Montgomery County Behavioral Health Crisis System Enhancement Plan

THIRD HORIZON
STRATEGIES

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Behavioral health needs have increased throughout the United States and in Pennsylvania. The Montgomery County Department of Health and Human Services, Office of Mental Health/ Developmental Disabilities/and Early Intervention, in consultation with the Offices of Managed Care Solutions and Drug & Alcohol, competitively selected Third Horizon Strategies (THS) to analyze the local behavioral health crisis system. THS began its work in March 2022 and continued for one year. The project goals were three-fold:

1. Analyze the current state of the Montgomery County public behavioral health crisis continuum for children and adults
2. Form a Crisis System Advisory Group (CSAG) to engage community stakeholders and utilize various other strategies to obtain qualitative input
3. Deliver a county-wide "Behavioral Health Crisis System Dynamic Enhancement Plan" (enhancement plan)

The enhancement plan is the culmination of THS' work over the last year and builds on the strong foundation already in place in Montgomery County.

THS used a mixed methods approach to conduct a system analysis and formulate recommendations. The team reviewed and analyzed available quantitative data sets on service utilization, augmented these data with extensive qualitative research, formed a CSAG, and engaged more than 118 stakeholders. THS also drew from national best practice literature, key informants, and its team's behavioral health subject matter expertise.

A robust and accessible behavioral health delivery system is essential to help keep people from getting into crisis and get into care quickly after a crisis. Consequently, THS' work did not solely focus on crisis services. Instead, it looked more broadly at the behavioral health services infrastructure present in the county, particularly for persons with serious mental illness, substance use disorder (SUD), children with serious emotional disturbances, and persons with co-occurring disorders.

THS synthesized its findings of the strengths, challenges, and opportunities in Montgomery County's crisis and broader behavioral health delivery systems into a systems analysis. The analysis revealed five main points:

- Montgomery County has many resources; better coordination between those resources would enhance the behavioral health system, including crisis services, and promote better outcomes for individuals and families.
- Montgomery County would benefit from improved collection and use of data.
- A crisis center would help fill a gap in the system, but it will not be a panacea. Montgomery County should define what challenges a center will and will not resolve.

- The behavioral health delivery system needs to be strengthened, by the community, to better support individuals' access to care, preventive and wellness services, crisis planning capacity, and availability of care post-crisis.
- Montgomery County should develop distinct strategies to address the unique needs of special populations, including children and families, people with limited English proficiency, and people with co-morbid conditions.

Informed by the system analysis and subsequent research, and with significant stakeholder and county input, THS formulated nine recommendations to enhance Montgomery County's behavioral health crisis system. These include:

1. **Promote essential principles for a modern behavioral health crisis system.** In its National Guidelines for Behavioral Health Crisis Care (2020) and its National Guidelines for Child and Youth Behavioral Health Crisis Care (2022), the Substance Abuse and Mental Health Services Administration (SAMHSA) offers detailed best practices for communities. Building upon the essential principles developed by SAMHSA, THS created a checklist to help Montgomery County gauge the extent to which the local crisis system aligns with the national guidelines. This provides a guiding vision and overarching framework for Montgomery County to use with partners and stakeholders.
2. **Sustain and build upon existing systems and structures that work well.** Montgomery County has a robust array of services and engaged stakeholders who have worked collaboratively to address behavioral health concerns for many years. THS recommends that the county sustain and build upon the existing systems and structures already serving an essential role in the community. THS identified opportunities to build upon and enhance these resources, such as additional data sharing.
3. **Develop a crisis center to meet crisis stabilization needs.** THS recommends that the county develops a 23-hour crisis stabilization service program, a.k.a. a "crisis center" staffed with a multidisciplinary team. THS advises the county to prioritize children and families, ensure the facility has separate entrances, and that staff is appropriately trained in meeting the crisis needs of children and families. Rather than having separate facilities, THS recommends that the walk-in center concurrently functions as a SUD assessment site and be able to initiate Medication Assisted Treatment.
4. **Explore the level of need for additional hospital alternative facilities, with a primary focus on the needs of children.** While the crisis center will provide "somewhere to go" for persons in a behavioral health crisis, THS is concerned that subacute services, or those that fall between inpatient and traditional outpatient care, are limited. Additional hospital alternative programs may be necessary, but it is only possible to determine with better data. THS, therefore, recommends that Montgomery County conduct a needs assessment. SAMHSA's guidelines recommend that youth in behavioral health crises receive care in the least restrictive setting possible and, if it is safe, at home and in the community. Consequently, THS recommends that the county explore the feasibility of developing an in-home crisis stabilization program for children and their families.

5. **Address barriers to improving timely access to behavioral health services.** THS has repeatedly heard from stakeholders that some community-based services have long waiting periods as demand has exceeded capacity. THS offers multiple strategies the county should undertake to bolster the behavioral health system and reduce wait times; increase awareness of non-clinical services that play a vital role in an individual's recovery journey; support workforce development, recruitment, and retention; form a behavioral health workforce committee; reduce administrative burden; and incentivize bachelor's level staff to attain their Licensed Bachelor of Social Work (LBSW).
6. **Use a data-driven approach to measure the impact of Montgomery County's Behavioral Health Crisis Enhancement Plan and components of the crisis system.** Managing behavioral health crisis systems is an iterative process that requires the consistent collection of data or knowledge that can be used to assess community needs and for ongoing quality improvement for the most effective crisis services possible. THS recommends that Montgomery County intentionally make more actionable use of data and increase transparency with providers and other stakeholders. THS also suggests specific key performance indicators the county can apply across different levels of care.
7. **Enhance cross-sector collaborations and information sharing.** Multi-sector collaborations can help advance systems improvements by bringing together partners to form a shared vision and collectively address issues. THS recommends continuing the CSAG with a new member charter, leadership structure, and defined goals to enhance cross-sector collaborations and information sharing.
8. **Advance behavioral health equity.** People of color, non-native English speakers, and other underserved populations face unique cultural barriers to behavioral health care. THS recommends that Montgomery County promote adherence to the national Culturally and Linguistically Appropriate Standards (CLAS), make all county-developed materials available in Spanish and increase access to culturally relevant support for people with behavioral health conditions.
9. **Advocate for local, state, and federal policy reforms.** In the systems analysis, THS identified numerous policy issues outside the county's locus of control requiring state action. THS recommends that Montgomery County commit additional energy and resources to its policy agenda and develop an advocacy strategy. Of all the potential issues, THS identified three as the most pressing:
    - Advocate with the state of PA to seek an 85 percent enhanced match from the Centers for Medicare & Medicaid Services (CMS) for mobile crisis services by covering such services through the new Medicaid mobile crisis option established in the American Rescue Plan Act (ARPA)
    - pursue legislative or regulatory action to ensure commercial insurance carriers pay for behavioral health crisis services with reasonable credentialing requirements
    - seek increased flexibility in psychiatric evaluation requirements for therapy, medication management, and partial hospitalization

THS offers a rationale for each recommendation, financial considerations, and steps to operationalize the recommendations.

A comprehensive and integrated behavioral health crisis system is the first line of defense in preventing tragedies such as suicide, criminal justice involvement, and preventable hospitalization. The proposed enhancement plan builds on the groundwork laid by Montgomery County for a highly functioning behavioral health crisis system.

INTRODUCTION

Behavioral health needs have increased throughout the United States. One out of every five people —51.5 million people – in the United States had a mental illness in 2019. The COVID-19 pandemic exacerbated the prevalence of mental illness, as fear, social isolation, loss of a loved one, economic impacts, and other stressors impacted the nation. At the height of the pandemic, 40 percent of adults reported they had symptoms of depression and anxiety, according to Kaiser Family Foundation. This has not been abated; as recently as June 2022, 33 percent of adults reported they had symptoms of depression and anxiety, higher than pre-pandemic levels of 11 percent. Provisional data from the U.S. Centers for Disease Control and Prevention shows that drug overdose deaths reached record levels in 2021, and suicide rates were back near a record high after two years of decline. And in 2020, mental health-related visits to emergency rooms jumped 31 percent among adolescents ages 12 to 17.

The number of adults with Any Mental Illness (AMI) in Pennsylvania has been increasing in recent years. Nearly 34 percent of Pennsylvanians have a mental illness or SUD, higher than the 31 percent prevalence rate for all Americans with a behavioral health diagnosis. In 2021, approximately 5,224 Pennsylvanians fatally overdosed.

Montgomery County, Pennsylvania, data shows increased behavioral health needs among adults and children. In 2021, 4,833 calls were placed to the Montgomery County 911 call center for behavioral health emergencies. According to the 2021 Pennsylvania Youth Survey (PAYS), students in Montgomery County reported increased feelings of being depressed or sad, increased suicidal ideation, and feelings of failure. Furthermore, higher acuity levels are reflected in the total volume of 302 warrants (see Figure 1), which increased nearly 100 percent over a decade and make up a more significant proportion of the total number of crisis encounters (see figure 2).[1]

Figure 1: 302s by Month

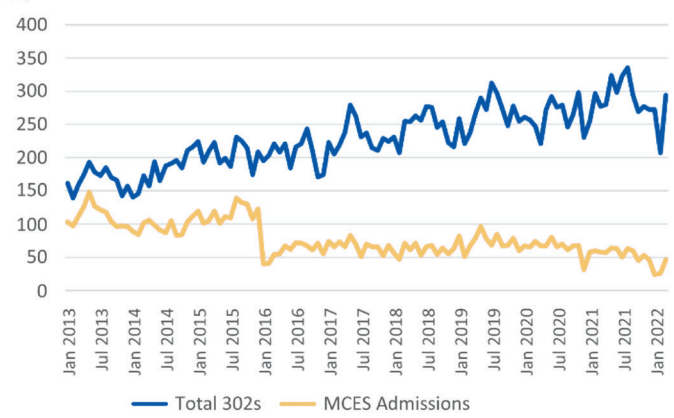
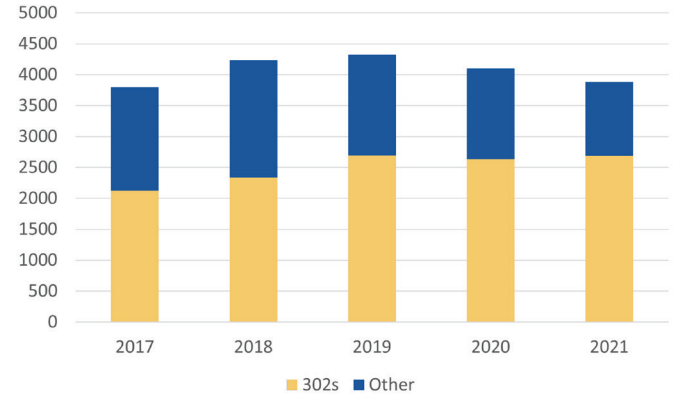


Figure 2: Total County Crisis Incidents 2017-2021



A comprehensive and integrated behavioral health crisis system is the first line of defense in preventing tragedies such as suicide, criminal justice involvement, and preventable hospitalization. A holistic crisis system addresses both mental health and substance use disorder (SUD) while coordinating with other systems of care.

The Montgomery County Department of Health and Human Services, Office of Mental Health/ Developmental Disabilities/ and Early Intervention, in consultation with the Offices of Managed Care Solutions and Drug & Alcohol, competitively selected Third Horizon Strategies (THS) to analyze the local behavioral health crisis system. THS began its work in March 2022 and continued for one year. The project goals were three-fold:

- Analyze the current state of the Montgomery County public behavioral health crisis continuum for children and adults

- Form a Crisis System Advisory Group (CSAG) to engage community stakeholders and utilize various other strategies to obtain qualitative input
- Deliver a county-wide "Behavioral Health Crisis System Dynamic Enhancement Plan"

This paper is the culmination of that work.

Guiding values and philosophical approach

THS developed the Behavioral Health Crisis System Enhancement Plan to reflect the Montgomery County Health and Human Services overall mission and guiding principles.

- Mission: Engaged and supported, Health and Human Services (HHS) staff work together with people and organizations across our County to make a positive difference in the lives of those we serve.
- Vision: Montgomery County residents live healthy, safe, and connected lives.
- Guiding Principles: In everything it does, HHS is mindful of:
  - Being trauma-informed
  - Maximizing diversity, equity, and inclusion
  - Working in true partnership with staff, partners, and the individuals and families it serves

The county's priorities include helping people access the resources they need and increasing prevention efforts to improve the overall quality of life while continuously improving its capacity to operate as one department.

THS is a boutique, strategic health care advisory firm focused on shaping a future system that actualizes a sustainable culture of health nationwide. The firm's mission and core values are highlighted below.

- Mission: We push against the status quo by designing integrated health and social systems so all communities, families, and individuals can thrive.
- Core Values:
  - Impact Driven: We relentlessly pursue transformation and reflect that commitment in our daily work and interactions with clients and communities.
  - Mission Obsessed: We strategically align ourselves with public and private entities to advance our mission to create a sustainable culture of health and well-being.
  - Equity-Centered: We strive for equity in all we do and advance equitable care delivery systems so all individuals, families, and communities can thrive.
  - Knowledge Powered: We bring subject matter expertise to strategically address market and community needs while embracing and learning from different perspectives.

THS' work in behavioral health is deeply personal, as several team members have direct or familial experience engaging with mental health and SUD delivery systems. The firm's team has decades of experience working in community behavioral health, and in-depth knowledge of

federal and state policy, enabling it to bridge policy and strategy with on-the-ground realities to support program implementation.

Several philosophical underpinnings guided THS' approach to the Montgomery County project:

- Behavioral health delivery systems must comprehensively address mental health and SUDs and be coordinated across providers, settings, and levels of care
- Behavioral health delivery systems should be recovery-oriented and trauma-informed and promote the least restrictive setting for individuals
- Data-informed decision-making should guide public investments
- A robust and accessible outpatient behavioral health delivery system is essential to help keep people from getting into crisis and get into care quickly after a crisis

Consequently, THS' work did not solely focus on crisis services. Instead, it looked more broadly at the behavioral health services infrastructure present in the county, particularly for persons with serious mental illness, SUDs, children with serious emotional disturbances, and persons with co-occurring disorders.

Methodology

THS used a mixed methods approach to conduct the system analysis and formulate recommendations. The team reviewed and analyzed available quantitative data sets on service utilization and augmented these data with extensive qualitative research and stakeholder engagement. THS also drew from national best practice literature, key informants, and its team's subject matter expertise in behavioral health.

Specific activities included:

- met weekly with the Director of Crisis and Diversion and periodically attended meetings with other department leadership
- reviewed available materials on the county behavioral health crisis system, including all public-facing documents, related Requests for Proposals (RFPs), and contract scopes of work
- compiled a community behavioral health services inventory
- researched crisis walk-in models throughout the county and elsewhere in PA and produced an issue brief with case studies
- gathered extensive qualitative information and engaged more than 118 stakeholders
- organized monthly CSAG meetings, including two in-person retreats
- facilitated eight focus groups (outpatient providers; county officials; child/family serving organizations and schools; consumers, peers, and advocates; mobile crisis; first responders; providers; and federally qualified health centers)
- interviewed numerous key informants
- conducted site visits to a peer and family support organization, the Department of Public Safety/9-1-1 call center, a Community Behavioral Health Center (CBHC), Montgomery County Emergency Services (MCES), a drug and alcohol (D&A) contracted provider, and a hospital
- met with Mental Health, Managed Care Solutions, and D&A Administrators and Deputies
- participated in many of the regularly scheduled county and regional meetings
- convened a 9-8-8 workgroup and assisted in the development of a county-specific FAQ
- conducted an in-depth review of pertinent state and federal regulations
- synthesized stakeholder input and substantial feedback from county leadership
- analyzed ten available data sets to better understand community needs, service utilization, and the impact of COVID-19 on the delivery system (see below for an overview of each data set)

1. **Montgomery County Emergency Services (MCES) Crisis Stats**
   MCES provided "Crisis Stats" from 2017 to 2021. Each crisis includes a date, referral reason, legal disposition (e.g., 302), petitioner, referral source, broader referral source category (e.g., hospital, police), if/where a Part VI physician's exam was administered, payer, and final disposition.

2. **Access Mobile Crisis Data**
   THS examined data provided by Access Services, Mobile Crisis Quarterly Reports from 2021-2022, broken out by children and adults. These reports are used primarily to look at services volume and source/number of referrals in and out of Mobile Crisis. THS also received individual intervention data with zip codes which we used to map the number of interventions to show locations where utilization is highest for children and adults.

3. **305 Ambulance**
   THS received an Emergency Medical Services (EMS) Record List Report for 2021 containing logs for the 305-specialty psychiatric ambulance. Each dispatch has a date/time, scene address, disposition, and destination address. THS used this data to evaluate the utilization of this service against capacity, looking at factors like time of day and distance traveled and mapped dispatch destinations as a complement to the mobile crisis maps.

4. **302 Warrants**
   THS reviewed 302 warrant tracking data from 2013-2021. The data contains a total volume of 302s served along with resulting dispositions (admitted/evaluated/denied/pending/etc.), broken down further by the facility. The data showed the evolving relationship between MCES and how/where the county processes involuntary commitments. This data also provided important insights into COVID-related challenges, capacity issues, and growing difficulties in tracking pending cases.

5. **Magellan Acute Inpatient Program (AIP) Bed Search Data**
   Magellan provided an "AIP Tracking Data" report of its members from January 2019 and updated it through June 2022. The bed search process is triggered if a member has not been assigned a bed within 24 hours by the provider, at which point Magellan supports the effort with greater involvement. All totals include only those members whom the provider did not successfully place in the first 24 hours. The information contained total utilization by month, complete counts by age group, totals for specialized beds (e.g., autism, COVID-19, pregnancy), totals by location broken down by child/adult, and totals by the number of days waiting for bed placement. Data showed that of members whose bed search progressed beyond the initial 24 hours, 52 percent waited two days or less for placement, and 90 percent were placed within one week. Just under 10 percent (9.7) of members had longer wait times, up to 40 days, though this was likely negatively impacted by COVID-19.

6. **Magellan Self-Reported Waitlist Data for Outpatient Services**
   Magellan collected self-reported data from outpatient providers comparing 2019 to the eight months of October 2021 to May 2022. This data offers a very limited picture as it is not collected longitudinally, does not account for duplication, and is based on self-report. Nonetheless, it is the only data source made available to THS for quantitative information about needs outpacing capacity in the outpatient system.

7. **County waitlist data for residential**
   THS examined a snapshot of county waitlist data from February 11 – March 11, 2022, for long-term structured residence (LTSR), community or transitional residence (CRR), licensed specialized personal care homes, and independent supported living (low-level of care). Available information included capacity, current occupancy, number on the waitlist, the

average length of wait on the waitlist, longest/shortest wait on the waitlist, the average length of stay, and source of funding. Discrepancies with occupancy, and not meeting capacity are thought to be due to staffing issues or more stringent occupancy limits imposed during the COVID-19 pandemic. Regardless of the reasons, the impact is that needs are going unmet for residential services.

8. **Mobile Crisis School-Hospital-PD Referrals**
   THS examined referral data collected by the county from mobile crisis from 2021 for schools, hospitals, and police departments. Files contained the referral date, referral source, and date of birth. THS calculated total referrals by department/hospital/school to see which places had the highest volume and the busiest days of the week for referrals by source.

9. **Mobile Crisis Family and Youth Satisfaction Surveys**
   THS examined annual survey reports for youth inpatient, outpatient, and mobile crisis. These reports are the product of Montgomery County's yearly contract with a Family Satisfaction Team (FST) to gather feedback from parents/caregivers and youth about their experiences with crisis services. Comparable satisfaction data for adults was not provided to THS.

10. **Magellan Montgomery County Crisis Services Outcomes Report**
    THS reviewed a Magellan analysis of outcomes for members who received crisis services from October 1, 2019, to September 30, 2021. Magellan analyzed the member population using a pre-during-post methodology. The "pre" period includes the 180 days before the member was provided a crisis service. The "during" period consists of a member's entire time engaged with a crisis service. The "post" period consists of 180 days after the member was discharged from a crisis service. A crisis episode was considered completed when there was a gap of 30 days in billed claims. The report includes four different types of crisis services: residential, walk-in, mobile, and telephone.

Limitations to analysis

THS' analysis was conducted within the contract parameters, and several limitations should be noted. THS was not contracted to perform a claims analysis, but rather reviewed data collected and analyzed by Magellan, the managed care organization contracted by the county. THS, and the county, have minimal access to hospital data (outside of MCES) and no access to private insurance data or interaction with commercial carriers. THS was provided only a narrow view of the county's financial data and was not contracted to do a financial analysis other than a high-level review of funding sources the county is utilizing in a braided fashion to support behavioral health crisis services.

A challenging factor in the data analysis was the impact of the COVID-19 pandemic on altering the behavioral health delivery system. Necessary public health measures led to capacity limitations such as bed closures, and the community experienced a loss of behavioral health workforce

in all community-based services. The pandemic's effects continue reverberating nationwide and locally in Montgomery County.

SUMMARY OF SYSTEMS ANALYSIS

THS synthesized its findings of the strengths, challenges, and opportunities in Montgomery County's crisis and broader behavioral health delivery systems into a systems analysis. In October 2022, THS presented its systems analysis to Montgomery County leadership (see appendices) and incorporated the group's requested modifications. THS then shared the revised analysis with the CSAG and facilitated a half-day retreat to garner their feedback and initiate dialogue on potential solutions to address barriers and challenges. The systems analysis was instrumental in informing THS' recommendations described later in this report. Selected excerpts of the analysis are included here, and the entire PowerPoint deck may be found in the appendices.

Key Takeaways

The main points of THS' systems analysis were:

- Montgomery County has many resources. Better coordination between those resources would enhance the behavioral health system, including crisis services, and promote better outcomes for individuals and families.
- Montgomery County would benefit from improved collection and use of data.
- A crisis center would help fill a gap in the system, but it will not be a panacea. Montgomery County should define what challenges a center will and will not resolve.
- The behavioral health delivery system needs to be strengthened by the entire community to better support individuals' access to care, preventive and wellness services, crisis planning capacity, and availability of care post-crisis.
- The county should develop distinct strategies to address the unique needs of special populations, including children and families, people with limited English proficiency, and people with co-morbid conditions.

IMPACT OF THE COVID-19 PANDEMIC

It is important to note that THS' work on the Enhancement Plan occurred during the COVID-19 pandemic. THS considered the pandemic's short- and long-term implications on behavioral health as the team developed the system analysis and formulated recommendations. History has shown that the behavioral health impact of disasters outlasts the physical effect, suggesting increases in both the prevalence and levels of acuity of mental health and SUDs will continue. The pandemic compromised service capacity in the short term as providers pivoted to telehealth and reduced facility occupancy standards to accommodate social distancing. There were also wide-ranging impacts on the behavioral health workforce, as providers were forced to simultaneously manage increased demand with their own pandemic challenges or trauma. Current utilization remains below pre-pandemic levels. The longitudinal impacts of the pandemic should continue to be studied.

System Strengths and Challenges

As noted above, THS completed a systems analysis and presented it to the county and CSAG for feedback in October 2022. Subsequent information was garnered through additional stakeholder conversations and county leadership. THS identified extensive strengths and persistent challenges in Montgomery County's behavioral health delivery system. The following is an updated iteration of that portion of the systems analysis. **It should be noted that this information is a synopsis only and is not intended to be exhaustive.** (See Figures 3 and 4).

Figure 3: System Strengths

Extensive resources and capacity

- Seven CBHCs and two FQHCs
- Administrative Case Management program
- Peer supports exist in clinical and non-clinical settings
- Student Assistance Program offers evidence-based screening, prevention, and treatment programming and other school-based supports

Strong collaborations

- Key stakeholders, including law enforcement, public safety, providers, community-based organizations, and peers/family advocates, are actively engaged
- County-specific and regional groups and forums are convened regularly
- Innovative pilots have emerged organically:
  - Access's Hub and Bridge models
  - Creative Health's co-responder approach

Child and family support

- Successfully wove values and principles of the systems of care initiative into the county's behavioral health delivery system
  - Included child-focused RFPs
  - Incorporated into system training
- Developed a dedicated bi-weekly meeting with system partners (Youth Services Integrated Team) to discuss children with high needs and collaborate on their treatment
- Included the voices of families and peers when developing new programs and supports by consult with FamilyWorx
  - Obtained additional family input via surveys

Key components of Montgomery County's crisis system

- County-specific 9-8-8 call center: MCES
- County-specific mobile crisis: Access
- County-specific Crisis Intervention Training (CIS) for law enforcement and first responders
- Magellan hospital bed tracking
- County position: Director of Crisis and Diversion

Figure 3: System Strengths (continued)

Ability to braid and creatively invest funding

- County retains control of Medicaid managed care dollars in partnership with Magellan
- County leverages human services, mental health, and SAPT block grants
- BJA grant
- ARPA funds
- Reinvestment funds earned under the Medicaid BH program were used to start up or expand programs and fund supportive services (e.g., housing)
- One-time request fund (end-of-year unspent county dollars)

County support during the COVID-19 pandemic

- Designed an alternative payment structure for provider reimbursement under Medicaid to provide financial stability
- Issued $12 million Workforce Stability Funds under Medicaid to providers for recruitment and retention efforts
- Increased Medicaid provider rate reimbursements
- Increased advocacy support; opened a Recovery Center run by Recovery Specialist and increased Parent Partner supports
- Provided a $2 million Reinvestment Fund opportunity for providers to improve their technology platforms to expand telehealth opportunities
- Collaborated with Career Link to target behavioral health workforce needs in their activities

Services for Individuals in need of D&A crisis services

- Warm handoff
- Operation Rebound
- Law Enforcement Treatment Initiative (LETI)

.

Synopsis only; not intended to be exhaustive of all resources.

Figure 4: System Challenges

Impact of the COVID-19 pandemic

- 14.5% increase in Medicaid membership
- What happens after the end of the PHE to folks disenrolled?
- Decrease in service utilization across all levels of care may be due to workforce issues and impact of the pandemic on membership
- Inpatient facilities struggle to keep hospital beds open and available due to COVID spread in congregant facilities and workforce issues

Needs increasing

- There is a higher volume of 302s
- Magellan reports utilization is increasing over time
- Providers and schools report levels of acuity and symptom severity have increased

Capacity challenges

- Staff vacancies impact access to care at all community-based levels of care
- Waitlists for outpatient treatment
- Residential occupancy is not meeting facility capacity, yet there are waitlists for this level of care as well
- ER "boarding" while waiting for a psychiatric bed
- Perception of a long wait for mobile crisis to arrive
- MCES walk-in is very small and cannot serve children

Data limitations

- No commercial data
- Limited hospital data outside of MCES
- Outpatient waitlist data is only self-report and not longitudinal
- No data on mobile crisis response time
- The system has increasing information loss
  - 302s with "pending" cases
  - NA dispositions

Figure 4: System Challenges (continued)

Fragmentation

- Primary care providers are considered secondary to or separate from the system
- Commercial carriers are not at the table
- Mental health and substance use disorder treatment is often viewed as distinct

Confusion around roles and responsibilities

- When to call which agency
- What to expect of a CBHC
  - After-hours care
  - Role in crisis care
- What to expect of an FQHC

Overarching workforce issues

- Workforce shortages contribute to wait times
  - Burnout and pay issues impact retention
  - Recruitment pipeline
  - Competition with telehealth companies and hospitals
- Licensure and credentialing issues
- Limited availability of bilingual workforce

Special populations or people with complex needs

- People in a behavioral health crisis with acute or chronic physical health needs may get turned away from psychiatric hospitals until they are "medically cleared"
- People with co-occurring mental health and SUDs may get shuffled between providers
- Children in behavioral health crises have fewer options for care
- They cannot be served MCES' walk-in facility, have long wait times for inpatient and residential levels of care, and may be sent out of the county
- People with limited English proficiency may get turned away or put on wait lists
- There are a limited (unknown) number of bilingual clinicians and many program materials are not available in Spanish

Synopsis only; not intended to be exhaustive of all resources.

THS also graphically represented some primary barriers adults and children encounter when moving through the behavioral health delivery system before, during, and after a crisis (see Figures 5 and 6). This helped inform the prioritization of THS' recommendations.

Figure 5: Montgomery County Crisis System Resources and Barriers – Adults

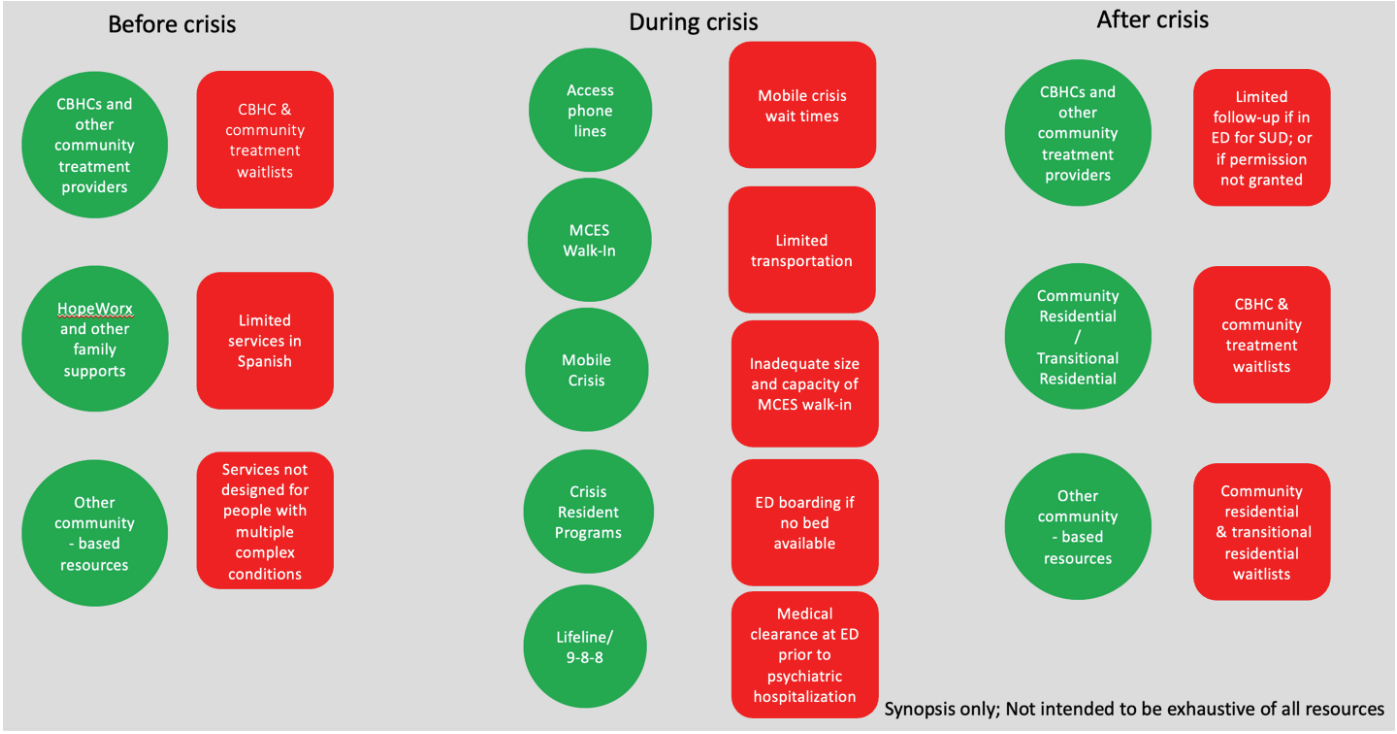
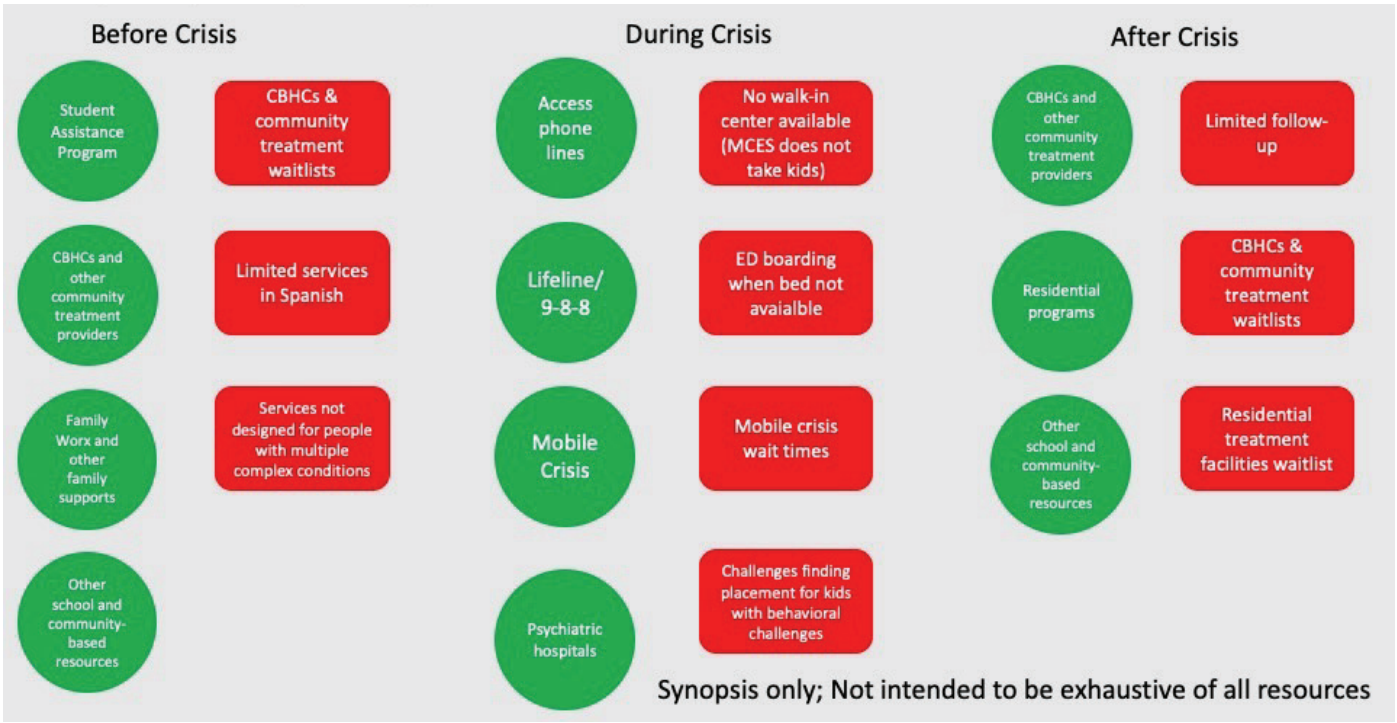


Figure 6: Montgomery County Crisis System Resources and Barriers – Youth and Families



RECOMMENDATIONS

Informed by the systems analysis and subsequent research, and with substantial input from Montgomery County leadership, THS formulated nine recommendations to enhance Montgomery County's behavioral health crisis system.

