providers when an individual from their clinic is in crisis?
- What is working well that you do not want to see disrupted?
- What is most frustrating?

In addition to the community focus groups, Beacon collaborated with Regional Program Managers to host focus groups for the regional DBH staff. Each DBH staff focus group was one hour in length, and the same questions were posed as those for the community focus group.

In total, more than 250 stakeholders and DBH staff provided valuable feedback, insights, and recommendations for system improvements throughout the 17 Community and Regional DBH Staff Focus Groups.

Idaho Community and Regional DBH Focus Groups

Region	Location	Date	Focus Group
1	Coeur d'Alene, ID	June 27, 2019	Regional DBH Team focus group Focus group #1 Focus group #2
2	Lewiston, ID	June 20, 2019	Regional DBH Staff Focus group Community focus group
3	Caldwell, ID	June 26, 2019	Regional DBH staff Community Focus Group
4	Boise, ID	June 18, 2019	DBH team focus group Community Focus Group #1 Focus Group #2
5	Twin Falls, ID	June 17, 2019	DBH team focus group Community Focus group
6	Pocatello, ID	June 24, 2019	Regional DBH Staff focus group Community Focus group

Idaho Community and Regional DBH Focus Groups

7	Idaho Falls, ID	June 25, 2019	Community Stake Holder Meeting Meeting with Region 7 Staff 2nd Stake Holder Meeting

Crisis Center Tour and Interviews

The crisis centers are valuable components of the current crisis response in many Idaho communities. As such, the consultant team met with crisis center leadership to take a tour and to gather information on operations, utilization trends, and the unique role the centers play in the communities' crisis response. In addition, regional crisis center leadership attended all of the community focus groups.

Crisis Center Tours/Interviews

Region	Location	Date	Crisis Center
2	Lewiston, ID	June 20, 2019	Crisis Center Network
3	Caldwell, ID	June 26, 2019	Western Idaho Crisis Center
4	Boise, ID	June 19, 2019	Pathways Community Crisis Center
5	Twin Falls, ID	June 17, 2019	Crisis Center of South Central Idaho
6	Pocatello, ID	June 24, 2019	Southeast Idaho Behavioral Crisis Center
7	Idaho Falls, ID	June 25, 2019	Behavioral Health Crisis Center of East Idaho

Note: Additionally, a member of the consulting team visited the **Region 1** Crisis Center in Coeur d'Alene, the Northern Idaho Crisis Center, before the start of this Crisis Project engagement.

Surveys

Beacon distributed an electronic survey for those who could not participate in any of the respective focus groups (i.e., Community, Regional DBH, Advocate Focus Group(s)). Through this survey, we obtained 45 individual responses, with representation from all regions, but primarily Region 5. We have provided the questionnaire in **Appendix B**.

Payors' Roundtable

In August 2019, Beacon and the Division of Behavioral Health hosted a Payors' Roundtable to understand how a robust system of care could work in partnership with public and private payors and to identify cross-payor areas of opportunity for improvement and collaboration. Attendees included the Division of Behavioral Health, Optum, Idaho State Medicaid Program, BPA Health, Select Health, and Blue Cross of Idaho. Recommendations from the Payors' Roundtable are included in later in this report, and the full meeting summary is included in **Appendix C**.

Overall Impressions of Crisis Practices in Idaho

Perhaps more than anything else, the consulting team has been struck by the significant, broad, cross-sector engagement and investment in crisis system design conversation, and (in the case of the Crisis Centers) service rollout and delivery. The level of participation, not just in numbers, but in truly innovative and thoughtful conversation, was beyond expectation and well ahead of many other states, including those that might be considered more "advanced" or that have more crisis system components.

It is clear that staff and community stakeholders have put much thought into the development of a crisis system of care and that DBH state and regional leadership have worked hard and successfully cultivated good working relationships. Meanwhile, systems that do not have a primary "charge" to deliver crisis intervention appear to have a good understanding of their business reasons to invest in this work.

In nearly all of our conversations, there were individuals at the table with lived experience as recipients of crisis services or family members (including parents of minor and adult children). Their deeply personal experiences about when the system and its approaches help and when it harms are an essential orienting point as this work progresses. There is a tremendous amount at stake—lives and livelihood—and individuals with these experiences must help design the architecture of the system.

Themes from the Listening Tour

Many of the consulting team's observations were reflected in themes from the listening tour. What follows is a list of primary takeaways from those sessions. We will dive deeper into some of these themes in subsequent sections.

- Recognition that there is under-development in the areas of crisis prevention, early intervention, and post-crisis recovery and reintegration, contributing to:
  - High reliance on law enforcement response and involuntary evaluation procedures
  - Approaches that are experienced by some as uncomfortable/traumatizing
  - Approaches that may be keeping some individuals from seeking help
- Recognition that there is geographic variation in the availability of crisis services, with most services located in high population centers
- Providers of crisis response services largely operate separate and apart from one another rather than as part of an organized whole
- There is broad alignment on the desire to improve clinical and quality outcomes for individuals and families experiencing behavioral health crisis and improving a subjective crisis care experience
- Outside of the populous hubs, there are very few resources for those in crisis and their families—remedying this will be essential
- There is a desire to change the dynamic of law enforcement taking the lead in most crisis events
- There is a belief that good crisis support can be delivered voluntarily and locally and a recognition of the iatrogenic impact of some current practices (including the high reliance on LEAs)
- It is recognized that crisis services for children are lagging behind services for adults

- It is recognized that crisis services for individuals with co-occurring autism/IDD are limited
- Provider shortages are real—working to address this will help avoid the number of individuals who interact with the crisis system altogether and better support individual member throughput post-acute crisis intervention. In order to do this well, we need to think more broadly about the workforce; look at whole health and the role of community support works/non-licensed workers and peer supports, those who are integrated into the community's culture and can assist those in a crisis and work to keep those served out of crisis in the first place
- Regions are generally excited to implement mobile crisis capability, but that success will be commensurate with the evolution of a continuum of care to accept referrals for follow-up care
- Statewide requirements mixed with regional flexibility is viewed as a best practice
- There is a concern that services will be built without an adequate workforce to perform (heard examples of this with newly rolled out YES services)
- Data is lacking and not coordinated

State-Level Advancements and Innovations

There has been a considerable effort at the state level to advance crisis services and to lay the foundation for further advancement. First on this list is Medicaid expansion. Though community-based crisis intervention is not a required Medicaid benefit, it is an allowable service. While Medicaid is not sufficient to fully fund a crisis system of care (because the system will also serve non-Medicaid recipients, and because not all essential components are reimbursable under Medicaid) the fact that more individuals qualify will be of great benefit in allowing the state to implement a sufficiently comprehensive system.

Medicaid expansion has given DBH an opportunity to rethink its use of regional teams that have historically provided treatment services to individuals who are indigent. DBH anticipates that most individuals that they have historically served will qualify for Medicaid and that care can be transferred to private providers. DBH has identified the direct provision of crisis services—beginning with the launch of mobile crisis services—as a new priority for the regional teams, and we concur with this thinking. Community crisis services are a critical component of a community safety net, often serving individuals who are new to the system, those who are insufficiently connected to or fully disengaged from active treatment services, and those with complex and/or co-morbid conditions who aren't always served well in traditional programs.

DBH leadership has noted that the state is missing "the high-level view" of the crisis system and views the ability to provide real-time oversight as a key priority and an opportunity to align pieces and parts of the system that are not sufficiently involved and connected.

Youth Empowerment Services (YES) Implementation

The Jeff D. class-action lawsuit and settlement entitles children and youth with serious emotional disturbance (SED) to additional services, including crisis services. The program born out of the Jeff D. case is called Youth Empowerment Services (YES). YES provides a new way for families to find the mental health help they need for their children and youth, using a strengths-based and family-centered team approach to individualized care. Through a coordinated and collaborative effort, multiple child-serving agencies will work with the family to build a treatment plan around the unique needs and strengths of each child.

Under the YES program, class members are to have new services available to them.[7] Crisis Response Services (24/7) include Crisis Respite, Crisis Response Services, and Crisis Intervention. The development of this program has brought child-serving systems together, and has given voice to parents and led to thoughtful consideration of the specific treatment needs of youth and support needs of the parents and other caregivers on whom children are so reliant. Crisis intervention is one of five new Medicaid reimbursable services as of 2018. The crisis intervention component of YES will be strengthened by this broader crisis system of care initiative.

There are approximately 21,000 potential class members requiring behavioral health services. Within that group, it is estimated that 12,624 are currently served in the Medicaid system, 6,446 are privately insured, and 1,554 remain uninsured.

Crisis Centers

It is clear that the development and deployment of the crisis centers was an example of smart thinking: the centers have state standards and regional flexibility and a great recovery-oriented philosophy. It is easy to anticipate that Mobile Crisis Teams and Crisis Centers will find each other to be a key resource.

Idaho's Behavioral Health Crisis Centers are designed to be short-term (less than 24 hours) community resources that fill the gap for individuals experiencing a crisis who may otherwise end up in jail or the emergency room. These crisis centers were intended to serve as a link to the existing behavioral health services available in the community, which may be beyond reach or access when a person is in crisis. The design is based largely on a model developed in Billings, Montana.

Over the past few years, seven centers—or crisis center networks as seen in Region 2—have opened across the state in Boise, Caldwell, Coeur d'Alene, Idaho Falls, Lewiston, Pocatello, and Twin Falls. The state has provided approximately $1.5 million in annual operating costs, plus $200,000 in startup funds. After two years, crisis centers must have a plan in place to take over 50 percent of the funding. Below is a list of crisis centers and their respective locations:

- Pathways Community Crisis Center of Southwest Idaho—Boise, Idaho
- Western Idaho Crisis Center—Caldwell, Idaho
- Northern Idaho Crisis Center—Coeur d'Alene, Idaho
- Behavioral Health Crisis Center of East Idaho—Idaho Falls, Idaho
- Crisis Center Network—Lewiston, Idaho
- Southeast Idaho Behavioral Crisis Center—Pocatello, Idaho
- Crisis Center of South Central Idaho—Twin Falls, Idaho

The rollout of crisis centers within each region of Idaho is notable for many reasons, including:

- Blended funding models
- Cross-sector partnerships
- Strategic co-location with other services such as recovery centers and health clinics

[7] Class Member: Idaho residents with a serious emotional disturbance who are under the age of 18, have a diagnosable mental health condition, and have a substantial functional impairment; the diagnosis must be based on the Diagnostic and Statistical Manual of Mental Disorders (DSM).

- Peer specialist-rich staffing models
- Oversight boards
- State-level facility/performance expectations while allowing locally influenced approaches
- General adherence to principles of recovery

Most importantly, the crisis centers have demonstrated that crisis treatment need not be solely delivered in hospitals, but can indeed be delivered locally, voluntarily, briefly, and collaboratively.

Two primary limitations that are clear to all:

1. The centers are not readily accessible from all areas of very large regions. They are located in locales that already tended to be more resource-rich. It will be very interesting to watch the role out of Region 2 which is de-centralizing its crisis center program so that there will be four centers across the region and will recruit locally (so that centers are staffed by those who are connected to the community).
2. The centers are not available for children and teenagers who often must leave the state to access acute treatment services.

State-Supported Competency Development

The state has supported the development of several models that are relevant to effective crisis systems of care, including:

- Rollout of CIT
- Zero Suicide Initiative
- MHFA/ASIST training
- Trauma-informed Care

Regional Highlights: Advancements and Innovations

Following the visit to each of the seven regions, the consulting team prepared a summary report outlining themes from the listening sessions and program tours. These reports were reviewed by regional team leadership for accuracy and finalized for use by DBH and the regions as they move forward in their planning for the rollout of mobile crisis intervention and other crisis system initiatives. The highlights below are not intended to capture all of the advancements and innovations within each region. Rather, we view them as collectively capturing an array of crisis system initiatives—most specifically for adults. Coupled with the new mobile crisis intervention program, the state could create a comprehensive set of services that spans all 5 phases by scaling each of these local initiatives at a statewide level. Please see the table at the end of this section for more details.

