3.a.ii. – Behavioral Health Community Crisis Stabilization Services

Summary	Resources in Place	Challenges	Resource Needs

• The PPS will establish a Community Crisis Clinical Leadership Team(CCCLT) to develop protocols and facilitate collaboration between providers and PPSs.
• Contracts with Medicaid MCOs will be pursued to develop sustainable funding.
• CCCLT will ensure that the IT systems developed and enhanced will facilitate necessary data sharing.
• The CCLT will also serve as a quality and utilization committee that will work to fill service gaps
	• The existing behavioral health crisis service system includes:
	  • Specialty psychiatric services in hospitals operated by all 3 hub providers.
	  • Inpatient detox beds at NUMC
	  • Mobile Crisis Teams (MCT) for children and adults
	  • 24/7 crisis hotline run by LI Crisis center.
		• Coordination and responsiveness problems with existing services.
		• Patients referred to ongoing care from hospital or ED fail to engage.
		• Crisis services are not accessible after hours and on weekends.
		• Lack of respite programs.
		• Transportation barriers.
		• Cost of capital/ infrastructure needs.
			• A walk-in behavioral health urgent care.
			• Enhanced MCTs
			• Expanded clinic hours
			• Care managers workforce
			• Regulatory changes needed to permit off-site clinical treatment services and telepsychiatry.
			• Medically and non-medically supervised transportation services.
			• Conversion of existing congregate residences into apartment treatment programs

3.a.ii Behavioral Health Community Crisis Stabilization Services

Project Objective: To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.

Project Description: Routine emergency departments and community behavioral health providers are often unable to readily find resources for the acutely psychotic or otherwise unstable behavioral health patient. This project entails providing readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis. The Behavioral Health Crisis Stabilization Service provides a single source of specialty expert care management for these complex patients for observation monitoring in a safe location and ready access to inpatient psychiatric stabilization if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.
2. Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
3. Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
4. Develop written treatment protocols with consensus from participating providers and facilities.
5. Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.
6. Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).
7. Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
8. Ensure that all PPS safety net providers are actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
9. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
10. Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.
11. Use EHRs or other technical platforms to track all patients engaged in this project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

In the Nassau-Queens PPS (NQP) service area 20.5% of Medicaid readmissions, and 9.6% of avoidable ED visits, have a mental health or substance abuse primary diagnosis. Many people who show up in the ED do not require an admission, but have no alternative. Residential and respite programs are alternatives that, if expanded, could provide assessment and treatment for Medicaid recipients experiencing an acute behavioral health (BH) crisis. Transportation barriers and homelessness further contribute to reliance on the ED. Stakeholder forum participants in Nassau cited a need for alternatives to ED visits and inpatient hospitalization for individuals in a BH crisis.

Other system inadequacies persist:
- The child mobile crisis unit in Nassau is unavailable weekends; the adult mobile crisis unit is open 10:00 am– 8:30 pm but wait times are 24-48 hours. Timely intervention can prevent exacerbation of problems, inappropriate ED use, and in extreme cases, death.
- Nassau provides a BH helpline 24/7, but it is not staffed by clinicians, and does not have bilingual staff (a translation service is used).
- A number of BH agencies have closed (see Assets and Resources), merged, cut back hours of service or maintain waiting lists according to focus group participants.
- First responders and law enforcement officers lack sufficient training to divert individuals in a BH crisis from the ED; uniform standards of evaluation are also lacking.
- Patients in crisis entering an ED on evenings or weekends are often admitted to locked inpatient psychiatric units, in the absence of alternatives.
- Peer support staff may be cost-effective resources for enhancing access to care, but they are not widely available.

Our proposed enhancements include:
- Improving crisis hotline services with paramedic dispatch/enhanced crisis-management capabilities.
- Enhancing mobile crisis team (MCT) services to offer 24/7rapid-response coverage and follow-up visits, and adding a nurse, paramedic and/or a prescriber to the MCT.
- Creating a rapid-response team to serve high ED utilizers in high-density communities to help residents better manage BH exacerbations rather than transferring them to the nearest ED.
- Developing urgent-care BH walk-in clinics and enhancing capacity in existing clinics to provide immediate outpatient treatment on an extended-hours basis.