Recommendation 1: Promote essential principles for a modern behavioral health crisis system.

In its National Guidelines for Behavioral Health Crisis Care (2020) and its National Guidelines for Child and Youth Behavioral Health Crisis Care (2022), the Substance Abuse and Mental Health Services Administration (SAMHSA) offers detailed best practices for communities. These are increasingly recognized as the essential principles for a modern behavioral health crisis system and provides a guiding vision and overarching framework for Montgomery County to use with partners and stakeholders.

The clear inclusion of SUD crisis within the behavioral health definition is significant in the SAMHSA guidelines. Policies, planning, and operationalization of a community-based behavioral health crisis system should fully address the needs of individuals with co-occurring mental health and SUD and individuals whose primary diagnosis or crisis needs are related to substance use. Montgomery County should continue building a modern, integrated, holistic crisis system.

Strategy: Utilize the THS checklists, and the entire enhancement plan, to guide county funding investments, coalesce local planning efforts, and draw attention to the importance of a comprehensive behavioral health crisis response.

Building upon the essential principles developed by SAMHSA, THS created two checklists (figure 7, based on the 2020 guidelines, and figure 8, a youth-focused checklist based on the 2022 guidelines) to help Montgomery County gauge the extent to which the local crisis system aligns with the national guidelines. The checklist is structured as a yes/no, unknown, to reflect what components are already in place, what components are missing, and what THS could not conclusively determine. Each principle is then tied to the relevant THS recommendation(s).

THS recommends that the county review identified gaps with the CSAG and other stakeholders and continue to develop strategies that result in a comprehensive, integrated, and modern crisis system.

ADDRESSING THE NEEDS OF CHILDREN AND FAMILIES

Children in behavioral health crises have fewer options for care. The walk-in center at MCES does not serve children and families. Children may experience long wait times for inpatient or residential levels of care and sometimes must be sent out of the county for services. Nationally and locally, there is a severe shortage of child psychiatrists, behavioral health professionals overall, and those trained to work with the specific, nuanced needs of children and families. Rather than making separate recommendations to improve Montgomery County's behavioral health delivery system for children and families, THS infused guidance throughout this document. Highlights include:

- Continue to invest and strengthen the Student Assistance Program (SAP) and other school-based strategies to prevent substance misuse and promote mental well-being.
- Bolster the outpatient system, and address workforce issues to increase system capacity to deliver targeted services to children and families.
- Prioritize children and families when developing the new crisis center.
- Conduct a needs assessment and feasibility analysis to determine if an in-home crisis stabilization program is needed.

Figure 7: SAMHSA Crisis Guidelines Checklist

SAMHSA Guideline	Achieved in Montgomery County? (Current state)	Relevant THS Recommendation
Widely recognized elements of good crisis care:		
An effective strategy for suicide prevention	Yes	1 and 2
An approach to better align care to the unique needs of the individual	Unknown	1 and 8
A preferred strategy for the person in distress that offers service focused on resolving mental and substance use crisis	Yes	1 and 2
A key element to reduce psychiatric hospital bed overuse	No	3 and 4
An essential resource to eliminate psychiatric boarding in emergency departments	No	3 and 4
A viable solution to the drains on law enforcement resources in the community	Yes	3 and 4
Crucial to reducing the fragmentation of mental health care	No	All
CORE ELEMENT: Regional Crisis Call Hub Services		
Minimum expectations		
Operate every moment of every day	Yes	1 and 2
Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received	Yes	1 and 2
Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit	Yes	1 and 2
Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call	Yes	1 and 2
Coordinate connections to crisis mobile team services in the region	Yes	1 and 2
Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed	Yes	1 and 2
Best Practices to Operate Regional Crisis Call Center		
Incorporate Caller ID functioning	Yes	1 and 2
Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need	Yes	1 and 2
Utilize real-time regional bed registry technology to support efficient connection to needed resources	Yes, Magellan bed registry for Medicaid only	1 and 2
Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode	No	5

Figure 7: SAMHSA Crisis Guidelines Checklist (continued)

CORE ELEMENT: Mobile Crisis Team		
Minimum expectations		
Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation	Yes	1 and 2
Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times	Yes	1 and 2
Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations	Yes	1 and 2
Best Practices to Operate Mobile Crisis Team		
Incorporate peers within the mobile crisis team	Yes	1 and 2
Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion	Yes	1 and 2
Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement	Yes	1 and 2
Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care	No	1 and 2
CORE ELEMENT: Crisis Receiving and Stabilization Services		
Minimum expectations		
Accept all referrals	No	3
Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program	No	3
Design their services to address mental health and substance use crisis issues	Yes	3
Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed	No	3
Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community	Yes, for adults	3
Offer walk-in and first responder drop-off options	Yes	3
Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders	Unknown	3
Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated	Yes	3
Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated	Yes	3

Figure 7: SAMHSA Crisis Guidelines Checklist (continued)

Best Practices to Operate Crisis Receiving and Stabilization Services		
Function as a 24 hour or less crisis receiving and stabilization facility	Yes	3
Offer a dedicated first responder drop-off area	Yes	3
Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support	Yes	3
Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources	Yes, Magellan has bed search support for Medicaid members only	3
Coordinate connection to ongoing care	No	3 and 5
ESSENTIAL PRINCIPLES OF A MODERN CRISIS CARE SYSTEM		
Addressing Recovery Needs		
Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration	Unknown	1
Create engaging and supportive environments that are as free of barriers as possible, including eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections	Unknown	1 and 3
Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options and offer materials regarding the process in writing in the individual's preferred language whenever possible	Unknown	1 and 8
Ask the individual served about their preferences and do what can be done to align actions to those preferences	Unknown	1
Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities	No	1
Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery	Unknown	1
Significant Role for Peers		
Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible; peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age	Yes	1 and 8
Develop support and supervision that aligns with the needs of your program's team members	Yes	1 and 2
Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system, including (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility	Yes	1 and 3

Figure 7: SAMHSA Crisis Guidelines Checklist (continued)

Trauma-Informed Care		
Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed	Yes	1 and 2
Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments	Yes	1 and 2
Zero Suicide/Suicide Safer Care		
Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members	Yes	1
Mandate completion of Applied Suicide Intervention Services Training (ASIST) or similar training by all team members serving individuals who receive crisis services	Yes	1
Incorporate suicide risk screening, assessment and planning into the crisis provider's practices	Yes	1
Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record of the crisis provider	Yes	1
Commit to a goal of Zero Suicide as a state and as a crisis system of care	Yes, for county; unknown for state	1
Safety/Security for Staff and People in Crisis		
Commit to a no-force-first approach to care	Unknown	1 and 3
Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions	Unknown	1 and 3
Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis	Unknown	1 and 3
Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all	No	1 and 3
Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area	No	1 and 3
Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program	Yes	1 and 3
Law Enforcement and Crisis Response—An Essential Partnership		
Have local crisis providers actively participate in CIT training or related mental health crisis management training sessions	Yes	1 and 2
Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices	Yes	1 and 2
Include training on crisis provider and law enforcement partnerships in the training for both partner groups	Yes	1 and 2
Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care	No	6 and 7

Source: SAMHSA, 2020, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit
https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth)

SAMHSA Guideline	Achieved in Montgomery County? (Current state)	Relevant THS Recommendation
Across all services, SAMHSA strongly encourages		
Keep youth in their home and avoid out-of-home placements as much as possible.	No	3,4, and 5
Provide developmentally appropriate services and supports that treat youth as youth, rather than expecting them to have the same needs as adults.	Yes	1 and 2
Integrate family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.	Yes	1 and 2
Meet the needs of all families by providing culturally and linguistically appropriate, equity-driven services.	No	8
CORE ELEMENT: Regional Crisis Call Hub Services		
Essential Operations		
Operate every moment of every day (24/7/365). Be staffed to answer every contact from youth and families, as well as from agencies and organizations that serve these populations (e.g., schools). If resources are not available to support this, coordinate overflow coverage with another youth- and family-trained crisis center (SAMHSA, 2020a).	Yes	1 and 2
Have protocols and resources in place to quickly access translation services, and TTY (teletypewriter) for those who are deaf or hard of hearing. Have sufficient capacity and oral fluency in languages that match the community need.	Yes	1 and 2
Gather data on call volume, response time, user satisfaction, and outcomes to inform a continuous quality improvement process, which should include regular review of call data to identify and address disparities, identify service gaps, and determine training needs.	Yes	1 and 2
Technology		
Incorporate Caller ID functioning.	Yes	1 and 2
Implement GPS-enabled technology in collaboration with partner crisis mobile teams to dispatch care more efficiently.	Yes	1 and 2
Build technological capacity to incorporate texting, chat, and video. Recent research has shown that telehealth might improve help-seeking behavior for youth, and some youth report texting is their preferred method of communication.	Yes	1 and 2
Utilize real-time regional bed registry technologies that integrate information about which facilities have openings for youth.	Yes, Magellan bed tracker for Medicaid members only	1 and 2
Staffing and Training		
Staff crisis call centers with an interdisciplinary team of child and adolescent behavioral health clinicians, family and youth peers, and other trained team members. As much as possible, hire staff whose racial, ethnic, linguistic, and sexual orientation or gender identities are representative of the communities served.	Yes	1 and 2
Ensure all responders receive relevant training on developmentally appropriate supports and services available in the region or community.	Yes	1 and 2

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth) (continued)

Providing Services		
Assess for risk of self-harm or suicide in a manner that meets Lifeline Suicide Risk Assessment Standards and assess for risk of harm to others. Use developmentally appropriate tools and protocols.	Yes	1 and 2
The National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit also directs Lifeline crisis center staff to adhere to the Lifeline's Imminent Risk of Suicide model.	Yes	1 and 2
If needed, coordinate connections to mobile crisis response teams and crisis facilities that offer developmentally appropriate services. Provide warm hand-offs and coordinate transportation as needed.	Yes	1 and 2
With the family's permission, schedule home- and community-based follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode, in collaboration with the mobile response team.	No	5
CORE ELEMENT: Mobile Crisis Team		
Essential Operations		
Respond to crises on location in home- and community-based settings, including schools and postsecondary institutions, recreational centers, homeless shelters, and other community centers.	Yes	1 and 2
Implement real-time GPS technology in partnership with the region's crisis center hub.	Yes	1 and 2
Be available to respond quickly to crises. Arriving onsite within one hour of dispatch is the general standard most mobile crisis teams follow	Unknown; Access is just beginning to track time to deployment	6
Staffing and Training		
Have access to a licensed and/or credentialed clinician in a supervisory role who has expertise and experience using evidence-based assessment tools with youth populations.	Yes	1 and 2
Incorporate youth and family peers within the response team.	Yes	1 and 2
Provide staff training about how to describe mobile response services to youth, their caregivers, and other callers. The entire approach should be framed in terms of acceptance and help, never blaming youth or families. Situations which result in frequent calls for the same young person should be framed as special challenges that need to be addressed with action plans that support transition to community-based or wraparound services.	Yes	1 and 2
Respond without law enforcement accompaniment unless special circumstances warrant their inclusion. Safe reduction of unnecessary police involvement is critical for youth of color, who are more likely than their White peers to face harsh consequences like school exclusion and arrest.	Yes	1 and 2

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth) (continued)

Onsite Needs		
Mobile response teams may use a standardized screening and assessment tool to help promote shared understanding across providers. Standardized tools are also intended to reduce the impacts of bias.	Yes	1 and 2
De-escalation strategies are intended to increase safety while decreasing emotional distress. Sometimes this requires helping family members to recognize their own behavior in that moment, because it can be difficult For a young person to be calm if their family member is at a heightened emotional state.	Yes	1 and 2
Creating a crisis or suicide safety plan is a key component of ensuring the young person's short-term safety and long-term stability. This should be a collaborative and strengths-based process that identifies and integrates their natural supports.	Yes	1 and 2
Mobile response teams may coordinate a transition to community-based mental health services, crisis receiving and stabilization services (described in the next section), or a hospital setting.	No crisis stabilization and receiving center is available for youth; yes for other levels of care	3
CORE ELEMENT: Crisis Receiving and Stabilization Services		
Essential Operations		
Accept all youth referrals, at least 90% of the time, with a "no rejection" policy for first responders. Offer walk-in and first responder drop-off options that accept youth.	No	3
Offer developmentally appropriate services to address mental health and substance use crisis issues impacting youth.	No	3
Do not require medical clearance prior to admission; instead, provide assessment and support for medical stability while in the program.	No	3
Include beds within the real-time regional bed registry system, identifying how many beds are available for youth.	Yes, Magellan bed tracker for Medicaid members only	3
Collect data on crisis resolution, user satisfaction, and other outcomes, and review these data to develop quality improvement plans.	No	3
Staffing and Training		
Be staffed at all times with a multidisciplinary team with expertise in meeting the needs of youth, which may include: youth and family peer support providers; psychiatrists, psychiatric nurse practitioners, or physicians; social workers, counselors, and crisis specialists.	No	3
Have staff who can assess physical health needs and deliver care for most minor physical health challenges. Have an identified pathway to transfer the young person to more medically staffed services, if needed.	No	3
Ensure that staff have appropriate youth and family expertise and experience.	No	3
Provide training to all staff on effective crisis management strategies that minimize the use of seclusion and restraint. Staff should also be trained in the safe, respectful, and appropriate use of seclusion and restraint. Such actions should only be used by trained personnel as a last resort and for brief periods of time.	No	3

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth) (continued)

Facility Setting		
If the facility serves both youth and adults, have separate receiving and support areas. If the facility serves both younger children and adolescents, it is also ideal to have separate areas for them.	No	3
Provide spaces that are trauma-informed in their design and that promote dignity as well as safety (e.g., open and airy design with inviting colors; no barriers, such as Plexiglass, that separate or isolate people in crisis).	No	3
Provide spaces that are calming and welcoming and that offer developmentally suitable supports for youth and families.	No	3
Provide confidential spaces for families to gather, with the young person and without, where they may receive clinical services and support.	No	3
Providing Services		
Screen for risk of self-harm, suicide, and risk for violence using tools that are designed or appropriate for youth.	No	3
If short-term individual and family therapies are provided, integrate community-defined evidence programs and cultural adaptations of evidence-based interventions, in addition to traditional evidence-based interventions.	No	3
Provide warm hand-offs to home- and community-based, youth-serving care.	No	3 and 5
Incorporate some form of intensive support beds, either within the facility's own child and youth services area or with a partner that also offers children- and youth-specific crisis services.	No	6
CORE VALUES AND PRINCIPLES		
Addressing Recovery Needs		
Meaningfully integrate the SOC values of family-driven, youth-guided, and culturally and linguistically responsive at every level of service. Respect the preferences of youth and families as much as possible while ensuring safety.	Yes, family driven; not culturally & linguistically responsive	8
Create engaging environments that do not use barriers to separate or isolate people in crisis.	Unknown	3
Engage youth and families in shared decision-making.	Unknown	3
Support youth in identifying their strengths and natural supports that will aid their recovery.	Unknown	3
Ensure that multilingual staff or translation supports are available so that youth and families accurately understand the choices available to them.	No	8

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth) (continued)

Trauma-Informed Care		
Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.	Unknown	1
Create engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.	Unknown	1 and 3
Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options and offer materials regarding the process in writing in the individual's preferred language whenever possible.	Unknown	1 and 8
Ask the individual served about their preferences and do what can be done to align actions to those preferences.	Unknown	1
Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities.	No	1
Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.	Unknown	1
Significant Role for Peers		
Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.	Unknown	8
Develop support and supervision that aligns with the needs of your program's team members.	Yes	1 and 2
Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members, and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.	Yes*	3
Trauma-Informed Care		
Seek to employ staff that reflect the racial, ethnic, sexual orientation and gender identity, cultural, and linguistic diversity of the community to be served.	No	8
Ensure that crisis call center, mobile response team, and crisis stabilization services staff receive training on trauma-informed care.	Yes*	3
Promote use of strengths-based approaches that support young people's resiliency and acknowledge that healing from trauma is possible.	Yes	1 and 2
Provide training to key systems partners (e.g., schools, law enforcement) on trauma and trauma informed crisis management approaches that limit the use of seclusion and restraint, including de-escalation training.	Yes	1 and 2

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth) (continued)

Trauma-Informed Care (continued)		
Integrate trauma screening (e.g., Trauma Screening, Brief Intervention, and Referral to Treatment, also known as T-SBIRT). Ensure that staff are trained to implement trauma screenings in a sensitive and developmentally appropriate way.	Yes	1 and 2
Provide training to staff and volunteers about secondary traumatic stress, including the unique stress of working with children who have been traumatized	Yes	1 and 2
Significant Role for Peers		
Hire youth and family peer support providers. As much as possible, peer supporters should reflect the communities served (e.g., BIPOC families, LGBTQI+ youth)	No	8
Provide ongoing support, training, and developmentally appropriate supervision for peer support providers	Yes	1 and 2
Integrate peers within each of the core services (crisis call centers, each mobile response team, and at crisis receiving and stabilization facilities)	Yes*	3
Refer families and youth to peer support services in their local area	Yes	1 and 2
Zero Suicide/Suicide Safer Care		
Lead: commit to a goal of Zero Suicide for children and youth as a crisis response system	Yes	1 and 2
Train staff in how to talk to youth and families about suicide, how to use non-stigmatizing language and trauma-informed approaches to youth considering or attempting suicide, and when and how to assess for imminent risk.	Yes	1 and 2
Identify youth at risk of suicide using evidence-based assessment tools	Yes	1 and 2
Engage youth using developmentally appropriate suicide safety planning tools	Yes	1 and 2
Treat: youth at risk of suicide should receive appropriate care that directly addresses their suicide risk and behavioral health crisis, rather than being subjected to police detainment, seclusion, long periods of ED boarding, or similar practices	No	3,4, and 5
After the immediate crisis response and stabilization, transition young people to appropriate, community-based services that address long-term suicide risk and behavioral health needs	Unknown	5
Improve policies and practices: collect and regularly review data related to youth and families who call in for suicide-related concerns, youth who screen positively for suicide risk, and their outcomes (e.g., follow-up supports)	Yes	6

Figure 8: SAMHSA Crisis Guidelines Checklist (Youth) (continued)

Safety/Security for Staff and People in Crisis		
Commit to a "no force first" policy to minimize the use of seclusion and restraint	Unknown	1
Provide comprehensive staff training on the experiences of youth placed in restraint or seclusion; trauma-informed approaches; and effective, person-centered alternatives to restraint and seclusion. Including youth and families to talk about their experiences with seclusion and restraint is an effective part of training.	Yes	1 and 2
If seclusion or restraint occur, both the staff and the young person should be debriefed, together or separately depending on the needs of the young person.	Unknown	1
Employ prevention strategies to limit situations that may result in seclusion or restraint, such as individual assessments for risk of violence and active safety planning.	Unknown	1
Create spaces that feel safe, comfortable/comforting, and nonconfining. Provide youth-specific areas so that they are not exposed to adults in crisis	No crisis stabilization and receiving center is available for children; yes, for other levels of care	3
When promoting 988 or other crisis response services, use images and messaging that communicate a sense of physical and emotional safety.	Yes	1 and 2
Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (EMS)		
Provide Crisis Intervention Team for Youth (CIT-Y) trainings or similar curricula to law enforcement, including school resource officers and other law enforcement officers embedded in youth-serving agencies.	Yes	1 and 2
Establish clear policies and protocols for 911 dispatch to divert calls to the crisis response system, when appropriate to do so.	No	1 and 6
If they are not co-responders, train crisis response staff on when to contact law enforcement or emergency medical services.	Yes	1 and 2
If possible, co-locate crisis call center responders and/or mobile crisis teams with 911 services.	No	1
Have local crisis responders, including youth and family peer supporters as feasible, participate in trainings with law enforcement on topics related to the partnership.	Unknown	1
Incorporate regular meetings between crisis response and first responders to identify and address challenges. Discussion topics should include strategies to better respond to youth, families, and youth-serving agencies like schools. Use these as opportunities to create shared language as well.	Yes	1 and 2
When appropriate, adopt a "no refusal" policy for first responders and law enforcement bringing youth to crisis receiving facilities and expedite the process in lieu of justice settings.	No crisis stabilization and receiving center is available for children	3
Provide training specific to responding to youth with disabilities.	Unknown	1
Share aggregate data regarding youth- and family-related calls to crisis call centers and 911 to identify opportunities for outreach, awareness building, and diversion.	No	6 and 7

*Yes for call center and mobile response; no crisis stabilization center is available for children
Source: SAMHSA, 2022, National Guidelines for Child and Youth Behavioral Health Crisis Care https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep-22-01-02-001.pdf

Recommendation 2: Sustain and build upon the existing systems and structures that work well

As noted in the strengths section, Montgomery County has a robust array of services and engaged stakeholders who have worked collaboratively to address behavioral health concerns for many years. THS recommends that the county sustain and build upon the existing systems and structures already serving an essential role in the community.

Strategy: Clearly articulate how the system works and the county's vision for building the system (driven by this enhancement plan).

As with any complex delivery system, there is some confusion among stakeholders in Montgomery County about roles and responsibilities in addressing behavioral health crisis. The county is committed to "building crisis muscles" and increasing awareness and understanding of the full continuum of care and the important part each stakeholder plays. THS advises that Montgomery County work with contracted providers to clarify roles and expectations in the system and then work outward to connect to the next level of stakeholders that engage with people in crisis (e.g., law enforcement, schools.) The county should consistently describe how it is working towards a more holistic and integrated system that reduces fragmentation between mental health, SUD and other providers and systems of care.

In addition, THS notes specific recommendations to sustain and build upon key components of the existing crisis infrastructure as outlined below.

Director of Crisis and Diversion

Five years ago, the MH/DD/EI Administrator retooled a director-level position to create the Director of Crisis and Diversion role, which has proven highly valuable. The role itself, and the person in the post, Anna Trout, are the glue to the various parts of the crisis system. The director supports the cultivation of cross-sector relationships, data, and information collection, and ongoing problem-solving and gap-filling to improve the crisis system. THS recommends that the county continue to invest in this critical role.

Montgomery County Emergency Services (MCES)

Started in 1974, MCES provides crisis intervention, short-term inpatient and residential treatment, and education related to life-threatening psychiatric emergencies and the diversion of persons with serious mental illness from inappropriate criminal justice involvement. MCES serves in a leadership role in providing extensive, high-quality training to law enforcement and other first responders on de-escalation and diversion, and historically housed the 302-crisis commitment office and the delegates (now moving under the county) and managed the 305-ambulance deployment. Out of 824 recorded 305-ambulance deployments in 2021, 54 percent of persons were taken to MCES, while 29 percent were taken to another hospital or care facility. While there are legitimate concerns about MCES' capacity and ability to serve medically complex patients, it remains a valuable resource in

the county, particularly for helping adults with serious mental illnesses.

THS recommends that the county work with MCES to collect and review data on patients turned away, problem-solve, and identify strategies to ensure close coordination between MCES and the proposed new crisis center (see recommendation #3). The county should work with MCES to assess how the new crisis center and MCES complement each other.

In addition, MCES may be able to play a more prominent consultation role with other hospitals receiving patients on a 302, such as through telehealth. This could help reduce emergency department boarding and help fill gaps in psychiatric expertise for hospitals that identify such gaps.

Suicide prevention hotline/9-8-8

Montgomery County is fortunate to have a well-established suicide prevention hotline operated by MCES. The transition to 9-8-8 has been described as mental health's "carpe diem moment." The county should maximize the new line's opportunity to connect community members to care who previously may not have accessed services. MCES has a strong track record of connecting callers to Access mobile crisis services when appropriate. While the county has preferred callers to contact Access directly, particularly schools and child-serving organizations, the 9-8-8 infrastructure will likely continue to gain traction with expanded federal funding. The number is easier to remember than any other call line.

THS advises that Montgomery County continues to monitor the impact of 9-8-8, maximize the opportunity it presents to market crisis services to community members in need, and engage in advocacy around geolocation, which would help ensure calls are routed locally rather than to call centers outside the county. THS also recommends that the county and MCES work with the public safety/911 call center to gauge if they are receiving calls that may have been appropriately served by 9-8-8. (See 9-8-8 process maps in Appendices.)

Access mobile crisis

Access embraces a strong philosophy of diversion and meeting people where they are. They work closely with local law enforcement and have innovated collaboration models with willing departments, including the "Hub" and "Bridge" models. Access has demonstrated some strong outcomes. According to Magellan data, 88 percent of clients who received a mobile crisis intervention were successfully diverted from hospitalization within seven days. The Georgia Department of Behavioral Health and Developmental Disabilities helped develop the Crisis Now mental health crisis services model and offered one national benchmark to measure diversion. Georgia's goal is to divert 85 percent of mobile crisis interventions from more intensive levels of treatment.

A frequently cited challenge for mobile crisis teams is managing increased service demand, limited staff/resources, and lengthy response time – particularly when serving a large area. Over the course of this year-long engagement, Access has taken steps to decrease the time from referral to deployment by adding a second deployment location and working with its electronic health record (EHR) vendor to make modifications that will enable it to begin to track time from call to arrival on site.

THS recommends that the county continue to invest in mobile crisis services, require collection and reporting of time from call to deployment, and monitor the impact of the new deployment site. THS also advises that the county work collaboratively with Access to build stronger relationships with drug and alcohol treatment providers, who have historically not referred many clients to Access.

Student Assistance Program (SAP)

Montgomery County has invested in school-based prevention programming, social/

emotional learning, mental health, and SUD support for school-age children. The county has been awarded a $1.5 million grant from the Bureau of Justice Assistance to build upon this foundation. THS recommends that the county continue to work closely with the schools to monitor needs and promote more robust connections between schools and CBHCs or other community-based providers.

Peer and Family Support

Montgomery County has an impressive array of peer and family supports in clinical settings (e.g., Peer Specialists/Certified Recovery Specialists) and outside of clinical settings (e.g., Family Worx, Hope Worx/FERNS, Creating Increased Connections groups). THS recommends that the county continue to promote these invaluable services. Some stakeholders, such as first responders and federally qualified health centers (FQHCs), reported that they needed to be made aware of the availability of these services and how easy they are to access.

Administrative Case Managers (ACMs)

Uniquely, Montgomery County has provided each of the CBHCs funding for an ACM position. ACMs deliver short-term support for community members who may or may not receive other mental health services. Some ACMs serve as hospital liaisons (e.g., Merakey refers to the position as such), but people in these roles can engage in a wide variety of outreach and assistance. The ACMs serve a critical role, particularly in supporting people waiting to get in for psychiatric assessment or therapy. THS recommends that the county continues funding ACMs and monitoring program expansion needs. Further, the county could play a leadership role in convening ACMs across the CBHCs to promote collaboration and share best practices and lessons learned in the field.

Montgomery County Office of Drug and Alcohol funded services for people in crisis

The county supports various efforts for individuals experiencing a behavioral health crisis due to co-occurring disorders or primary substance use disorder needs. These include "warm handoff" from the emergency department to Certified Recovery Specialists, some emergency transportation to hospitals and connection to intensive outpatient programs, Medication Assisted Treatment, and/or peer support; "operation rebound," in which a Montgomery County Office of Drug and Alcohol funded Certified Recovery Specialist and Norristown Police Department officer engage with individuals who congregate in identified high substance use areas of Norristown and offer access to care; and the Law Enforcement Treatment Initiative (LETI) that provides training to law enforcement to determine the needs of and offer a diversion option to individuals being arrested for substance-related issues.

THS recommends that Montgomery County continues to strive for a behavioral health crisis system that supports whole-person care. This may include integrating programs and funding opportunities currently fragmented between mental health and D&A.

Recommendation 3: Meet crisis stabilization needs by developing a crisis center.

In its best practices toolkit, SAMHSA defined three core elements of a crisis system:

(1) Regional Crisis Call Center,

(2) Crisis Mobile Team Response, and

(3) Crisis Receiving and Stabilization Facilities (a.k.a. crisis center).

As previously noted in this report, Montgomery County has a well-established regional crisis call center (MCES) and a high-functioning and growing mobile crisis team (Access). However, while there is one crisis center in the county on the MCES campus, the facility is very small, does not serve children and families, and does not have the capacity or building layout to fully meet the county's needs.

Crisis stabilization services are an immediate and unscheduled behavioral health intervention responding to an individual's acute behavioral health issue. The goals of a crisis center include providing immediate services that de-escalate the person, stabilize or resolve the immediate problem, prevent them from harming themselves or others, and reduce unnecessary involvement with more costly and restrictive settings such as hospitalization or the criminal justice system.

Strategy: Develop a 23-hour crisis center that serves both adults and children

THS recommends the county develops a 23-hour crisis stabilization service program, a.k.a. "crisis center," that serves adults, children, and families and is staffed with a multidisciplinary team that includes, at a minimum, a prescriber (psychiatrist or psychiatric nurse practitioner), nurse, mental health, and SUD professionals, with credentials aligned with proposed 55 Pa. Code §§ 5240 and Department of Drug and Alcohol Programs (DDAP) codes and certified peer/recovery specialists. The county should formalize expectations for cross-system or intra-facility communication and collaboration. The center's vendor(s) should work closely with other providers and hospitals to move clients through different levels of care as needed.

THS advises a new crisis center complementing and coordinating with the MCES facility. The county should prioritize children and families. The "National Guidelines for Child and Youth Behavioral Health Crisis Care," published by SAMHSA in November 2022 (see Figure 8), describes a framework that states and localities can consider as they develop or expand their crisis safety net for youth and families. The document further outlines best practices for Crisis Receiving and Stabilization Facilities that serve children and youth. THS recommends that Montgomery County and its vendor(s) adhere to these guidelines for operations, staffing and training, facility setting, and service delivery. Most importantly, THS recommends that the county secure a facility allowing separate entrances and waiting areas for children and families vs. single adults; the vendor(s) selected to operate the walk-in center should have proven experience and expertise in serving children and families.