Region I: The region believes that mobile crisis response will be an important advancement. They articulated a vision for a future system that is experienced as less coercive, more supportive, and with an increased focus on prevention/early intervention—particularly for children and for those living in rural areas. Panhandle Health District has a clinic in every county in Region I, and work is underway to leverage these locations as outposts and further integrate behavioral health services and programs available via the DBH team. These advancements will augment existing Region I assets and innovations including:

- Use of technology and hospital-based civil commitment hearings (Bonner County) and eliminates the need for law enforcement transport for hearings
- EMS post-discharge follow-up services
- PHQ-9 Depression screening during PCP visits (Marimn Health Services)

Region II: The implementation of crisis centers and mobile crisis response will introduce substantial new and welcome resources in this region, where in three of the counties there is a single Medicaid-contracted service provider. Considerable thought has gone into imagining a future crisis system of care. It is noteworthy that every single hospital in the region was represented at the community forum. The region is taking a novel and smart approach to the rollout of crisis centers—opting to use a "decentralized" model that will co-locate crisis beds in four areas of the region and then allowing those centers serve as service "hubs." There is a recognition that locally recruited staff are most likely to be trusted by those in crisis and that local knowledge will be essential in cross-sector collaboration. This decentralized model will help on both counts. Current assets:

- Walk-in crisis support services (Lewiston)
- Crisis Centers are beginning to open. In Lewiston and Moscow, the centers will be co-located with Recovery Centers. In Orofino, the center will be co-located with a private mental health center

Region III: The regional DBH team currently focuses nearly all of its time and resources on law enforcement-involved, and court-ordered/mandatory services and functions. The region has a relatively high Designated Examiner (DE) rate, and this has limited their ability to develop upstream services despite a desire to do so. The Crisis Center has been a welcome addition to the region and is demonstrating the value of an alternative, voluntary, and collaborative crisis care model. The Crisis Center is strategically co-located with the Canyon Recovery Center and a local health clinic. The partners are mutually committed to a whole-person healthcare approach. DBH team members articulate a vision to move away from use of DE's so that staff has the time and freedom to proactively intervene, support the person in distress, and remediate at the lowest level. The team would like to expand upon a model that includes co-response with paramedics building on a model that is already underway in Payette County. Promising local crisis system innovations include:

- 911 accommodation registry (Canyon County); accommodation information is linked to the address within the dispatch call system
- MH/DD system co-response model for DE and competency restoration leading to more appropriate interventions
- Hospital aftercare program
- Community Paramedic follow up program (Payette County)
- Introduction of CIT in the region

Region IV: The crisis system of care in Ada County has been exemplary in the state and features some system components that rival those in national best-in-class systems. The Ada County system has achieved significant cross-sector collaboration, built services using blended funds, sought and won competitive grants, and most of all, never rests on its laurels. The county is on the cusp of trying new technology to enhance communication and speed referrals (for a wide array of services and supports—not limited to formal treatment services--to aid in relieving a crisis) and continues to hone its newer paramedic/clinician co-response (PET) model. However, it is acknowledged that the bulk

of the innovation is centered in Ada County and not in the three surrounding, more rural counties; and although there is some mobile crisis response capacity in Ada, Elmore, and Valley counties, the innovations have largely focused on crisis services for adults.

It is also acknowledged that individuals in crisis may experience coercive care. Participants in the listening sessions, including parents, articulated a vision for an experience of care that is more dignified and less traumatic for individuals and their families. This vision included:

- Increased use of peer specialists
- Increased understanding of and support to families and caregivers
- New strategies for transporting individuals from the community to treatment services
- Tele-solutions for court appearances to reduce the use of handcuffs, police transport, and orange jumpsuits (for court appearances)

The team is actively shifting its thinking to a regional mindset and expanding Phase 1, 2, and 5 capabilities. The region is envisioning a "recovery care team" to offer higher risk individuals intensive, brief, community-based supports in lieu of inpatient treatment. Examples of crisis system innovation in Region IV include:

- Accommodations Registry (Ada County)
- Seven to 14-day "Crisis Enrollment Program" serves as an upstream, outpatient diversion service provided by DBH (Ada County with a plan to expand the concept)
- Seasoned CIT officers and a mature CIT program
- CIT, cross-sector teaming, and follow-up process (focus on highest risk/frequently seen individuals by the county law enforcement agencies and 911)
- One-stop criminal justice re-entry resource center
- PET team program (field-based medical assessment, facilitating direct admission, less traumatic for the person in Crisis)

Region V: The region boasts a fair number of crisis system component "parts," but DBH staff and system stakeholders described a system that is experienced by consumers, providers, and law enforcement as being generally fragmented and not supported by a holistic and coordinated system of care. There is an emphasis on acute crisis response (Phase 3 and less so on Phases 1, 2, 4, and 5). It is acknowledged that the bulk of the services are located in Twin Falls and not in the other seven, less populous counties. There is a strong emphasis on law enforcement and Emergency Medical Technicians (EMT) as crisis first responders rather than behavioral health specialists. Stakeholders describe significant gaps in care for children, individuals with IDD, and older adults. DBH envisions a mobile response model that minimizes the use of law enforcement and pairs clinicians and peer specialists to provide an in-community bi-disciplinary response. The team believes that mobile crisis response, dispatched from an urban hub such as Twin Falls, could be highly impactful to reduce the need for law enforcement to respond to crises, and could provide community-based services that can deter from hospitalization. When indicated, peers or a social worker/mental health professional could accompany first responders. In rural areas, a process is already underway, spearheaded by NAMI and in partnership with law enforcement, to identify local clinicians who can participate in a phone tree and provide in-person response with or in place of law enforcement. These approaches can build on existing innovations in the region that include:

- Strong peer support services
- DBH walk-in crisis support
- DBH seven-day crisis service (employee assistance program-like model) with access to prescriber when indicated
- CIT trained officers (not across the entire region)
- Crisis center with a protocol for a warm, rapid hand-off from law enforcement
- Crisis Center co-located, walk-in DBT group twice weekly

Region VI: The crisis system in Region VI has many positive features, particularly considering the rural nature of five of the six counties in the region and the limited resources available in the community. A primary strength in this region is the relationships and community partners who are highly invested, innovative, and collaborative. The DBH team provides outreach and training and displays a willingness to go into the community. Much of the time, the DBH team is focused on DE-related activities and Phase 5 recovery/reintegration activities. The team describes underdevelopment of Phase 1 and 2 activities and a lack of mechanisms for sharing information between key players. The future system is envisioned to be focused on upstream services and attending to individuals with long-term care needs.

The team also identifies a desire to address the needs of individuals who do not meet criteria for involuntary holds, but who are struggling in the community. Often, caregivers and family members of these individuals are stressed and exhausted, and they are frustrated when law enforcement agencies do not feel that they can act. There is a desire to expand and build a "non-criminal justice-focused" crisis system. There was a substantial conversation about the way individuals perceive law enforcement involvement in a crisis episode ("Have I done something wrong?"), and a desire to change that experience. The region anticipates expanding use of peer support specialists to crisis services and is considering how to actively use nursing staff as part of their mobile and other crisis services set. Nursing co-response on mobile interventions can be particularly useful for older adults and individuals who are medically compromised. Region VI has had recent and significant success in forwarding the relationship between law enforcement and the behavioral health system—particularly with the opening of the crisis center in which three law enforcement agencies are key partners. Notably, many people are getting to the crisis center without any law enforcement involvement at all—creating a very different care experience. Region VI is nicely poised for expansion and plans to build on existing assets and innovations, including:

- Monthly cross-sector housing meeting
- Children's daily on-call crisis consultation clinician
- Children's crisis beds at Bannock House
- Robust post-hospital aftercare coordination and support
- Introduction to crisis center given to new probationers
- Crisis center co-location with free clinic, Recovery Center and Health West

Region VII: Historic response to behavioral health crises in Region VII relies on emergency rooms and law enforcement, with limited provision of community-based clinical response, particularly upstream of an acute crisis. Often, at various stages of the intervention continuum, the focus is on assessment and referral to future services, rather than the use of brief treatment and an effort to resolve crises at the lowest level possible. This means each part of a limited crisis system must do some duplication of effort in an already stretched system. The existing parts of the system are

described as strong, but the varying players are generally working in silos and "spread thin" because they must "wear many hats." This is compounded by a behavioral health workforce shortage, which places a further strain on DBH teams and existing resources. There is an achievable vision to build towards a more strengths-based and resolution-focused system of care. Overall, the system is currently focused on Phases 3 and 4 of the continuum, and missing Phases 1, 2, and 5 (focus of future vision).

The introduction of the Crisis Center has filled a gap in the continuum and offers an opportunity for hospital diversion for adults (over the age of 18). The DBH team has experience in resolution-focused approaches, even if the model is not to scale. There is strong collaboration amongst key players already taking place in the community and a foundation for stakeholder engagement to build upon. CIT training is available in the region, and, in Bonneville County particularly, is developing into a program that is "more than just training." There remains an over-reliance on law enforcement and too little clinical involvement in crisis management. Focus group participants envision a system in Region VII where treatment is provided in a more resolution-focused and trauma-informed way, with less use of approaches experienced as coercive and more support and respite for parents/families. There is a desire for more education throughout the region to reduce stigma around mental health issues, including for behavioral health providers, who in some cases have relied upon law enforcement to assist with difficult individuals. Local innovations include:

- CLUB regional housing services
- Child Protective Services (CPS) use of Family Group Decision Making model and parent psychoeducation in supporting child tenure in-home/community
- Stepping Up initiative to reduce the number of people with mental illness in jail
- The Crisis Center and Recovery Center are both operated by the same agency, and this has allowed for some sharing of resources
- Use of an amnesty box in the Crisis Center
- First Episode Psychosis program
- Crisis Center collaboration with IDOC to support individuals at the point of re-entry
- 30-day Hospital Aftercare program

Obtaining a Comprehensive System by Offering Services to Address all Phases in the Crisis Care Model

Below is a snapshot of how a crisis system of care in Idaho could be implemented if some of the regional highlights described above were brought to scale across the state. This compilation of services across the five phases would be the start of a well-rounded system of care.

Phase 1 Crisis Prevention	Phase 2 Early Intervention	Phase 3 Acute Intervention	Phase 4 Crisis Treatment	Phase 5 Resolution and Reintegration
Region I: PHQ-9 depression screening	**Region II and V:** Walk-in crisis support services	**Region IV:** Mobile crisis Intervention (expanding to all regions)	**All Regions:** Regional Crisis Centers	**Region I and III:** EMS/paramedic follow up visits

Phase 1 Crisis Prevention	Phase 2 Early Intervention	Phase 3 Acute Intervention	Phase 4 Crisis Treatment	Phase 5 Resolution and Reintegration
Region IV: One-stop criminal justice re-entry resource center	**Region IV and V:** 7-14 day brief, resolution-focus, crisis intervention	**Region IV:** PET team (EMS/crisis team co-response)	**Region I:** Hospital and tele-based commitment hearings	**Region III and VII:** 30-day post-hosp. aftercare program
Region III and IV: Accommodation Registries	**Region VI:** Children's on-call crisis consultation clinician			**Region IV:** CITC focus on high risk/frequent users of 911, LEAs; focus on resources and engagement
Region VI: Monthly cross-sector housing meeting		**Region III:** MH/DD co-response model for DEs and restoration		**Region V:** Walk-in DBT group (co-located with Crisis Center)
Region VI: Introduction to Crisis Center given to new probationers				**Region VII:** First Episode Psychosis program

Moving Idaho Forward: Challenges to Address when Creating an Optimal Crisis System of Care

Historical Habits of Practice Prevail

Although there are pockets of innovation across the state, broad progress is limited by historical habits of practice and a generally under-developed crisis service that relies highly on law enforcement, use of involuntary procedures, emergency departments, and inpatient psychiatric services. Past experiences with this type of system and the stigma that comes from using it are factors that influence engagement and adherence. As we heard it expressed in meetings across the state, mental health crisis response today is too often experienced as an extension of law enforcement or child protective services or as overreach by "big government".

It is essential to differentiate crisis intervention as a health care service, separate and apart from the criminal justice system. This differentiation must start with understanding any deeply held beliefs of the system/service providers about individuals in crisis (and in the case of children in crisis, their parents), and care management processes before it can be expected to deliver a different product. While there are times that law enforcement agencies and courts necessarily engage individuals with behavioral health conditions (see the section that follows) it should not be due to a lack of services. Most people should be able to receive behavioral health services with no criminal justice contact.

In addition, some stakeholders in the system feel confined by the rules (i.e., policy, protocol, habit of agency/system) and what they view as their role in a crisis (i.e., the authority must be called, and I must step out of the way). In this view, there are a limited number of people who hold crisis expertise and are charged with carrying out those tasks. In a future state, crisis roles, responsibilities, and commensurate competencies are expanded well beyond that core group.

The Mental Health System for Children and Families is Underdeveloped

The Jeff D. class-action lawsuit that has resulted in a new set of mental health treatment services is promising. Under the Youth Empowerment Services (YES) implementation, children and families should have access to a range of new services. These services include crisis intervention, and the principles of care promote interventions that are collaborative, family-centered, and strengths based.

It is important to remember that as it stands today, the YES system is still more aspirational than practiced. There is not yet a full contingency of service providers, there are challenges with service access, and it will take time for agencies/treatment providers to practice new skills and master necessary competencies.

We heard from parents in many of our listening sessions about their experiences when their children are in crisis. In the absence of a comprehensive community-based system and a lack of community-based crisis services for children, families have had to seek care from inpatient hospitalization and residential treatment facilities—and these levels of care are not (and of course, should not) be easy to access. These programs are often hours away from the family home and sometimes out of state. In addition, school districts have had limited options when they are concerned about crises that occur in their facilities. The lack of treatment services drives higher usage of other children's systems, namely child protective services and juvenile justice.

DBH does not have the experience in working with children and families in crisis that it has in working with adults. This will need to be an area of purposeful attention. The crisis system—particularly the Centralized Call Center, can and should be alert to issues related to child access to YES services and be monitoring and tracking crisis episode dispositions that involve out of home placement, referrals to juvenile justice or child protective services, and working with the broader children's system to mitigate the risk of these dispositions.

While there likely will be insufficient volume to support dedicated 24/7 children's crisis teams, the teams that are formed will need specialized training in strengths-based interventions with children in crisis and in effective collaboration with parents. Building a strong pool of child-trained "second responders" to provide extended community-based crisis support, along with development of regional crisis stabilization beds are recommended and described in the Crisis Service Array section of this document.

Because there is so much to do in standing up a statewide crisis system, it can be tempting to start with serving adults and address "specialty" populations later. The consulting team does not believe Idaho has that option for children and their families given the current circumstances.