- Developing or expanding peer-supported, BH crisis respite housing.
- Developing crisis stabilization units, staffed by licensed BH clinicians.
- Expanding telepsychiatry to support availability of licensed BH practitioners.
-Creating observation beds within EDs to allow intensive management of BH emergencies without an inpatient admission.
- Increasing outreach and education to providers, schools, first responders and others who refer to the ED, including local law enforcement officers—who often have first contact with individuals in a BH crisis—about how and when to refer them to the new/expanded services we develop.

NQP will establish a project committee to develop evidenced-based assessments, disposition protocols, and Memorandums of Understanding between providers and partners participating in the project.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

This project will target all Medicaid beneficiaries, from pre-adolescent to geriatric, who have a mental health (e.g., depression, bipolar disorder, psychosis) and/or substance use disorders and experience a BH crisis, such as suicidality, psychosis, agitation, interpersonal conflict, or due to caregiver burnout.

We will provide services that are racially, ethnically, culturally and linguistically sensitive and appropriate to all subpopulations. Services will also be tailored to outreach to and address the specific needs of the following populations at risk, who are often challenging to reach, including: homeless youth, LGBTQ, and frail elderly, and other low-income populations who may be vulnerable to crisis due to unstable housing, few social supports or illness that impairs problem-solving and impulse control.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

NQP has a large number of assets and resources that can be mobilized toward achieving DSRIP goals. These include community-based organizations, health homes, residential providers, mobile crisis teams, hospitals, peer-run services and an array of community support services. However, existing services are limited, and have become more so with closures in recent years, including: continuing day or child day treatment centers (5), psychiatric inpatient units (3) and mental health clinics (4). Existing services are not centrally coordinated, difficult to access when a crisis is occurring, and they are generally not staffed by clinicians.

24 hour, 7 days a week Telephone Triage Center:

- Nassau County operates a crisis-line, 227-TALK (8255), which serves individuals experiencing a BH crisis or urgent care need, countywide 24/7. Additional BH providers are needed to expand service capacity.
- LIJ operates a 24/7 call center staffed by RNs, EMTs and paramedics capable of call intake, care navigation and nurse advice, via a system called ECNS (Emergency Communications Nurse System). Call center currently does not serve BH patients but the existing infrastructure can be used to add BH providers and provide BH training to existing staff.

Rapid Response Mobile Crisis Team:
- Pilgrim Psychiatric Center and South Shore Child Guidance Center operate a Mobile Crisis Team in Nassau County, from 10 am to 11 pm, seven days per week, overseen by the Nassau County Dept. of Mental Health, Chemical Dependency and Developmental Disabilities Services. We will leverage this existing resource to enhance the availability of mobile crisis teams.
- Transitional Services for New York is a community behavioral health residence program. This program will add two 2-person de-escalation teams to serve the more than 500 housing units on and near the grounds of Creedmoor, to help manage the interpersonal/ behavioral health crises of high-utilizers of ED and inpatient services.
- LIJ and its affiliated 24/7 Community Paramedic is a professional trained in care navigation and treatment of mental health situations to respond on demand. Services include clinical assessment, on-hand formulary, care navigation and telemedicine for face-to face interactions with psychiatrists. We will use this existing infrastructure to develop a rapid response mobile crisis team.

Extended Hours Walk-In Crisis Clinics:
- The Charles Evans Health Center provides health services, including mental health services, to any community resident from Nassau, Suffolk and Queens Counties. The Center serves a predominantly developmentally disabled population. This facility is available to add an extended-hours walk-in crisis clinic.
- COPAY, Inc.is a chemical dependency outpatient center located in Great Neck that serves individuals ages 12 and older and is fully bilingual (English and Spanish). COPAY treats clients with chemical dependency, co-occurring mental health problems, and relationship/marital problems. Hours of operation are 9 am to 9 pm. This facility is available to add an extended-hours walk-in crisis clinic.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The NQP's biggest challenges identified and proposed solutions:
- Funding: Existing services are underfunded. Some newly proposed services are not presently reimbursed. DSRIP funds will be used to establish and sustain the project in the short term. Longer term, we will contract with payers to sustain future access to services.
- Physical Plant: Space is needed to support crisis respite and expand access to urgent care/walk-in clinics outside an ED. Repurposing existing assets is an option (see Resource Needs).