The county should use mobile crisis deployment and 305 ambulance data to inform where the walk-in center is physically located (see Figures 9 and 10). Norristown and Pottstown, two population centers in the county, both had the highest

IDEAL COMPONENTS OF A CRISIS CENTER SERVING CHILDREN

SAMHSA guidelines and best practices being learned from other crisis center providers nationwide should inform Montgomery County's new crisis center as it seeks to serve both adults and children. These include but are not limited to:

- Provide separate entrances and milieus for children vs. adults.
- Provide a calming and welcoming environment and confidential spaces for families.
- Staff the center with a multi-disciplinary team, including family support/peer specialists.
- Staff should specialize in offering trauma-informed care and developmentally appropriate services for children to address mental health and substance use crisis issues impacting youth.
- Do not require medical clearance before admission; provide assessment and support for medical stability while in the program.
- Meet the needs of all families by providing culturally and linguistically appropriate services.
- Conduct age-appropriate screening for self-harm and suicide risk.

number of deployments over the last two years. The county should also consider the location of MCES when deciding where to physically site the walk-in to help maximize the use of both facilities.

THS also received youth mobile crisis deployment data from Access Services. Montgomery County should use this data when considering where to physically cite a crisis

Figure 9: 2021 Access Mobile Crisis Deployments by Zip Code

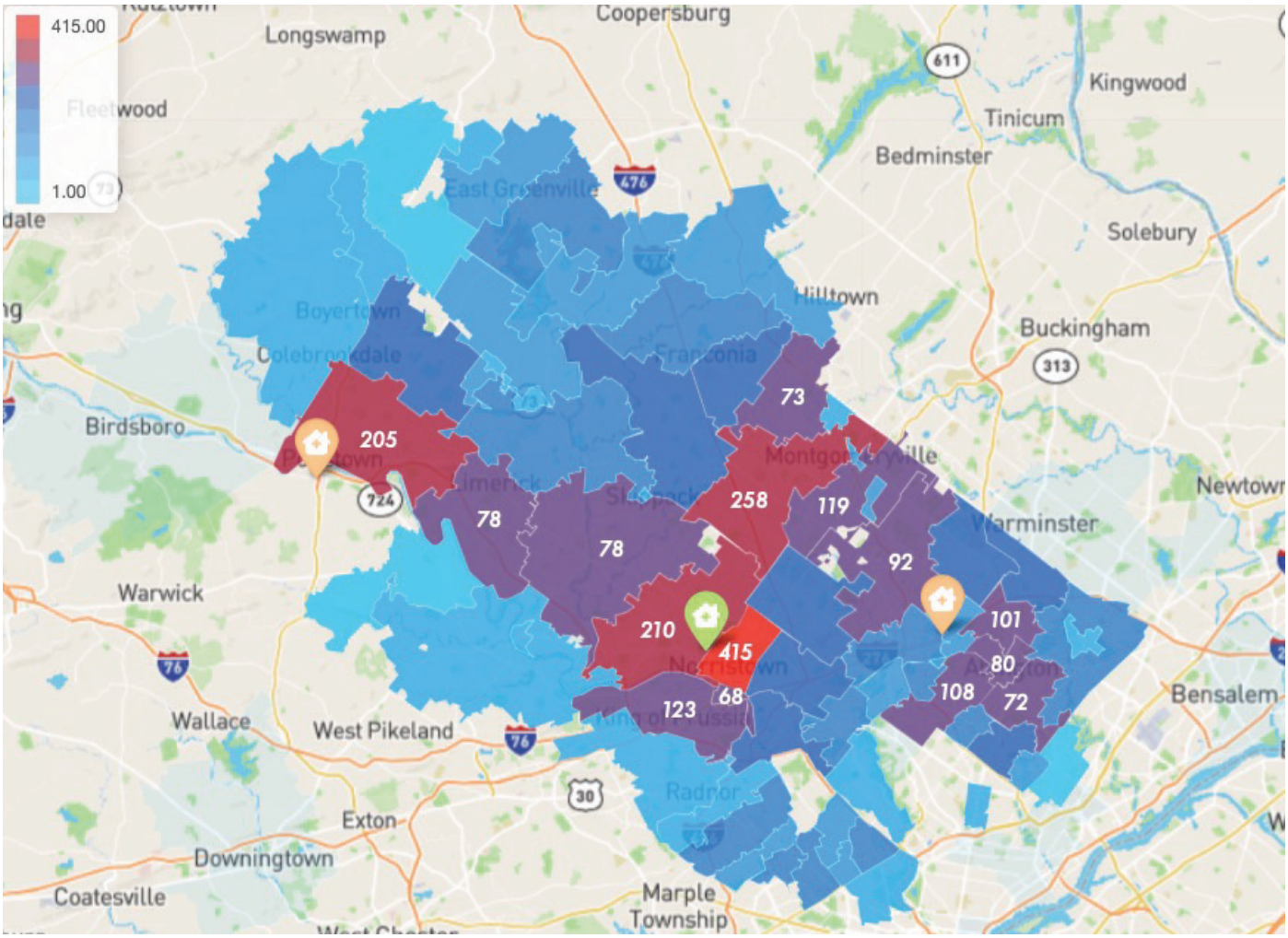
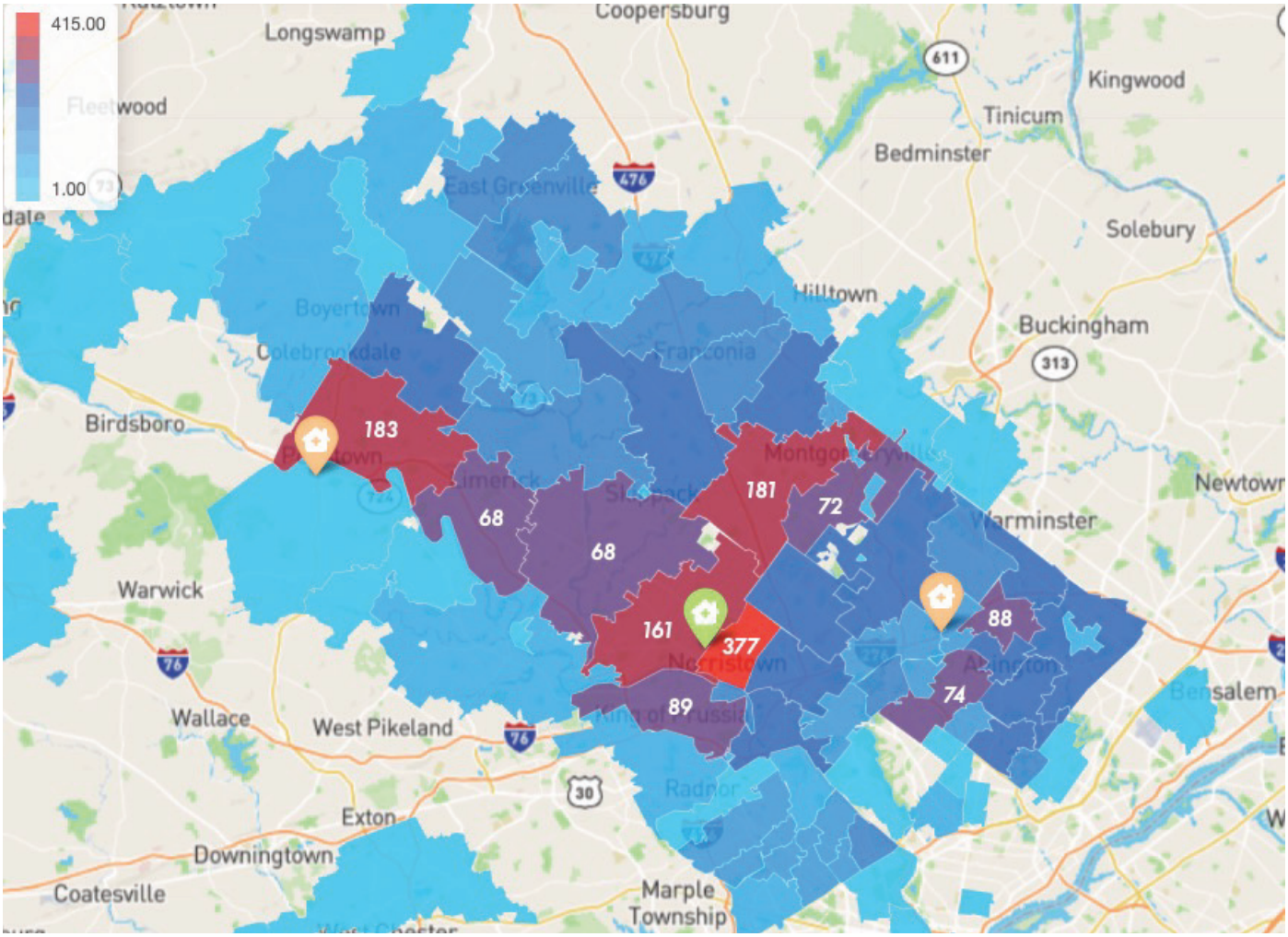


Figure 10: 2022 Access Mobile Crisis Deployments by Zip Code



center that serves children and families. Data in each map is tied to zip code (boxes filled in with color), while the boxes only with red outlines are the school districts (see Figures 11 and 12). Youth mobile crisis data follows the same trends as the previous data from Access. There are heavy concentrations in the higher populated areas, particularly in Pottstown and Norristown areas.

Figure 11: 2021 Youth Access Mobile Crisis Deployments by Zip Code

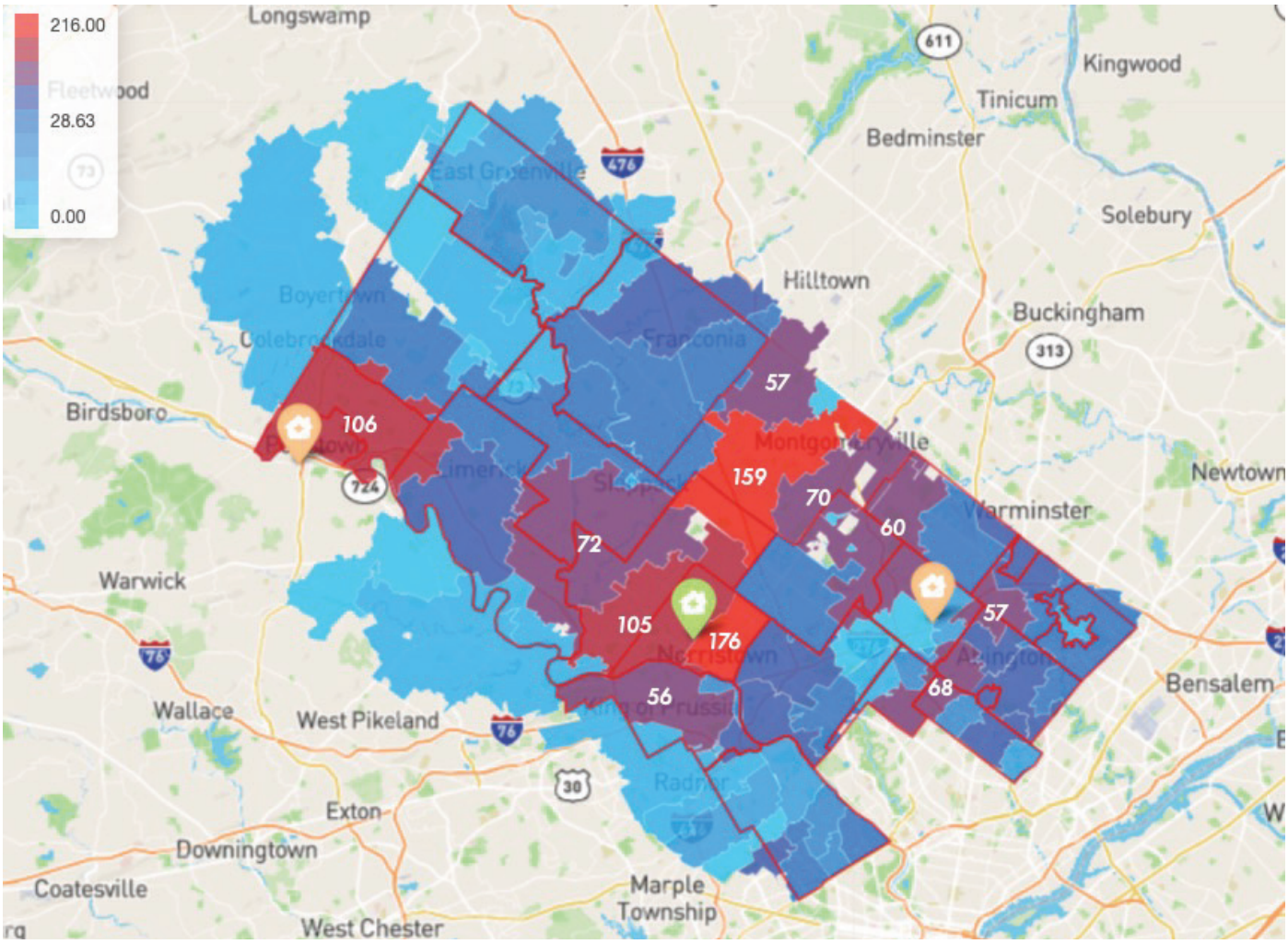


Figure 12: 2022 Youth Access Mobile Crisis Deployments Zip Code

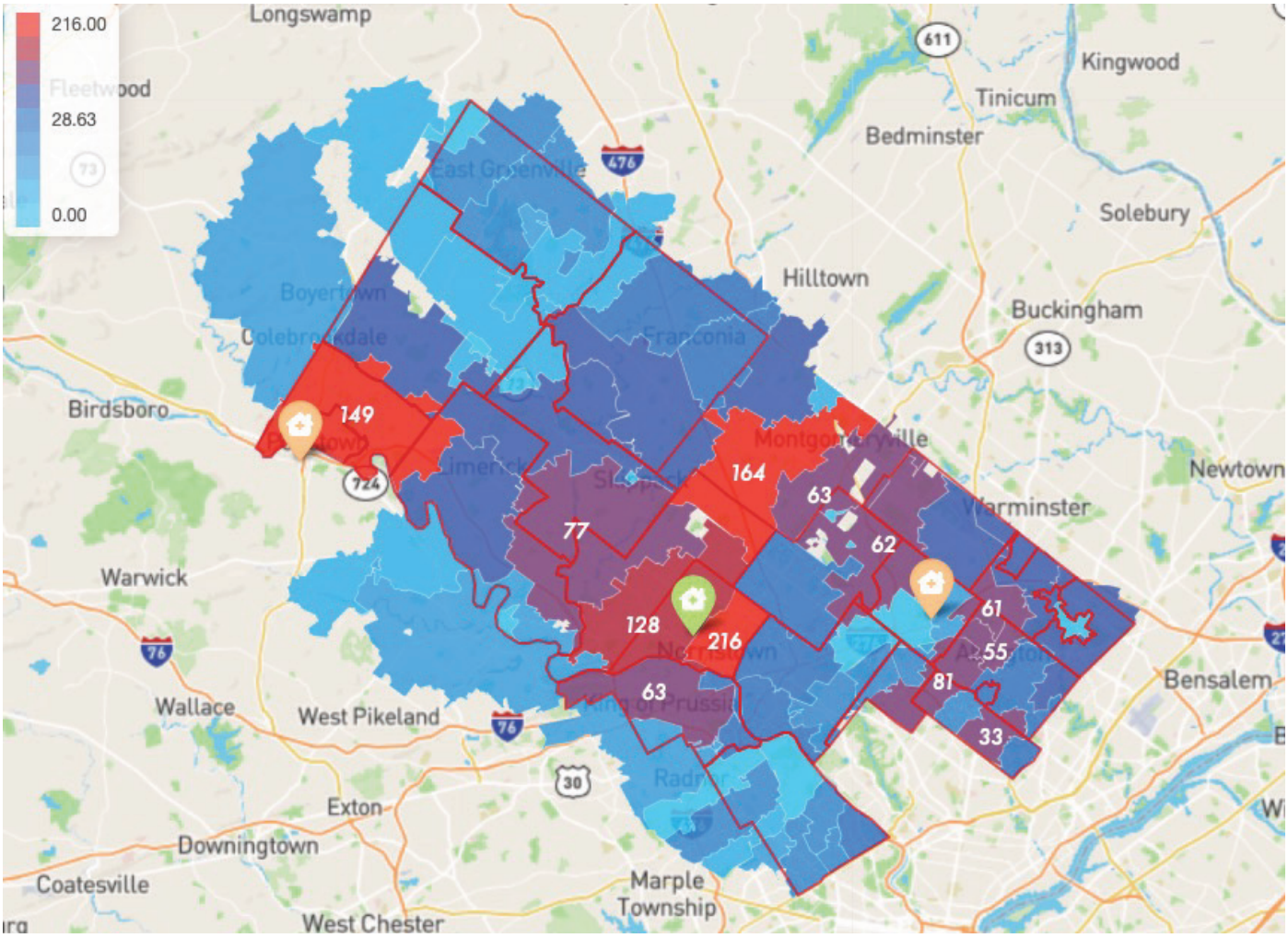
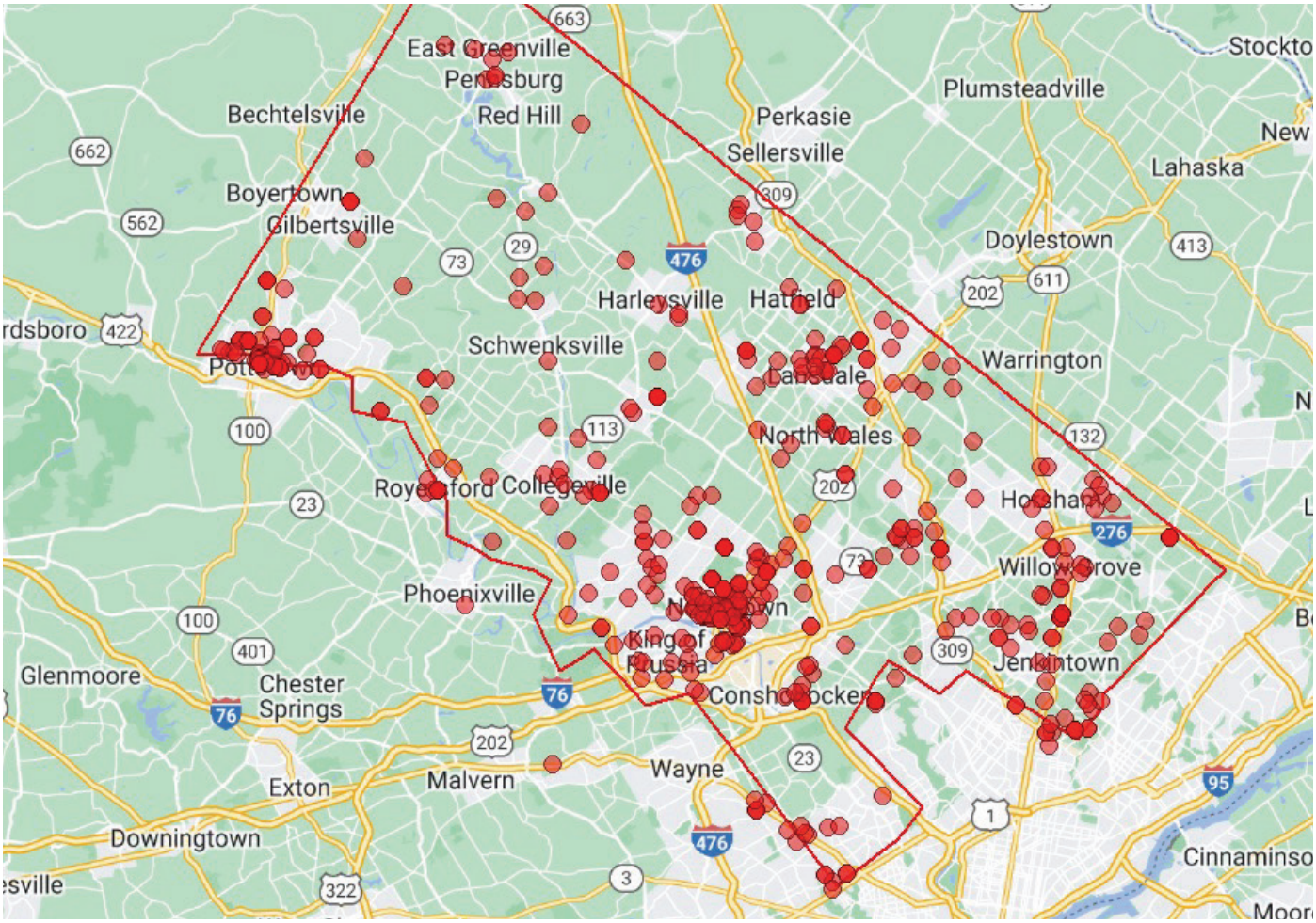


Figure 13: Montgomery County 305 Ambulance Deployments (N = 824) 2021



Data on the 305-specialty ambulance deployment (see Figure 13) shows similar patterns to the mobile crisis, with the highest concentrations in the two urban centers.

Rather than having separate facilities, THS recommends that the walk-in center concurrently functions as a SUD assessment site. DDAP regulations refer to these assessment services as "Intake, Evaluation, and Referral Activities." These are regulated by Chapter 709 Subchapter D and Chapter 711 Subchapter C. The county may need to allow subcontracting arrangements to ensure that the managing entity is well-versed in mental health and SUD regulations and can provide high-quality services to people in crisis regardless of their primary diagnosis.

The crisis center should limit patient episodes of care to 23 hours. THS' review of Pennsylvania regulations found that a specific length of stay for walk-in crisis services is not defined. Still, Title 55, Chapter 1153, defines "Inpatient services" as treatment provided to an individual who has been admitted to a treatment institution or an acute care hospital or psychiatric hospital on the recommendation of a physician and is receiving room, board, and professional services in the facility on a continuous 24-hour-a-day basis. DDAP regulations appear to have a similar definition for inpatient facilities triggered by a 24-hour timeframe. THS concludes that it is necessary to avoid hitting the continuous 24-hour threshold to be considered an outpatient facility and not subject to regulations governing inpatient facilities.

THS recommends that the new Montgomery County crisis center be designed to provide the following services and programming features:

Staffed by a multi-disciplinary team that includes, at a minimum, a prescriber (psychiatrist or psychiatric nurse practitioner), nurse, mental health and SUD professionals, and certified peer/recovery specialists.

Mental health and SUD triage and assessment are conducted.

Psychiatric evaluation, with 24/7 on-call medical services offered.

Medical clearance capabilities are available on-site.

The center strives for a no-reject policy.

Bed search assistance is offered for those requiring a higher level of care (working in conjunction with Magellan for Medicaid beneficiaries).

The center provides transportation assistance/ability to transport clients to ER or return home (Note: this may be covered under the Non-Emergency Medical Transportation benefit for Medicaid members).

All staff are trained in recovery-oriented, trauma-informed, and culturally competent care.

The center can induct Medication Assisted Treatment (MAT) on-site (or through telehealth if the regulatory framework allows).

Bilingual staff or on-call translation services are available.

The center offers referrals to community resources and can mobilize natural supports.

The center can connect clients to access outpatient services.

- Preferably, the crisis center will have access to scheduling systems so initial intake appointments can be made immediately for clients who still need to be connected to providers. For clients already under the care of a CBHC or other outpatient provider, the crisis center should be able to work with that provider to schedule an urgent appointment.

Another important consideration in the design of the crisis center will be balancing the needs of people who are voluntarily seeking services with those who may be dropped off by first responders or on a 302 hold. The county and its vendor(s) will need to ensure the safety of all patients and staff. THS recommends that the walk-in center have security trained in de-escalation techniques rather than armed guards. None of the walk-in centers THS interviewed for the case studies

paper had armed guards. Additionally, while SAMHSA recommends crisis centers have a "no rejection" policy, there should be written protocols defining when, albeit rarely, a patient will need to be transported to an ED or when law enforcement intervention will be necessary.

THS recommends that the county obtains feedback from the CSAG on the draft crisis center RFP and the intended programming components. While CSAG has provided input over the last year, it has been somewhat abstract. Now that there is an actual draft RFP and the county is moving towards implementation, it is critical that stakeholders more closely vet the concepts and give input on the more granular details.

At the February 2023 CSAG meeting, members urged the county to address transportation needs in conjunction with the crisis center, including as part of the RFP process. There is currently only one "305" ambulance serving the entire county. Suggestions included investing in an additional "305" ambulance, ensuring the crisis center vendor(s) had vans or other means of transporting clients and coordinating with mobile crisis for client transportation.

Financial considerations:

As noted in the strengths section of the systems analysis, Montgomery County is well-versed in braiding funds. Core financing across the behavioral health crisis services continuum is summarized below (see Figure 14).

Figure 14: Financing Options Available to State and Localities

Source of Funding	Funding	Total Amount	Applicable Components in BH Crisis Services Continuum				Allowable Use of Funds		
			Regional Crisis Call Center Hub	Crisis Mobile Teams Response	Crisis Recieving and stabilization Center	Broad Community-Based Crisis Services	Planning & Design	Infrastructure	Services
CMS	Medicaid waivers	Varies by State	X	X	X	X		X	X
	Enhanced matching rates for mobile crisis intervention	Varies		X					X
	CCBHC demo	Varies		X	X	X		X	X
SAMHSA	Community Mental Health Services Block Grant	$2.9B (FY22 budget request)	X	X	X	X	X	X	X
	CCBHC expansion grants	$375M (FY22 budget request)		X	X	X		X	X
	Substance Abuse Prevention and Treatment Block Grant	$6.5B (FY22 budget request)	X	X	X	X		X	X
	SAMHSA State Opiod Response Grant	$1.42B	X	X	X	X		X	X
	SAMHSA Tribal Opiod Response Grant	$37.6M	X	X	X	X		X	X
	SAMHSA 988 appropriations	$282M (FY22 allocation)	X					X	X
State 988 Mobile Phone Fees		Varies	X	X	X	X		X	X

Source: Crisis Now
Date: March 2, 2022

Montgomery County has already secured ARPA funds and allocated Medicaid and County reinvestment funds for this purpose. Additional state funds may be available to the county based on the Pennsylvania Behavioral Health Commission's Recommendation #3: Expand Capacity for Services and Supports, which calls for $39 million and explicitly references the crisis continuum and 24/7 walk-in centers. However funding from the commission would be a one-time investment, not ongoing support.

Most crisis centers interviewed by THS have a mix of Medicaid, commercial insurance, Medicare, state and county funding, and private philanthropy. Montgomery County projections anticipate that 50 percent of patients the walk-in center will serve will have Medicaid.

In addition to billing specific service codes for psychiatric assessment and mental health treatment, according to Crisis Now, per diem codes are another source of revenue for crisis-receiving and stabilization facilities. These include S9484 for one- to four-hour visits and S9485 if the encounter is more than four hours.

Another long-term funding strategy Montgomery County may want to explore is a local county tax initiative. There are multiple examples of behavioral health crisis services and facilities funded partly by voter-approved tax initiatives, such as Larimer County (Colorado), King County (Washington), and Sonoma County (California).

Montgomery County should advocate for a portion of the county allocation (5.047 percent of the Pennsylvania total) in opioid settlement funds to be dedicated to the crisis center. Between the Johnson and Johnson and Distributor's settlements, the total value for the state is anticipated to be $1,070,609,642. Per the settlement agreement, "funds should be spent equitably across the county in a way that most effectively abates the effects of the Opioid misuse and addiction." Montgomery County should build the case that the crisis center will help achieve this goal and aligns with approved uses of the funds, including opioid abatement via evidence-based treatment strategies, wrap-around services, and diversion. This is particularly true given that the walk-in center will also serve as a SUD screening and assessment site and will offer MAT induction.

Given that the settlement funds may be available for up to 18 years, Montgomery County should actively seek start-up funding and a portion of the county's allocation for operating costs for the walk-in center.

Steps to operationalize the recommendation:

- Advocate for a portion of local opioid settlement allocation to be dedicated to the crisis center development and ongoing operations
- Review and modify the county's draft RFP based on the guidance offered in this report
- Provide a public comment period and seek feedback from the CSAG
- Release a competitive RFP
- Obtain vendor proposals

- Utilize a community panel/CSAG members (who are not applicants) to review proposals
- Select a vendor and move to contract
- Monitor the impact of the crisis center against key performance indicators and its impact on other components of the behavioral health delivery system

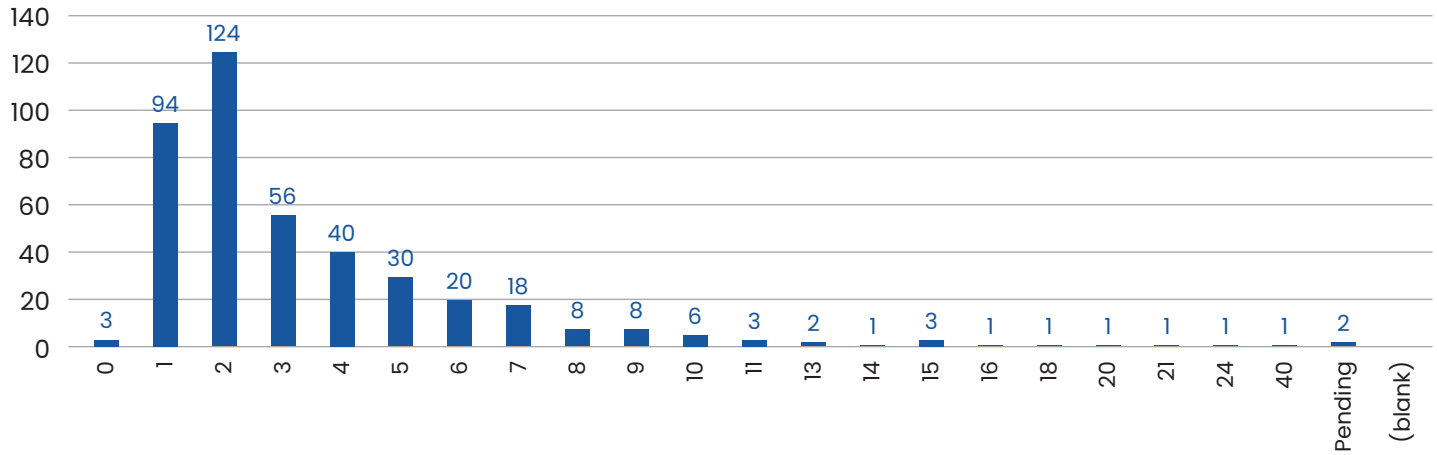
Recommendation 4: Explore the level of need for additional hospital alternatives, with a primary focus on children's needs.

While the crisis center will provide "somewhere to go" for persons in a behavioral health crisis, THS is concerned that subacute services, or those that fall between inpatient and traditional outpatient care, are limited. Notably, in 2021, 402 people with Medicaid waited in local EDs for over 24 hours for inpatient psychiatric care. This number would be higher if Medicare and commercial insurance patients were added.

Magellan provided an "AIP Tracking Data" report of its members from January 2019 and updated it through June 2022 (see Figure 15). The bed search process is triggered if a member has not been assigned a bed within 24 hours by the provider, at which point Magellan supports the effort with greater involvement. All totals include only those members whom the provider did not successfully place in the first 24 hours. The information contained total utilization by month, complete counts by age group, totals for specialized beds (e.g., autism, COVID-19, pregnancy), totals by location broken down by child/adult, and totals by the number of days waiting for bed placement. Data showed that of members whose bed search progressed beyond the initial 24 hours, 52 percent waited two days or less for placement, and 90 percent were placed within one week. Approximately 10 percent (9.7 percent) of members had longer wait times, up to 40 days, though this was likely negatively impacted by COVID-19.

Many crisis centers around the country (and elsewhere in Pennsylvania) offer a higher level of care in the same building or campus. Crisis residential services go by different names (Crisis Residential Unit, Crisis Stabilization Unit (CSU), Crisis Respite, etc.). In Pennsylvania, although the Crisis Residential Program (CRP) nomenclature has traditionally been used, recent state behavioral health crisis planning documents have introduced CSU. Regardless of the naming convention used, these programs refer to a short-term, community-based, homelike setting with multi-day lengths of stay, often serving as a step-down from, or alternative to, psychiatric hospitalization. These settings aim to provide supervised care around the clock, stabilize the patient and get them back into the community.

Figure 15: Montgomery County MCS AIP Tracking Data, January 2019 through January 2022



Montgomery County has two CRPs: Carol's Place and Horizon House. Neither program serves children under 18. There is limited data on the level of demand for these services and the number of people who are turned away.

However, Magellan data in the *Montgomery County Crisis Services Outcomes Report* show that CRPs have a significant impact. Of all levels of care, CRPs saw the highest diversion rate. Ninety-eight percent of people with crisis residential stays were diverted from the hospital. The length of stay (LOS) at CRPs has been longer than the program's intended, with an average LOS of 36.33 days. It is worth noting that while the CRPs are designed to be used for diversion from any hospitalization, they sometimes function as "step-down" services after a patient has already been hospitalized.