Working with Law Enforcement Agencies (LEAs)

DBH and LEAs have worked collaboratively in many parts of the state to improve practices. There was law enforcement participation in meetings in every region (thoughtful, invested participation, not just attendance). Crisis Intervention Team (CIT) training is fairly widespread in Idaho, with considerable cooperation between agencies in terms of training. We also heard about parts of the state where the 40-hour CIT training model has been a barrier to adoption. It is difficult to convert to CIT in rural/frontier areas given the very small number of law enforcement officers in some jurisdictions who are covering very large geographic areas. As noted in an article in *The Journal of the American Academy of Psychiatry and the Law*, it is worth exploring and supporting alternative training schedules including segmenting the course over several weeks or even months that can make this more feasible.[8]

There was less evidence of CIT as a program, as evidenced by an ongoing collaborative model between law enforcement and the behavioral health system, continuous training, model development, debriefing, collaborating on approaches to working with high volume/high-risk users, etc. The under-development of the crisis system (absence of mobile crisis intervention, drop-off community treatment sites) in most areas is a key part of this. These existing partnerships should enhance the rollout of mobile crisis intervention services by DBH and support maturation of CIT to more of an ongoing community care model.

Designated Examiner (DE) Evaluation is Misconstrued as "Crisis Intervention"

The work of the crisis system in Idaho today is largely comprised of tasks and functions related to DBH's role as Designated Examiner (DE). This includes managing requests, completing evaluations, attending court hearings, further evaluations to drop commitments, and tracking the movement of individuals through this process who are perceived as needing an involuntary detention. It is estimated that 70 percent of crisis team time is spent in work related to the DE role. This is true even in Ada County, which actively markets its voluntary mobile treatment services. There, the program manager reports that the team receives about 240 DE-specific requests a month and 100 field responses (some of which will result in a DE evaluation).

In most of Idaho, a DE evaluation is viewed as synonymous to crisis intervention and mobile crisis response. Calling the crisis line is understood by experienced crisis service users as activating a legal authority. Potential consequences in this type of model include:

- People call the crisis team on their own, or another's behalf to secure hospitalization, as opposed to asking for crisis intervention that would hopefully diminish the need for a higher level of care.
- People choose not to call the crisis team to avoid experiencing the loss of control that they believe it will entail, and these individuals are left to self-manage serious crises.
- People experience crises that do not fall within the narrow scope of practice of the team, and they either don't call because it isn't "bad" enough or are screened out without getting adequate crisis relief.

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[8] Segmented Versus Traditional Crisis Intervention Team Training. Gary S. Cuddeback, Robert A. Kurtz, Amy Blank Wilson, Tonya VanDeinse, Stacey E. Burgin. Journal of the American Academy of Psychiatry and the Law. Online. Sep 2016, 44 (3) 338-343

For the person receiving a DE evaluation the process can be very lengthy. If a physician in an emergency department initiates the hold, the physician files paperwork with the court. The judge has 24 hours to sign the order. The DE then has 24 hours to complete the evaluation and another 24 hours to make a decision after that first contact. If this examination is "positive", meaning the person is found to meet criteria for involuntary treatment, a second DE is performed within 72 hours by a psychologist, psychiatrist or nurse practitioner. This is finally followed by a court hearing which occurs within five days of the initial petition. All of this is unfolding while an individual remains in an emergency department that is not designed to provide a comfortable, private multi-day stay. This multi-phase process is certainly more complicated than it is in some other states. It is quite arduous for the individuals who are the target of the evaluation. More problematic is the reliance on the process in the absence of available voluntary crisis services, which can be reduced even while efforts to improve the process move forward.

It is not uncommon to hear a professional who requests mobile crisis response that does NOT result in hospitalization express their view that "nothing was done"—t his is an indicator of a deeply held belief that the GOOD treatment occurs in hospitals.

In Ada County, the team is rarely, if ever, able to initiate an examination the day the requests come in—the stack of requests builds throughout the day and the assignments are divvied out to DEs the next morning. The team desperately wants to "flip the script" so that most of the calls are received by the team prior to the decision to initiate a treatment hold or the paperwork is filed with the court.

Although skilled and caring clinicians are providing these examinations, they are prescribed assessments, tied to a specific state statute, and cannot be understood to be treatment services. The DE is functioning as an authority, with power to make a decision to hospitalize against the wishes of the person in crisis. This is an approach that is *done to* rather than *done with* a person. Though use of the process cannot always be avoided, it is, and must be understood as contrary to person-centered and recovery-oriented care.

Modern day crisis intervention can and should be a treatment service, used as the response of first choice when a call is received from the community, a family member, a hospital or a law enforcement officer. If the crisis system redesign is effective, the primary request from the community will be for a mobile crisis intervention, which as the name indicates, is a brief intervention/support/treatment service intended to resolve the crisis scenario and supports community tenure when possible. Resolution-focused treatment hones in on the essence of the crisis and finding idiosyncratic ways to diminish suffering and risk of harm, resolve issues, and develop new understandings and strategies. The focus is less on the provider trying to gain an understanding of what is happening and more on creating an environment in which the service user/family gains an understanding of what is happening. It is not a service that is limited to an assessment, a level of care determination, and referral.

The DE examination in this scenario would then be used as an "exception" or when resolution-focused intervention fails to result in sufficient relief/harm reduction, and the recipient does not or cannot voluntarily consent to a higher level of care.

Long after Idaho launches its mobile crisis service, it is expected that callers will continue to be confused about the difference between mobile crisis response and the DE process, so ongoing methods for educating professionals and the public will be essential.

Financial Misalignment

Currently, the funding and contracting model in Idaho does not place a singular payor organization or State agency accountable for services delivered to individuals throughout a full episode of care. The care continuum ranges from preventative services to services delivered during or as a result of a crisis episode, and after-care services such as outpatient behavioral health that are often necessary to support longer-term stability post-crisis. An unintended result of this systemic structure has been an inherent disincentive to invest in preventative services, such as crisis diversion, or to bear the cost of more expensive services—it is much easier to allow other payors or other parts of the system to fund the higher cost services.
For example, in the current Idaho structure, traditional outpatient mental health services are contracted via a managed care organization, as well as crisis hotline services. However, higher-level services such as psychiatric hospitalization are funded through state general funds or fee-for-service by the State Medicaid program directly, and there are no financial or contractual mechanisms in place to incentivize avoidance or diversion from these high-cost services.

Additionally, the Medicaid fee-for-service program (payor for inpatient services) is not incentivized or able to directly influence the preventive services under the purview of the managed care contract and the provider network. The Payors' Roundtable highlighted a similar challenge for individuals covered by commercial carriers. There is a lack of service array for community-based outpatient and diversionary services, and a lack of awareness of resources such as Crisis Centers, hotlines, or DBH clinics. As a result, inpatient hospitalization and 911 are the primary resources for commercially covered/funded individuals.

The result of the financing/contracting incentive structure is that individuals are at risk of falling through the cracks. Individuals experience repeated "assessment and referral" cycles at multiple stages of the system until they reach a crisis state and access the highest level of care (hospitalization). Additionally, because the full range of provider organizations, from outpatient to crisis to inpatient providers, are not contracted via the same payor organizations, there is a lack of data sharing and care coordination/case management that leads to further fragmentation as experienced by the individual.

Maximize Federal Financial Participation

Currently, the Idaho crisis system is not maximizing Medicaid funding to the greatest extent possible. As Medicaid expansion launches and 90,000+ individuals are anticipated to become eligible, it will become increasingly important to maximize available federal match, which will fund services for Medicaid expansion adults at a match rate of 90 percent in 2020 and beyond. Specifically, the crisis intervention services, crisis response, and peer support services provided in the seven Crisis Centers are currently supported by state-funded grants, even when delivered to individuals covered by Medicaid. Community behavioral health, care coordination, and crisis intervention services provided via DBH clinics, mobile response, or walk-in appointments and delivered by Division employees are not billed to Medicaid. Additionally, telephonic crisis response services delivered by various hotlines are not currently billed to Medicaid.

Of notable importance is the need for the State to obtain encounter and claims data related to the provision of crisis services to individuals covered by Medicaid. This data will be critical to ensure future actuarial rate-setting activities are correct, and to account for the true cost and utilization of services by individuals covered by Medicaid. Additionally, by better leveraging Medicaid funds, the State can prioritize state-only funds and federal block grants for services and populations that cannot be supported by Medicaid, such as transportation, housing supports, workforce development activities, services for non-citizens, or the room and board (non-treatment) component of bed-based crisis programs.

The expectation for the crisis centers to develop sustainability plans that should include billing Medicaid and other insurers will "free up" current state funding to repurpose into addressing the other needed improvements to the larger crisis system.

Enhance Systems Coordination and Data Sharing

We heard repeatedly at listening sessions that there is lack of coordination between crisis services and other levels of care. Each service is largely operating in a silo—not readily connected to other parts. Additionally, mechanisms to facilitate the flow of individuals in crisis and data between parts of the system is underdeveloped. There are minimal methods for tracking capacity and demand and crisis episode throughput. Specifically, for the delivery of crisis services, this is problematic. Real-time, transparent tracking of movement and timeliness is essential for an effective, thriving, crisis system of care. This is what helps tie together disparate parts across multiple systems and helps the person in crisis experience care as coordinated, seamless, and as brief as possible. Crisis systems reliant on claims-based data (or any other type of encounter data that has a lag) are hampered in their ability to be nimble. An analogy to disaster work is useful here. It is not very helpful to get data two weeks after the hurricane strikes. Rather, it is helpful to see the hurricane coming and have:

- Ready information about the services/supports that are ready to be deployed
- An easy way for needs to be communicated in real-time
- Pre-established methods of communication/service dispatch
- Feedback loops to be sure dispatched services occurred as planned

In a disaster, this is all real-time, managed by a command center with high logistical capability. In the behavioral health crisis system of care space, when these real-time mechanisms are not in place, resources are squandered, care is delayed, and people experience unnecessary suffering. It also makes for a frustrating environment for the crisis workforce.

In the current system, there a lack of data sharing among payor systems when an individual experiences a crisis. For example, because services for individuals are siloed amongst multiple payor organizations and services are often not billed to Medicaid, there is no single entity that has access to claims/encounter data that can tell the story of an individual's full spectrum of service use and use analytics to calculate risks scores and predict future utilization. Additionally, the responsible payor organization (e.g., managed care organization, Medicaid, BPA, private payors) for follow-up, case management, or diversion is not alerted to interactions with crisis providers such as: crisis or suicide hotlines, 911, crisis centers, or walk-in clinics so that they may follow up, offer diversion services, or initiate case management

The WITS system is an open-source web-based clinical and administrative system that creates a strong foundation to improve data sharing among providers and payors. Currently this system is used by mental health, substance use, and crisis providers and payors, and is a repository for administrative and treatment information on Medicaid and non-Medicaid enrollees; however, it is not used consistently or regularly by all providers/first responders/payors. Furthermore, inconsistent use of documentation and user error within WITS adds additional complexity. The State is actively working on improvements to the WITS system to make it more accessible, effective, and interoperable. If used widely, WITS (or some similar management information system) has the potential to greatly improve data sharing among siloed systems.

Fill Gaps in Coordination of Care and Peer Services

Throughout the focus group sessions, a common theme that emerged from participants was the lack of accountability for coordination in the current behavioral health system; particularly for those most at risk or are frequent utilizers of emergency services and higher levels of care. Participants described a fragmented a siloed system in which there is no single accountable person or organization that is responsible for an individual's health outcomes, or responsible for assisting the individual throughout an entire episode of care (i.e., pre-crisis, crisis, after-care).

It was also apparent that the full spectrum of peer support services has been inconsistently adopted across the state, and there is confusion on behalf of providers regarding the ability to add peer support service within their practices.

Creating a Best in Class Crisis System of Care in Idaho

The remainder of this paper will focus on the specific recommendation at the State and Regional levels intended to support the State of Idaho with the creation of a best in class Crisis System of Care. We have included recommendations related to workforce, service array, policy, organization, and financing.

As we think about Idaho, its geography, the varying regions, cultures and lifestyles, and the complexities of building a crisis workforce, a few Crisis System of Care descriptors come to mind that would benefit all communities:

- **Organized Centrally:** Through a centralized call center and broad use of technological efficiencies and logistical processes, staff will be able to efficiently schedule and dispatch regional and local teams. This central hub also enables efficient management of data collection, movement of resources, and the establishment/mapping of Wi-Fi-enabled hubs/sites/shared spaces throughout each region. The Central Call Center would liberally use tele-solutions for daily regional huddles, team development, and as a mode of service delivery.
- **Diversified Workforce:** Use a non-traditional, local workforce by building crisis competency among individuals already living and working in communities around the state who are locally known and trusted. These individuals would be supported by a specialized, regional workforce who would be licensed clinicians and may be used for either face-to-face or tele-solutions.

- **Community-Based Workforce:** "De-centralizing" the workforce promotes the local growth of crisis workforce and facilitates timely response to remote areas. In addition, flexible staffing models allow for full-time, part-time, per diem, and 'secondary role' crisis responders.
- **Collaborative Stakeholders:** System stakeholders within and across communities should work together to ensure individuals feel supported throughout their experiences (e.g., through warm handoffs, follow-ups). A collaborative approach efficiently moves data and information to move throughout the system and enables best-practice services are shared and implemented in communities throughout the state.
- **Relief/Resolution Mindset:** While the prevailing goal of every phone and face-to-face contact, this system-wide mindset offers individuals the earliest possible opportunity to feel relief. It also serves as a staff/service efficient approach in a state that needs every single contact/service episode to count.
- **Competent Workforce:** Staff must be trained in person-centered, strength-based, resolution-oriented, trauma-informed, harm-reducing, and whole-health focused approaches to ensure the outcomes envisioned by the state.
- **Non-coercive:** As a general operating principle and guide as the Crisis System of Care is developed, individuals must not feel coerced. The system should strive for collaborative decisions 99 percent of the time and minimal DE involvement. It is especially critical that individuals who voluntarily enter the crisis system are not required to undergo DE evaluations, as this would transform a voluntary and collaborative process into an involuntary situation. The principle of maintaining non-coercive practices is important in modern crisis systems nationally, but also an important attribute given an overall statewide cultural philosophy of personal autonomy that is free of government interference.