- Staffing: Recruiting and training staff for challenging work during less-than-desirable hours is difficult. Options include pay incentives, leveraging existing 24/7 infrastructure of LIJ EMS services/staff, and telepsychiatry so that a physician can work a shift from a "hub" to provide services to a call center, mobile crisis team, and walk-in clinic.
- Transportation: Clients in a BH crisis often lack transportation. Mobile crisis teams, with non-medically supervised transportation, a call center and telepsychiatry will lessen barriers.
- IT coordination: Implementing a fully integrated system to support scheduling, dispatching, logging, tracking, patient records, etc., is complex. We will adopt interim solutions (e.g., use of secure email and secure messaging) as a bridge to having a fully integrated system.
- Homelessness: If a crisis respite program has a 7-day limit, it is unable to accept homeless patients since this timeframe is insufficient to arrange for longer-term housing. An extension, for example to 21 days, is needed to better serve homeless patients.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. Overlap will occur in Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and Health & Hospitals Corporation PPSs also serve Queens. Due to their geographic proximity, particularly eastern Queens, it is possible that overlap will occur.

LIJ is a member of NSLIJ which is a member of the ACP Board of Directors. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices or problems being encountered with the other PPS as they arise. ACP plans to pursue project 3.a.ii.

In expanding the availability of crisis stabilization services, NQP partners will coordinate efforts for patients with BH conditions across the care continuum. This will be accomplished in part through linking all partners to the RHIO thereby sharing patient information as appropriate. Other PPSs will also be utilizing the RHIO. This common HIT platform will become a vehicle for the PPSs to understand the patients' clinical history and care plans, and utilization of crisis services. The project team will develop MOUs with any other PPS with whom our geography overlaps that is also implementing project 3.a.ii to facilitate communication. It does not appear that any other PPS in our area is undertaking 3.a.ii.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Call Center: Computer hardware and software and expansion of existing space to accommodate call center expanded coverage to NQP's providers' patients.

Mobile Crisis: Vehicles, computer hardware and software, and office space to expand the currently fragmented crisis response system.

Crisis Stabilization Unit/ Urgent Care/Walk-in Centers/ED Observation Beds/Community Crisis Respite: Construction and building resources, as well as computer hardware and software, are needed to repurpose existing building spaces to accommodate the expansion of services that will keep behavioral health patients in crisis out of the ED and out of inpatient units, as well as improve safety. For example, space from Zucker Hillside Psychiatric Hospital can be repurposed for a walk-in clinic and crisis stabilization unit. Transitional Services for New York, Inc. has beds on the grounds of Creedmoor Psychiatric Center that can be repurposed for respite housing. Additionally, Project REAL (Residential Experience in Adult Living) has a building which can be repurposed for a walk-in clinic.

Telepsychiatry: Computer hardware and software to expand the capability to locations where it currently does not exist.

IT: EHR software, hardware and interface development—to connect all entities who serve behavioral health patients in crisis, including hospitals, clinics, mobile crisis teams, call centers, law enforcement, residences, first responders; and implementation, training and maintenance costs to insure that there care is coordinated, non-duplicative and addresses the complicated needs of behavioral health patients experiencing crisis.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
North Shore University Health Home (participating partner and LIJ affiliate) ; FEGS Health and Human Services System	Health Homes for Medicaid Enrollees with Chronic Conditions	9/1/12		A Health Home is a care coordination program whereby all of an individual's caregivers communicate with one another so that a patient's needs are comprehensively addressed. It is the health home's responsibility to develop a longitudinal care plan to address these needs. Information is shared notifications are sent in real time, care plans are updated and community partners are engaged all in an effort to keep the patient out of the emergency room and hospital

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

This project will place a greater emphasis on crisis stabilization services than has been in the projects listed above.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.