Strategy: Conduct a needs assessment to determine if an additional hospital alternative is needed for adults

Additional hospital alternative programs may be necessary, but it is only possible to determine with better data. THS, therefore, recommends that Montgomery County conducts a needs assessment. If a new CRP/CSU is warranted, THS recommends this be considered as Phase 2 of building out the crisis center. An alternative to an additional facility may be to expand the evidence-based Assertive Community Treatment (ACT) teams, which already exist in Montgomery County but have limited capacity, according to stakeholders interviewed.

Strategy: Explore the feasibility of developing an in-home stabilization program for children and adolescents

SAMHSA's guidelines recommend that youth in behavioral health crises receive care in the least restrictive setting possible and, if it is safe, at home and in the community. Hospitalizations and justice system involvement should be safely reduced or prevented whenever possible. One way to divert young people from the emergency room and inpatient hospitalization is through an in-home stabilization program. In-home stabilization is a short-term crisis intervention designed to serve children, adolescents, and their families as a preventive approach to those at risk or following a mobile crisis or crisis center intervention.

According to Paper No. 4 in the *From Crisis to Care* series, "The provision of crisis stabilization services in homes and communities for up to six to eight weeks to meet the needs of youth and families who require ongoing stabilization after an initial mobile response is a critical component of a continuum, as are appropriately designed settings for acute care. Attention to the needs of diverse populations is essential to ensure equity and access. The stabilization services provided after a crisis are important to ensure that all youth and families have the resources to implement crisis plans, improve functioning and well-being, maintain safety, and decrease the likelihood of future crises or other poor outcomes."

Sample in-home services include assessment, parent education programs, peer support, coping and conflict management skill-building, behavior management training, and warm hand-offs to other community-based resources and services. Furthermore, there are several evidence-based practices (EBPs) that can be utilized with intensive in-home services, including Family Centered Treatment (FCT), Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST).

THS recommends the county surveys behavioral health providers to determine which home-based EBPs are currently being used within Montgomery County. That would be an important place to start as the county explores

the need for additional hospital alternative programs for children. Then, the county could work with providers to offer additional home-based crisis stabilization services for a designated time.

Financial considerations:

According to the National Crisis Residential Funding Survey conducted by TBD Solutions, Medicaid is the single largest payer of CRPs/CSUs. Seventy-eight percent of respondents indicated they have a fee-for-service payment model, and 73 percent of those have a bundled set of services paid together at a per diem rate. The average per diem rate is $453. Given that Montgomery County has two CRPs already, county funding data and Medicaid claims data should be available to help inform the costs of implementing a third facility.

THS did not find available data to determine the potential cost of implementing or expanding an in-home stabilization program for children, adolescents, and their families. However, several states include intensive in-home services among their covered behavioral health services under their Medicaid State Plan.

Steps to operationalize the recommendation:

- Work with current CRP providers to track demand or unmet needs
- Monitor the impact of the crisis center and assess the number of patients whose needs are met, the number of patients transferred to inpatient facilities, and the number of patients who would benefit from an "in-between" level of care
- Obtain data from behavioral health providers on the availability of evidence-based practices delivered in the home
- Explore the feasibility of expanding home-based crisis stabilization services for children, adolescents, and their families; determine what services are currently covered by Medicaid in Pennsylvania

Recommendation 5: Address barriers to improving timely access to behavioral health services.

THS has repeatedly heard from stakeholders that outpatient services have long waiting periods, as demand has exceeded capacity. While there is limited data on persons turned away, Magellan did collect self-reported

Figure 16: Magellan Collected Outpatient Waitlist Data Through Provider Self-Report
(note: does not include drug and alcohol outpatient providers)

	Level of Care	2019	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Montgomery County Total	Outpatient Therapy	354	773	905	1067	966	865	1030	1140	1162
	Outpatient Medication Management	50	185	338	293	259	127	211	177	42
	Family Based Services	21	237	120	103	86	100	108	132	78
	Blended Case Management	82	289	241	229	193	207	241	234	213
	Peer Support	27	104	118	99	58	91	89	115	130

data from outpatient providers comparing 2019 to eight months of October 2021 to May 2022 (see Figure 16). In May of 2022, this data shows that the number of persons waiting for outpatient therapy was striking (1162). The outpatient behavioral health delivery system needs to be strengthened to help keep people from getting into a crisis and get into care quickly after a crisis hits.

Strategy: Pilot or incentivize same-day access, low-barrier clinics.

Same-day services are increasingly recognized as best practices in community behavioral health and have been offered by the U.S. Department of Veterans Affairs (VA) since 2016. Some examples of community behavioral health providers offering same-day access around the country include Prince William County (Virginia), Aurora Mental Health Center (Colorado), and Best Self (New York).

According to a study of 169 organizations in 25 states, behavioral health centers that changed to same-day access saved an average of 1.2 hours in staff time, reduced their client wait times (in the number of days) by 44 percent, increased their intake volume by 19 percent, and saved annually $20.1 million.

Some states have made competitive funding available to local jurisdictions and providers to implement same-day access. For example, the Colorado Behavioral Health Administration is providing grants to implement "treatment on demand" with the goals to a) prepare providers to offer same-day access and b) initiate medication-assisted treatment, SUD counseling, peer support, and navigation services.

While some providers in Montgomery County offer same-day services for an intake, they do not offer same-day psychiatric evaluation or therapy appointments. Administrative Case Managers (ACMs) have been used to help provide some level of care in the interim. Still, there is a need for people to get prompt psychiatric evaluations. Stakeholders described that clients could not get the full slate of community-based services until they get an evaluation, and they may have to wait to receive one for up to three months.

Some specialized firms provide clinical consulting services on same-day access and "just-in-time" prescriber scheduling. Same-day access includes developing systems to offer same-day assessments in a virtual environment to improve client satisfaction and engagement while reducing client no-shows. Just-in-time prescriber scheduling moves the client from a diagnostic assessment to a psychiatric evaluation within three to five days, which increases client engagement.

THS recommends that Montgomery County provides funding for a pilot program or otherwise incentivize the development of same-day access or low-barrier bridge clinics. This may involve creating new positions or reallocating existing personnel for outpatient providers to have same-day access services

for people with severe behavioral health needs. Bridge clinics should include assessment, medication management, and brief therapy. While crisis intervention services are designed to de-escalate acute needs, bridge clinics can be more upstream and serve as a resource to open the door to ongoing care and treatment. The approach could reduce wait times for services by getting people into a level of care immediately, even if they continued to wait to be assigned a permanent therapist. It should also be noted that unlike the crisis center proposed in recommendation #3, these same-day access services would have designated hours rather than be available 24/7.

The county should issue an RFP for one-time funding to support organizations that aim to improve access to behavioral health – including mental health and SUD treatment by developing a bridge clinic or same-day access model. Funded providers should be required to report on how the pilot increased access to care and decreased wait times for services. Grant funds could be used for "firehouse" capacity, meaning the ability to be open and available to provide services on demand but with the knowledge that there may initially be a reduced number of billable encounters until patients and referral sources get accustomed to same-day access. The firehouse analogy derives from the fact that fire departments must be staffed regardless of whether there is a fire and are viewed as a public good, supported through tax revenue.

Acknowledging that many behavioral health providers contract with multiple payers to provide services is important. Montgomery County has minimal leverage with commercial carriers or Medicare. Consequently, the biggest impact of county support for same-day access services will be on Medicaid beneficiaries/ individuals enrolled in Health Choices.

Financial considerations:

Given that bridge clinics or same-day access clinics may have inconsistent encounters, at least initially, the county should make flexible funding available to support "firehouse" capacity. This would reduce the pressure on the provider organization to rely solely on fee-for-service reimbursement from scheduled encounters. THS proposes that the county tries this out on a limited, pilot basis with two vendors. Capacity grants would not be intended to cover the staffing costs in full, as billable encounters would generate reimbursement. According to zip recruiter, the average annual salary for a Psychiatrist in Pennsylvania is $225,000. THS proposes the county fund 0.5 FTE at each pilot site for a combined annual cost of $225,000 or $450,000 total over the two-year contract period.

Additionally, the county should consider paying for consultation for same-day access/real-time prescriber services on behalf of providers.

Steps to operationalize the recommendation:

- Develop a draft RFP and obtain outpatient provider input on the program structure
- Issue competitive RFP and collect applicant responses
- Select two vendors and implement the program and two-year contract period
- Based on outcomes (e.g., clinic reporting on increased access to care and decreased wait times for services), determine if the pilot should be expanded

Strategy: Increase awareness of non-clinical services that play a vital role in an individual's recovery journey

Montgomery County has an impressive array of therapeutic and community-based services, such as peer and family support specialist programs, to support individuals

with mental health and SUD. Yet, clients may not know about these services or recognize their efficacy. Access to other supports while pursuing psychiatry and therapy may support an individual's recovery. THS recommends that Montgomery County proactively disseminates information about these services (e.g., Creating Increased Connections, HopeWorx/FamilyWorx) to contracted providers to ensure they promote them to their clients or individuals seeking care.

Strategy: Support workforce development, recruitment, and retention

Nationally, behavioral health organizations are having trouble recruiting staff and are experiencing high turnover as clinicians experience burnout, vicarious trauma, and feeling overwhelmed. In the National Council for Mental Well-Being survey, 97 percent of member organizations surveyed say it has been difficult to recruit employees, including 78 percent who say it has been very difficult. In an open-ended question, organizations said the main obstacles they face in recruiting employees include a lack of applicants overall, specifically a lack of qualified applicants, inability to offer a competitive salary, and burnout from COVID-19.

The intake and assessment documentation demands for behavioral health, particularly in publicly funded delivery systems, are more extensive than other health care disciplines and result in reduced time for service delivery while exacerbating provider burnout.

Locally, there is a consensus among Montgomery County provider organizations that there is a severe behavioral health workforce shortage. Community-based providers commented that they are losing clinical staff to private practice or digital-first/telehealth companies.

THS recommends that Montgomery County continues its efforts to bolster the behavioral health workforce while implementing new strategies and investments. The county has and should continue to: advocate with the state for rate increases, cost of living adjustments, and hiring or retention bonuses; encourage or incentivize innovative use of peers and other non-licensed behavioral health staff; promote pipeline development through collaborations with Career Link and other organizations and universities; and advocate with the state for regulatory change that modifies the scope of practice requirements (e.g., Nursing coverage and medication distribution in residential programs).

In addition to continuing the efforts listed above, THS recommends the county:

Strategy: Convene a workforce coalition or workgroup to strategize directly with behavioral health provider organizations.

A direct line of communication between the county and providers may offer new insights, fruitful brainstorming, and collaborative

THS RECOMMENDS THAT THE COUNTY CHARGES THE WORKGROUP WITH DEVELOPING WORKFORCE RECRUITMENT AND PIPELINE STRATEGIES SUCH AS:

earned or paid media campaigns

scholarships

loan forgiveness or loan repayment

sign-on bonuses, relocation, housing search assistance

and additional partnerships with regional academic institutions

planning. This workgroup could be a stand-alone entity or a subcommittee of the CSAG.

The workgroup should also identify and promote best practices in provider-level retention (e.g., where providers have successfully retained clinical staff, what have they done well? What have they built regarding organizational culture, benefits, etc., that makes people want to stay?) Specific areas to consider include salary, total compensation package, paid time off policies, employee wellness programs, approaches to support work-life balance, flexible schedules (e.g., shift work, 32-hour work weeks), and ongoing professional development, training, and advancement strategies.

Additionally, THS advises that the workgroup address the need for a more diverse, culturally, and linguistically competent behavioral health workforce (see also recommendation #8.)

Financial considerations:

Convening the workgroup should require minimal financial investment besides staff time to coordinate and participate in the group. However, the county should anticipate that some of the strategies determined by the workgroup may have associated costs. In a report released in October 2022, the Pennsylvania Behavioral Health Commission recognized the need to address workforce issues and made it their top recommendation – Recommendation #1: Stabilize, Strengthen, and Expand the Workforce. Montgomery County may be able to access funds allocated by the commission toward addressing this recommendation.

Steps to operationalize the recommendation:

- Solicit workgroup volunteers from various facets of the behavioral health delivery system, including CBHCs, crisis service providers, SUD providers, and hospitals.
- Convene and facilitate workgroup using a monthly cadence.
- Utilize nationally available research and reports from other states, such as Colorado, and review behavioral health workforce legislative efforts, such as in California.
- Determine workgroup priorities; establish a set of behavioral health workforce recommendations and determine what can be done locally vs. what requires state-level advocacy.
- Pursue implementation of recommendations and state advocacy strategy (Note that this may overlap with or inform THS recommendation #9.)

MAXIMIZING TELEHEALTH

The general assembly approved, and Pennsylvania Governor Tom Wolf signed into law, House Bill 2419. The bill supports access to behavioral health services by permanently authorizing services to be delivered via telehealth and modernizing psychiatric supervisory time requirements to extend the reach of providers. Additionally, at the federal level, the 2023 Omnibus appropriations bill extends numerous Medicare behavioral health-related telehealth flexibilities made initially possible due to the COVID-19 Public Health Emergency (PHE). Montgomery County should partner with outpatient providers to review the new regulations and explore opportunities to utilize telehealth in new ways to expand service capacity.

Strategy: Advocate with State of PA to consolidate regulations or provider waivers to reduce providers' administrative burden.

The overregulation of the behavioral health field is considered a significant barrier to innovation. It profoundly impacts the workforce, limiting access to services and the efficient use of public dollars. THS cautions the county to evaluate how attempts to improve outpatient services should include an analysis of the potential constraints within existing regulations. Behavioral health providers in Montgomery County point out that they must currently do a full assessment upon the point of contact and complete a treatment plan within five days. Further, there are different mental health and SUD assessments and regulations, complicating the delivery of co-occurring services for people with co-occurring disorders.

The county should assess what advocacy is needed with the state of PA (see also recommendation #9). This should include waiving elements of comprehensive psychosocial assessments, extending deadlines for treatment plans, eliminating separate treatment plan documentation, and allowing payment and regulations that support a certain number of encounters before full intake completion.

Financial considerations:

This recommendation has no known hard costs. However, it will require the county to dedicate staff time to a review of contracting processes, regulatory review, and advocacy with the state.

Steps to operationalize the recommendation:

- Meet with outpatient providers to obtain additional information and detail about what is burdensome within the existing system
- Evaluate current county reporting requirements and identify opportunities to consolidate or reduce reporting burdens
- Elevate concerns to state officials (see also recommendation #9)

Strategy: Incentivize bachelor-level staff to attain their Licensed Bachelor Social Worker (LBSW)

LBSW is the first level of licensure in Pennsylvania. While the state first implemented the licensure in 2020, rules are expected to be promulgated in early 2023. This requirement may impact staffing for the mobile crisis teams.

THS recommends that the county allocates funds for provider organizations impacted by the new credentialing requirements to create salary incentives and cover licensure fees and other costs to entice the existing workforce to

take the next step toward licensure. This could include resources that cover the expenses incurred when an employee takes time away from duties to attend training/educational programs or provide grants to cover salary expenses for non-billable staff until the individual receives the appropriate credential to bill for services. This approach to "grow your own" workforce development would assist behavioral health organizations in providing a professional development glide path for staff while improving employee retention and reducing turnover.

Financial considerations:

According to the National Association of Social Workers Pennsylvania chapter, there is a $75 application fee and a $250 examination fee for clinicians applying to become an LBSW. Montgomery County should cover these costs on demand. Additional expenses should be determined in conversation with host organizations seeking to "grow their own" workforce.

Steps to operationalize the recommendation:

- Monitor for new state regulations and educate providers about upcoming changes
- Survey behavioral health provider organizations to ascertain the level of interest in assisting staff in obtaining their LBSW and related financial costs beyond the application and exam fees
- Issue guidance to organizations on how to qualify for assistance
- Make funding available
- Monitor program impact

Recommendation 6: Use a data-driven approach to measure the success of Montgomery County's Behavioral Health Crisis Enhancement Plan and components of the crisis system

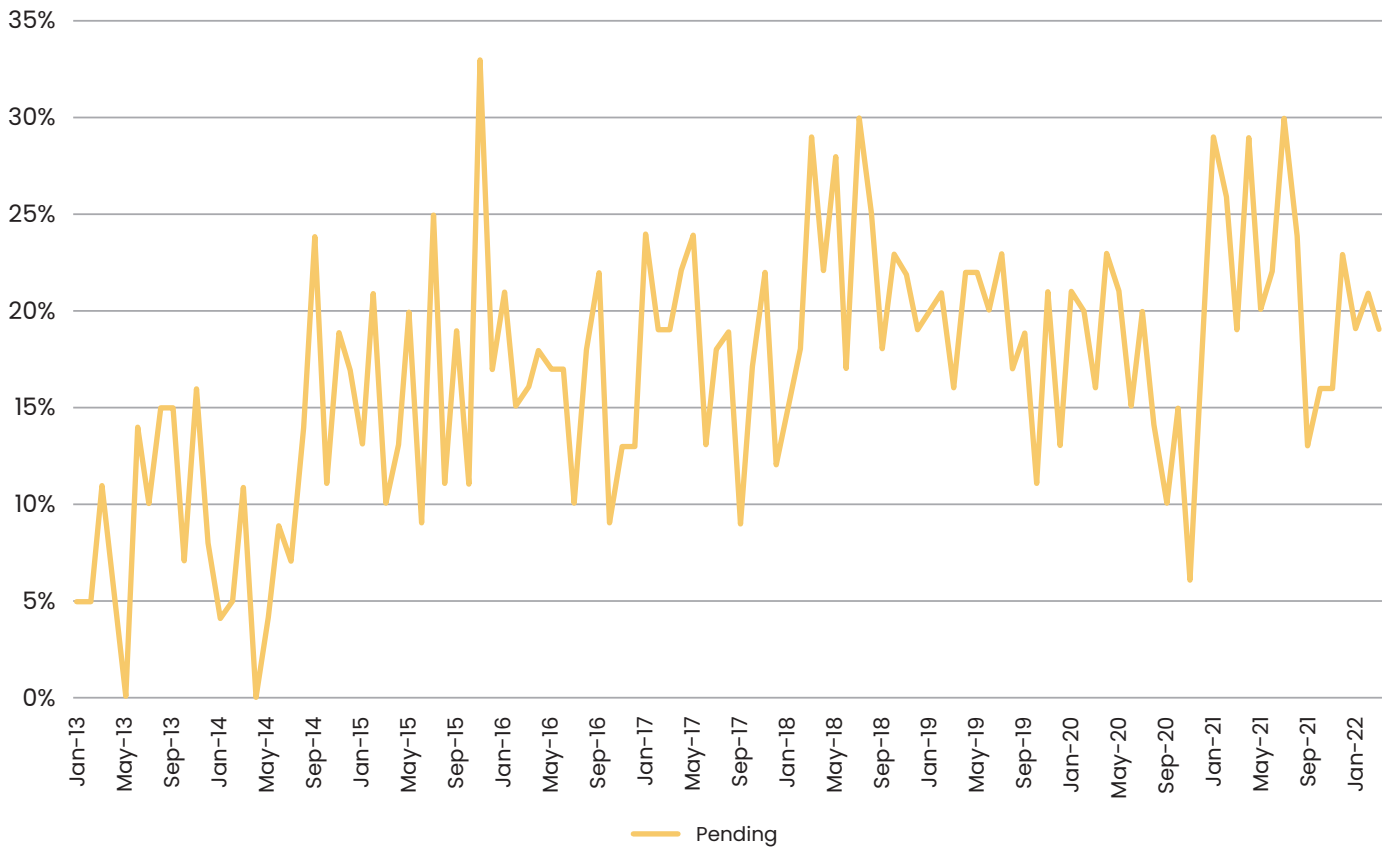
Managing behavioral health crisis systems is an iterative process that requires the consistent collection of data or knowledge that can be used to assess community needs and for ongoing quality improvement for the most effective crisis services possible.

THS recommends that Montgomery County intentionally makes more actionable use of data and increase transparency with providers and other stakeholders. THS encountered hurdles in collecting data for this analysis and gaining a complete picture of behavioral health needs and service utilization. MCES and Access shared line-level variable data openly. Medicaid provided summarized reports upon request. The county does not have access to any commercial data. Lastly, while the county Managed Care Solutions has direct management over Magellan for the behavioral health carve-out, data for other county-funded programs and services are maintained separately from Medicaid data.

One example of where the county would benefit from additional data is in understanding the final disposition of community members placed on a 302 hold. As the system grows and becomes more complex, gaps in understanding the final dispositions of patients are increasing. Within the county's 302 tracking system, 20-30 percent of cases have no resolution or communication about what happened to them (see Figure 17). This may be because the client was commercially insured.

To the extent that the county wishes to understand better its coordination of care efforts across its total population, efforts should be made to bring disparate data sets together in one place. At a minimum, county stakeholders

Figure 17: Ratio of Pending 302 Cases to Total Non-Admissions



should continue to meet regularly and review department data and insights to improve the alignment of data collection methods with the questions that need to be answered for system improvement. The need for this was noted at the first CSAG meeting THS convened.

Strategy: Determine key performance indicators for Montgomery County's behavioral health crisis system

THS recommends that Montgomery County selects key performance indicators across the different levels of care within the behavioral health crisis system. The county should look at indicators assessing increased crisis resolution, ensure timely response rates from the suicide prevention hotline/9-8-8 call center and mobile crisis teams, and successfully divert people experiencing a behavioral health crisis from higher levels of care.

Another critical step THS recommends is for the county to establish new data measures and continuously monitor demand vs. capacity in the behavioral health delivery system. For example, the county should collaborate with outpatient providers to determine the best way to gather data on service wait times and people turned away. Similarly, the county should work with crisis residential programs. As mentioned in recommendation #2, the county should partner with Access to gather and review data on mobile crisis deployment times. These data elements are currently missing, making it more challenging to clearly define service gaps and areas where improvements are needed.

In its "From Crisis to Care" series, the National Association of State Mental Health Program Directors (NASMHPD) paper #3 offers an overview of additional data measures the county could consider collecting and building into a crisis data dashboard. While the NASMHPD report looks at statewide programs, there are also relevant examples for Montgomery County.

National Council for Mental Wellbeing similarly offers quality measures in its paper, "Quality Measurement for Crisis Care."

Crisis Now's assessment framework also offers a useful tool that Montgomery County and contracted providers could utilize to assess system performance (see Figures 18, 19, and 20).

KEY PERFORMANCE INDICATORS RECOMMENDED BY THS FOR MONTGOMERY COUNTY

- **9-8-8 call center: call abandonment rate (under 10%)**
- **Mobile crisis: resolve crisis/ diversion rate (60% or higher) and time to deployment (60 minutes or less)**
- **Crisis walk-in center: support diversion rate (60% or higher)**
- **Outpatient services: time to first appointment (7-10 days or less)**

Figure 18: Crisis Now Scoring Tool: Call Center Hub

Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
Call Center Exists	Meets Level 1 Criteria	Meets Level 2 Criteria	Meets Level 3 Criteria	Meets Level 4 Critieria
24/7 Call Center in Place to Receive BH Crisis Calls	Locally operated 24/7 Call Center in Place to Receive Calls	Hub for Effective Deployment of Mobile Teams	Formal Data Sharing in Place Between Crisis Providers	Data that Offers Real-Time Air Traffic Control (Valve Mgmt) Functioning
Answer Calls Within 30 Seconds	Answer Calls Within 25 Seconds	Answer Calls Within 20 Seconds	Answer Calls Within 15 Seconds	GPS-Enabled Mobile Team Dispatch by Crisis Line
Referral to Community Resources or Connection to Care	Warm Hand-off to BH Crisis Providers	Directly Connects to Facility-Based Crisis Providers	Coordinates Access to Available Crisis Beds	Shared Bed Inventory and Connection to Available Crisis and Acute Beds
Meets NSPL Standards and Participates in National Network	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services	URAC Call Center or Similar Accreditation	Single Point of Crisis Contact for the Region	24/7 Outpatient Scheduling with Same Day Appointment Availability
	Call Abandonment Rate Under 20%	Call Abandonment Rate Under 15%	Call Abandonment Rate Under 10%	Call Abandonment Rate Under 5%
	Shared MOUs / Protocols with Crisis Providers	Some Call Center Access to Person-Specific Health Data	Some Access to Person Specific Data for All Crisis Providers	Real-Time Performance Outcomes Dashboards Throughout Crisis System
	Priority Focus on Safety / Security	Some Peer Staffing within Call Center	Shares Documentation of Crisis with Providers	Shared Status Disposition of Intensive Referrals
			Peer Option Made Available to All Callers Based on Need	Trauma-Informed Recovery Model Applied
			Systematic Suicide Screening and Safety Planning	Suicide Care Best Practices That Include Follow-up Support
				Full Implementation of all 4 Crisis Now Modern Principles (Required)

Figure 19: Crisis Now Scoring Tool: Mobile Outreach

Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
Mobile Teams are in Place for Part of the Region	Meets Level 1 Criteria	Meets Level 2 Criteria	Meets Level 3 Criteria	Meets Level 4 Critieria
Mobile Teams Operate at Least 8 hours Per Day in Part of the Region	Mobile Teams are Available Throughout the Region at Least 8 hours Per Day	Mobile Teams are Available Throughout the Region at Least 16 hours Per Day	Formal Data Sharing in Place Between Mobile Teams and All Crisis Providers	Real-Time Performance Outcomes Dashboards Throughout Crisis System
Mobile Teams Respond to Calls Within 2 Hours Where in Operation	Mobile Teams Respond to Calls Within 2 Hours Throughout the Region	Mobile Teams Respond to Calls Within 1.5 Hours Throughout the Region	Mobile Teams Respond to Calls Within 1 Hour Throughout the Region	GPS-Enabled Mobile Team Dispatch by Crisis Line
Mobile Teams Complete Community-Based Assessments	Mobile Team Assessments include All Essential Crisis Now Defined Elements	Directly Connect to Facility-Based Crisis Providers as Needed	Support Diversion Through Services to Resolve Crisis with Rate Over 60%	Support Diversion Through Services to Resolve Crisis with Rate Over 75%
Mobile Teams Connect to Additional Crisis Services as Needed	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services	Some Mobile Team Access to Person Specific Health Data	Mobile Teams Receive Electronic Access to Some Health Information	All Mobile Teams Include Peers
	Shared MOUs / Protocols with Call Center Hub	Shared MOUs / Protocols with Call Center and Crisis Facility-Based Providers	Shares Documentation of Crisis with Providers	Shared Status Disposition of Intensive Referrals
	Priority Focus on Safety / Security	Trauma-Informed Recovery Model Applied	Some Peer Staffing within Mobile Teams	Meets Person Wherever They Are - Home/Park/ Street / Shelter etc.
			Systematic Suicide Screening and Safety Planning	Real-Time Access to Electronic Health Records
				Suicide Care Best Practices That Include Follow-up Support
				Full Implementation of all 4 Crisis Now Modern Principles (Required)
				Full Implementation of all 4 Crisis Now Modern Principles (Required)

Figure 20: Crisis Now Scoring Tool: Crisis Receiving Center

Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
Sub-Acute Stabilization is in Place for Part of the Region	Meets Level 1 Criteria	Meets Level 2 Criteria	Meets Level 3 Criteria	Meets Level 4 Critieria
Have 24/7 Access to Psychiatrists or Master's Level Clinicians	Some Form of Facility-Based Crisis is Available Throughout the Region	Crisis Beds / Chairs Available at a Ratio of at Least 3 per 100,000 Census	Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers	Real-Time Performance Outcomes Dashboards Throughout Crisis System
In Counties with Sub-Acute Stabilization, at Least 1 Bed / Chair per 100,000 Census	Crisis Beds / Chairs Available at a Ratio of at Least 2 per 100,000 Census	Offers Crisis Stabilization / Observation Chairs as well as Sub-Acute / Residential	Crisis Beds / Chairs Available at a Ratio of at Least 4 per 100,000 Census	Crisis Beds / Chairs Available at a Ratio of at Least 5 per 100,000 Census
	Shared MOUs / Protocols with Other Crisis Providers	Multiple Providers Offering Facility-Based Crisis Services	Support Diversion From Acute Inpatient at Rate Over 60%	Support Diversion From Acute Inpatient at Rate Over 70%
	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services	Some Crisis Facility Access to Person Specific Health Data	Incorporates Crisis Respite Services into the Facility-Based Crisis Continuum	No Refusal to First Responder Drop offs as Primary Service Location
	Priority Focus on Safety / Security	Trauma-Informed Recovery Model Applied	Operates in a Home-Like Environment	Bed Inventory and Referral Centralized Through Crisis Line
		Direct Law Enforcement Drop-Offs Accepted	Systematic Suicide Screening and Safety Planning	Suicide Care Best Practices That Include Follow-up Support
		Least Restrictive Intervention and No Force First Model	Some Peer Staffing within the Crisis Facility	Utilize Peers as Integral Staff Members
			Sub-Acute Stabilization Receive Electronic Access to Some Health Information	Shared Status Disposition of Intensive Referrals
			Shares Documentation of Crisis with Providers	Law Enforcement Drop-Off Time Less Than 10 Minutes
				Full Implementation of all 4 Crisis Now Modern Principles (Required)

THS further recommends that the county, in partnership with Magellan, continues to do deep dives into hospitalization data to identify Medicaid members with multiple hospitalizations, and assess contributing factors for this cohort, such as the prevalence of comorbid conditions and the interaction between length of stay and outpatient follow-up within seven days of discharge.

Financial considerations:

Montgomery County has already allocated funds for developing a data warehouse,

but additional resources may be needed to broaden its utility. There may also be cost implications for contracted providers to support timely data sharing and continuous quality improvement efforts.

Steps to operationalize the recommendation:

- Inventory data sets that are collected and managed by the county
- Determine what analytics and reports will be shared with CSAG and other community partners at select intervals to increase transparency and promote collaborative problem-solving
- Work with contracted providers to develop and track key performance indicators and other data measures
- Determine if additional steps are needed to improve the county's use of data

Recommendation 7: Enhance cross-sector collaborations and information sharing.

Multi-sector collaborations can help advance systems improvements by bringing together partners to form a shared vision and collectively address issues. Stakeholders are interested in coordinating across systems, learning from each other, and collaboratively planning for system-level improvements. In key informant interviews, focus groups, and CSAG meetings, participants frequently expressed appreciation for the opportunity to get together to problem solve and a desire to have more of a voice in county processes/ decision-making.

Some additional stakeholders may need to be brought to the literal and proverbial table so the county can continue to work towards a more holistic behavioral health crisis system. For example, THS interviewed two FQHCs. Both expressed that they wished they interacted with other parts of the delivery system more regularly and commented that the community needed to better understand the role FQHCs play in behavioral health. Further, mental health and D&A providers may need to be more closely aligned to increase coordination and enhance prevention and treatment services for people with co-occurring disorders.

Stakeholders also identified that there needs to be more clarity between various entities in the system about the roles they each plan in addressing behavioral health crises, which could be resolved through the CSAG by more structured information sharing and dialogue around roles, responsibilities, and expectations.

Strategy: Continue the Crisis System Advisory Group (CSAG)

Throughout this project, the CSAG has proven an effective way to organize, coordinate, and engage providers, first responders, community leaders, and people with lived experience in pursuit of improving the crisis system. THS recommends that the county continue to convene the CSAG as a county-wide collaborative for ongoing behavioral health care system improvement.

Ninety-five percent of respondents indicated that the CSAG was a valuable resource that should continue. The most cited reason CSAG members have enjoyed participation (50 percent) was that it provides a "platform to provide input on the strengths, challenges, and opportunities" in the system.

THS recommends that the county considers several elements to sustain and grow the CSAG.

Leadership and Composition

The most cost-effective and sustainable way to operate the CSAG would be for county staff to lead the group. In the CSAG survey conducted by THS on the group's future, 11 individuals from various backgrounds said they would "be willing" to play a leadership role. While a county-led process may be cost-effective and sustainable, such leadership could be time intensive. For this reason, and to continue to foster collaboration between the community and the county, THS advises the county to explore co-leadership roles with interested and appropriate community partners.

THS advises the county to invite additional provider participants, including more CBHCs, SUD providers, hospitals, faith community leaders, and FQHCs. Additionally, several survey respondents vocalized a desire to see more active engagement from individuals with lived experience and peers.