Workforce Strategy will be Needed

Some of the advancements that are highlighted in this report (e.g., Medicaid expansion, YES implementation, upcoming mobile expansion) are tremendously exciting and instantly challenging when considering how all of the new services will be staffed. Indeed one of the concerns expressed at multiple listening sessions was whether private providers have the capacity to accept transfers from DBH of individuals who will soon qualify for Medicaid. Similar points were made about YES services—a needed expansion of services but without a sufficient workforce.

It is not likely that an influx of licensed independent clinicians will be relocating to Idaho—so that level of care cannot be looked at as the workforce solution. Eligible service providers must include individuals already living in Idaho and Medicaid service definitions will have to follow suit whenever it is possible.

In imagining the crisis system of care, it will help to think broadly about who can be part of the crisis "workforce." Again, this is comparable to a disaster response system strategy—think about crisis training, preparedness, and competency across sectors. Crisis response will not necessarily be full-time jobs for most, but you will be able to draw on these resources as necessary.

There is value in recruiting locally and allowing for a decentralized staffing model as opposed to dispatching staff from a centralized site in larger cities. Who lives in communities now, knows the communities well, has local credibility, and is likely to stay?

We suggest opening any crisis training offering to a broad group of service providers and paraprofessionals who are interested in building crisis competency.

The consulting team heard in multiple meetings that individuals might not be willing/comfortable seeking government-operated services or formal mental health services. This may work to the advantage of addressing traditional workforce limitations. Some of these suggestions include those gleaned in listening sessions:

- Growing peer support/parent peer support positions (as a stand-alone service)
- Consider career ladder opportunities for entry-level/lower-level positions
- Recruiting licensed practical nurses, individuals with a bachelor's degree in social sciences, psychiatric technicians, emergency department technicians, emergency medical technicians, and teacher's aides
- Recruiting/cross-training public health workers
- Consider park rangers as potential first responders
- Consider training cultural brokers (e.g., farm bureau-trained group and faith-based leaders trained in mental health first aid)

If this broad group of individuals can form the core of localized, rapid initial response, then licensed clinicians can either dispatch to the scene or join via tele-solution when the initial intervention indicates the need. Alternatively, they may be able to offer or facilitate non-LEA transportation to a local service hub, crisis center, or emergency department.

There are smartphone apps that can simplify scheduling for this type of de-centralized, part-time, on-call model—that can push out shifts for folks to sign up for and to inform the centralized call center/dispatch team about the available resources at any point in time. An example of this is When to Work[9] software that staff can download on their phones and use to do things like view their schedules, request vacation, pick up shifts, and read manager messages.

There were several regional conversations about assuring that practitioners "work to the maximum of their license" and that work that can be done by non-licensed providers be pushed to that level.

Workforce Training

A set of core competencies and, where applicable, certification processes, can tie this diverse and decentralized workforce together. An individual does not have to have a certain level of education or clinical license to learn and use the skills. With a lean workforce, it is essential that every contact whether by phone or in person, be a competent and beneficial contact. As we learned during our listening sessions, several of these models are already available in parts of Idaho.

[9] https://whentowork.com/mobile-employee-scheduling.htm

- Learning from individuals with lived experience and family members
- Recovery/resiliency principles,
- Delivering interventions that are person/family-centered, strength-based, collaborative and resolution-focused
- Engaging and supporting parents and other caregivers
- Trauma-informed care
- ASIST Training and/or Mental Health First Aid
- Basics of Motivational Interviewing
- Safety planning

For the professional (non-crisis team) workforce, there are two relatively recently disseminated models for supporting individuals with suicidality in various treatment settings, including outpatient. It is essential that outpatient clinics increase their confidence in supporting individuals in the community when it can be safely managed—reducing the use of DE and LEA responses, reducing the use of inpatient treatment and avoiding the potential iatrogenic risks of these approaches. Expanded outpatient clinic competency will also help post-crisis episode when individuals can be linked to clinicians who specialize in this work. Both of the models highlighted here are evidence-based and connected to the Zero Suicide Initiative.

1. **Assessment and Management of Suicide Risk (AMSR):** AMSR's research-informed risk formulation model helps health and behavioral health professionals feel confident navigating challenging conversations and offers key strategies for providing compassionate care to people at risk for suicide.[10]
   - There is a Train the Trainer option for AMSR
   - AMSR is for direct care staff as well as clinicians with a master's or doctoral degree in a behavioral health field
   - There are specialized modules for varying levels of care and type of care provider

2. **Collaborative Assessment and Management of Suicidality (CAMS):** CAMS, first and foremost, is a clinical philosophy of care. It is a therapeutic framework for suicide-specific assessment and treatment of an individual's suicidal risk. It is a flexible approach that can be used across theoretical orientations and disciplines for a wide range of individuals who are suicidal across treatment settings and different treatment modalities.[11]
   - There is not a Train the Trainer option for CAMS
   - There are both web-based and classroom learning options

Medical and Social Partnership: Screening, Brief Intervention, Referral to Treatment (SBIRT)

SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders (SUDs) and those at risk of developing these disorders. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral

[10] http://zerosuicideinstitute.com/amsr/about-amsr
[11] https://cams-care.com

change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

- Any health worker could be trained in SBIRT
- There are a lot of tools available to guide this brief intervention as well as formal training
- This is an approach that can be used in multiple settings, including mobile crisis response, Crisis Centers, emergency departments, emergency medical services response, and health clinics.
- It is a non-judgmental, collaborative model that uses motivational interviewing and harm reduction techniques along with a screening tool and educational materials.

Crisis Service Array

We recommend that the state consider a relatively modest number of new crisis services, aimed at continuing to shift the location of services away from emergency departments and to the community, and building on the success that Crisis Centers have had in this regard. To the degree that it is feasible, we recommend maximum flexibility on the location of service delivery reimbursing for home and community-based services and transportation services. Recommended services align with eight best in class core system components (identified in introduction):

Service Detail

1. Centralized Call Center

Eligibility: No age/payor restrictions. Can make determinations about who is not eligible for mobile response (based on setting they are living in, or service set they are receiving in the community).

The Centralized Call Center cross-cuts all Crisis System of Care Phases and is the organizing, "intelligence" hub of the statewide crisis center; that maintains a 10,000 ft. view of real-time crisis activity is nimble in matching resources and demand; works in real-time to assure that the system is functioning and acts swiftly to mitigate when it is not. Providers of crisis services work with the Call Center throughout an episode, data is exchanged between these players, and they collectively ensure a viable strategy in collaboration with the person in crisis, family members, and community stakeholders.

- Resolution-focused engagement/consultation with all callers, including those in crisis and those engaging a person in crisis in the community (some crises can be sufficiently resolved, or timely services arranged, to the satisfaction of the caller via this type of consultation, —reducing the need for an immediate mobile response.)
- Dispatch (includes verbal/electronic communication from Call Center to Crisis Responder regarding the nature of the crisis, location, known safety plan/advance directive/accommodation requests, known treatment history)
- Resource management, this could include:
  - Transportation management
  - Bed capacity tracking
  - Service authorization (such as peer specialty second responder service—described below)
  - Scheduling initial appointments

- Data warehouse
  - Crisis episode data, response timeliness, referrals in/out
  - Repository for crisis plans, psychiatric advance directives, alerts, accommodation registries
  - Ability to receive/pull data from other treatment providers
  - Ability to push data out to responding crisis teams
- Peer warm line/warm transfer capability
- Follow up calls

2. Mobile Crisis Intervention (first responder teams)

Eligibility: No age/payor restrictions.

There are an array of models to consider, and regions have been given the latitude to select a regionally relevant model. We will advise, however, that regions steer away from LEA co-response models as the primary model. This type of response should only be used when there is a law enforcement reason to respond. This service would allow for a clinician to join via a tele-solution when a face-to-face response is not feasible. Mobile Crisis Intervention services feature:

- 24/7/365 availability
- In-community response within an average of one to two hours by at least one person who might be a peer specialist or "certified" crisis responder (not necessarily a licensed clinician)
  - This could include arranging to meet at Wi-Fi-capable, designated hubs, or sites within each county
- An emphasis on engagement, brief treatment/support, problem-solving, harm reduction, safety planning, and accessing any needed resources. This is not a service that is limited to the level of care determination.
- Prescriber consultation capability (via tele-solution)

3. Specialized Crisis Response Services (second responder teams)

Eligibility: Could be limited to individuals with Medicaid/uninsured, with a defined target group for each of the services.

It will likely not be feasible to have specialty 24/7 crisis teams; however, a pool of specially trained individuals[12] could provide a timely secondary response, and we think this would be useful for three groups, to begin with:

- Children and families
- Individuals with IDD (Look at the North Carolina START program as a potential model which has three regional START teams that cover the state) [13]
- Peer Outreach and Engagement (for at-risk individuals who are not linked and ambivalent about treatment services

[12] Individuals would not necessarily need to be fulltime or dedicated positions, could support some de-centralization, and have some seven-day a week flexibility
[13] https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/nc-start

These services would be provided within the context of a still-resolving crisis episode, would be brief in nature (i.e., up to 14 days). The decision to use a second responder team could be made in conjunction with the Call Center to prioritize need/control access/help to set treatment objectives. Again, a scheduling app can aid the Call Center in understanding the available resources at any given time. The focus of the work might include:

- Crisis stabilization and brief treatment
- Care coordination/cross-system meetings
- Comprehensive safety or behavioral planning
- Parent/caregiver engagement, support

4. Peer Support Services

Eligibility: Could be limited to individuals with Medicaid/uninsured

While Peer Support Services (inclusive of adult peer specialists and parent peer support specialists) can and should be embedded in several of the proposed services, it is worthwhile to build this as a stand-alone crisis support service that can be accessed and "authorized" via the Call Center. It is anticipated that as a stand-alone service, it would most likely be used for early crisis intervention and to support recovery/reintegration.

5. Child/Adolescent Regional Crisis Stabilization Beds

Eligibility: Could be limited to individuals with Medicaid/uninsured.

There is such a dearth of children's inpatient treatment beds in Idaho that this recommendation rises fairly quickly to the top of the list. It is a service that can support the YES expansion, prevent admission to restrictive, distant, and even out-of-state hospitals, foster homes, detention centers, and referrals to RTFs. Tying access to the "specialty child and family team" would help to control front and back door of this type of bed. One to three day length of stay is reasonable and sufficient in most instances (especially if ensuring the beds are not used as emergency Child Protective Services placement). This type of bed is best used when paired with an active, parent-involved, community player-involved, resolution-focused care model.

Several states have successfully implemented specialized programs to provide stabilization beds for children and adolescents. One such program is Community-Based Acute Treatment (CBAT) for children and adolescents, in which short-term, crisis stabilization, therapeutic intervention, and specialized programming are offered to individuals. These services are offered in a staff-secure environment with a high degree of supervision and structure, with the goal of supporting the rapid and successful transition of the individual back to the community. [14]

6. Outpatient Specialty Clinics for Individuals with Suicidality

Eligibility: Individuals with Medicaid/uninsured, privately insured, as covered.

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[14] https://www.masspartnership.com/pdf/CBATSpecsFINALJul2014.pdf

The infusion of specific competencies into an existing level of care via evidence-based training of clinical teams that can support individuals with suicidality in the community; and work in a coordinated and collaborative fashion with the person in crisis, mobile team, and hospital teams when there is agreement that a higher level of care is needed.

7. Clinic-based Brief, Outpatient Crisis Services

Eligibility: Could limit to Medicaid/Uninsured.

- Expansion of model being used in Region IV and Region V
- Provided by DBH regional teams (or contractor)
- A clinic-based alternative to mobile crisis response
- Same or next day scheduling via call center
- Employee assistance program-like approach, with expectancy that this brief service is sufficiently resolving and referral to ongoing services may not be necessary

8. Post-Hospital Stabilization Service

Eligibility: Medicaid/Uninsured, not currently linked to services for individuals with complex risks/needs/tenuous community connections to support successful recovery/reintegration.

- Expansion of the model being used in Regions III and VII
- Could be delivered by DBH or a contracting agency and "authorized" by the crisis center
- Up to 30 days
- Peer-inclusive team
- Individuals receiving this service would remain under the radar of the crisis call center

9. Psychiatric Consult Line

Eligibility: No payor/age restrictions.

The purpose of this service is to build the competency and capacity of physicians and physician extenders/other prescribers in varying settings to address the psychopharmacological needs of their patients, to consider differential diagnoses, and to consider when referral for specialized services is indicated. Focus would be physicians/prescribers working in primary and specialty health care settings. This is not intended as a telemedicine service. The state could lead the way in this area and facilitate the implementation and operation of the consult line.

The Project ECHO program is an additional offering that could be utilized to upskill and enhance the training of physicians and behavioral health counselors. Through this hub-and-spoke organized program, a specialist/subject matter expert connects via video link to community-based practitioners to offer mentorship and case-based learning.

The recommended "new" services above are specific to persons who are experiencing a behavioral health crisis and are not intended to be a replacement for a comprehensive array of behavioral care funded through Medicaid or commercial insurance. For the prevention and early intervention of a behavioral health crisis for persons experiencing a significant mental illness, severe emotional disturbance, or who has an intellectual or developmental disability, DBH may want to consider working with Medicaid to review the existing non-crisis specific behavioral health benefits and limits. Additionally, the State may want to consider additional rehabilitation option or 1915(i) services such as assertive community treatment or community psychiatric support and treatment to ensure that comprehensive community-based levels of care are available.

Competencies to Support Further Development of a Crisis System of Care in Idaho

In addition to the recommendations for specific services, in this section, we offer a set of overarching recommendations followed by a summary of regionally specific recommendations that are a product of our series of tours, DBH meetings, and listening sessions.

Expand Peer Services

To inform and speed the transformation from crisis response in its current form to the modern day system that Idaho envisions, we recommend maximizing the involvement of individuals with lived experience and family members in service design, evaluation, oversight, and direct practice. Individuals with lived experience and their insights are invaluable into what helps or harms individuals in crisis. These individuals will be of great benefit to the traditional behavioral health workforce and allow insight into reasons for reducing coercive approaches, creating viable alternatives to inpatient treatment, to understand the business reasons for attending to the burden, exhaustion and support needs of parents and other caregivers whose children/family members are struggling and suffering, often chronically. Directly, adult peer and parent Peer Support Specialists can be employed to provide:

- Consultation regarding recovery and engagement strategies to clinical team members
- Fast, in person, initial crisis response (Phases 2 and 3)
- Transportation solutions (Phases 2 and 3, in lieu of law enforcement when consistent with safety)
- Engagement, bridging, connecting to resources (Phase 4 and 5)
- Parent/caregiver peer support (Phases 2 through 5)

Enhance Core Crisis Competencies

We recommend that crisis competency expectations are written into all service definitions and performance specifications for all mental health and substance use services. Expectations could include the ability to:

- Aid in the development of meaningful safety plans, psychiatric advance directives, and accommodation requests.
- Accommodate reasonable capacity (commensurate with the size of agency/type of service) each week for unscheduled/rapidly scheduled early crisis intervention of individuals who are in or should be in treatment
- Develop in-house, first-line crisis consultation to support/join in-session clinicians who have individuals in crisis and whose needs exceed the skills of the particular clinician.
- Provide meaningful on-call services (for agencies that are required to so). On-call services are robust and resolution-focused, are answered by individuals who can access clinical notes and crisis plans, and who can facilitate a plan for an in-house urgent FTF service.
- Develop policies and procedural guidance on how to access the crisis system when necessary using least restrictive methods
- Coordinate with crisis treaters as necessary
- Monitor and plan individualized means of supporting individuals in the aftermath of crisis episodes.

Adopt a Quadrant Model for Rethinking Psychiatric Hospitalization

Front and center in any conversation about developing a crisis system of care should be the likelihood of good health outcomes in those who come into contact with the system, with two key considerations:

1. In its current operation, is the crisis system and each of the component services within the system improving the health of the individuals who are receiving them?
2. Is the system alert to, tracking, and actively working to mitigate "iatrogenic" risks of receiving services from this very same system and each of the component services within the system?

"Iatrogenic" relates to the harm that comes from treatment (a word of Greek origin meaning "brought forth by a healer"). Although iatrogenic risk is a topic of routine discussion in primary medicine, the same is not generally true in the greater mental health field where the term is often unknown and/or the concept is not understood other than in the use of psychotropic medications. One notable exception is in the use of restraints. There continues to be substantial efforts to eliminate the use of restraints in facilities due to the high risk of iatrogenic harm (psychological and physical), including the risk of fatality.

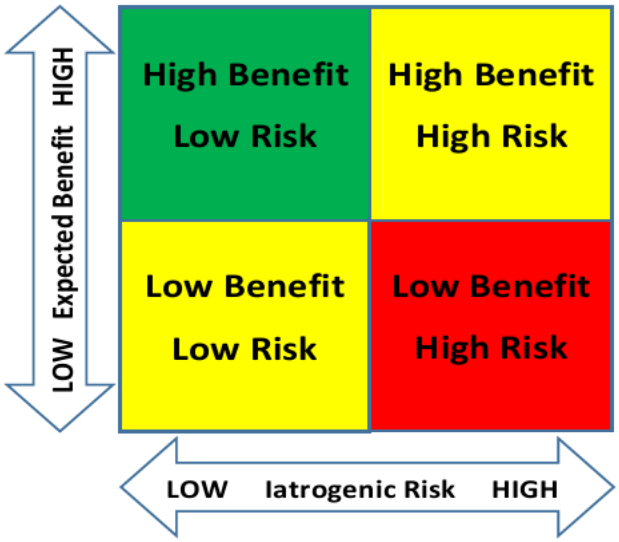
Iatrogenic harm is 1) generally unintended, and 2) often avoidable. However, if a system/agency/practitioner does not recognize the possibility of harm, there will not be steps to mitigate it (or even a recognition that the system model or practitioner interventions might be the cause of the harm). Often, signs of iatrogenic risk from mental health interventions include decompensation, intense emotion, disengagement, powerlessness, refusal, and other fight/flight/flee reactions. These responses can easily be interpreted as a sign of the person's underlying condition rather than as a normal response to approaches that are experienced as harmful.

In the context of developing modern crisis systems of care, it is useful to recognize how much of the field's historic crisis response practice has revolved around evaluating the need for hospitalization, use of involuntary processes to compel this level of care, and use of law enforcement and courts for

various components of this work. This includes, but is not limited to, a determination of risk, conveyance for legal purposes, and transportation because alternatives are not available or customary. Criteria for commitment is relatively similar from state to state but does not speak to the need to consider iatrogenic harm in the determination. There is an inherent bias in commitment laws that presumes the proposed treatment is good for the person being committed and that his/her judgment, as evidenced by treatment refusal, is impaired.

When a state or local system builds a comprehensive crisis system of care, there should be a shift away from a primacy view of inpatient psychiatric hospitalization and commitment procedures in addressing behavioral health crises. While this is what should occur, historical approaches can evoke a sense of 'safety' in the providers of treatment and the system at large. It can feel dangerous to shift to less restrictive, community-based, and voluntary forms of treatment. It is essential that the limitations and risk of historic practices are understood so that the risks of maintaining the status quo become clear and give rise to investment in newer, less restrictive practices and a greater ability to individualize treatment.

The Quadrant Model for Re-Thinking Psychiatric Hospitalization, depicted on the following page, looks at the intersectionality of two person-specific considerations for individuals thought to need psychiatric hospitalization: the expected health benefit and the iatrogenic risk. Note the essential subjectivity of this—health benefit and iatrogenic risk must be considered from the perspective of the person hospitalized—this is quite different from a practitioner saying, "we are hospitalizing you, for your safety and you will be better for it."



Source: Madenwald Consulting, LLC

Expected Benefit: The benefits of inpatient hospitalization tend to be oversold and viewed as the pre-eminent behavioral health service—so much so that you can be sent there involuntarily, to a facility that has an open bed, and it might be located hours from your home. In reality, the efficacy is certainly well shy of 100 percent (understanding this takes more of a practice-based consideration since there is minimal literature on the effectiveness of this level of care.) A query that is useful is:

> *Considering all of the individuals that we have hospitalized in the past year, what percent of individuals experienced a good health benefit from that service?*

Further inquiry can elicit information about factors that are likely to increase/decrease expectancy of a good health benefit.

Iatrogenic Risk: The risks of inpatient hospitalization tend to be under-considered, but rarely are there NO harmful effects, and for some individuals the iatrogenic risk is very high. A query that is useful:

> *In what ways can inpatient hospitalization result in iatrogenic harm? What systemic factors or facility factors increase the likelihood of iatrogenic harm? What person-specific factors increase the likelihood that an individual will experience iatrogenic harm?"*

The greatest disservice, of course, would be to individuals who fall in the red box in the above illustration: those who receive no health benefit, yet suffer iatrogenic harm. There are certainly steps that can and should be taken to increase the health benefits of psychiatric hospitalization while reducing the risks. However, this exercise should also add to growing community consensus that allows alternative, community-based models of care to flourish.

Continue to Train and Promote Zero-Suicide Initiatives

Idaho is among the states that have invested in adopting a Zero-Suicide Initiative through the Department of Health and Welfare's Suicide Prevention Program.[15] The Zero Suicide framework is a set of tools and strategies to promote organization-wide transformations toward safer suicide care in health and behavioral health care systems.[16] The Zero Suicide Initiative puts forward the provocative and foundational belief that suicide deaths for individuals under the care of health and behavioral health systems are preventable, not as a way to point blame, but to promote the study of these adverse events, to mitigate risks, and to hone system/practitioner competency.

Key to this initiative is the development of a cross-the-continuum behavioral health workforce that is competent and capable of supporting individuals with suicidal thinking, including on an outpatient basis, with collaborative consideration of the potential health benefits/iatrogenic risks of a higher level of care. If the primary systemic response to a person reporting suicidal thinking is to stop treatment, call the police and/or initiate an evaluation for inpatient treatment, and/or any forced involuntary evaluation/care, then the resulting iatrogenic harm can influence the individual's future actions. In the future, individuals may no longer be honest with the treatment provider about that which most threatens his or her life. Building out the capacity of outpatient treatment providers to support individuals with suicidal thinking will be of great value and will do much to support a strong crisis system of care in Idaho.

Differentiate between a Crisis Intervention Service and a DE Evaluation

A DE evaluation is a well-defined process. Crisis Intervention, as a treatment service is not well defined or understood. A clear delineation is essential and this likely needs to start in-house. It sounds easier than it is in practice. The DBH teams have years of experience conducting DE evaluations—they know the components of the tool and the questions they need to answer in order to form a recommendation. Resolution-focused crisis intervention is fundamentally about the

[15] https://healthandwelfare.idaho.gov/Families/SuicidePreventionProgram
[16] http://zerosuicideinstitute.com/zero-suicide

treatment—not the written document. It is an entirely different focus and skill set and even if so inclined, teams do not have the time to do much in this space.

Ideally, the individuals conducting DE evaluations are different from those that provide resolution-focused crisis intervention. This is partly because it is hard to switch back and forth. It is also in part to ensure that individual in crisis are certain about what is happening and what their rights are in any given intervention. The Crisis Intervention team is more public facing; the DE evaluation team, less so. If Idaho operationalizes a centralized call center, this simplifies the process for service requesters—the people answering the crisis call will help to determine the proper first response and offer information about the nature of the service recommended.

As mentioned previously in the report, developing one-pager type tools will be useful to educate the community. These could include:

- Definitions/differences between DE process and Crisis Intervention as a treatment service
- Business reasons for reducing use of DEs
- Decision guides for calling law enforcement, using emergency departments vs. using less restrictive mobile and site-based crisis services.

With a more robust crisis intervention service available, there is increased opportunity for stabilization in the community or through less-restrictive treatment options and fewer need to initiate the DE process. This system change may provide rationale for simplifying the involuntary treatment process—perhaps allowing for a single specialized DE evaluation from a dedicated team. This approach could perhaps take DBH out of the direct evaluation process altogether—using specialized evaluator as an objective third party.

Law enforcement agencies, emergency departments, and judges will be essential partners in reducing the use of the DE process and will want to see evidence that the reduced use is not creating any harms. Tracking this data is important.

Finally, in every state, there seems to be factors that result in the use of involuntary processes for reasons other than the person's condition. In Idaho, we learned that there are individuals who are involuntarily hospitalized so that the cost of the care is billed to the county rather than the individual who cannot afford the cost of it. Factors in other states include use of involuntary processes as a way to secure transportation (by law enforcement or ambulance), as a blanket though ill-advised "risk-management" strategy of an emergency department, or for convenience of a receiving hospital. It is helpful to know what aberrant incentives might be at play in Idaho so that they can be addressed in a way that has less consequence for the individual in crisis.

Define the Role of the State and Regional Behavioral Health Authority

As DBH shifts its focus away from the provision of state-funded clinic services to the provision of crisis service to all Idahoans, we see the ability of DBH to also enhance their role as the state and regional behavioral health authority. As WICHE proposed among its set of recommendations in the 2018 Behavioral Health System Redesign Report, DBH should be a guarantor of services by

administering, monitoring, and ensuring the quality of care; leading collaborative efforts; and integrating operations within DBH. Some of DBH's capabilities in this capacity should include:

- Maintaining a 10,000-foot view
- Mapping/hot-spotting
- Convening/collaborative-building
- Data-mining
- Minding and addressing the "gaps" in care through strategic initiatives and service contracting
- Service management (watching trends in timeliness, length of an episode, front door access issues/back door discharge issues)
- Tracking and seeking to minimize the use of approaches most likely to be experienced as iatrogenic (e.g., law enforcement touches, requests for DEs, CPS referrals related to mental health crises, involuntary hospitalization, out of home services when a great distance from home)

Regional Recommendations

The listening sessions and tours in each region were well attended. Numerous topics were covered, and great ideas were discussed. Summaries were prepared for and sent to DBH leadership in each region to aid in planning. The summaries all included a set of considerations and represented a mix of what was heard in the sessions and ideas from the consulting team. These are not offered with an expectation that each item should be carried out, but they are worth a further conversation to determine which, if any, the region might feel interested and ready to pursue. Recommendations from one region may apply to many, the detailed list in the appendix is a reflection of the discussion with any given region.