Develop a Member Charter and Define Shared Values

During the February 2023 CSAG retreat, stakeholders encouraged the county to begin its next phase of work with the CSAG by developing a member charter that defines roles and expectations, goals for the group, and a shared set of values for the region's behavioral health system.

Structure of committees

THS recommends that the county explore a subcommittee structure within the CSAG. Based on the interests expressed by respondents to THS' survey and discussions, and informed by the recommendations in this enhancement plan, potential subcommittees could include:

- Crisis Center Committee
- Workforce Committee
- SUD/MH Integration Committee
- 302 Review Committee

THS also recommends that the entire CSAG serve as an ongoing forum through which community partners can play an increased role in advocating for local, state, and federal policy change. This would be an opportunity also to support the county's efforts when such priorities align (see recommendation #9.)

Financial considerations:

Ongoing convening, regardless of structure, can have nominal costs, such as staff time for county officials to lead or attend. However, structural concerns around how best to organize such a group in an ongoing manner may have fiscal implications.

Strategy: Increase Role Clarity Among Stakeholders

As with any complex delivery system, there is some confusion among stakeholders in Montgomery County about roles and responsibilities in addressing behavioral health crises. The county is committed to "building crisis muscles" and increasing awareness and understanding among stakeholders of the full continuum of care and the important part they each play. The Crisis and Diversion Director has a vital role in doing this. Written materials that reflect the behavioral health crisis system, and its various components, should be circulated and revised regularly. The county could utilize the CSAG to increase role clarity

by continuously reviewing data, mapping community processes (or revisiting existing process maps) and promoting increased communication across partners and between the county and funded entities.

Furthermore, the county has expressed interest in gauging the extent to which providers meet best practices in crisis planning and the use of medical advance directives. THS recommends that the county survey providers and determine what is currently being done and whether there is a need to incorporate further requirements or reporting mechanisms into county-funded contracts.

Recommendation 8: Advance Behavioral Health Equity

People of color may face unique cultural barriers to care. The cultural stigma around mental health care can prevent people from seeking care. Some studies have found that mental illness stigma tends to be higher among non-white racial and ethnic groups. Lack of diversity among mental health professionals and limited training in cultural competency can also deter people of color from accessing services. These issues are compounded for non-English speakers.

According to 2020 census data, Pennsylvania's population is more racially and ethnically diverse than a decade ago. Pennsylvania's Hispanic or Latino population, which includes people of any race, was 1,049,615 in 2020. The Hispanic or Latino population grew by 45.8 percent, while the population not of Hispanic or Latino origin declined by 0.2 percent from 2010-2020. Montgomery County is predominately non-Hispanic and Caucasian (72 percent). However, that means nearly one-fourth of the population are people of color. Two percent of community members have limited English proficiency, according to the 2020 census, and this number is expected to increase.

Stakeholders report that people who do not speak English as their primary language, with Spanish being the top language and Russian second, have unique cultural and linguistic barriers to accessing care. There has yet to be a concerted or organized effort to address these barriers in the county.

THS recommends the county adopts three low-cost but potentially high-impact tactics to improve services for people of color and non-native English speakers: promote adherence to the evidence-based Culturally and Linguistically Appropriate Services (CLAS) standards in contracts, make all county behavioral health-related materials available in Spanish (and other languages if population size warrants), and increase culturally relevant support by developing a partnership with local groups that advocate for and provide targeted services to people of color. The following strategies elaborate on each of the recommendations.

Strategy: Promote adherence to CLAS standards

The evidence-based national CLAS standards are intended to advance health equity, improve quality, and reduce health care disparities. SAMHSA grantees are required to follow the standards as they establish a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services. Free resources and training on CLAS are available through the U.S. Department of Health and Human Services, Office of Minority Health.

Cultural competence is embedded in the CLAS standards. Culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Knowledge of a culture's attitudes toward mental illness, substance use, and help-seeking practices is essential in understanding individual client needs. Behavioral health crisis providers need to learn

and understand how identification with one or more cultural groups influences each client's beliefs about healing and treatment. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.

THS recommends that Montgomery County make adherence to the CLAS standards an expectation in its contracts with providers

of behavioral health services and make available training and technical assistance on adopting CLAS standards. The county should also incentivize providers to attain adequate bilingual capabilities and translation services by making sign-on bonuses or salary differentials available to recruit and retain bilingual clinicians and other staff. Note: This overlaps and should be coordinated with county-led workforce efforts discussed in recommendation #5.

Strategy: Make all county behavioral health-related materials available in Spanish (and other languages if population size warrants)

Montgomery County Office of Mental Health has extensive information about accessing services and community resources on its website. It has also published guides, directories, fact sheets, and, most recently, an FAQ document about 9-8-8. However, these materials have only been available in English. THS recommends that the county translates all public-facing materials into Spanish and evaluate the need to translate them into other languages, such as Russian.

Strategy: Increase culturally relevant support by developing a partnership with local groups that advocate for and provide targeted services to people of color

Behavioral health disparities can be further mitigated by addressing unique cultural barriers and improving social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. THS recommends that Montgomery County strengthen and formalize relationships with providers in the region that offer specialized services for Latinos and other people of color. The county can also facilitate more robust ties between those groups and behavioral health providers. Lastly, the county can invite specialty organizations to participate in groups, such as the CSAG, to bring an essential and missing voice to the table in planning around enhancing the behavioral health crisis system.

Financial considerations:

The direct cost of this recommendation will be obtaining translation services for county web-based and printed materials. There may also be costs to the county in incentivizing behavioral health providers to make hiring bonuses or salary differentials available to bilingual staff.

Steps to operationalize the recommendation:

- Revise county contracts and scopes of work to reflect adherence to CLAS standards is required
- Identify all public-facing materials that need to be translated
- Obtain translated documents and web-based materials
- Outreach groups offering culturally relevant services; invite them to participate in CSAG and engage with providers
- Monitor cultural and linguistic competency needs in the behavioral health delivery system

Recommendation 9: Advocate for local, state, and federal policy reforms

In the Systems Analysis, THS identified numerous policy issues outside the county's locus of control requiring state or federal action. The county already advocates with the state of Pennsylvania on multiple topics. Still, given the momentum created partly by the CSAG meeting over the last year, there may be a new opportunity to work across sectors to drive an advocacy agenda (see previous recommendation).

At the October 2022 in-person meeting, CSAG members suggested that an association such as the National Alliance for the Mentally Ill (NAMI) could lead or coordinate these efforts. THS recommends adding policy as a structural area of focus in continuing the CSAG, as noted under recommendation #3. However, the county may also have opportunities to be more proactive with its advocacy, which may be separate and distinct from a community-driven advocacy effort that the CSAG could undertake. The county engages directly with state officials at the Office of Mental Health and Substance Abuse Services (OMHSAS) and may have access to forums to provide direct input.

Strategy: Refine the county's policy agenda, determine priorities, and develop an advocacy strategy

THS recommends that Montgomery County commits additional energy and resources to its policy agenda and develops an advocacy strategy. Of all the potential issues, THS identified three as the most pressing.

THS recommendations for policy priorities:

Advocate that the state seeks an 85 percent enhanced match from the Centers for Medicare & Medicaid Services (CMS) for mobile crisis services by covering such services through the new Medicaid mobile crisis option established in the ARPA.

On November 2, 2022, Montgomery County leadership asked THS to assess CMS regulations to inform its understanding of whether state requirements (likely to be proposed in new state regulations) that a licensed clinician approve every mobile intervention is necessary to comply with federal law. Specifically, the county understood that this requirement stems from the state's decision to cover mobile crisis services under Medicaid's rehabilitative services option. They asked THS to assess whether there is another option or category through which the state could authorize mobile crisis, whether there is a waiver process that the state could pursue, and whether other states have configured their mobile crisis teams in such a way that a licensed clinician does not have to approve every mobile service.

Medicaid statute and regulations governing the rehabilitative services option define these services as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."

As an alternative to the rehabilitative services option, states can also cover mobile crisis services through the new Medicaid mobile crisis option established in the ARPA. In December 2021, CMS released guidance to states in December 2021 on implementing this option and qualifying for an enhanced 85 percent federal match. The State of Oregon was the first state to implement this option.

The new ARPA Medicaid mobile crisis option requirements are narrower concerning the role of a physician or other licensed professional than in the rehabilitative services option. These services must be furnished by a multidisciplinary team that includes "at least one behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under state law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the state through a state plan amendment (or waiver of such plan)."

The statutory language does not require a physician to recommend, approve, or provide other mobile crisis services. If Montgomery County's mobile crisis services meet all the statutory Medicaid mobile crisis requirements, including serving people with SUD crises and being available 24-7, it might be advantageous to cover the mobile crisis services in Montgomery County through this new option rather than through the rehabilitative services option. The federal government would match state spending on these services at an 85 percent federal matching rate. The new Medicaid mobile crisis service requirements do not need to be met statewide; if some regions of the state meet them, the state can authorize them only in those areas of the state.

THS recommends that Montgomery County advocates that the State of Pennsylvania pursue the new option under ARPA. This would garner the enhanced federal match and allow for narrower guidance on the authorizing provider type. However, the state's scope of practice guidelines may still require the assessment to be provided by a licensed behavioral health professional.

Pursue legislative or regulatory action to ensure commercial insurance carriers pay for behavioral health crisis services with reasonable credentialing requirements.

Crisis services providers in Montgomery County have highlighted challenges with being able to bill for services provided to commercially insured clients. In 2022, OMHSAS convened several meetings in which the nine commercial plans in Pennsylvania indicated they have billing codes for behavioral health crisis services. However, current licensure and credentialing standards may be prohibitive. Crisis providers across the country and in Pennsylvania are increasingly vocal about the need to allow for non-licensed staff, out of the recognition that what makes crisis workers effective is engagement and interpersonal skills, considering significant behavioral health workforce shortages, and as they strive to include more peer services/ staff with lived experience.

THS recommends that Montgomery County advocates for state legislation or regulatory action requiring that commercial plans cover behavioral health crisis services and allow greater flexibility in who provides those services. The State of Washington offers one model.

Previously, emergency services were only covered if delivered in a hospital setting. The new Washington law expands the definition of emergency providers and facilities and mandates all plans provide reimbursement to include behavioral health emergency providers, such as crisis stabilization units, evaluation and treatment facilities, and mobile rapid response crisis teams. The law

also defined a "behavioral health emergency services provider," which allows for increased flexibility in the range of provider types that cover the crisis continuum of care.

As described by the Kennedy Forum, *"Like Washington, states should make clear that these requirements are necessary for health plans to meet their obligations under MHPAEA to cover behavioral health emergency services at parity with physical health emergency services. Indeed, even without legislation, states should ensure that health plans are entirely in compliance with MHPAEA requirements concerning behavioral health emergency services."*

Seek increased flexibility in psychiatric evaluation requirements for therapy, medication management, and partial hospitalization.

Pennsylvania regulations for Outpatient Psychiatric Services 55 PA Code Chapter 1153 detail that a psychiatric evaluation is a prerequisite to obtaining other behavioral health services. As noted earlier in this report, outpatient providers have more demand than capacity and face severe workforce shortages, leading to long waiting times. The county is limited in what it can do without state-level regulatory change. Further, the waiver request may be burdensome for providers and unwieldy for MCS/Magellan to manage.

THS, therefore, recommends that Montgomery County advocates for regulatory change at the state level. There is some precedence for this; In 2020, the state began to allow for an order rather than a complete psychiatric evaluation for children within the Intensive Behavioral Health Services. The goal should be to provide increased access to behavioral health services, not impose additional barriers to care. Rather than eliminating the requirement, the state could allow a certain number of encounters/ treatment sessions before the psychiatric evaluation is completed.

It should be noted that federal guidelines 42 CFR 440.230 provide broad state flexibility in state Medicaid agencies establishing medical necessity and utilization management criteria. Hence, the prerequisite of the psychiatric evaluation is at the discretion of the State of Pennsylvania.

Other issues that might be part of the policy agenda, as identified in the "opportunities" section of the systems analysis:

- Identify opportunities to consolidate regulations and reduce the administrative burden on providers
- Continue to pursue increased flexibility in funding, COLAs, and rate increases
- Elevate mid-level clinicians' ability to approve treatment plans and diagnoses.
- Revisit Certified Community Behavioral Health Clinics
    a. Bipartisan Safer Communities Act creates new incentives and opportunities
        - PA was in the Demonstration before, but the state found the reporting requirements burdensome. There is some negotiation happening with CMS
- Align state regulatory frameworks for MH and D&A, including ensuring adequate crisis responses for people in crisis due to SUD or overdose
- Assess new opportunities from CMS to expand and sustain school-based behavioral health services

CMS recently clarified its policy on how schools can bill Medicaid and will issue additional guidance next year to simplify the process. It will also provide grants to states expanding access to Medicaid-covered services in schools.

Steps to operationalize the recommendation:

- Review THS recommendations and refine the priorities
- Establish the policy agenda and develop an advocacy strategy, including engaging the CSAG and other community partners
- Implement advocacy strategies with regulatory agencies and the state legislature
- Assess the impacts made and update policy priorities

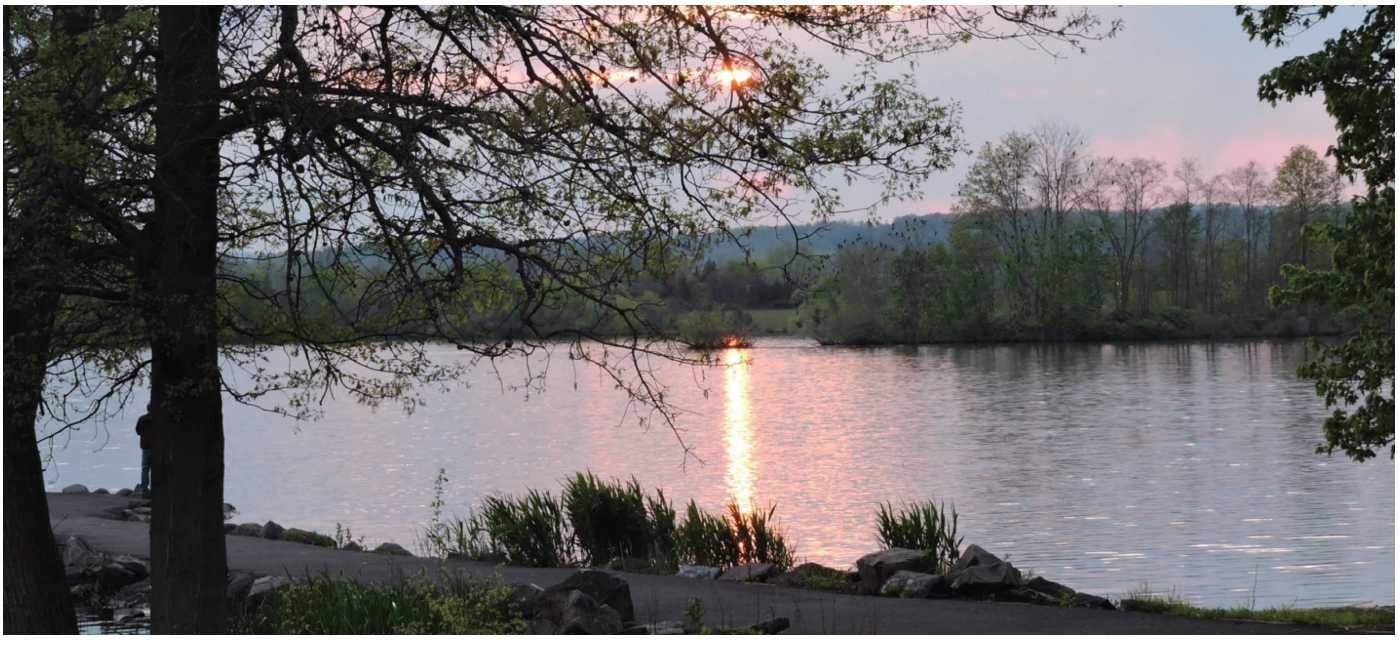
CONCLUSION

Montgomery County, Pennsylvania, data shows increased behavioral health needs among adults and children. The Montgomery County Department of Health and Human Services, Office of Mental Health/Developmental Disabilities/and Early Intervention, in consultation with the Offices of Managed Care Solutions and Drug & Alcohol, competitively selected Third Horizon Strategies (THS) to analyze the local mental health crisis system. THS began its work in March 2022 and continued for one year.

THS' work on the Enhancement Plan occurred during the COVID-19 pandemic. THS considered the pandemic's short- and long-term implications on behavioral health as the team developed the system analysis and formulated recommendations.

THS synthesized its findings of the strengths, challenges, and opportunities in Montgomery County's crisis and broader behavioral health delivery systems into a systems analysis and formulated nine recommendations designed to enhance not only crisis services but the entire behavioral health continuum and services that are essential to help prevent people from getting into crisis and get into care quickly after a crisis.

A comprehensive and integrated behavioral health crisis system is the first line of defense in preventing tragedies such as suicide, criminal justice involvement, and preventable hospitalization. The proposed enhancement plan builds on the existing assets and the groundwork laid by Montgomery County. By addressing service gaps, improving multi-stakeholder communication and coordination, maximizing data, and addressing regulatory barriers, Montgomery County will achieve a highly functioning behavioral health crisis system that, ultimately, saves lives and creates hope for people with mental health and SUD conditions.



APPENDICES

9-8-8 Process Maps

THS Convened a 9-8-8 workgroup to monitor and advise the county on implementing the 9-8-8 behavioral health/suicide prevention hotline. Stakeholders met four times over the course of the project. THS facilitated a process mapping exercise for stakeholders to identify how crisis calls in Montgomery County are routed, triaged, and responded to, determined by where the call is picked up. The group also developed a process map integrating the county's new crisis center under development.

9-8-8 Frequently Asked Questions (FAQ)

In collaboration with Montgomery County, THS developed an FAQ on 9-8-8 to help inform the community about the new crisis line and how it fits with the other remaining crisis call lines, such as those operated by Access (mobile crisis).

Crisis Centers Brief

THS interviewed seven crisis centers from across the country based on the following criteria: 1) prominence and reputation in the behavioral health field, 2) prior connection or relationship with THS, and 3) years in operation – all centers have provided services for a minimum of one full year; most have operated for three years or more. Based on this research, THS developed case studies and identified common themes to provide Montgomery County with an overview of existing models and practical guidance, so they do not have to recreate the wheel.

CSAG Survey

Between April 2022 and February 2023, Third Horizon Strategies (THS) convened monthly meetings with key community stakeholders to gain feedback on the crisis system in Montgomery County. This group is called the Crisis System Advisory Group (CSAG). All members were asked to complete a survey to guide the county on utilizing the CSAG once the THS engagement ended.

Regulatory Review

At the request of Montgomery County, THS completed a regulatory review of pertinent state and federal regulations that may have implications for the behavioral health crisis system enhancement plan, particularly related to developing a crisis center.

Stakeholder List

Throughout this engagement, THS prioritized speaking with key community stakeholders. This is a comprehensive list of all 118 stakeholders engaged through key informant interviews, focus groups, the CSAG, the 9-8-8 workgroup, and/or review of materials.

Systems Analysis

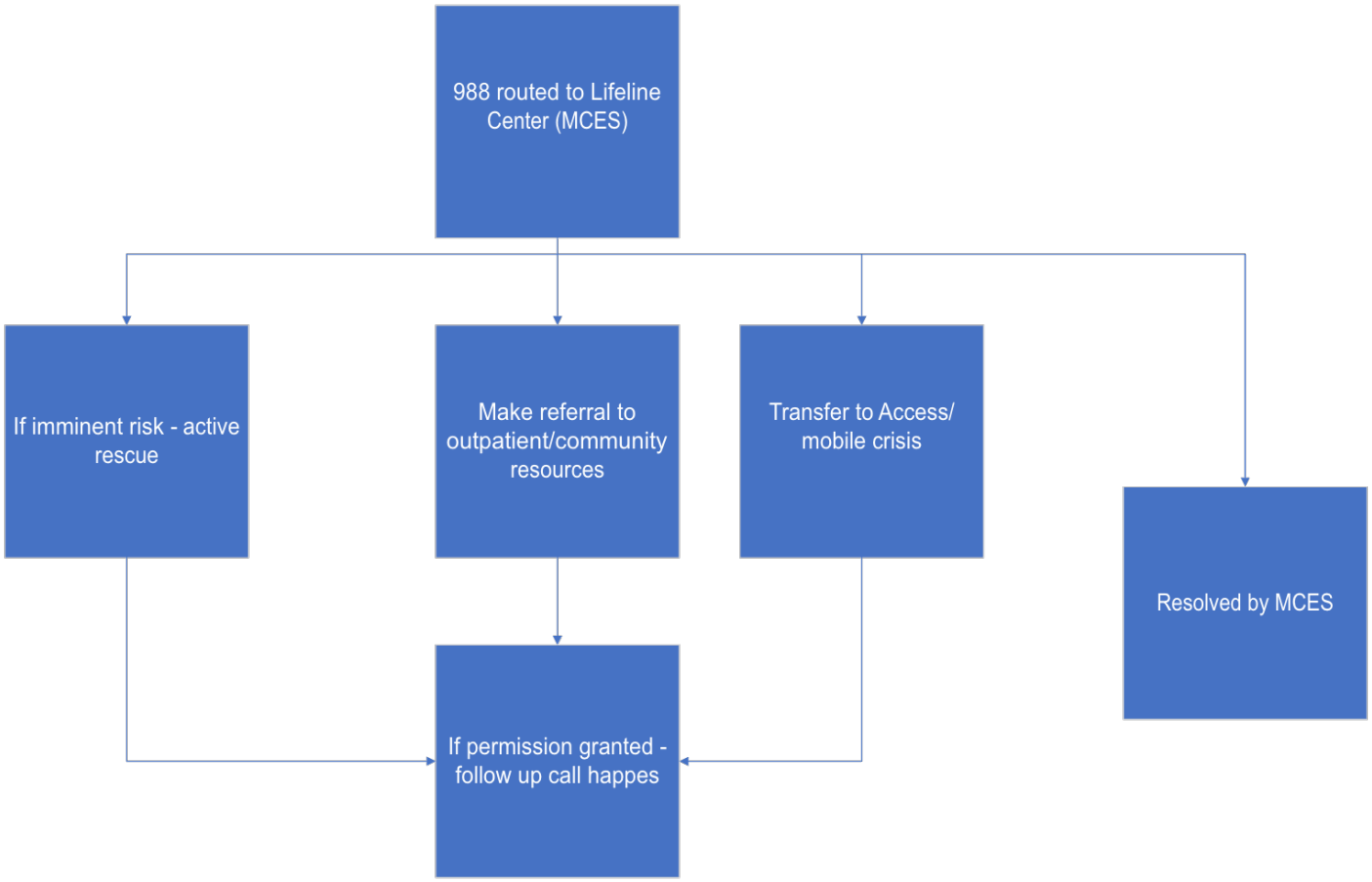
In October 2022, Third Horizon Strategies presented the "Montgomery County Behavioral Health Crisis Systems Analysis" to county leadership and to the CSAG with three goals:

1. Discuss THS's findings on the strengths, challenges, and opportunities for Montgomery County's behavioral health crisis system.
2. Stimulate discussion and obtain input on the analysis to help inform the recommendations phase.
3. Lay the groundwork for the final "Crisis System Enhancement Plan."

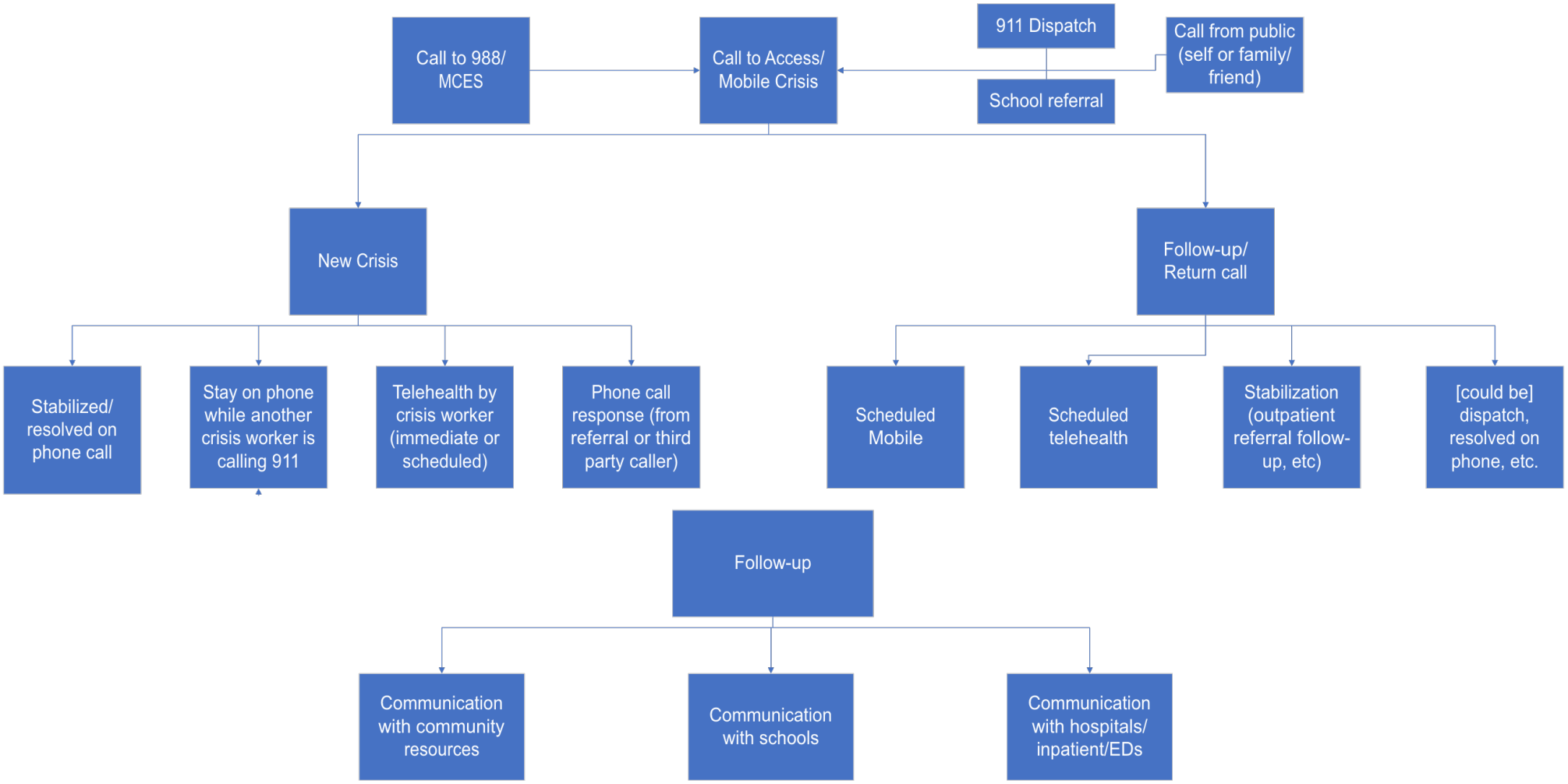
While the analysis was subsequently updated with additional input from the county for the body of this paper, the original presentation is included as an appendix.

9-8-8 Process Maps

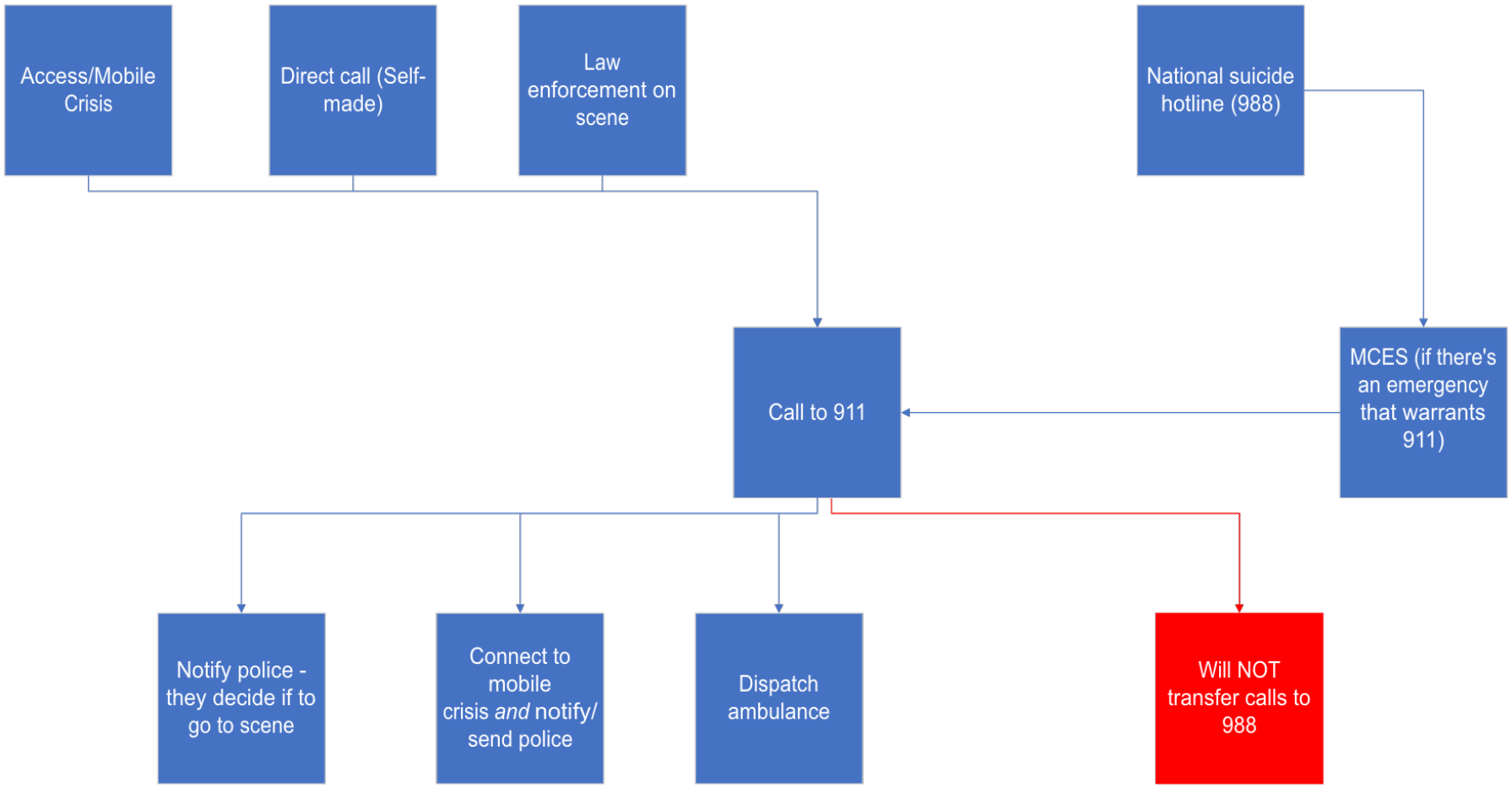
9-8-8 Workgroup Process Map: Call into 9-8-8 (Current State)



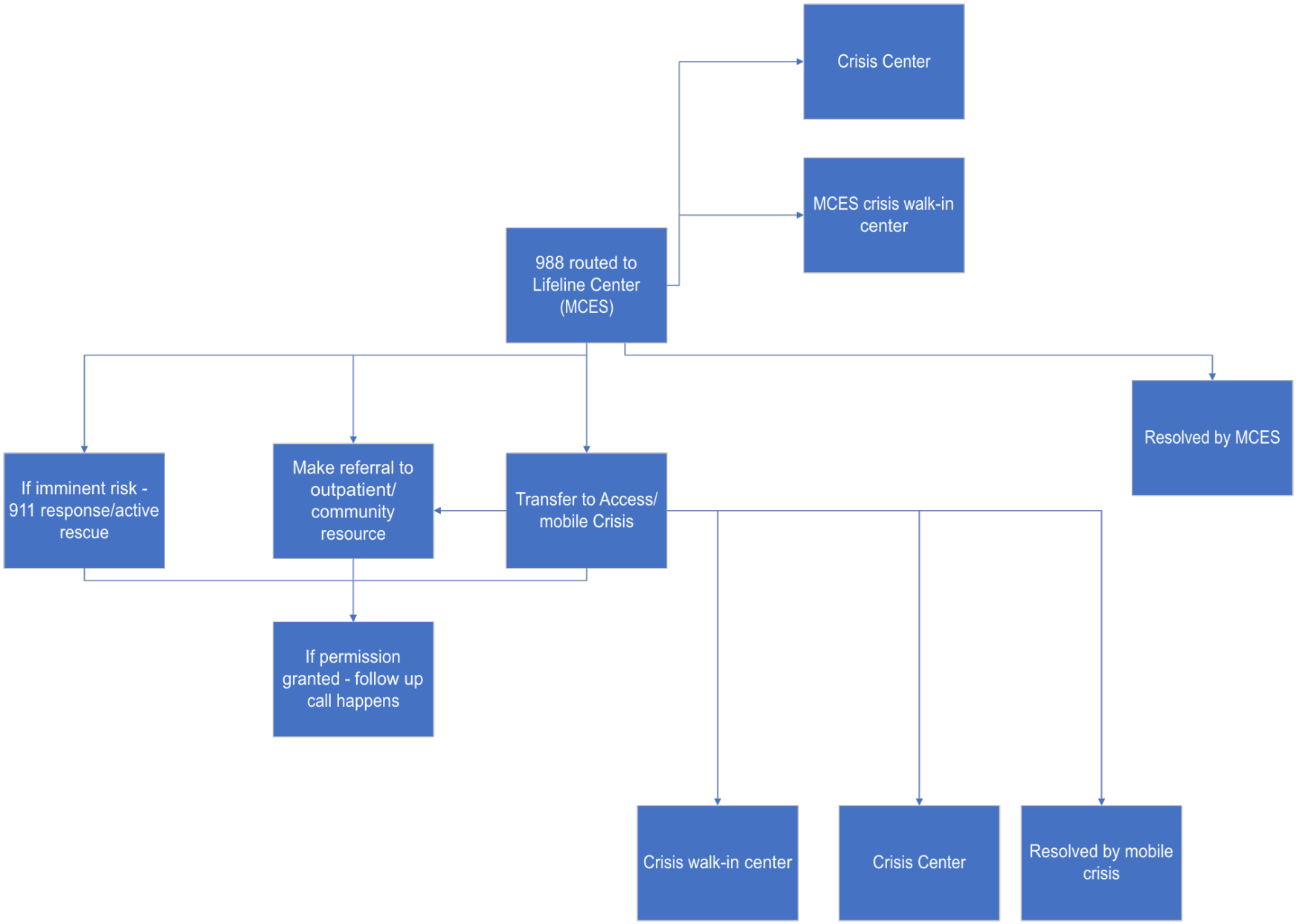
9-8-8 Workgroup Process Map: Call into Access Mobile Crisis



9-8-8 Workgroup Process Map: Call into 911



9-8-8 Workgroup Process Map: Call into 9-8-8 With New Crisis Center



Montgomery County, Pennsylvania

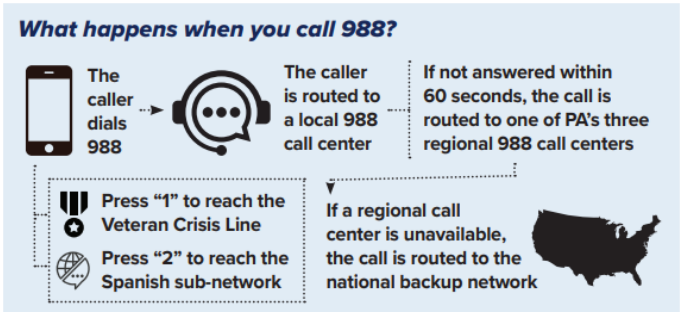
988 FAQ

A Direct Link for Suicide Prevention and Crisis Support

988 is a national crisis hotline for anyone experiencing a mental health or substance use crisis. Trained counselors answer the hotline to offer phone-based support and/or connections to local resources, at no cost to the caller. In Montgomery County, MCES has operated the National Suicide Prevention Lifeline call center since 2014, and now answers calls to 988. ***Note: Calls to 988 are routed according to area code and will ring until a counselor answers the phone, meaning that calls placed in Montgomery County may be answered by outside call centers under certain circumstances.*** **988 went live July 16th, 2022.**

Q: Is 988 available for both mental health and substance use crises?

A: 988 can be used by anyone who needs support for themselves or a someone they know during a suicidal, mental health, and/or substance use crisis — no matter where they are or where they live.



Q: What is the difference between 988 and 911?

A: Calls to 911 typically result in first responders such as EMS or law enforcement being deployed to address an emergency. Law enforcement response is often not necessary or appropriate for behavioral health crisis situations. 988 is a behavioral health crisis number, and calls are handled by trained counselors.

Q: How do 988 and 911 interact?

A: 988 counselors may transfer a call to 911 if they believe the caller is in immediate danger to themselves or others. There is close collaboration between 988, crisis services, and 911 in Montgomery County to ensure community members access appropriate care as needed.

Q: Is 988 available to children and adolescents?

A: Yes, 988 can be used by anyone who needs support for a suicidal, mental health, and/or substance use crisis regardless of their age.

Q: Will the existing National Suicide Prevention Lifeline number (1-800-278-8255) go away?

A: Moving to 988 does not mean the 1-800-278-8255 number goes away. Dialing either number will get people to the same services. 988 is intended as an easier-to-remember way for people in crisis to access a strengthened and expanded network of call centers. Additionally, the launch of 988 does not impact access to MCES Crisis Walk In, the Commitment Office, or the hospital program at MCES. All three will continue to be reachable via 24/7 the MCES direct hotline at: **610-279-6102.**

Q: Must I call 988 in Montgomery County to get help if I am in crisis?

A: **NO!** Access Services continues to operate the **Montgomery County Mobile Crisis Hotline**, which can be reached 24/7 at **1-855-634-4673**. Calls to 988 may be transferred to Access if Mobile Crisis, Peer Talk Line, or Teen Talk Line support is needed.

Anyone who wishes to connect directly to the Mobile Crisis Hotline (in particular: schools, first responders, social service providers, and individuals and families already connected to Access Services) is strongly encouraged to call 1-855-634-4673 to avoid the need to have your call transferred or the possibility of a call being answered by an out-of-county call center.

THIRD HORIZON STRATEGIES

KEY CONSIDERATIONS FOR INVESTING IN A CRISIS CENTER:

A SYNTHESIS OF CASE STUDIES

A comprehensive and well-coordinated behavioral health crisis system is the first line of defense in preventing tragedies such as suicide, criminal justice involvement, and preventable hospitalization. Third Horizon Strategies (THS) is under contract with Montgomery County, Pennsylvania, to assess its mental health crisis system, work with key stakeholders to identify gaps in care, and create a "Mental Health Crisis Dynamic Enhancement Plan."

In its *"National Guidelines for Behavioral Health Crisis Care"* best practices toolkit, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined three core elements of a crisis system:

1. **A 24/7 Regional Crisis Call Center**, staffed by clinicians, provides crisis intervention capabilities (telephonic, text, and chat) and meets National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement.
2. **Crisis Mobile Response Teams** are available to promptly reach any person in the service area in their home, workplace, or any other community-based location of the individual in crisis.
3. **Crisis Receiving and Stabilization Facilities** provide short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

The Montgomery County Emergency Services (MCES) operates a regional crisis call center, which is part of the National Suicide Prevention Hotline. The county also has a crisis mobile response team managed by Access Services. While MCES has a small area within their psychiatric facility that can serve as a crisis receiving and stabilization facility, the county is assessing the feasibility of developing a physically larger and more extensive, 24/7 crisis resource center to meet the demand for walk-in services for children and adults in the county experiencing a mental health or substance use crisis.

This paper aims to provide Montgomery County with an overview of existing models from around the country, and practical guidance, so they do not have to recreate the wheel. It is not intended to be an exhaustive or highly detailed "how to" guide but rather a resource that may lead the county to seek further conversations with any or all the interviewees.

RESEARCH METHODOLOGY

THS consultants selected and interviewed seven crisis resource centers based on the following criteria: 1) prominence and reputation in the behavioral health field, 2) prior connection or relationship with THS, and 3) years in operation – all centers have provided services for a minimum of one full year; most have operated for three years or more.

THS actively sought to interview both child and adult serving centers. Most centers address mental health and substance use disorder (SUD) crises, though they are not all equipped to handle an overdose or

provide medically supervised detoxification services. It is noteworthy that the crisis walk-in centers interviewed evolved in different ways that were organic to their communities and the nuances of local funding resources. Of the seven centers, two are in Pennsylvania, and five are outside the state.

THS consultants (senior director) and managers or analysts conducted the interviews. The interviewers used a question guide to elicit information on program and facility design, best practices, and lessons learned. THS also reviewed websites and materials provided by the interviewed organizations.

THS interviewed the following individuals:

All Health Network, Littleton, Colorado

- *Jen Bock, Chief Clinical Officer*

Common Ground, Pontiac, Michigan

- *Heather Rae, President and Chief Executive Officer*

Connections Health Solutions, Phoenix and Tucson, Arizona

- *Morgan Matthews, Director of Corporate Development*
- *Dr. Chris Carson, Co-Founder, and Chief Medical Officer*

Guidelink Center, Iowa City, Iowa

- *Abbey Ferenzi, Executive Director*

Philadelphia Children's Crisis Response Center, Philadelphia, Pennsylvania

- *David Mauermann, Regional Director of Business Development*
- *Cassie Wolfe, Program Director*

University of Pennsylvania Medical Center (UPMC) resolve center, Pittsburgh, Pennsylvania

- *Jewel Denne, Assistant Deputy Director for Mental Health Services*
- *Camelia Herisko, Vice President of Operations and Patient Care Services, and Chief Nursing Officer at UPMC Western Psychiatric Hospital (UMPC)*

WellPower, Denver, Colorado

- *Marissa VanDover, Associate Director of Crisis Services*

THS also acknowledges Travis Atkinson, Director of Clinical and Crisis Consultation with TBD Solutions, for his assistance.

DEFINITIONS

Behavioral health: the wide range of emotional, cognitive, and addiction disorders that are sometimes segmented into "mental health" and "substance use disorders."

Crisis Resource Center, Crisis Walk-In Center, Crisis Stabilization Center: These terms are often used interchangeably. According to SAMHSA, a crisis receiving and stabilization facility "provides short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment." Most operate 24 hours a day, seven days a week, and are staffed by a multi-disciplinary team who offers psychiatric assessment, information, and referral to resources.

Crisis Stabilization Unit (CSU): Small inpatient facilities of less than 16 beds designed to offer people in a behavioral health crisis a safe, secure environment that is less restrictive than a hospital.

Crisis Residential Programs (CRP): A short-term residential alternative to psychiatric hospitalization or support following hospitalization for individuals in active psychiatric distress.

SUMMARY OF FINDINGS, BEST PRACTICES, COMMON THEMES

Centers should be designed with specific goals in mind

Interviewees discussed the importance of a community upfront defining its aims for a crisis center, how it will measure success, and how it will add to the overall continuum of behavioral health care. Interviewees identified several common goals, including:

- Divert people in behavioral health crises away from jail and/or the emergency room
- Offer an alternative for families or first responders to bring people in crisis
- Provide a safe and welcoming place for people in crisis to access needed resources
- Conduct behavioral health assessments to ensure people in crisis connect to an appropriate level of care

Once the center has defined its goals, it must communicate its role within the more extensive system to the community and key stakeholders. As Heather Rae, CEO of Common Ground, pointed out, "under-building" or under-resourcing a crisis center can create problems as stakeholders assume that the center can address all crisis needs. Thus, it is vital that centers accurately project capacity needs and manage public expectations.

Common Ground uses the Crisis Resource Need Calculator – a Crisis Now tool that helps communities understand the potential health care costs associated with delivering care for all individuals requiring behavioral health crisis care – to estimate the needs of the 1.2 million people in their county. According to Heather, the index indicates they need three more centers to adequately cover the county's crisis needs.

While not explicitly referencing the calculator, Jen Bock indicated that AHN has determined that the second county it serves needs an additional crisis walk-in center to meet behavioral health crisis demands. They are currently pursuing the development of this second location.

Crisis walk-in centers are the most impactful if they are one component of a more extensive, well-coordinated crisis system.

While creating a physical location for people in crisis may reduce unnecessary emergency department (ED) utilization, it will not be sufficient to meet the increasing demand for behavioral health services. Communities must bolster routine, preventive, and outpatient behavioral health care to ensure fewer people end up in crisis in the first place and/or can access care post-crisis.

SAMHSA acknowledges this in the toolkit, stating, "Crisis services should not be viewed as stand-alone resources operating independent(ly) of the local community mental health and hospital systems but rather an integrated part of a coordinated continuum of care. Services needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode."

The Roadmap to the Ideal Crisis System (Roadmap), published by the National Council for Mental Well-Being, is a comprehensive (200-page) report which offers the essential elements, measurable criteria, and best practices for behavioral health crisis system. According to the report, "continuity of care through the crisis episode and facilitation of smooth transition through different levels of service intensity in the crisis continuum are both essential elements of an ideal crisis system."

Interviewees described how they are striving to facilitate smooth care transitions. For example, AHN and WellPower each explained how their centers coordinate care internally and connect people to their lower levels of care (outpatient services) or higher levels of care (CSUs, ATUs). Guidelink connects people to various services through organizations with an on-site presence.

It can be challenging for crisis centers not connected to hospital systems to coordinate with EDs. Several interviewees discussed that if someone comes to the walk-in center and the center determines the person needs to go to the ED, they often do not hear back about

what happens after the person is transferred there. Ideally, in a well-coordinated system, the necessary data sharing agreements are in place, and all parties view themselves as one component of the system.

Interviewees also spoke about the need to clarify the differences between a crisis walk-in center and a crisis residential program (CRP) to the community and key stakeholders. Both are important parts of an overall behavioral health crisis system. Since stays in walk-in centers are not intended to be more than 23 hours, most do not have individual rooms, beds, or other kinds of facilities one would expect to find in a CRP.

The look and feel of the center are essential.

All interviewees voiced a desire to create a comfortable environment that does not feel like a hospital. They all pointed out that design features such as the physical layout, furniture, availability of food, beverages, and toiletries, in addition to who first greets the client, are important components of the center's look and feel.

For example, the UPMC resolve center has a large foyer at the entrance that satisfies a comfortable environment. They also have television rooms, an on-site cook, and meeting rooms for therapy, all built around this entryway.

Some, such as Connections, have separate entrances for walk-in traffic instead of those being dropped off by law enforcement or Emergency Medical Services (EMS). Connections has a specific locked side door with a doorbell. Once a first responder rings that bell, the staff attempts to receive the patient within six minutes.

Security guards' presence can impact the center's look and feel. Most interviewees described that they had trained personnel who serve in a security function to de-escalate clients if needed, rather than armed guards or law enforcement. However, some additional security measures may be necessary. Guidelinks uses secured doors throughout their facility.

There was consensus among the interviewees that peers and other non-clinical staff play a vital role in shaping the feel of the center. All seven centers use peers and/or family advocates to help greet clients, triage their needs, and engage them in follow-up services. Abbey Ferenzi, executive director of Guidelinks Center, indicated that peers are vital to assisting clients in feeling heard. AHN places a high value on their peer specialist, who assists with greeting individuals, doing paperwork, managing the lobby, and acting as the communication liaison throughout the treatment process.

Centers serving children need to be specifically designed with children in mind.

According to National Council's Roadmap, there is a need for specialized programs and services to meet the unique needs of children. This involves designing separate spaces for the provision of crisis services and appropriate staff training.

Unfortunately, EDs often lack the specialized expertise to respond to a pediatric psychiatric emergency effectively. Further, children's psychiatric beds are in high demand nationally- often leading to children being "boarded" in the ED for hours, or even days, until an appropriate placement becomes available.

Five of the seven centers interviewed serve children and adults, while Guidelinks serves only adults, and Change to Philadelphia Children's Crisis Response Center solely serves children 3-17. Common Ground serves all ages, but crisis services for children will soon be transitioned to another entity and will operate out of the basement of the crisis center. They determined that this change would better meet the needs of children in crisis.

Cassie Wolfe, Program Director at the Philadelphia Children's Crisis Response Center, cautioned that there are additional complexities and legal issues in serving children. In her experience, discrepancies or disagreements about clinical recommendations and the appropriate level of care needed can result in children staying longer than is ideal while appropriate placement is obtained. The community needs to understand the role of the crisis walk-in center is not meant to be a foster care facility, shelter, or hospital.

This points to the need for crisis walk-in centers that serve children to be well coordinated with other systems of care such as child welfare.

Centers should be easily accessible.

Several interviewees noted that the success of the crisis walk-in center hinges on it being centrally located and accessible by public transportation and that the sponsoring organization provides transportation assistance. For example, AHN operates a van service (temporarily on hold during the pandemic) or uses rideshare services such as Lyft. WellPower's walk-in center is in a busy urban center with multiple bus lines. This helps facilitate a person in crisis literally being able to walk in as needed.

UPMC resolve also stressed that location is crucial. They operate two crisis walk-in centers in Allegheny County and are currently soliciting proposals that will offer residents informal mental health supports. While not currently feasible, they would ideally recommend multiple resource centers to spread services around the county.

Case Studies

All Health Network

All Health Network (AHN) is a community mental health center that provides services in two suburban counties (Arapahoe and Douglas) to the south of Denver, Colorado. AHN operates a crisis walk-in center that is part of a statewide continuum of crisis services, including a statewide hotline operated by Colorado Crisis Services, regionally operated mobile crisis services, and crisis walk-in centers. AHN's crisis center is open 24 hours a day, seven days a week, without age or insurance restrictions. AHN submits claims for all billable Medicaid services and bills commercial insurance and Medicare. Additional financing comes from state general funds managed by regional administrative service organizations.

According to Chief Clinical Officer Jen Bock, the walk-in center's goal is to provide an access point for services in a more welcoming, less restrictive environment that doesn't involve the criminal justice system or hospitalization. In the past fiscal year, AHN saw 1340 unique clients and provided 1836 services.

The facility has phone intake counselors who answer AHN's 24/7 crisis line and assist with locating placement, arranging transportation, and coordination of care for individuals who come through the walk-in center. AHN also has a peer specialist and Licensed clinicians who conduct crisis evaluations, and unarmed security trained in de-escalation.

The AHN crisis center does breathalyzer tests and basic vitals. However, they do not do full medical clearance. If individuals need medical attention beyond what AHN can provide on-site, they must send the patient to an ED for medical clearance. This is less than ideal, as Jen shared that once cleared, the ED often discharges them without proper coordination with the crisis center, meaning the patient can fall through the cracks. Jen advised that communities developing crisis centers work toward creating bridge services so individuals receive adequate treatment and follow-up.

During the assessment process, the AHN team seeks to resolve the immediate crisis or gauge who may need to be connected to higher levels of care. On the same campus, AHN operates a crisis stabilization unit (CSU) for those needing two to five days of treatment and an acute treatment unit (ATU) with 16 beds for clients experiencing higher acuity levels. While the walk-in center serves all ages, the CSU and ATU are only for adults.

Once discharged, they follow up with the patient within 24 hours and again within 72 hours to keep them connected. They keep track of their follow-up data and report it to payers.

Common Ground

Common Ground is a 24-hour crisis services agency dedicated to helping youths, adults, and families in crisis. The organization operates a crisis center in the northern Detroit suburbs in Pontiac, Michigan. According to Heather Rae, President and Chief Executive Officer, Common Ground has a no-rejection philosophy of care. Walk-ins are permitted 24 hours a day, seven days a week. They have two separate entrances: the main lobby for walk-in services for self-referrals and those arriving by bus or ride services, and an emergency entrance for EMS. They also have a call center, mobile crisis, crisis residential program, and CSU on site. They are financed through braided funding streams, including Medicaid, allocations from a liquor tax, and other state and local funds.

Common Ground emphasizes peers in their staffing model. They do intake, crisis residential, sober support, and discharge planning. The crisis residential program staff includes peers, a psychiatrist, nurse, clinicians, art therapists, and a follow-up specialist. A partner organization provides case management. The sober support unit staff includes peers and paramedics/emergency medical technicians (EMTs). Heather indicated that given the availability of emergency services through 9-1-1, Common Grounds is not concerned about medical clearance.

They use various metrics to track success. Common Ground served 88,000 people last year in all their programs. They use a unique measure, called Hope Scale, before and after treatment. They also measure cost, wait times, and recidivism within 72 hours and 30 days. Their data shows that 742 people were diverted from jail to more appropriate services, and Oakland County taxpayers saved an estimated $7.8 million by diverting people from the ED.

Connections Health Solutions

Connections Health Solutions (Connections) is a private, for-profit company with two facilities in Arizona, one in Phoenix and another in Tucson, that has been offering services since 2009. The Phoenix facility is a Urgent Psychiatric Center, and the Tucson facility is an Crisis Response Center. Both facilities are available to walk-ins with 23-hour crisis observation units. The CRC has a youth 23-hour observation unit, while the UPC is only for adults. Their financing is from Medicaid, commercial insurance, and county funding.

Staffing at Connections is interdisciplinary. The team includes physicians, nurses (RNs and LPNs), case managers, peers, and behavioral health specialists. All staff is trained in verbal de-escalation and security techniques. Behavioral health specialists are also trained in physical restraint techniques based on Jujitsu through a program called SafeClinch.

Connections boast impressive outcomes. Connections stabilizes 65-70% of patients within 23 hours in lieu of inpatient psychiatric treatment, ED, or jail. 90% of Connections patients have a 7-day behavioral health outpatient follow-up.

GuideLink Center

GuideLink Center (GuideLink) is a community-initiated collaborative led by the Johnson County Board of Supervisors. They operate a crisis center in Iowa City, Iowa, which opened in February 2021. The county is a primary funder, with supplemental funding from commercial insurance and Medicaid billing. GuideLink is part of a group of state-designated crisis centers that meet monthly.

At the core of Guidelink's model is the strength of its community partnerships. They believe that building on the strengths of the various organizations allows for cooperation between providers instead of competition. They have 18 partners ranging from providers to government entities, including AbbeHealth, Mercy Iowa City, law enforcement, the University of Iowa, and Johnson County.

The center only serves adults, has 23-hour services, medically monitored detoxification, sub-acute, and acute capabilities. Patients can stay up to five days in acute beds if needed. Patients needing additional support are referred to community mental health providers, sub-acute stabilization, substance use services, peer support, general medical services, and housing and vocational support.

GuideLink had about 1,000 admissions in ten and a half months. They measure diversion and currently are diverting about 15 percent of people from EDs and 15 percent from prisons and jails. They also do client satisfaction surveys to understand better how to treat patients at the center.

Guidelink sees peers as an essential piece of their crisis model. They have one peer certified in mental health and substance use-related matters.

Philadelphia Children's Crisis Response Center

The Philadelphia Children's Crisis Response Center is part of Belmont Behavioral Health Systems, which has been providing Philadelphia with behavioral health services for over 75 years. They operate a crisis center that has walk-in services and residential beds. The center is a partnership between Belmont, the Children's Hospital of Philadelphia (CHOP), and the city of Philadelphia. Children older than three years old can be admitted. Their funding model is unique. The city of Philadelphia's Community Behavioral Health Department (which manages the Medicaid behavioral health benefit for Philadelphia) is the sole source of funding for the center and provides a lump sum payment.

The center serves children from the ages of three to 17. Children older than two (not three) years old can be evaluated, not admitted. Children 5-17 may be admitted to the Crisis Stabilization unit if they meet criteria, or referred for admission to inpatient levels of care. Because they are publicly funded and a generally safe place for children going through various guardianship issues, sometimes they see children who may not have an alternative place to go.

Philadelphia Children's Response Center does not do medical clearance and is not attached to a physical health site. So, they take children who need medical services to a hospital. Staffing at the facility is standard. They have a full-time pediatric psychiatrist and Medical Director who is the crisis model's center. All interviewees said that without her, the facility "would not work." They use nurses at the RN and LPN levels; however, LPNs are not permitted to work alone. The center does not have peer services, but a family advocate is on site.

One of the primary outcomes that the Philadelphia Children's Response Center tracks is how long it takes for a patient to be evaluated once they enter the facility. This measure is bucketed into three categories: evaluated under six hours, between six and 24 hours, and in 24 or more hours. They also look at what happens after the crisis period. Seventy percent of children who come to the facility receive outpatient treatment, which the staff sees as a significant positive outcome.

UPMC Resolve Center

The University of Pennsylvania Medical Center (UPMC) manages a crisis center in Pittsburgh, Pennsylvania, called resolve. The facility operates 24 hours a day, seven days a week, and is run by the UPMC Western Psychiatric Hospital in partnership with the Allegheny County Office of Behavioral Health. They have a call center on-site and provide crisis counseling, support, referrals, and intervention services for all ages. This includes walk-in and residential services for all ages. Allegheny County provides about 30 percent of its funding, with Medicaid-managed care entities funding the remaining 70 percent. The county has a separate crisis facility that serves individuals with SUDs, so resolve primarily serves people with mental health crises. However, the facility takes all patients, regardless of their diagnosis.

Resolve strives to be an open and welcoming environment, which leadership believes is vital in ensuring comfortability at a crisis center. They engage peers "from day one," and before offer people adequate room to store their belongings.

Additional staff at resolve includes crisis clinicians with a bachelor's or master's degree who complete the initial crisis assessment, nurses, one Certified Registered Nurse Practitioner, physicians, crisis technicians (degrees not required), service coordinators (a.k.a., case managers), mental health safety specialists, and peers.

They also have a mobile crisis team. Nurses can handle essential medical functions like chronic illness but triage more severe physical health conditions with local hospitals. Resolve does not do detoxification. Resolve is in the process of developing a mobile team, consisting of a clinician and a peer that initially will be available to law enforcement referrals in specific neighborhoods and will continue to learn from and expand this mobile composition. Executives have also thought about creating a residential center run by peers, acknowledging how important peers are in crisis treatment.

Jewel Denne, Assistant Deputy Director for Mental Health Services with Allegheny County, indicated she believes resolve is highly regarded because of the sheer volume of clients they serve and their impact as a diversion center. Follow-up is currently offered and they plan to expand follow-up capacity to include the use of peers as well as informal mental health support. Some clients are referred to a crisis residential program. Within seven days of discharge from the Crisis Residential Program, 80 percent of individuals had appointments or access to community services. Beyond clinical services, they believe it is equally essential to provide linkages to resources that address the social determinants of health.

WellPower

WellPower is a community mental health center in Denver, Colorado, that operates a 24/7 Crisis Walk-in-Center.
Like AHN, WellPower's center is part of Colorado's more extensive statewide system and receives partial financing from their regional crisis Administrative Services Organization. They also bill traditional payers for services (private insurance and Medicaid). The walk-in center serves all ages, regardless of mental health or SUD diagnosis.

According to Associate Director of Crisis Services Marissa VanDover, WellPower "holds out hope for people until they can hold it for themselves." They ensure people feel welcome at the walk-in center with small things such as offering them a warm cup of tea or coffee just as they enter the facility and find that helps with de-escalation.

WellPower's walk-in center has about 20 staff with interdisciplinary teams. To attract and retain the workforce, WellPower offers shift work (full-time employees work three, twelve, and a half-hour shifts, totaling thirty-six and a half hours a week). The organization built a small gym in an empty room at the facility to provide employees with this resource for use during downtime.

WellPower ensures people in need get connected to ongoing care and services. Peers conduct follow-up calls within one day after a visit to the crisis center. WellPower makes 24-hour appointments (including via telehealth) available within its system and offers warm hand-offs with other providers and in other parts of the state. WellPower can bring clients to their Recovery Center for addiction treatment services if needed.

WellPower is also a key partner in the Behavioral Health Solutions Center, operated by the city and county of Denver. According to Marissa VanDover, Associate Director of Crisis Services, both the WellPower walk-in center and the Solutions Center are essential community resources and serve complementary but distinct roles in meeting crisis needs. Whereas anyone can self-refer or be referred from another organization to the walk-in center, the Solutions center was explicitly designed as a place where police or first responders could bring adults (18+) needing temporary housing and voluntary treatment. The Solutions Center provides additional services beyond 24-hour crisis stabilization, including physical health screenings, crisis stabilization for up to five days, residential care for up to 30 days, and resource navigation services. The Solutions Center is primarily funded by the city and county of Denver, although they are the payer of last resort. Patients must reside in Denver to receive services.

CRITICAL CONSIDERATIONS FOR MONTGOMERY COUNTY

As Montgomery County explores the need for and potential investment in a crisis resource center, it will be imperative for the county to actively engage all stakeholders in critical elements of design, including where the facility would be physically located, building design, staffing structure, and overall philosophy of the center. The county should establish realistic goals for the center and key performance indicators that will be used. Decision-making should happen collaboratively around factors such as populations to be served and services to be offered on-site.

Montgomery County must also consider the ideal operating model to meet local needs. As demonstrated through the different case studies, crisis walk-in centers vary in terms of facilities managed by a single behavioral health provider organization, centers operated through a collaboration of multiple entities, or centers connected to a health and hospital system.

The centers featured in these case studies (and perhaps others) may be able to serve as valuable resources. Virtual or in-person tours may be beneficial to get a more first-hand sense of the center's look and feel.

Lastly, as Montgomery County considers the potential development of a crisis walk-in center, it will be essential to consider the limitations of what such a facility can and cannot address. There is a need nationally, in the state of Pennsylvania, and locally to strengthen the capacity of the entire behavioral health delivery system to help prevent people from getting into a crisis in the first place and to support their behavioral health care needs for the longer term after the immediate crisis has been resolved.