Payors' Roundtable Recommendations

We recommend DBH move forward with recommendations identified jointly in the August 2019 Payors' Roundtable, including to convene a quarterly payors meeting focused on collaboration and data sharing. Topics should include:

- Developing a shared release of information for crisis services
- Establishing all-payor database with protocols for information sharing when a crisis occurs (i.e., building upon WITS, Accommodations Registry, and new Idaho Health Data Exchange)
- All-payor funding of crisis services (including pre-crisis diversionary care, air traffic control, and post-crisis coordination)
- Developing joint strategies to address workforce shortages and invest collaboratively in workforce development
- Developing standardized information-sharing tools for consumers that can be used by providers, social service/community-based organizations, first responders, and payors (e.g., resource directory, fact sheets, Crisis Center contact info sheet)

Additionally, we recommend DBH leverage the existing work led by Region III, which has obtained funding from Blue Cross of Idaho Foundation to explore the development of a joint system-of-care initiative. The Division should monitor this work closely, to ensure feedback is provided to the legislature and to determine how the learnings can be applied to a statewide perspective.

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Financing a Crisis System of Care

Design Principles, Best Practice Examples, and Considerations for Idaho

Much like emergency services, crisis services are most effective when they are available to the entire community. Those receiving services can include children, adults, or older adults, and can range from individuals with a history of severe and persistent mental illness or SUD or those who have never accessed behavioral health services before. The nature of a comprehensive crisis system, with a complex range of programs and services for addressing various individual situations, often makes it difficult to finance crisis services within the constraints and eligibility parameters of one particular funding stream.

Funding that is tied to a specifically defined population, or categorical funding streams (e.g., youth in foster care) can make it difficult to build a continuum of crisis services, in which the nature of the services requires a "fire-house" staffing model that needs to respond to individuals immediately, often before establishing insurance status or categorical program eligibility. Overcoming these limitations requires the development of an overall strategy that can leverage multiple funding sources to support a system that is available to meet the immediate needs of individuals in crisis. The system must have the capacity and processes that are capable of reconciling, braiding, and maximizing multiple funding strands—ultimately supporting the provision of services that exceed far beyond what a single system could have mobilized. Best practices can be leveraged from other states that have grappled with these policy challenges and implemented comprehensive, population-based crisis models.

Principles in Designing Crisis System Funding and Contract Models

Populations for Coverage and Access. An exemplary behavioral health crisis response system should be payor-blind, and available to the entire community regardless of age, income level, or insurance status. This population-based model allows multiple funding sources to be leveraged to support a single system and provides for a safety net that can be nimble and meet the needs of any individual experiencing a behavioral health crisis, regardless of eligibility. Additionally, payor-blind systems support the provision of immediate services prior to establishing eligibility criteria, recognizing that often in a behavioral health crisis identification/eligibility screening is not promptly feasible.

Payment Methodologies and Contracting Structures. It is important to consider how the financing and contracting design for a crisis system can support Idaho's goals and objectives, maximize multiple funding streams, and support the performance & accountability that the State seeks to achieve. For example:

- **Payment Model:** Since behavioral health crises impact public and private spheres, a joint public and private solution is optimal. In a true public-private partnership, multiple funding streams are leveraged to fund the crisis system. The first questions to ask when developing the payment model is how a public health/firehouse model is funded and proportionally what level of funding is provided by the state and Medicaid funds and at what level and method do private payors/commercial insurance contribute? Two examples are provided on the following page:

1. **Traditional Insurance Model:** All crisis services are reimbursable, with fixed codes and encounters built into the process. Providers bill Medicaid for Medicaid covered services, commercial insurers for commercial any covered benefits, and DBH for state-funded services. All payors then reimburse providers for the provision of covered benefits provided specifically for their assigned individuals. Massachusetts uses a model like this today and has a code set for commercial payors who reimburse for crisis services.
2. **Insurance Pool Model:** DBH creates a "Crisis Pool" comprised of state crisis funds and fees paid by commercial insurers (Medicaid could be included as well). Fees are collected as a payor tax (percent of premium) or a per member per month fee. Crisis services are reimbursable, with fixed codes and encounters built into the process. Providers either bill Medicaid or DBH. Medicaid reimburses all covered services for Medicaid enrollees, and the DBH "Crisis Pool" reimburses providers for all other non-Medicaid services and services to non-Medicaid individuals.

- **Incentivizing Prevention:** In designing the financing and contracting model for a crisis system, Idaho should consider creating contractual and financial incentives or requirements to drive investment in preventive and upstream services that can keep high-risk individuals out of the crisis system.
- **Coverage for Rural Areas:** Best practice states like Washington or Arizona have adopted a policy of "regionalization" in which rural counties are regionalized with more urban/populous counties to create a larger risk pool and service area that can attract vendors/payors to serve an entire region. This model limits the risks inherent in a county-by-county purchasing approach of rural areas being underserved. Idaho is well-positioned to adopt this approach, building on the existing foundation provided by the seven behavioral health regional authorities.
- **The Economy of Scale:** Because resources are typically highly limited for crisis, economy of scale should be leveraged in a crisis system design order to maximize resources, particularly for shared services. For example, a single crisis hotline managed at a statewide level is likely to be more cost-effective than managing multiple regional hotlines, which creates duplicative administrative costs incurred by each region. An added benefit of a statewide approach is more streamlined "marketing", driving awareness and availability of crisis services across all of Idaho.

Administrative functions such as reporting on block grant expenditures, claims or encounter data adjudication, eligibility verification, or coordination of benefits can be centralized to achieve maximum efficiency. For this reason, developing crisis services that are specific to a single eligibility category (e.g., a crisis line for foster kids) is not recommended, and can result in duplication of services that could otherwise be shared across populations.

Funding Sources. High-functioning crisis systems are supported by multiple funding sources that can include Medicaid, private insurance, state funds for indigent populations, SAMHSA block grants, and other available funding sources (e.g., population-specific grants, State earmarks or provisos). For example, in Tennessee, private insurers pay for about 2 percent of those crisis services, and self-pay is collected for higher-income individuals. In Massachusetts, commercial insurers account for 20 percent of all crisis interventions. In Michigan, freestanding crisis centers have contracts with private insurers to bill for services.

For individuals covered by Medicaid, crisis-related services are Medicaid reimbursable, and Medicaid should be pursued to the maximum extent. For example, the following crisis-related services are typically Medicaid reimbursable:

- Behavioral health hotline services (often referred to as crisis response)
- Warm lines
- Crisis intervention services (supporting mobile crisis response)
- Case management/Care Coordination
- Peer services
- Short-term crisis residential stabilization services
- 23-hour crisis stabilization beds
- Psychiatric advance directive statements

Maximizing Medicaid can make available non-Medicaid funding sources, which are recommended to be preserved and strategically re-directed to fill gaps, build infrastructure, and support populations or services that Medicaid will not. To accomplish this, states can employ "braided funding," defined as: braiding multiple funding streams that are originally separate, and brought together (by a "payor") to pay for more services than anyone stream can support, and then carefully pulled apart with separate fund source accountability to report to funders on how the money was spent.

For example, state, block grant, foundations, and local funds (where available) may be leveraged to support crisis services for indigent, non-citizen, or Medicare-only individuals, or services for all individuals that cannot be reimbursed by Medicaid (e.g., transportation, housing, outreach, capacity building, training, court costs, infrastructure). These funds can also be strategically directed to support preventive or diversionary services for high utilizing non-Medicaid individuals to reduce this population's utilization of high-cost crisis or inpatient services.

Data and Rate Setting. To ensure continued Medicaid funding to support crisis services utilization, encounter data,[17] or claims data must be sent back to the Idaho State Medicaid system for utilization tracking and to inform actuarial rate setting. This requires all crisis providers, including hotline vendors, to have the capacity to support encounter reporting.

Best Practice Practical Examples (Washington)

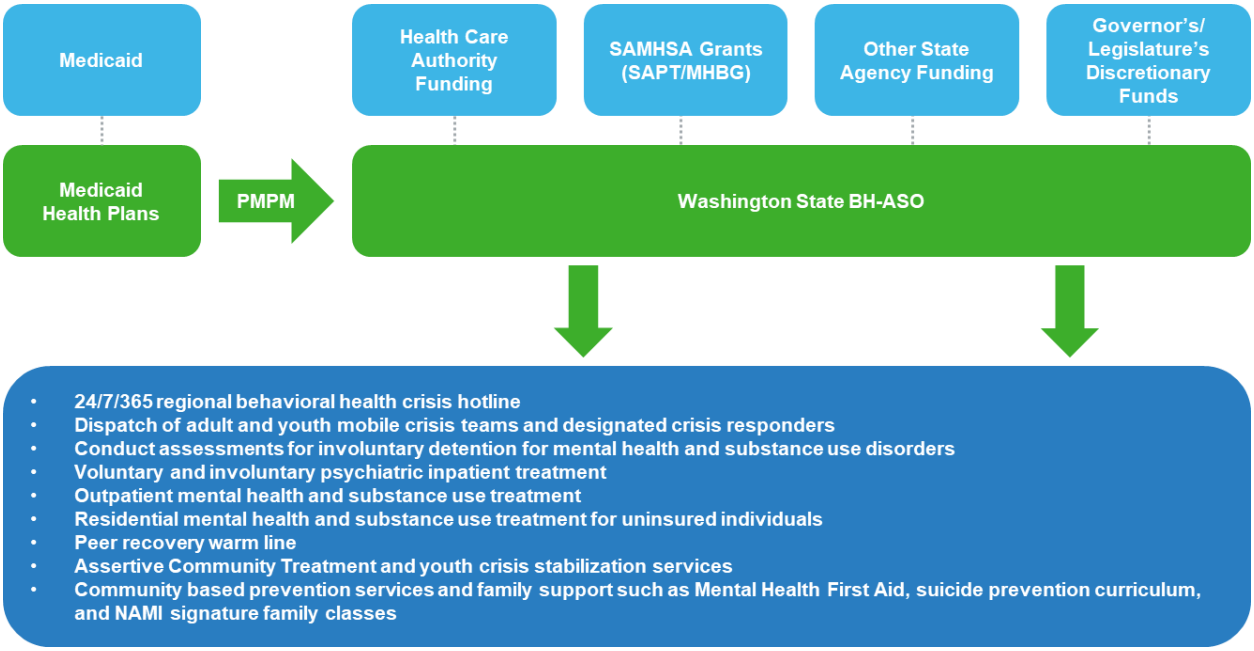
Braided Funding Model and Contracting Design. Washington's braided funding model and contract design allows a single, centralized entity to braid an unlimited number of available funding streams to support a crisis continuum and related support services, for all populations. The centralized entity, known as the Behavioral Health Administrative Service Organization (BH-ASO) is the recipient and manager of multiple contracts, funded by various funding sources, including:

- Medicaid funds contracted from integrated MCOs to the BH-ASO
- Federal block grant funds contracted from the State to the ASO
- Criminal Justice Grant funds contracted from the State to the ASO
- State General Funds contracted from the State to the ASO
- State provisos, which are legislatively directed to support specific programs

Washington's contracting structure requires accountable Medicaid payors (MCOs) to subcontract to the BH-ASO for all Medicaid-reimbursable crisis services, ensuring Medicaid funds are maximized

[17] Encounter data are records of health care services for which MCOs or ASOs pay. Encounter data is conceptually equivalent to paid claims records that state Medicaid agencies create when they pay providers on a fee-for-service data. When MCOs/ASOs pay providers on a sub-capitated basis, they submit encounter data to the State to represent utilization of services.

for eligible individuals and services. This design requires the MCOs to use a sub-capitated payment methodology and conduct a semi-annual financial reconciliation to true-up payment based on actual utilization, a design that provides the BH-ASO with a steady and stable funding stream in the form of a PMPM to support crisis service delivery.



Because MCOs in Washington are technically at-risk for crisis services for their members and conduct a semi-annual financial reconciliation with the BH-ASO, the MCO remains strongly incentivized to invest in prevention or diversionary services that will keep individuals covered by Medicaid out of the crisis system. Before this, when outpatient/preventive behavioral and crisis services were bi-furcated across payors with no singular at-risk entity, there was an incentive to cost-shift into the crisis system. Additionally, the Washington model allows for private insurers to contract with the BH-ASO to support services for commercial or individual market members.

The BH-ASO contracts with a network of crisis service providers and is responsible to undertake the administrative work inherent in a braided funding system, such as reporting and tracking each cost based on individual eligibility. The BH-ASO typically funds crisis service providers using a capitated payment methodology which allows the crisis providers to maintain a "firehouse model" of 24/7 services, and to focus largely on delivery of services rather than navigating the multitude of complex billing and reporting requirements that can be different with each funding source.

Data Sharing. Because of the formal contractual agreement between Medicaid MCOs and the centralized BH-ASO, there is an ability to share data back and forth for individuals covered by Medicaid. For example, the BH-ASO is required to share crisis hotline call notes with an individual's MCO within 24 hours, to support continued care coordination and outreach efforts by the MCO. In the event a commercial insurance plan contracts with the BH-ASO to support crisis services for their members, this same data-sharing ability would apply.

Additionally, utilization data for individuals covered by Medicaid flows directly from the BH-ASO to the Medicaid MCOs. This encounter data is used by the MCOs to support data analytics and predictive modeling to identify high-risk individuals and is also shared from the MCO to the State to support actuarial rate setting.

Interagency Agreements to Support Braided Funding ASO Model. In 2016 when Washington launched the BH-ASO crisis model, the State Medicaid agency and Department of Social and Human Services (DSHS) were different State authorities. As such, to support the contracting authority under a single agency, the two agencies employed the use of service level interagency agreements that transferred block grant and state general funds from DSHS to the State Medicaid Agency for contracting with a single BH-ASO. This strategy allowed for centralized contracting authority under one agency, despite bi-furcated state budgeting authority.

The interagency/SLA strategy served as an interim solution until 2019, when the legislature formally merged authority and funding for community behavioral health to the State Medicaid Agency, providing for more centralized authority under a single agency.

In Idaho, a similar approach could be employed to integrate contracting authority across multiple Divisions with Department of Health and Welfare (DHW). In this way, all state funders are engaged in the design, funding, and oversight of crisis service delivery, recognizing that multiple funding sources spanning several division authorities are likely to be braided to support the development of a system that serves multiple eligibility groups.

Local Engagement, Information Sharing, and Capacity Building. Washington's crisis model provides for a BH-ASO in each region of the state, and the contractually requires the organization to engage locally with counties, Accountable Communities of Health, criminal justice, first responders, and social service providers to identify capacity-building opportunities and crisis system delivery improvements that are driven at the community-level.

With purview over more flexible funding sources like block grants and state general funds, this allows the BH-ASO to develop community-driven plans that braid non-Medicaid funding sources to better support the crisis continuum and fill gaps that Medicaid cannot support. As a best practice, the State required each BH-ASO to manage a Behavioral Health Advisory Board that is at least 51 percent consumer-led, to ensure funding for new programs is developed in accordance with regional consumer needs. The BH-ASO is also contractually obligated to market information on the crisis hotline and other available services to consumers and social service agencies, a policy that serves to increase awareness of resources.

Designing a New Financing and Contracting Model for the Idaho Crisis System of Care

Idaho is well positioned to build from the strong foundation of services provided by DBH regional staff and crisis centers and to leverage the opportunity provided by Medicaid expansion to design a new financing and contracting model for services that will braid funding sources to support a crisis system that is funded for capacity to serve all. Specific recommendations include:

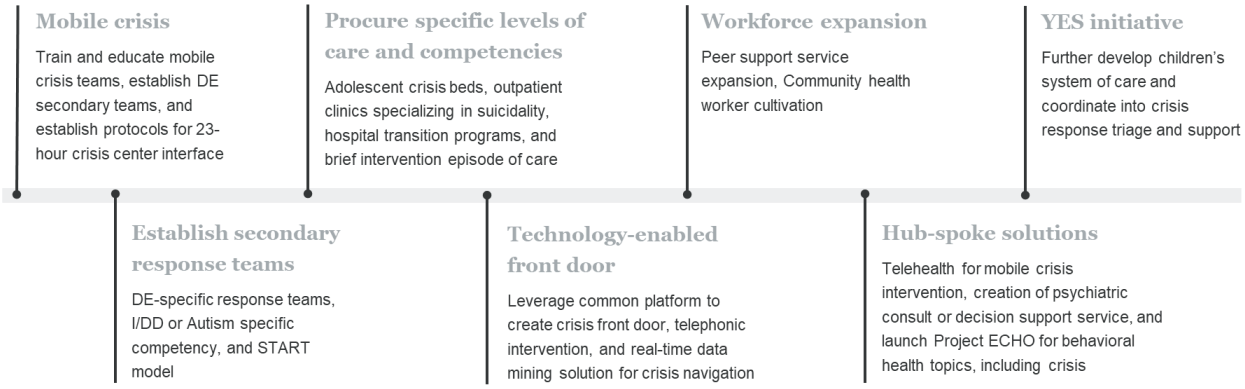
1. Designate a responsible body with authority to build a network of crisis service providers and to braid Medicaid, State Funds, block grant, and private payor funding to support the delivery of services to all individuals.
2. Review all existing regional or population-specific crisis hotlines and consider sunsetting duplicative hotlines and investing in a single statewide "air traffic control" that serves as a hotline as well as triage and dispatch for mobile crisis and potentially for DE's.
3. Conduct an actuarial study to assess historical crisis service delivery for individuals covered by Medicaid, understanding that services provided by DBH regional staff and Crisis Centers are not currently accounted for in the Medicaid PMPM. Re-base Medicaid rates for crisis response and crisis intervention services.
4. Using contract design or performance incentives/penalties, ensure that Medicaid payors are at-risk for their members' use of crisis services by requiring the statewide behavioral health organization to cover all crisis response intervention services delivered to their members, either by serving as single-payor organization identified in the models below, or by required sub-contracting with this entity. Separate the contracting authority for crisis services and regional offices that deliver services with a clear firewall.
5. Evaluate the services delivered by Crisis Centers and regional staff, as well as an evaluation of licensure requirements with the aim that crisis response and intervention services provided in these settings will meet requirements for Medicaid billing. This should include an examination of Crisis Centers to potentially qualify as "23-hour crisis stabilization beds" under Medicaid rules.
6. Support any necessary infrastructure or technical assistance to allow Crisis Centers and DBH regional service providers to bill Medicaid and private payors.
7. Evaluate the 2-step Designated Examination process, with the goal of streamlining the DE process to the maximum extent.

Summary and Next Steps

Idaho has made great strides over the past several years in developing and implementing services to provide behavioral health crisis care to constituents. Introduction of the YES program, the opening of regional crisis centers, and various innovative practices evident within regions are all examples of Idaho's work to advance crisis services. Despite these activities, there remain opportunities for service improvement and for the creation of a statewide comprehensive crisis system.

We recognize there is much to consider when exploring the creation and enhancement of crisis systems of care, and we believe that this report has provided some concrete, actionable recommendations for Idaho to implement. However, we recognize that these steps cannot all occur at once. The state should develop a roadmap of short- and longer-term strategies that will ultimately result in a comprehensive system. A suggested list of near term actions is provided on the following page.

Recommended Investment Staging



Further evolution will require:

Core Component	Short-Term Actions	Long-Term Actions
1-800 "Front Door"	• Explore options for implementing a coordinated front door for the state • Consistently measure and track outcomes data	• Implement the chosen contact center solution • Promote the use of proactive crisis plans or accommodation registries for high risk members
Mobile Crisis Units	• Launch mobile crisis program, ensuring that the teams' functions are distinct from DE activities	• Ensure that there is strong coordination and communication between mobile teams, crisis centers, and other community stakeholders
Community-Based Locations	• Ensure that appropriate CBLs are available and accessible in the community • Raise awareness of available resources	• Drive CBL-first answer for crisis intervention • Enhance processes related to CBLs, such as no-refusal procedures and medical clearance support/triage
Integrated SUD/MAT Solutions	• Evaluate and expand SUD services available in the community, ensure access is available	• Integrate SUD-trained crisis responders into mobile teams • Educate crisis providers and community stakeholders about the array of SUD services
23-Hour Receiving Centers or Peer Living Rooms	• Encourage collaborative efforts among receiving centers in the regions	• Establish funding plan and implement accessible peer living rooms

Core Component	Short-Term Actions	Long-Term Actions
Providers of all LOC, Available for Urgent Access	• Promote urgent appointment access practices among exiting providers • Promote the use of and assist with the training of a non-traditional, local workforce	• Expand types and number of providers where appropriate
Crisis Collaboratives	• Establish best practices within regional collaborative teams	• Expand the collaborative nature of the regions to a state-wide scale
System Management and Oversight	• Evaluate options for organization to organize and manage the statewide crisis system	• Ensure that the statewide crisis system is functioning efficiently and effectively, implement continuous improvement processes • Track and disseminate process and outcomes data

A comprehensive crisis system of care is possible in Idaho—these services would bring benefits to individuals while strengthening the overall health of communities throughout the state. Idaho has already deployed many of the foundational services that the state can build upon to organize a comprehensive system, and many of the stakeholders we met throughout our engagement are willing and able to bring about these enhancements.

We are always available to answer any questions or further discuss any of the recommendations provided in this report. We truly appreciate the opportunity we have been given to participate in the important work of crisis system advancement in Idaho, and we look forward to witnessing the positive changes the state will implement.

Appendix A

Focus Group Agenda

State of Idaho Crisis Response System Consultation
Focus Group Agenda
June 2019

I. Introductions
- Beacon team: Kappy Madenwald, Eric Van Allen, Briana Duffy

II. Level set
- Why focus on crisis, why now?
- Brief review of SOW (between Beacon and the State)
- Purpose for the day
- Crisis System of Care Framework

III. Dialogue: Regional crisis resources and needs
- How do those in crisis experience crisis response in the community?
- How do their families experience it?
- For whom does the crisis system work best?
- For whom is it least productive?
- What is the crisis system experience like for treatment providers when one of their clients is in crisis?
- What is working WELL that you do not want to see disrupted
- What is most frustrating?

IV. Wrap up
- What happens next?

Appendix B

Survey

1. Which Idaho region do you work, live or receive services in?
2. How do those in crisis experience crisis response in the community?
3. For whom does the crisis system work best?
4. How do families experience the crisis system?
5. What about the crisis system is working well in the region? What do you not want disrupted?
6. What are opportunities for improvement in crisis services/the crisis system?
7. What else should be taken into consideration while developing a more robust crisis system?

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Appendix C

Payors Meeting Summary

Executive Summary and Key Recommendations

The Idaho payors meeting identified areas of opportunity for collaboration across payors, and a willingness and desire to continue engaging to identify solutions related to crisis services. Participants described a system that is currently siloed and agreed that Medicaid expansion offers a fresh opportunity to restructure, improve coordination, address gaps in the service continuum and focus on data-sharing and care coordination. Key recommendations included:

- The State could convene a payor conversation (quarterly) focused on collaboration. Topics should include:
    a. Developing a shared release for crisis services;
    b. All-payor database with protocols for information sharing when crisis occurs (building upon WITS, Accommodations Registry, and new Idaho Health Data Exchange);
    c. All-payor funding of crisis services (including pre-crisis diversionary care, air traffic control and post crisis coordination);
    d. Developing joint strategies to address workforce shortages and invest collaboratively in workforce development;
    e. Developing standardized information sharing tools for consumers that can be used by providers, social service/community-based organizations, first responders and payors (i.e., resource directory, fact sheets, Crisis Center contact info sheet).
- The State and payors agreed that a centralized "air traffic control" system is necessary, to provide a centralized crisis hotline and dispatch service and improve coordination amongst multiple fragmented hotline systems, providers and payors.

Full Meeting Notes

Attendees: Ross Edmunds, Idaho Division of Behavioral Health (DBH); Candace Falsetti, DBH; Ben Skaags, DBH; Sara Bartles, Optum; Drew Ollivant, Idaho State Medicaid; Sara Stith, Idaho State Medicaid; Randy Workman, Idaho State Medicaid; David Welsh, IDate State Medicaid; Sarah Woodley, BPA Health; Scott Whittle, Select Health; Jenny Roberts, Blue Cross of Idaho; Idaho Department of Health and Welfare Director Dave Jeppson

I. <u>Table-Setting: State Officials (Dave Jeppesen)</u>

- State officials highlighted that the State is at a crossroads when it comes to behavioral health. The Governor has been participating in town halls across the State, and this is one of the only topics that comes up consistently at every meeting.
- The State has made significant strides in improving access to BH services in recent years, including:
    - Services provided by Ross' team

    - SUD service expansion
    - Crisis Centers
    - Inpatient MH in Treasure Valley
- Optum Contract which has "done what it was asked to do" (set standards and hold providers accountable)
- Medicaid expansion will propel the State forward to the next chapter in improving service delivery
    - Need to redesign emergency crisis service system
    - It needs to work for all populations, not just in a silo
    - It needs to be a comprehensive system that includes braided funding
- This work can only happen if everyone comes together, including payors and providers
- This is critical to fix now, as the largest generation in the country is millennials and the prevalence for anxiety & depression for this population is higher than any other

II. Discussion: What is your role as a payor in the crisis system? What kind of services do you have?

Optum

- We have a crisis phone line available that can answer a call from anyone and is staffed with a Master's level clinician
- Workflow is: Member calls > triage and de-escalation>referral to local provider or community resources >follow up call from Optum the next day to ask if they need additional assistance getting appointment
- For individuals who are not on Medicaid, there is a referral to resources or sometimes a welfare check is requested
- Crisis intervention and crisis response is part of Optum's fee schedule, and can be done via telephone or in-person

BPA

- Our system is very similar to what Optum does
- We have an after-hours risk line and can triage telephonically, sometimes de-escalate on the phone or sometimes call emergency response (911)
- BPA follows up with Medicaid clients the next day
- There are often established relationships in the community between hospitals and local providers, and clients go directly into the ED and then get referred to a local provider without BPA involvement
- There are no billable services related to crisis via BPA
- Right now, crisis calls to the after-hours line managed by BPA are very few and typically related to SUD

Select Health (Commercial Carrier)

- They don't have a specific crisis relationship because they are on an at-risk carrier, and the health plan primarily conducts care management

- Crisis is delegated to St. Luke's
- One of the areas of harm is that members hit a crisis system, they don't' know anything about an ACO or their network – they are going to providers who are not quality vetted, they are experiencing financial harm which is further exacerbating their crisis
- The other issue in Idaho is that members are especially susceptible to the national advertising that looks to pull people away from Idaho and put them in highly motivated profit driven treatment centers, that basically have no interface with local providers

Blue Cross

- There is an after-hours nurse partnership line but Blue Cross doesn't currently have data on whether that is being called for a MH crisis
- Care managers often have direct relationships with high-risk clients, and they may be assisting w/ crisis directly

III. How do your members experience a crisis?

- DBH articulated an example of how the fragmentation of the system leads to higher costs and lower outcomes. There was an example provided of an extremely high cost individual who was in crisis and hospitalized over 30 times, and it was a BCBS client. There is no coordination or data sharing across these payors, even though they are serving the same client.
- There are "a couple steps skipped" in terms of services – individuals are going straight to hospitalization because it is the only option, and there are not diversion opportunities or step-down

IV. What kind of data exchange happens today if any? Do you receive any information if your member contacts a crisis hotline?