APPENDIX: PROGRAMS AT A GLANCE

	Location(s)	Populations Served	Services	Financing	Staffing	Square Footage
All Health Network	Littleton, CO	MH and SUD WIC: All ages CSU: Adults ATU: Adults	• 24/7 • Walk-in • Evaluations • Crisis Stabilization Unit • Residential • Medical clearance Peer support • Therapy • Call center • Case management • Co-responder	• Medicaid billing for all eligible services • State funding for non-Medicaid, under contract with Administrative Services Organization (ASO) • Commercial insurance	• MA-level clinicians • Phone intake counselors • Peers • Security	4,579 sq. ft. *(w/o CSU)*
Philadelphia Children's Crisis Response Center	Philadelphia, PA	MH only Ages 3 to 17	• 24/7 • Walk-in • Evaluations • Crisis Stabilization Unit • Residential	• The Community Behavioral Health Department gives them a lump sum every year • Do not bill for services	• Full-time pediatric psychiatrist and Medical Director • MA-level clinicians • RNs and LPNs • Family advocate (no peers)	12,934 sq. ft.
Common Ground	Pontiac, MI	MH and SUD All ages	• 24/7 • Walk-in • Evaluations • Crisis Stabilization Unit • Residential • Mobile crisis	• Medicaid • State tax revenue • Some Commercial	• Psychiatrist • MA-level clinicians • Peers • Paramedics/ EMTs • Art therapists	44,000 sq. ft.
Connections Health Solutions	Tuscon and Phoenix, AZ	MH and SUD All ages	• 24/7 • Walk-in • Evaluations • Crisis Stabilization Unit	• For-profit • Medicaid • Some Commercial	• MDs, Nurse Practitioners, and Physicians Assistants • RNs and LPNs • Case managers • Peers • Behavioral health specialists (security)	Square footage varies by the size of the facility (number of beds or chairs). *The organization has its own guidelines for determining space requirements.*

APPENDIX: PROGRAMS AT A GLANCE

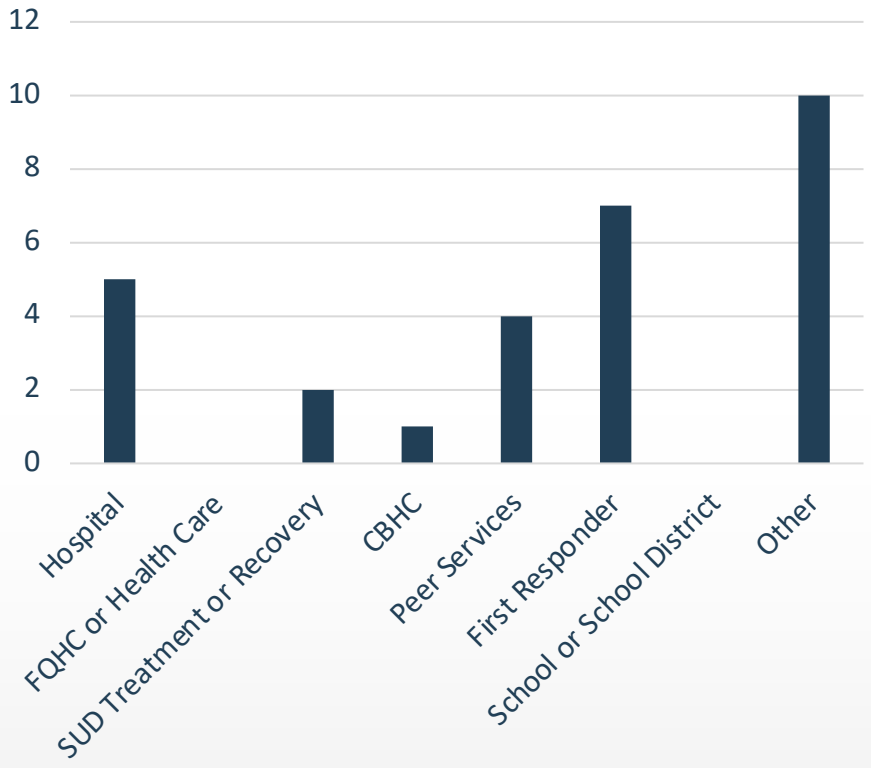
GuideLink Center	Iowa City, IA	MH and SUD Adults	• 24/7 • Walk-in • Evaluations • Detoxification • Crisis Stabilization Unit • Residential • Mobile crisis	• County • Medicaid • Some Commercial • Some state funds	• Prescribers • Nurses • Peers (Dual-certified in MH and SUD) • BA-level triage staff	23,000 sq. ft.
WellPower	Denver, CO	MH and SUD All ages	BH Solutions Center • Crisis Stabilization Unit • Case management • Transitional shelter Walk-in Crisis Center • Walk-in • Peer support • Case management	BH Solutions Center • City and County of Denver Walk-in Crisis Center • ASOs • Medicaid • Commercial	• MA-level clinicians • Nurses • Peers • 70 staff at the BH center and 20 at the WIC.	4,100 sq. ft.
UPMC resolve	Pittsburgh, PA	MH and SUD All ages	• 24/7 • Walk-in • Residential • Call center • Mobile crisis	• County • Medicaid • Commercial	• Physicians • MA-level clinicians • Nurses • One CRMP • Technicians • Peers • Case managers • Safety specialists	Unknown

THIRD HORIZON STRATEGIES

Future of the CSAG: Survey Results

Tym Rourke, Senior Director

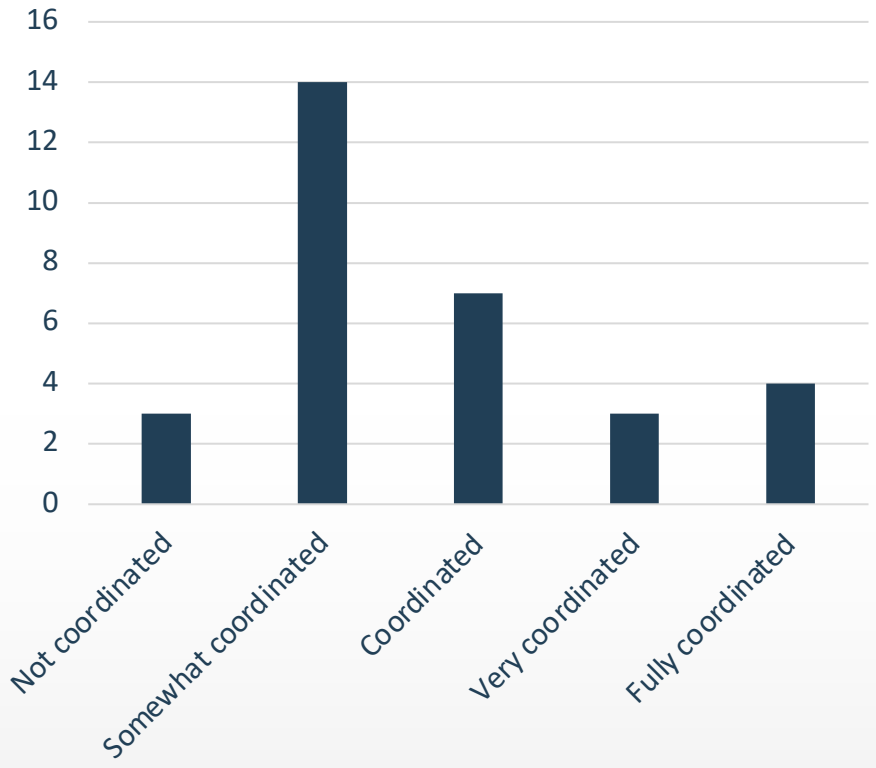
Please identify the nature of your work in the behavioral health system in Montgomery County.



- **29** total responses
- **28%** are clinicians
- **86%** work directly with individuals

Other: County government (x2), crisis services (x3), housing, BH Managed Care Organization, advocacy (x2)

How coordinated do you feel stakeholders are in addressing the county's complete continuum of behavioral health services?



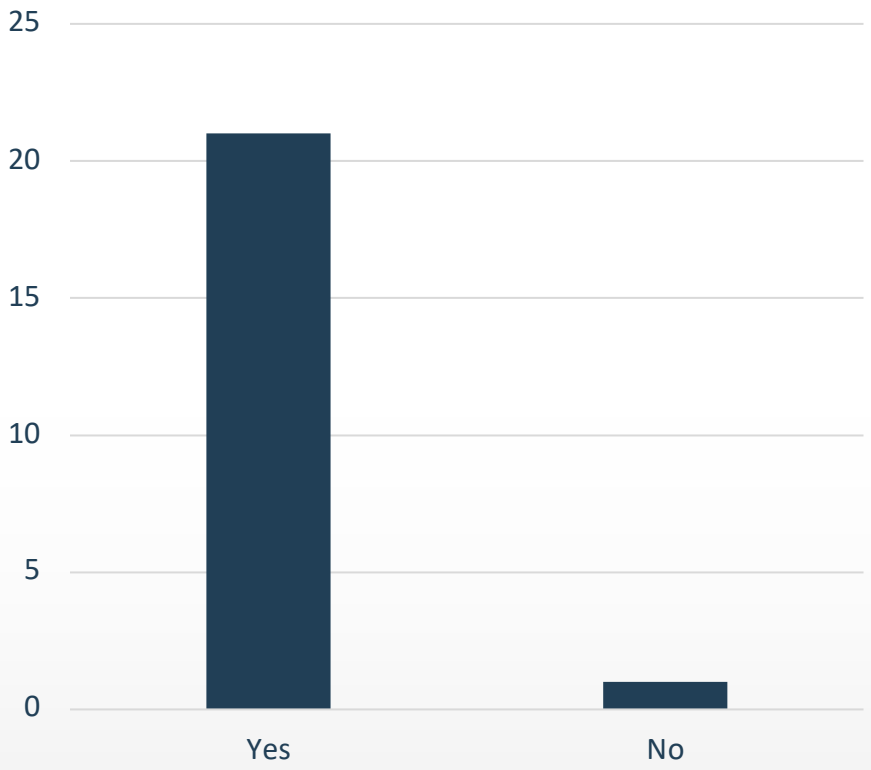
- **27** total responses
- **52%** feel stakeholders are only *somewhat coordinated*
- **89%** believe stakeholders are *somewhat coordinated*, *coordinated*, or *very coordinated*
- **0%** feel stakeholders are *fully coordinated*

Other than the CSAG, what coalitions, partnerships, and regularly occurring meetings do you or your organization attend to better coordinate services and care for people in the county?

- Hub and Bridge Programs
- Suicide Prevention Taskforce
- National Alliance on Mental Illness
- CCBHC Collaborative
- Continuum of Care (CoC) Meetings
- Stepping Up
- MontCo Re-Entry Initiative
- RTF Transition Meeting*
- Bucks-Mont Collaborative
- Community Support Programs

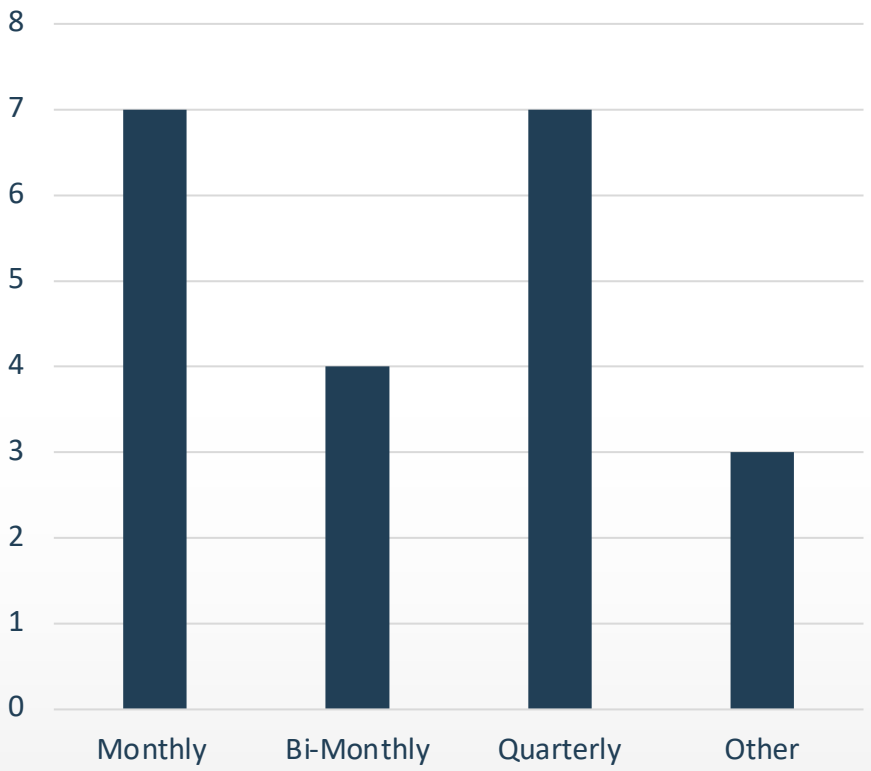
*RTF = residential treatment facility

Do you think the CSAG should continue to operate after the planning process is complete?



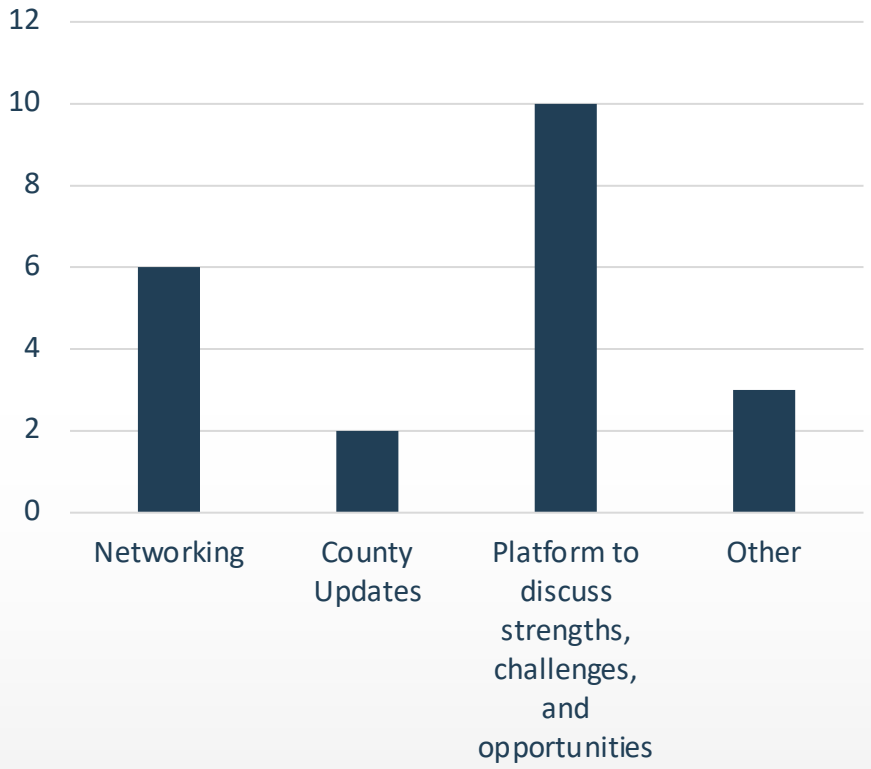
- **22** total responses
- **95%** think that the CSAG should continue beyond this planning process
- **1** person believes that the CSAG is not needed anymore. In their words, “hopefully, the foundation is built.”

How often do you think the CSAG should meet?



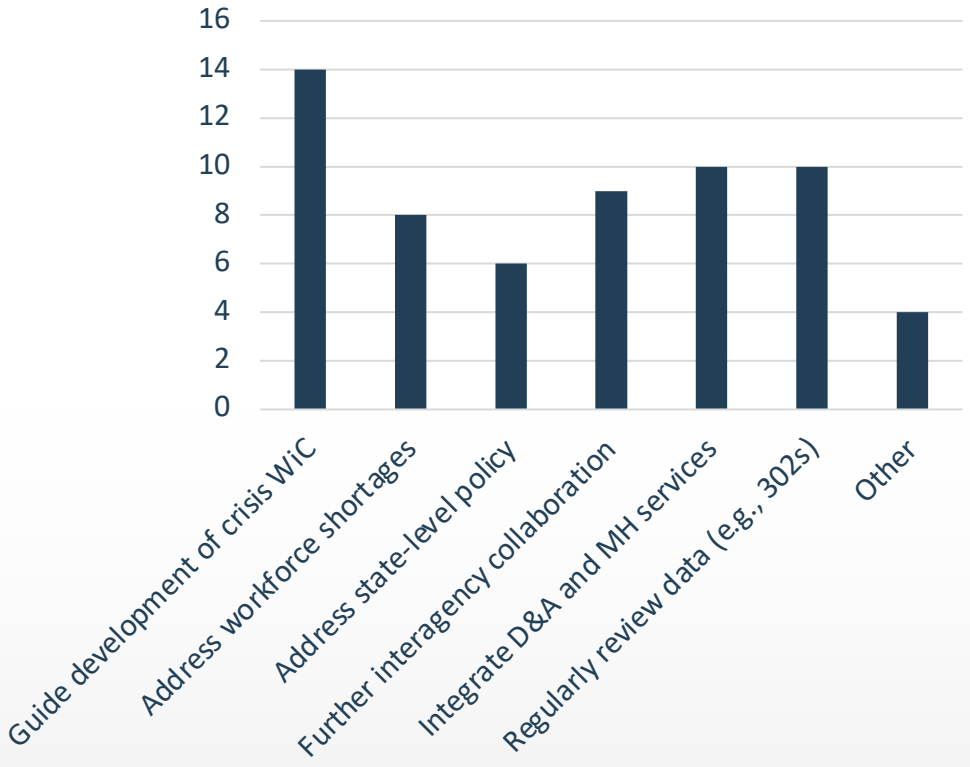
- **21** total responses
- **33%** think that the CSAG should meet monthly
- **33%** want the CSAG should meet bi-monthly

What have you enjoyed most about the CSAG?



- **21** total responses
- **48%** enjoyed discussing strengths, challenges, and weaknesses
- **29%** appreciated the opportunity to network

If the CSAG were to continue, what top three activities would you want the CSAG to accomplish?



- **19** total responses
- **14** respondents put the development of a guide for the crisis walk-in center in their top three future CSAG activities
- **Reminder:** Respondents were asked to select three of the seven possible answers, which is why there are more responses to this question

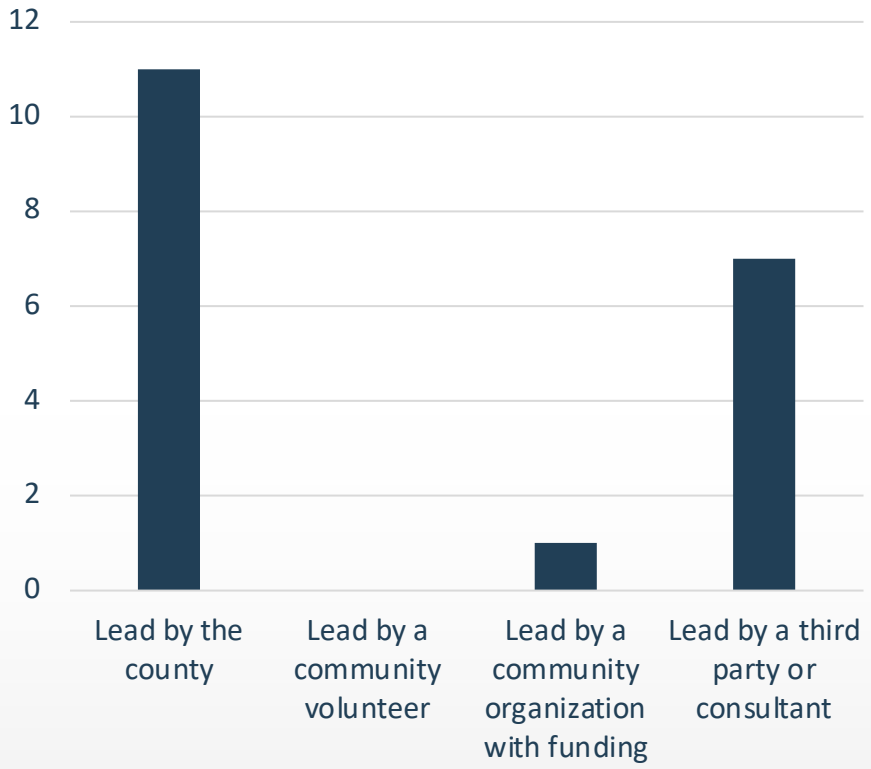
If the CSAG were to continue, are there any operational improvements you recommend?

- More agencies attend
- In-person meetings
- Define common values
- More people with lived experience
- Incorporate workgroups

If the CSAG were to continue, what partners, organizations, or stakeholders should be added to ensure the full continuum is engaged?

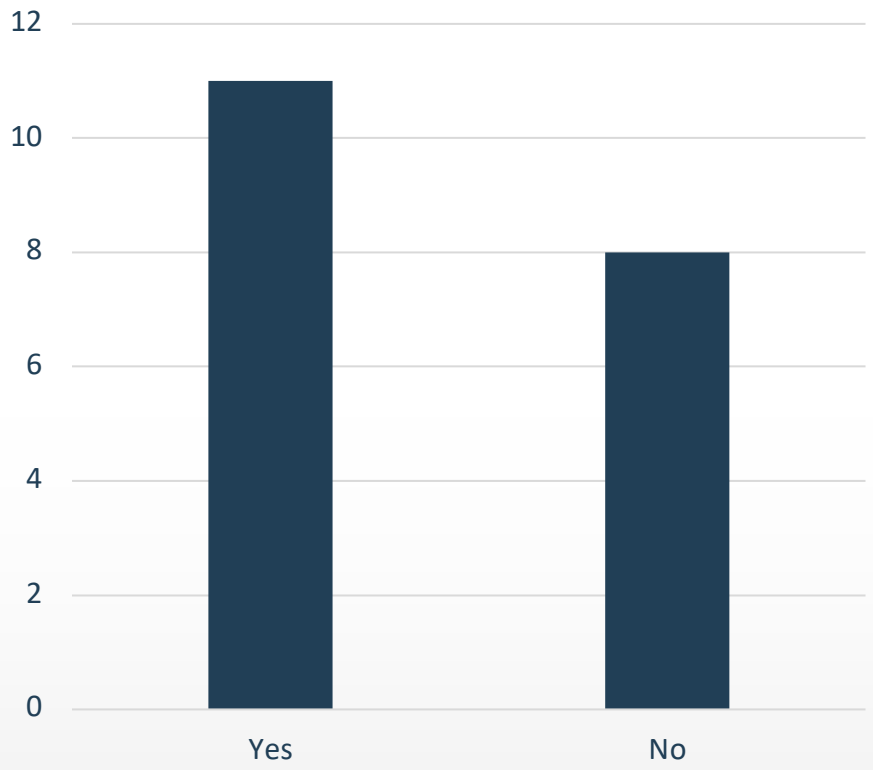
- Minority representation
- Hospital-based providers
- People with lived experience
- Commercial payers
- Emergency department providers
- Representatives from schools
- Faith-based organizations
- Outpatient providers
- Individuals who work with children
- Peers

If the CSAG were to continue, what method would you most prefer for its coordination?



- **19** total responses
- **58%** want the county to run the CSAG when THS' contract is over
- **37%** believe an independent third-party or consultant should lead the group

Would you be willing to play a leadership role in an ongoing convening?



- **19** total responses
- **11** CSAG members are willing to play a future leadership role in the group

THIRD HORIZON
STRATEGIES

TO: Anna Trout, Crisis and Diversion Director, Montgomery County
FROM: Mindy Klowden, Senior Director, THS
Moses Gur, Manager, THS
DATE: November 29, 2022
SUBJECT: Montgomery County Crisis System Enhancement Plan Regulatory Review

Background

At the request of Montgomery County, Third Horizon Strategies (THS) conducted a review of pertinent state and federal regulations that may have implications for THS' mental health crisis system enhancement plan, particularly related to the development of a crisis walk-in center. The county asked for detailed information to better understand the licensing structures and requirements that impact crisis intervention facilities in Pennsylvania.

Specifically, the county requested THS help answer the following question:

> ***Main Question:*** *What regulations and bulletins apply to operating site-based behavioral health crisis services in Pennsylvania? How are current places licensed, and what regulations bind them? Underlying theme- how do we make this sustainable?*

This memo provides a synthesis of the most relevant findings for Montgomery County leadership consideration as the county pursues crisis system enhancement planning and the development of one or more crisis stabilization or walk-in facilities.

Summary of Key Findings

THS' recommendations, as they relate to each section of the paper, are included in bold. Some of the key findings include:

- THS' analysis found that there are multiple regulatory frameworks that may be pertinent depending on the walk-in center's design. Yet not all Montgomery County's questions can be clearly answered solely through policy analysis. **In some areas, Montgomery County may want to consult with an attorney for legal opinion.**
- A specific length of stay for Walk-In Crisis Services is not defined, rather Title 55, Chapter 1153, defines "Inpatient services" as treatment provided to an individual who has been admitted to a treatment institution or an acute care hospital or psychiatric hospital on the recommendation of a physician and is receiving room, board, and professional services in the facility on a continuous 24-hour-a-day basis. THS concludes that avoiding the continuous 24-hour threshold is necessary to be considered outpatient in nature.
    - DDAP regulations appear to have a similar definition for inpatient, triggered by a 24-hour timeframe.
- There are service definitions and staffing requirements defined for Walk-in Crisis Services, per Title 55, Proposed Chapter 5240.

- While Montgomery County's RFP for a 24/7 Assessment Site refers to a "screening, referral, and assessment site" the DDAP regulations use the language "Intake, Evaluation, and Referral Activities." These are regulated by Chapter 709 Subchapter D and Chapter 711 Subchapter C, neither of which include language regarding staffing requirements.
- Zoning laws and health and safety codes vary by municipality.
- THS did not find PA-specific regulations that speak directly to specific considerations for children and families in a Walk-In Crisis Services facility, so instead, the memo summarizes national best practices. Importantly, this includes having separate receiving areas if one facility serves both adults and children and families.
- THS concluded that EMTALA does not apply if the walk-in center is an outpatient facility.
- THS analyzed the implications of the State of Pennsylvania's decision to cover mobile crisis services under Medicaid's rehabilitative services option. THS concluded that the new Medicaid mobile crisis option might allow for more flexibility in staffing and would draw down an 85% federal match. However, licensed professionals may still be required per the state's scope of practice guidelines.

Methodology

THS reviewed a range of state and national regulations. To identify relevant codes, existing programs' licenses were identified through the Human Services Provider Directory, filtered to "Crisis Intervention." Crisis facilities in Pennsylvania are licensed by the Department of Human Services with authority given by Article X Section 1007 of the Human Services Code. The Department regulates licenses under Proposed Chapter 5240, as directed by the Pennsylvania Bulletin Volume 23 & Mental Health Bulletin Number OMH-92-16. It is important to note that programs held under this code offer a range of levels of care, including walk-in centers, mobile crisis, crisis residential, and more.

Beyond these rules, THS further examined all relevant or cited chapters in Pennsylvania Code, additional related bulletins, the Medical Assistance Program payment regulations, the Pennsylvania Health and Safety Code, Title 28, Part V (Drug and Alcohol Programs), and select national regulations.

Crisis Intervention Center – Regulatory Crosswalk

The table below offers a crosswalk of different regulations and issues of consideration when implementing a crisis intervention facility in Pennsylvania

Programmatic Component	Regulation	Regulatory/Licensing Body	Key Language
Service Eligibility	Title 55, Proposed Chapter 5240 – Section 12	Department of Human Services - Office of Mental Health and Substance Abuse Services	Services shall be reimbursable when provided to adults, adolescents, and children and their families who exhibit an acute problem of disturbed thought behavior, mood, or social relationships.
Staff Requirements			
Walk-in Crisis Services & Crisis Residential Services	Title 55, Proposed Chapter 5240 – Section 31	Department of Human Services - Office of Mental Health and Substance Abuse Services	(a) to qualify as a mental health professional under this chapter, an individual shall have at least one of the following:

			(1) A master's degree "in social work, psychology, rehabilitation, activity therapies, counseling, education, or related fields and 3 years of mental health direct care experience. (2) A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education, or a related field, or be a registered nurse; and 5 years of mental health direct care experience, 2 of which shall include supervisory experience. (3) A bachelor's degree in nursing and 3 years of mental health direct care experience. (4) A registered nurse license, certified in psychology or psychiatry. (b) Mental Health Crisis Intervention (MHCI) service crisis workers who are not mental health professionals shall be supervised by a mental health professional and, one of the following: (1) Have a bachelor's degree with major coursework in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, nursing,

			counseling, education, or a related field. (2) Be a registered nurse. (3) Have a high school diploma or equivalency and 12 semester credit hours in sociology, social welfare, psychology, gerontology or other social science and 2 years of experience in public or private human services with 1 year of mental health direct care experience. (4) Have a high school diploma or equivalency and 3 years of mental health direct care experience in public or, private' human services with employment as a mental health staff person prior to January 1,1992. (5) Be a consumer or a family member who has 1 year of experience as an advocate or leader in a consumer or family group and has a high school diploma or equivalency. (d) an MHCI service medical professional is (a psychiatrist, a physician with 1 year or mental health experience, or a CRNP authorized to diagnose mental illness)
Drug & Alcohol Programs	Title 28, Chapter 704	Department of Drug and Alcohol Programs	While Montgomery County's RFP for a 24/7 Assessment Site refers to a "screening, referral, and assessment site" the DDAP regulations use the language "Intake, Evaluation, and

			Referral Activities." These are regulated by Chapter 709 Subchapter D and Chapter 711 Subchapter C, neither of which include language regarding staffing requirements. **Chapter 704 outlines staffing requirements for all other DDAP programs; below are the sections and summaries:** 704.1 Scope: The chapter applies to staff employed by drug and alcohol treatment facilities, except for staff employed in Intake, Evaluation, and Referral Facilities. 704.2 Compliance Plan: Governing body shall approve a written compliance plan 704.3 General Requirements for Projects: part (d) requires that inpatient facilities have awake staff coverage 24 hours a day. Chapter 704.4 Compliance with staff qualifications: established grandfathering and requirements for specific levels of staff. Chapter 704.5 Qualifications for positions of project director and facility director: Programs shall have a project director responsible for overall project management and staff and a facility directory responsible for the overall management of the facility. Directors must have a master's degree and 2 years of experience or equivalent education and experience. Chapter 704.6 Qualifications for the position of clinical supervisor: A full-

			time clinical supervisor is required for every eight full-time counselors or counselor assistants. Supervisors must have a master's degree and 2 years of experience or equivalent education and experience. Chapter 704.7 Qualifications for the position of counselor: Counselors must have a current license as a physician, a master's degree, or equivalent experience. Chapter 704.8 Qualifications for the position of counselor assistant: A person who does not meet the requirements for counselor may be employed as an assistant with the necessary experience, however a program may not hire more than one counselor assistant for each employee who meets the requirements of clinical supervisor or counselor. 704.9 Supervision of counselor assistant: A counselor assistant shall be supervised by a full-time clinical supervisor or counselor 704.10 Promotion of counselor assistant: If a counselor assistant meets the requirements for counselor they may be promoted to the position of counselor. 704.11: Staff development program: The project director shall develop a comprehensive staff development program for agency personnel including policies and procedures for the program indicating who is responsible and the time frames for completion of the following components:

			• An assessment of staff training needs. • An overall plan for addressing these needs • A mechanism to collect feedback on completed training. • An annual evaluation of the overall training plan. 704.12: Full-time equivalent (FTE) maximum client/staff and client/counselor ratios: (a) General requirements. Projects shall be required to comply with the client/staff and client/counselor ratios in paragraphs (1)—(6) during primary care hours. These ratios refer to the total number of clients being treated including clients with diagnoses other than drug and alcohol addiction served in other facets of the project. Family units may be counted as one client. (1) Inpatient nonhospital detoxification (residential detoxification). (i) There shall be one FTE primary care staff person available for every seven clients during primary care hours. (ii) There shall be a physician on call at all times. (2) Inpatient hospital detoxification. There shall be one FTE primary care staff person available for every five clients during primary care hours. (3) Inpatient nonhospital treatment and rehabilitation

			(residential treatment and rehabilitation). (i) Projects serving adult clients shall have one FTE counselor for every eight clients. (ii) Projects serving adolescent clients shall have one FTE counselor for every six clients. (4) Inpatient hospital treatment and rehabilitation (general, psychiatric or specialty hospital). (i) Projects serving adult clients shall have one FTE counselor for every seven clients. (ii) Projects serving adolescent clients shall have one counselor for every five clients. (5) Partial hospitalization. Partial hospitalization programs shall have a minimum of one FTE counselor who provides direct counseling services to every ten clients. (6) Outpatients. FTE counselor caseload for counseling in outpatient programs may not exceed 35 active clients. (b) Counselor assistants. Counselor assistants may be included in determining FTE ratios when the counselor assistant is eligible for a caseload. (c) Exemption for transitional living. Specific client/staff ratios are not required for transitional living facilities.