- Right now there are multiple crisis lines and if a member calls one crisis line, there is no information sharing with other payors
- Payors do receive information about hospitalizations, but it typically takes 4 days
- Medicaid does know when their clients are hospitalized or receiving other services, as long as they are not in the State hospital
- There is a new health data exchange coming online as well as Telligen, a quality improvement organization (QIO), and within that system you can see if a Medicaid client has an assigned provider/care coordinator and appointments, etc.
- Commercial payors described crisis system as a "complete black box" and any information that is shared is typically relationship-based and not due to any systemic processes in place that facilitate information sharing

V. As payors, how do you interact with resources like the Crisis Center?

- Members who know about the Crisis Centers is often because an outpatient provider tells them about it (Optum)

- Optum clients are also often involved with DBH they might be part of an ACT team, etc. and they find out about Crisis Centers via DBH
- Most payors are not getting data from the Crisis Centers, and some Centers don't get eligibility data/personally identifiable information
- There is one Crisis Center in Boise that is talking w/ private insurers about buying into the resource as part of a sustainability plan, otherwise this is not being discussed
- For Select Health (Commercial Carrier) they do not offer Crisis Centers as a resource, but it's possible their delegated providers (St. Luke's, St. Joe's and St. Al's) might refer, or more likely the police will drop-off
- Blue Cross does not have crisis as a covered benefit and does not interact with Crisis Centers

VI. Visioning Statement – What are ideas for an ideal future state?

- There needs to be more intermediate levels of care (residential, step-down options, diversion)
- There needs to be additional providers within the State that can serve complex patients, so they are not being sent out-of-state: need to develop BH workforce pipeline
- Standardized release: there is an opportunity to create standardized medical release forms to further the ability to do information sharing across systems/providers/payors? Group would like to keep exploring this as an area of opportunity.
- Accommodations Registry: This registration is payor agnostic and will contain crisis plan information, similar to a psychiatric advanced directive – group would like to build awareness and use of this across the State for information sharing.
- Group agreed that a centralized air traffic control is necessary, as the current practice of multiple hotlines that are segmented by payor or population are not serving the community well.
- Improvements in case management and care coordination are vital, currently there is little data exchange from crisis providers back to payors, or across providers about shared members (i.e. PCP's and crisis providers, hospitals and BH outpatient providers, first responders and BH outpatient providers, etc.)

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Appendix D

Regional-Specific Recommendations to Advance the Provision of Crisis Delivery, identified by Group Participants

Region I

- Consider brief, cross-sector sequencing exercises, so partners recognize/remedy cumulative impacts on service users (for example, cumulative wait times, repeat storytelling, individuals experiencing service denial from multiple entities)
- Develop high service user (top 25) strategies
- Implement multidisciplinary team meetings (planning for this is underway)
- Implement next stage CIT Program development (several regional departments already collaborating)
- Consider the application of Cherokee Integrated Health Model to scale across the region (being used by Marimn Health right now)
- "Diverse counties, diverse approaches" across regions—develop practice guides for each, promoting movement toward a new vision
- Find opportunities to take tele-solutions to scale, such as:
  - Identify good Wi-Fi zones/zone partners throughout each region
  - Find local initial responders/engagers
  - DHW or Panhandle Health District has office space in every region (not necessarily space for meeting with the individual)
- Target training initiatives to community partners who are more likely to first engage someone in crisis
- Pursue grant opportunity for juvenile justice diversion initiative
- Ensure a balance of diversion vs. step-down usage of the crisis center
- Invest in training for community behavioral health treaters to build comfort in safety planning and in supporting individuals with suicidal ideation in the community

Region II

- Build upon the hub model in each county
- Develop a strong local understanding about the difference between coercive and collaborative/person-centered approaches (including threats to involve child protective services) and work to minimize approaches that are iatrogenic
- Grow a competent crisis supporters & first to respond group from teacher's aides, medical paraprofessionals, EMT, park rangers, clergy. This 'grow your own' approach invests in the individuals most likely to already be present & stay in the communities.
  - Build local, tech-level crisis positions (might be on-call) out of this group, bring in clinical/specialized support via tele-strategies
- Operate at the top of one's license/work scope
- Because of both scarcity and distance, it is important that every contact is an opportunity for relieving support, minimizing the need for a person to be referred on elsewhere (reduce "magic bed" thinking)
- Introduction of maintenance level of care (perhaps using peer support specialists) to add to existing outpatient treatment capacity

- Given cultural aversion to seeking behavioral health services, pursue inroads via trade groups/ associations such as the Farm Bureau. Seek to recruit peer specialists or trusted persons from these groups
- Resolve the background check barrier hindering the ability to recruit and hire additional peers
- Re-connect with schools about opportunities to provide in-school supports
    - Emphasize school & parent collaborative partnering in anticipating and planning for crisis response
- Fast-track local availability of tele-treatment. Work has been done here but some obstacles remain. There may be reciprocal licensure opportunities.
- Support crisis first responders via stress inoculation/compassion fatigue training and approaches

Region III

- Build out a strength-based, trust-building engagement model for use throughout the crisis continuum
- Develop strategies to bridge the prescription gap between hospital discharge and first appointment
- Move from CIT training to CIT programming—a more comprehensive strategy between law enforcement agencies and the behavioral health system to divert from both jails and emergency departments
- Develop strategies to incent landlords to accept housing vouchers
- Explore ways that community treatment providers can build out the crisis portion of their business using available services. Support this build-out with payment incentives (think financial incentive for offering urgent appointments) and reduce disincentives (lack of reimbursement for activities like continuity of care planning, mobile-to-community work, MDT meeting participation).
- Develop SUD crisis competencies (including SBIRT)
- Reduce disincentive for law enforcement agencies to transport to emergency departments by eliminating the need for them to stay in most circumstances. Some EDs and law enforcement agencies have worked out rapid transitions—seek to cement these procedures and expand the practice and in turn, seek new opportunities with law enforcement that is mutually beneficial. Engage county commissioners in this work if necessary.
- Develop a reimbursement model for co-response with paramedics/EMTs
- Develop a repository system for psychiatric advance directives/WRAP plans/crisis alerts
- Build more robust telehealth capability. Lifeways already have some capabilities in this area.
- Re-introduce cross-sector collaboratives with crisis systems-of-care development and oversight as a key focus.

Region IV

- Track and actively work to reduce approaches that are experienced as coercive
- Work towards “putting people at ease when in crisis” as a key goal of the intervention. Provide relief and resolution at each and every point of contact.
- Use trauma-informed approaches that reduce iatrogenic harm for persons in crisis and family members
- Provide stress-inoculation and compassion fatigue training and approaches that reduce vicarious traumatization of crisis first responders (including mobile crisis teams)

- Make the process clearer and more transparent for all, and particularly for an individual in crisis and their family members. Examine habits of practice that limit the sharing of information (e.g., individual understands the commitment findings and proceedings and the stress that comes from that process).
- Move forward with the plan to hold court hearings via teleconference (e.g., traveling judges/ magistrates is another model that could be considered)
- Maximize the role that others beyond the regional crisis team play in service delivery. The regional team is skilled and accustomed to delivering most crisis services themselves, but the difficulty of covering most of the region given the staffing and distance is apparent. Some of this work/planning is already underway:
  - Innovative local partnering for mobile response
  - The team has already met with key agencies about adding crisis appointments
  - Think about further ways to build crisis competencies across sectors (particularly in prevention, early intervention, and recovery/reintegration)
- Focus on treatment adherence & service preservation as a key crisis prevention tool. Data transparency will help tremendously.
- Examine the entirety of crisis episodes that require DE intervention, including who initiates the DE, when, and why. There is an opportunity to do this in the near future as the team transitions actively into a Mental Health Authority role and function with key responsibility for overseeing the Crisis System of Care. Participants reported that team time is heavily bogged by tasks related to DEs, such as conducting the exams, court hearings, etc. There is likely: 1) ability to divert; 2) ability to streamline processes; and 3) ability to reduce the wait time for the initial exam when it is necessary.
- Develop a single point of entry that is broadly known such as a designated crisis hotline even if there are many ways to get there (e.g., warm line transfer)
- Streamline the process for emergency room crisis center Allumbaugh House transfers to shorten the transfer times, address medical symptoms/gap in Medication-Assisted Treatment (MAT)
- Streamline communication strategies—gaps in communication are a major factor identified in each of the meetings. One participant described the need to build the "connective tissue" between each of the parts. This relates to focus areas like:
  - Care continuity
  - Shared definitions
  - A broader understanding of partners and their roles, (e.g., "This is what I wish I knew" sessions were recommended)
  - Tele-solutions to expand reach & speed initial response
- Begin to fill in the gaps of service options for children to reduce the use of out-of-state residential treatment facilities and extended stays in hospitals;
- Understand how crisis episode of care are different by payor and the impact on access, payment, etc. This will speak to the public health nature of crisis systems of care—it is not limited to individuals in DBH target population groups, but all people in the region who may have crisis needs. Solutions, accordingly, are not solely the responsibility of DHW.
- Examine available contractual levers at the State level to centralize and drive improved accountability at the provider and payor level, and to create performance measures that can be incentivized and tracked through the payor-provider contractual relationship.

Region V

- Position mobile crisis team response as a Phase 2/Phase 3 service (broaden the definition) and respond before acuity peaks
- Develop a decision tree as envisioned for "in lieu of 911/emergency department" options
- Maximize upstream early intervention components (walk-in and 7-day service model) and less restrictive/coercive service components (Crisis Center)
- Develop layperson competency (MHFA, trauma-informed care, QPR)
- Consider the development of "spokes" in addition to the current vision of Twin Falls as a crisis system hub. This could include recruiting mental health workers/peer supports in smaller communities who provide an initial mobile response either while someone else is en route or until someone can join via tele-solution.
- Develop tele-solutions to speed DE response
- Develop medical clearance strategies to reduce the need for interim transport to emergency departments
- Explore diversion opportunities specifically at Canyon View. It is estimated that three to four people a week have very short stays in Canyon View (less than 48 hours). This is indicative of a diversion opportunity, or the ability to intervene differently in the emergency department (or via mobile crisis) to decrease the need for admission.
- Examine who is initiating DEs, when, and why, and introduce new and soon-to-be-introduced service pathways as a mechanism to avoid unnecessary DEs. Stakeholders reported that 50 percent of individuals evaluated by a DE are not committed. Of the 50 percent who are committed, 50 percent are released by the 72-hour mark. This suggests that many do not need a DE.
- Offer training such as CIT and MHFA to volunteer EMTs

Region VI

- Round out the system with attention to crisis prevention and early intervention—shifting the position of the crisis response upstream on the continuum (pre-involuntary status, and in advance of law enforcement response when there are no contraindications to doing so)
- Build out a brief treatment/resolution-focus to crisis response, rather than more narrowly focusing on assessment and referral
- Develop a clear menu of services and definitions (Tele-assessment, mobile crisis intervention, DE assessment) and decision trees to broaden the ways that cross-sector players think about asking DBH for assistance
- Infuse peer role in crisis response services and peer/recovery coach within the Crisis Center
- Evolve the CIT model from one that is primarily about the 40-hour training to a CIT program that is a law enforcement/behavioral health system collaborative. Note, this is not the same as a co-responder model. Right now, although many officers/deputies have the training, they still largely are sole community responders to crisis without a well-developed mechanism even to consult. Recent partnering on the crisis center should be a great springboard to this.
- When the level of need is "on the fence" start with the Crisis Center who can monitor and step a person up to the Emergency Department when indicated (this is invited by the Crisis Center)
- Reduce law enforcement wait time in emergency departments
- Pursue Accommodation Registry idea with law enforcement agencies as another way to expand CIT principles
- Explore alternative transportation options. The team described the difference in experience if transport is by emergency medical services (EMS) versus law enforcement

- Formalize good relationships and processes with memorandums of understanding (MOUs) where that makes sense (e.g., mutual protocols, means of transferring information, methods for problem-solving concerns)
- Consider a mobile response innovation that pairs a clinician and a nurse when there are key risk indicators. Specific strategies for that co-response could include offering screening for dementia, medication reconciliation/consulting with pharmacy, consideration of co-morbid conditions, and performing a nursing exam. This strategy could also aid in developing a protocol that eliminates the need for medical clearance for most people.
- Explore Board of Education/university opportunities to build a competent crisis workforce
- Move forward with tele-solution opportunities

Region VII

- Look for opportunities to braid/blend funding to expand local crisis capacity regardless of service modality (developmental disabilities/mental health/substance use disorder)
- Consider the utility of development of small residential brief treatment programs (via future IMD waiver)
- Seek to understand the "clog' at the acute care level
- Collaborate with Idaho Department of Housing and Urban Development (HUD) (who is looking for community partners) regarding monies available for transition-aged youth
- Develop a protocol to shorten the transition of care between transporting law enforcement officers and receiving emergency departments
- Examine habits of practice that have evolved for beds of all type that have limited access
- Collaborate with system partners to develop mobile response protocols that reduce the use of emergency departments and promote tenure in placement (e.g., Assisted Living Facilities). This may require some change of policy for how a facility addresses suicidality.
- Develop continuity of care protocols and mechanisms for communication that can help to inform future high-tech methods of conveying information
- Build out a model of support of parents of children in crisis that is empathic, empowering and activating
- Further efforts on establishing tele-capability in all of the DHW sites in the regions, including establishing protocols
- Address any licensure board concerns about tele-health