			(d) Exceptions. A project director may submit to the Department a written petition requesting an exception to the client/staff and client/counselor ratios in this section. The petition shall describe how the characteristics of the program and its client mix support the request for the exception and shall be approved by the governing body. Granting the petition shall be at the discretion of the Department. Long-term residential facilities and halfway houses which include a client's participation in schooling or employment as part of a treatment day are examples when requests for exceptions will be considered.
Service Descriptions			
Walk-in Crisis Services	Title 55, Proposed Chapter 5240 – Section 91	Department of Human Services - Office of Mental Health and Substance Abuse Services	The walk-in crisis service is service provided at a provider site involving face-to-face contact with individuals in crisis or with individuals seeking help for persons in crisis. Service is available at a designated facility. Service includes assessment, information, and referral, crisis counseling, crisis resolution, accessing community resources and back-up, including emergency services and psychiatric or medical consultation. The service also provides intake, documentation, evaluation, and follow-up.
	Pennsylvania Bulletin Volume 23, No. 10, Pages 1048	Department of Human Services - Office of Mental Health and Substance Abuse	This service is provided in a face-to-face meeting with a person in crisis, or a person seeking help for a person in crisis, as the provider's designated facility. Because this is a

		Services (at the time, the Department of Public Welfare, MH/MR office)	face-to-face contact, the services include assessment, information, and referral, crisis counseling, crisis resolution, accessing community resources and back-up, including emergency services and psychiatric or medical consultation the service also provides intake, documentation, evaluation, and follow-up which is for the purpose of facilitating entry into another mental health treatment program
Crisis Residential Service	Title 55, Proposed Chapter 5240 – Section 141	Department of Human Services - Office of Mental Health and Substance Abuse Services	The crisis residential service is a service provided at small facilities that provide residential accommodations and continuous supervision for individuals in crisis. The service provides a temporary place to stay for consumers who need to be removed from a stressful environment or who need a place in which to stay to stabilize or until other arrangements are made. Access shall be provided through approved referral sources.
	Pennsylvania Bulletin Volume 23, No. 10, Pages 1049	Department of Human Services - Office of Mental Health and Substance Abuse Services (at the time, the Department of Public Welfare, MH/MR office)	This section specifies that these are small facilities that provide residential accommodations and continuous supervision for individuals in crisis. The service provides a temporary place to stay for consumers who need to be removed from a stressful environment or who need a place in which to stay to stabilize or until other arrangements are made. Access shall be made through approved referral sources
Drug & Alcohol Programs	Title 28, Chapter 701	Department of Drug and Alcohol Programs	*Health care facility*: (i) A general, tuberculosis, chronic disease, or other type of hospital—but not hospitals caring exclusively for the mentally ill—a skilled nursing facility, home health

			care agency, intermediate care facility, ambulatory surgical facility, or birth center—regardless of whether the health care facility is created for profit, nonprofit, or by an agency of the Commonwealth or local government. (ii) The term does not include an office used primarily for the private practice of medicine, osteopathy, optometry, chiropractic, podiatry, or dentistry; nor a program which renders treatment or care for drug or alcohol abuse or dependence, unless located within a health facility; nor a facility providing treatment solely on the basis of prayer or spiritual means. (iii) The term does not include a mental retardation facility except to the extent that it provides skilled nursing care. (iv) The term does not apply to a facility which is conducted by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of a religious denomination." *Inpatient hospital activity*—The provision of detoxification or treatment and rehabilitation services, or both, 24 hours a day, in a hospital. The hospital shall be licensed by the Department as an acute care or general hospital or approved by the Department of Public Welfare as a psychiatric hospital. *Inpatient nonhospital activity*—A nonhospital, residential facility,

			providing one of the following drug and alcohol services: (i) Residential treatment and rehabilitation services. (ii) Transitional living services. (iii) Short-term detoxification.
Facility Requirements			
Crisis Walk-in Services	Pennsylvania Mental Health Bulletin Number OMH-93-10	Department of Public Welfare	The facilities of crisis walk-in service providers may be licensed against 55200.45 relating to the physical facility of Psychiatric Outpatient Clinics. These guidelines will be superseded by the published, final regulations, Chapter 5240.
Crisis Residential Services	Title 55, Proposed Chapter 5240 – Section 143	Department of Human Services - Office of Mental Health and Substance Abuse Services	(a) Facility capacity is limited to eight beds. (b) The facility shall meet National, State, and local laws relating to building codes and access and food preparation and handling. (1) The facility shall be appropriate for the purpose for which it is used. (2) One facility may not serve both adults and children. (3) Staff persons of adolescent and children's units shall have training in child's mental health as well as access to mental health and medical professionals with education and training in child development and child mental health issues. (4) Facilities for children and adolescents shall be age appropriate. They may include

			distinct units for older children or adolescents, or both. (c) A facility shall be unlocked from the inside and occupancy shall be voluntary.
	Pennsylvania Bulletin Volume 23, No. 10, Pages 1049	Department of Human Services - Office of Mental Health and Substance Abuse Services (at the time, the Department of Public Welfare, MH/MR office)	"This section obligates providers to national, state, and local laws relating to building codes, access, and food preparation. Violation of these laws may be cause to withdraw licensure and terminate eligibility" "The provision that the facility be appropriate for the purpose for which it is used is intended to give licensing and other oversight authorities maximum latitude in inspections." "To prevent the facilities from being used for violent persons or for commitment purposes, occupancy shall be voluntary, and the facilities unlocked from the inside"
	Pennsylvania Mental Health Bulletin Number OMH-93-10	Department of Public Welfare	Prior to publication of final regulations, crisis residential facilities may be licensed against the Physical Facilities Standards of the Community Residential Rehabilitation Services regulation, 55 Pa. Code, 555310.71-73. These guidelines will be superseded by the published, final regulations, Chapter 5240.
Drug & Alcohol Programs	Title 28, Chapter 705	Department of Drug and Alcohol Programs	Chapter 705 – Physical Plant Standards
Maximum Stays			
Walk-in Crisis Services	Title 55, Chapter 1153	Department of Human Services – Medical Assistance Manual	A specific length of stay for Walk-In Crisis Services is not defined, rather Title 55, Chapter 1153, which outlines Medical Assistance payment conditions for Outpatient Psychiatric Services, "Inpatient services" are defined as treatment

			provided to an individual who has been admitted to a treatment institution or an acute care hospital or psychiatric hospital on the recommendation of a physician and is receiving room, board and professional services in the facility on a continuous 24-hour-a-day basis. Avoiding the continuous 24-hour threshold is needed to be considered outpatient in nature. Furthermore, In its *"National Guidelines for Behavioral Health Crisis Care"* best practices toolkit, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined "Crisis Receiving and Stabilization Facilities" as providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment. The National Council for Mental Wellbeing, in its "Roadmap to the Ideal Crisis System" elaborates that the 23-hour limit on observation is required for the services to not be considered inpatient, but it is important to provide continuation if needed. "If at the end of a 23-hour period, the next best step remains unclear but there is good reason to expect that it will become clearer within the next 12 hours or so, an ideal system would allow for readmission to that level of care up to an additional 23 hours."
Crisis Residential Services	Title 55, Proposed Chapter 5240, Section 145	Department of Human Services - Office of Mental Health and Substance Abuse Services	(a) Service is billable while the consumer is in residence. (b) A unit of service is 8 hours or a major portion thereof.

			(c) A maximum stay is 120 hours (5 days). An additional stay is authorized if recommended by a physician, psychiatric nurse practitioner licensed psychologist or licensed social worker and approved by the county administrator.
Drug & Alcohol Programs	Title 28, Chapter 709.42 (This language for Intake Evaluation and Referral Activities is duplicated in Title 28, Chapter 711.41 as well) Title 28, Chapter 701 defines maximum stays for other types of programs.	Department of Drug and Alcohol Programs, Intake, Evaluation, and Referral Activities, Project Management	Chapter 709 and 711 regulations speak to hours of operation and the length of the process for Intake, Evaluation, and Referral Activities but do not specifically limit length of stay: "(d) The intake project shall operate at least 5 days of the week and for a minimum of 40 hours per week. Additional hours should be appropriate to the population served by the intake project. (e) The intake process shall proceed expeditiously to avoid discouragement and should not exceed a period of 48 hours." *Long-term detoxification treatment*—Detoxification treatment for more than 30 days but not in excess of 180 days. *Long-term residential facilities*—Facilities where the average length of stay exceeds 90 days. *Short-term detoxification activity*—The provision of detoxification services in a residential facility, not to exceed 7 days. *Short-term detoxification treatment*—Detoxification treatment for 30 days or less.

THS Recommendations: Based on THS' analysis of these various regulations, it seems that if Montgomery County wants to avoid the walk-in center being subject to inpatient regulations, it must ensure clients do not exceed the threshold of 24-hour continuous stays.

During the crisis walk-in case studies interviews, THS heard from several centers that their approach to managing this when a client needed more time at the facility was to have the client step outside and then return for a new episode of care. However, one of the centers indicated they had experienced much longer stays and were not penalized.

THS also recommends that Montgomery County ensure the crisis walk-in center staffing plan meets the guidelines of Title 55, proposed chapter 5240-section 31, and those in Title 28, chapter 704, so that mental health and SUD services are readily available.

Additional Documents and Regulations Reviewed

The next section of this memorandum provides a summary of the additional documents and regulations THS reviewed at the request of Montgomery County.

Physical Facility Requirements

Per Pennsylvania Mental Health Bulletin Number OMH-93-10, crisis residential facilities may be licensed against the Physical Facilities Standards of the Community Residential Rehabilitation Services regulation, 55 Pa. Code, 555310.71-73. In contrast, crisis walk-in service providers may be licensed against 55200.45 relating to the physical facility of Psychiatric Outpatient Clinics. This bulletin references specific sections within these chapters. However, the chapters include additional sections on components such as staffing patterns, linkages with mental health services, and organizational structure, which are not explicitly referenced. It needs to be clarified if these additional chapters have any bearing on these existing crisis programs. Furthermore, the Pennsylvania Mental Health Bulletin Number OMH-93-10 states it supplements the Mental Health Bulletin Number OMH-92-16, which is no longer available online and thus could not be reviewed. THS could not clarify if the 92 bulletin still has any bearing on existing or new crisis programs.

Recommendations: N/A

Seclusion and Restraint Considerations

Title 55, Part VII, Subpart C, Chapter 5200 (Mental Health Procedures) establishes procedures for treatment and applies to "all involuntary treatment of mentally ill persons, whether inpatient or outpatient and for all voluntary inpatient treatment of mentally ill persons." The chapter outlines legal matters more than clinical or operational requirements. It outlines proceedings and rights for all who seek mental health treatment (14 of age and up) or are involuntarily subjected to mental health treatment. Utilized/necessary forms, patient rights, notices, and other legal matters are outlined. These rules do not differentiate by type of facility or program.

Pennsylvania Mental Health and Substance Abuse Bulletin Number OMHSAS-02-01 provide guidance for a wide range of facilities, including Crisis Walk-In and Crisis Residential services. It extensively details procedures, practice, and philosophy and does not outline differences by type of facility or program.

Recommendations: THS recommends that Montgomery County consult with legal counsel if there are further questions related to seclusion and restraint.

Health and Safety Code

Title 28, Health And Safety Code, primarily regulates hospitals and other health facilities overseen by the Department of Health. Psychiatric facilities listed in title 55 are missing from this chapter and may be held to local life, fire, and safety codes.

Recommendations: THS recommends that Montgomery County consult with the local government body responsible, based on where the crisis walk-in center may be physically located.

Zoning Laws

Zoning laws are outlined in the Pennsylvania Municipalities Planning Code, as regulated by the Department of Community and Economic Development. Section 601 gives power to each municipality to enact, amend, and repeal zoning ordinances.

Recommendations: THS recommends that Montgomery County consult with the local government body responsible, based on where the crisis walk-in center may be physically located.

Philadelphia Crisis Response Center (CRC) Model

In a Request for Proposals issued by the Philadelphia Community Behavioral Health (CBH) in January of 2022, the division sought providers who can develop CRC programming that emphasizes 24/7 active and resolution-focused interventions. In the RFP, it is stated that applicants should note that specific sections of proposed 55 Pa. Code §§ 5240.91, which are directly relevant to the RFP, are in Subchapter C –Walk-In Crisis Services. However, there are also requirements for providers of all crisis services, outlined in proposed 55 Pa. Code §§ 5240.1 through 5240.91, which must be responded to in the application. Throughout the RFP, proposed 55 Pa. Code §§ 5240 are the only regulations cited for consideration.

Recommendations: N/A

2022 RFP for 24-Hour Screening, Assessment, and Referral Model

The Office of Drug and Alcohol issued an RFP for a 24-hour screening, assessment, and referral site in 2022. The RFP required that candidates maintain an unrestricted license to provide substance use services from the PA Department of Drug & Alcohol Programs. Respondents were also asked if agencies "have current staff who meet the minimum education and training (MET) requirements as established by the State Civil Service Commissions for one or the following classifications: D&A Case Management Specialist, D&A Case Management Specialist Trainee, D&A Treatment Specialist, D&A Treatment Specialist Trainee. If no current staff meet the requirements, describe efforts to recruit staff who will meet the required MET."

Recommendations: THS recommends that Montgomery County determine if it will want one primary contractor to manage the crisis walk-in center and the 24-hour screening and assessment site or if these will be separate contracts to manage co-located services. Either way, psychiatric screening and assessment, and SUD screening and assessment should both be available and integrated to the extent possible.

Specific Considerations for Children, Youth, and Families

THS consulted national resources to obtain guidance on specific considerations for a crisis walk-in center serving children, youth, and families.

The "*National Guidelines for Child and Youth Behavioral Health Crisis Care,*" published by the Substance Abuse and Mental Health Services Administration in November 2022 describes a framework that states and localities across America can consider as they develop or expand their crisis safety net for youth and families. THS reviewed this document to identify best practice guidelines that the County should consider when designing a facility that serves children and youth exclusively or alongside adults.
In these guidelines, Crisis Receiving and Stabilization Facilities are described as follows:

> "There are several types of crisis facilities that can help youth with more intensive care and safety needs than can be met through home- and community-based services. Examples include crisis stabilization centers, 23-hour beds/observation units, respite care, walk-in services, and the Living Room Model (Saxon et al., 2018). Depending on the young person's needs, facilities can offer a safe environment and short-term care that effectively diverts youth from hospitalization, or they can function as a step-down service after hospitalization.
>
> The shared goal of these services is to help youth return home and transition to outpatient supports (if needed) as quickly as possible (SAMHSA, 2014a). Some residential settings, such as respite care facilities, are intended to reduce strain on families and prevent longer-term out-of-home placements (Bruns & Burchard, 2000). Crisis stabilization facilities often have a small number of beds (e.g., 6-16), and they may operate in a residential, home-like setting (Saxon et al., 2018). They also typically have a maximum period of stay, ranging from less than a day (23-hour units) up to two or three weeks.
>
> Sample services include assessment, rapid stabilization, observation, medication management, peer support, brief individual and family counseling, care coordination and service linkages, and discharge planning. Peer support providers and other crisis response paraprofessionals or professionals often staff facilities. Psychiatrists, psychiatric nurse practitioners, or physicians may provide supervision and medical consultation (Saxon et al., 2018)."

The document further outlines Expectations and Best Practices for Crisis Receiving and Stabilization Facilities that serve children and youth:

- Essential Operations
    - Accept all youth referrals, at least 90% of the time, with a "no rejection" policy for first responders. Offer walk-in and first responder drop-off options that accept youth (SAMHSA, 2020a).
    - Offer developmentally appropriate services to address mental health and substance use crisis issues impacting youth.
    - Do not require medical clearance before admission; instead, provide assessment and support for medical stability while in the program (SAMHSA, 2020a).
    - Include beds within the real-time regional bed registry system, identifying how many beds are available for youth (see Note about Bed Registries).
    - Collect data on crisis resolution, user satisfaction, and other outcomes, and review these data to develop quality improvement plans.

- Staffing and Training
    - Be staffed at all times with a multidisciplinary team with expertise in meeting the needs of youth, which may include: child and family peer support providers; psychiatrists, psychiatric nurse practitioners, or physicians; social workers, counselors, and crisis specialists (SAMHSA, 2020a).
    - Have staff who can assess physical health needs and deliver care for most minor physical health challenges. Have an identified pathway to transfer the young person to more medically staffed services if needed (Bostic & Hoover, 2020).
    - Ensure that staff has appropriate youth and family expertise and experience.
    - Provide training to all staff on effective crisis management strategies that minimize the use of seclusion and restraint. Staff should also be trained in the safe, respectful, and appropriate use of seclusion and restraint. Such actions should only be used by trained personnel as a last resort and for brief periods (see Safety/Security for Staff and People in Crisis).
- Facility Setting
    - If the facility serves both youth and adults, have separate receiving and support areas. If the facility serves both younger children and adolescents, it is also ideal to have separate areas for them (Bostic & Hoover, 2020).
    - Provide trauma-informed spaces in their design that promote dignity and safety (e.g., open and airy layout with inviting colors; no barriers, such as Plexiglass, that separate or isolate people in crisis) (SAMHSA, 2014c).
    - Provide calming and welcoming spaces that offer developmentally suitable support for youth and families (e.g., privacy for adolescents, and space for young children to play safely) (Bostic & Hoover, 2020).
    - Provide confidential spaces for families to gather, with the young person and without, where they may receive clinical services and support (Bostic & Hoover, 2020).
- Providing Services
    - Screen for risk of self-harm, suicide, and risk for violence using tools that are designed or appropriate for youth. For examples, see Onsite Needs: Assessment Tools.
    - If short-term individual and family therapies are provided, integrate community-defined evidence programs and cultural adaptations of evidence-based interventions in addition to traditional evidence-based interventions (National Latino Behavioral Health Association, 2021).
    - Provide warm hand-offs to home- and community-based, youth-serving care.
    - Incorporate some form of intensive support beds, either within the facility's child and youth services area or with a partner offering children- and youth-specific crisis services.

Recommendations: THS is concerned that there is currently no crisis walk-in resource in Montgomery County for children, as MCES' small facility only serves adults. THS recommends that the county fill this gap either through a stand-alone child- and family-centered crisis center or a shared facility with separate entrances and observation areas.

THS also reviewed Pennsylvania regulations to assess for any critical differences in the requirements or guidance for crisis care delivered to Children and Youth as compared to that provided to adults:

- Title 55, Chapter 3800 Applies to Child Residential and Day Treatment Facilities. Though the chapter does not explicitly reference crisis care, it is of note that Section Chapter 3800.2,

Applicability, states that these regulations apply to "Any premise or part thereof, operated in a 24-hour living setting in which care is provided for one or more children who are not relatives of the facility operator, except as provided in § 3800.3."
    - This further emphasizes the distinction between 23-hour and 24-hour care and which regulations would apply under which circumstances.
- A Regulatory Compliance Guide released by the Department of Public Welfare in 2013 further elaborates on the above regulations. It outlines all requirements for a facility that provides 24 Residential and Day Treatment care for children as defined in Title 55, Chapter 3800.
- Title 55, Proposed Chapter 5260, released in PA Bulleting Vol 23, No. 18, regulated Family Based Mental Health Services for Children and Adolescents. Providing care that meets the threshold outlined in this chapter would make these rules apply to the program and as such, require approval to provide these services.
    - The rule establishes that minors can access mental health services without parental consent. Crisis facilities should be prepared to manage a scenario where an adolescent seeks care independently and how to engage families in such instances.
    - Section 5260.22 establishes that during the period that Family-Based Mental health services are provided, the only other mental health services that the consumer may bill are:
        - Psychiatric partial hospitalization.
        - Psychiatric clinic medication visits.
        - Two intensive case management contacts per month. Eight contacts are permitted during the 30-day period before discharge from Family-Based Mental Health Services.
        - A psychiatric evaluation.
        - Psychological testing and evaluation.
        - Psychiatric inpatient services.
        - Emergency mental health services.

Recommendations: THS advises Montgomery County to seek legal counsel and consult with child welfare agencies if there are remaining questions about child welfare regulations.

Emergency Shelter Regulations

In Pennsylvania, "Emergency Shelters" are regulated by DHS. Several bulletins have been posted on the Emergency Shelter grant program. One regulation specifically describes Emergency Shelter Expenses, Title 55 Human Services, Chapter 289 Emergency Assistance.

The term is also used in Title 55, Chapter 2050, Eligibility For Services Funded Through The Adult Services Block Grant, Chapter 2050.3 Definitions:

- *Protective service*—A system of social service intervention activities to assist eligible persons in a crisis. The term includes social service activities necessary to remove the person from the dangerous situation as detailed in the written service plan. The term may also include the provision to the client, for no more than 30 days in 6 months, **emergency shelter** or housing in the form of room and board; transportation services; and if other resources, including Titles XVIII and XIX of the Social Security Act (42 U.S.C.A. § § 1395—1395xx and 1396—1396p) are not available, emergency health services and financial aid only if the client is any of the following:

- (i) In imminent danger of death or physical injury.
- (ii) Abandoned or abused.
- (iii) Acutely incapacitated mentally or physically.

Recommendations: THS recommends that Montgomery County clearly articulate that the crisis walk-in center is not an emergency shelter and is not intended to provide room and board. THS does not believe regulations for emergency shelters will be pertinent, but Montgomery County should consult legal counsel if there are further questions or concerns.

CMS Memorandum, Ref: QSO-19-15-EMTALA

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital cannot stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

THS reviewed the CMS memorandum, Ref: QSO-19-15-EMTALA, which describes the responsibility of an in-patient psychiatric facility to respond to a medical emergency. EMTALA applies to licensed hospital facilities. THS' concludes that EMTALA does not apply to a 23-hour walk-in facility, nor does a walk-in center qualify as an in-patient psychiatric facility, so this memorandum is not pertinent.

Recommendations: THS recommends Montgomery County seek legal counsel if there are further questions on a crisis walk-in center being subject to EMTALA.

Licensed Provider Requirements for Medicaid Coverage of Mobile Crisis Services/Rehab Option

On November 2, 2022, Montgomery County leadership asked THS to assess CMS regulations to inform its understanding of whether state requirements (that are likely to be proposed in new state regulations) that a licensed clinician approve every mobile intervention is necessary to comply with federal law. Specifically, the County understood that this requirement stems from the state's decision to cover mobile crisis services under Medicaid's rehabilitative services option. They asked THS to assess whether there is another option or category through which the state could authorize mobile crisis, whether there is a waiver process that the state could pursue, and whether other states have configured their mobile crisis teams in such a way that a licensed clinician does not have to approve every mobile service.

- Medicaid statute and regulations governing the rehabilitative services option define these services as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."
- Based upon THS research, it is not unusual for states to interpret the term "services recommended by a physician or other licensed practitioner of the healing arts" as requiring that a physician or similar

professional approve every service. However, it is also possible to interpret this requirement more flexibly, such as requiring that a physician or other licensed practitioner of the healing arts supervise the provision of mobile crisis services, identifying the clinical criteria for the provision of these services, and determining that all the services provided under such supervision that meet the clinical criteria meet the "recommended service" requirement. THS cannot advise on how common such an interpretation is or what programmatic or legal risk such an interpretation would entail. THS could connect the county with an individual with expertise in advising states on these requirements if helpful.

- In addition, crisis service plans must be signed off on by licensed mental health professionals. To the extent that the crisis service plan authorizes the provision of mobile crisis services, the "recommended by a physician or other licensed practitioner" requirement would be met. This narrows the number of people and services to which a specific authorization for each service must be provided.
- Although there is no publicly available data with which to state this definitively, it seems likely that most states cover mobile crisis services through the rehabilitative services option.
    - 1915 C waivers, managed care in lieu of services, and comprehensive section 1115 demonstrations are other possible ways states might authorize Medicaid mobile crisis services. However, information on the extent to which they do is not readily available from any public source.
    - For children, the requirements of the Early Periodic Screening Diagnostic and Treatment Program also pertain to Medicaid mobile crisis, as they do to all services provided to Medicaid beneficiaries who are children.
- States can also cover such services through the new Medicaid mobile crisis option established in the American Rescue Plan act (ARP). CMS released guidance to states in December 2021 on implementing this option and qualifying for an enhanced 85% federal match. The State of Oregon was the first state to implement this option.
    - The new ARP Medicaid mobile crisis option requirements are narrower concerning the role of a physician or other licensed professional than in the rehabilitative services option. These services must be furnished by a multidisciplinary team that includes "at least one behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State through a State plan amendment (or waiver of such plan)."
    - The statutory language does not require a physician to recommend, approve, or provide other mobile crisis services.
    - This option also includes several other requirements, including being available 24/7 to people who are experiencing a mental health or substance use disorder crisis. The team must perform an assessment, stabilization, de-escalation, coordination, and referrals to other services and be trained in trauma-informed care, de-escalation, and harm reduction. The team must also maintain relationships with community partners and providers. CMS implementing guidance encouraged additional aspects of service delivery, such as having approaches for people with limited English proficiency and on-scene prescribing. If Montgomery County's mobile crisis services meet all the statutory Medicaid mobile crisis requirements, including serving people with SUD crises and being available 24-7, it might be advantageous to cover the mobile crisis services in Montgomery County through this new option rather than through the rehabilitative services option. The federal government would match state spending on these services at an 85 percent federal matching rate. The new

Medicaid mobile crisis service requirements do not need to be met statewide; if certain areas of the state meet them, the state can authorize them only in those areas of the state.

- It is possible that provisions of the rehabilitative services option may be waived under section 1115 authority. However, both the legal and policy implications of such a waiver would need to be explored in more detail. However, 1115 demonstrations are not used for such a specific purpose alone. They are generally far more comprehensive.

Recommendations: There are several reasons the new Medicaid mobile crisis option may be beneficial to the State of Pennsylvania, and Montgomery County, including the enhanced federal match and the narrower guidance on the authorizing provider type. However, the state's scope of practice guidelines may still require the assessment to be provided by a licensed behavioral health professional.

About Third Horizon Strategies

Third Horizon Strategies is a boutique advisory firm focused on shaping a future system that actualizes a sustainable culture of health nationwide. The firm offers a 360º view of complex challenges across three horizons – past, present, and future– to help industry leaders and policymakers interpret signals and trends; design integrated systems; and enact changes so that all communities, families, and individuals can thrive. Learn more at www.thirdhorizonstrategies.com.

Montgomery County Behavioral Health Crisis System Stakeholders Engaged by Third Horizon Strategies

Name	Organization	CSAG	Focus Group	Key Informant Interview	Site Visit	Other	9-8-8 planning
Abbie Ferenzi	Abbe Health - Guidelink			X		X	
Abby Grasso	NAMI	X	X				
Alexis Moyer	Merakay	X	X				
Alli Briggs	All Health Network			X		X	
Allison (Delaney) Gontowski	Abington Township PD	X	X				
Alvin Wang	Montgomery County	X	X			X	X
Amanda Kingston	Jefferson Health				X		
Amber Eister	Creative Health Services		X				
Andrew Schmidt	Gaudenzia				X		
Andrew Parkins	Upper Providence PD	X					
Andy Trentacoste	Creative Health Services		X	X			
Angela Sharpe	FERNS					X	
Ann Ritter	Bowling Business Strategies					X	
Bill Myers	MCES				X	X	
Bridget Brown	Access Services	X					

Bridgette McGivern	Community Health and Dental			X			
Brooke Vaught	Hancock Elementary School		X				
Cathy Zalenski	Juvenile Probation		X				
Charles Clark	Montgomery County D&A			X			
Christine da Cunha	Abington PD	X					
Christine Jeffers	St Lukes		X				
Chris Scott	Resources for Human Development	X					
Clare Higgins	FamilyWorx	X	X		X		
Cristina Escobar	Norristown Regional Health Center			X			
Cynthea Kimmelman-DeVries	Montgomery County MH/DD/EI	X	X				
Damian Johnson	MCES	X	X				
Dana Lombardi	Magellan	X					
Danny Kuchler	HopeWorx					X	
Daryl MacKaverican	FERNS					X	
Dave Sparango	Cheltenham PD	X	X				
Dawn Tucker	Hatboro-Horsham SD		X				
Debra Donahue	Creative Health Services		X				

Derek Hammacher	Community Health and Dental			X			
Drew Carter	Montgomery County Managed Care Solutions			X			
Ed Martin	Montgomery County Dept. of Public Safety					X	
Elena Lupo	Guadenzia				X		
Emily Burger	Montgomery County HHS		X			X	
Erin Lewis	Montgomery County MH/DD/EI		X				
Erin Perry	Childrens Hospital of Philadelphia					X	
Erin Seifrit-Townsend	Montgomery County MH/DD/EI	X			X	X	X
Eunha Kim	Jefferson Health				X		
Felix Scherzinger	Colonial SD		X				
Gina Talarico	Eagleville Hospital	X					
Heather Rae	Common Grounds Crisis Center			X		X	
Jason Alexander	Capacity for Change					X	
Jeanne Ewing	Magellan	X		X			
Jed Johnson	Youth Center		X				
Jen Bock	All Health Network			X		X	
Jenn Bell	Montgomery County Office		X				

	of Children & Youth						
Jena Ostrowski	Creative Health Services			X			
Jennifer Cass	Montgomery County Dept. of Public Safety/911				X		X
Jennifer Erin	FERNS					X	
Jess Fenchel	Access Services	X					X
Jessica Keene	Cheltenham School District	X	X				
Joanna Muth	Montgomery County MH/DD/EI	X					
Jodie Davis	Central Behavioral Health		X				
Joe Viti	Montgomery County Youth Center		X				
Joel McIntosh	Norristown Regional Health Center			X			
John C. Becker	Guardian Recovery Services	X					
Julie Pettica	MCES	X	X		X		X
Karen Fithian	Abington-Jefferson Health				X		
Karleen Caparro	Creating Increased Connections	X	X			X	
Kathy Laws	Lived experience	X					

Katrina Harman	Upper Perkiomen School District		X				
Kayleigh Silver	Montgomery County Housing and Community Development	X					
Kelly Courtney	Resources for Human Development	X					
Kelly March	Guadenzia				X		
Ken Davidson	Second Alarmers Rescue Squad	X	X				
Ken Hellendall	Cheltenham Township, EMS Coordinator	X					
Kerry Greene	Montgomery County Office of Children & Youth		X				
Kiera Hendel	Suburban Community Hospital	X	X				
Kim Huen	Guadenzia				X		
Kim Renninger	HopeWorx/AdvocacyWorx	X	X		X	X	
Kimberly Kelly	Upper Perkiomen High School		X				
Kris Thompson	Lenape Valley Foundation			X		X	
Kristen Mahler	Resources for Human Development	X					
Lauren Blanchard	Eagleville Hospital	X					

Lauren Engelhardt	Central Behavioral Health		X				
LeeAnn Moyer	Montgomery County Managed Care Solutions					X	X
Madeline Lewis	Lower Merion PD	X	X				
Madison Sehn	Montgomery County Dept. of Public Safety	X			X	X	X
Maggie Mueller	Merakey	X					
Marissa VanDover	BH Solutions Center - Well Power			X			
Mark Boorse	Access Services	X	X			X	
Matt Phillips	Central Behavioral Health	X			X		
Meghan Scharg	Montgomery County Office of Managed Care Solutions	X			X	X	X
Merissa Vandover	Well Power Crisis Drop In/BH Solutions Center			X		X	
Michelle Monzo	MCES	X	X		X		
Michelle Schweitzer	Norristown Regional Health Center			X			
Missy Marinello	Youth Center		X				

Moira Tumelty	Access Services	X	X	X	X	X	X
Nancy Deangelis	Abington Hospital, Jefferson Health	X			X		
Neda Soltani	Montgomery County D&A			X			
Pamela Howard	Montgomery County MH/DD/EI				X	X	X
Paul Butler	MCES	X			X		
Paul DeMarco	MCES	X	X				X
Penny Johnson	HopeWorx					X	
Riley McConnell	Lower Merion Counseling & Mobile Services		X				
Rob Reitenaur	St Lukes		X				
Rob Rosenthal	Abington SD		X				
Samantha Null	Childrens Hospital of Philadelphia					X	
Sandie Beren	Montgomery County Office of Children & Youth		X				
Sara Spath	Montgomery County Office of Children & Youth		X			X	
Sarah Du	Resources for Human Development		X				
Scott Bendig	Montgomery Township PD	X					
Sharon Preston	Bucks County Office of MH			X		X	

Sheryl Weed	Juvenile Probation		X				
Stacey Cylinder	Montgomery County MH/DD/EI		X				
Sue Shannon	HopeWorx					X	
Susan Baptista	Merakey		X				
Taneesha Williams	Montgomery County Office of Children & Youth		X				
Theresa Benonis	St Lukes		X				
Tiffany Delgado-Bickley	Abington-Jefferson Health	X					
Tim Dunsmore	Child & Family Focus	X	X				
Timothy Pirog	Montgomery County MH/DD/EI		X				
Tracey Riper-Thomas	Montgomery County MH/DD/EI		X			X	
Travis Atkinson	TBD Solutions			X		X	
Vera Zanders	Montgomery County MH/DD/EI		X		X	X	X
Victoria Jankowski	Montgomery County D&A	X	X	X	X	X	X

THIRD HORIZON STRATEGIES

Montgomery County Behavioral Health Crisis System Analysis

October 2022

1

System Analysis Presentation Goals

THIRD HORIZON STRATEGIES

Provide an overview of THS' findings on the strengths, challenges, and opportunities for Montgomery County's behavioral health crisis system

Stimulate discussion and obtain input on the analysis to help inform the recommendations phase

Lay the groundwork for the final "Crisis System Enhancement Plan"

2

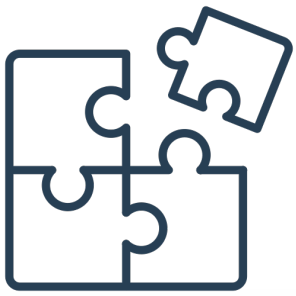
THS Methodology and Activities to Date

- Met weekly with the Director of Crisis and Diversion, and periodically attended meetings with other department leadership
- Reviewed available materials on the county behavioral health crisis system
  - Public facing documents
  - RFPs and contract Scopes of Work
- Analyzed available data sets
  - MCES data (including Lifeline)
  - Access data
  - 305 ambulance data
  - 302 data
  - Magellan: AIP bed search data
  - Magellan: Self-reported waitlist data for outpatient services
  - County waitlist data for residential
- Researched crisis walk-in models and produced issue brief with case studies
- Gathered extensive qualitative information and engaged more than 100 stakeholders
  - Organized monthly Crisis System Advisory Group meetings
  - Facilitated seven focus groups
  - Interviewed numerous key informants
  - Conducted site visits
- Participated in regularly scheduled county and regional meetings
- Convened 9-8-8 workgroup and assisted in the development of a county specific FAQ

3

Limitations to Analysis

- Limited access to Magellan data
  - THS was not contracted to do claims analysis
- No access to hospital data outside of MCES
- No access to private insurance data or interaction with commercial carriers
- Limited view of state regulations
- A narrow view of financial data
  - THS was not contracted to do a financial analysis



4

Biggest Takeaways

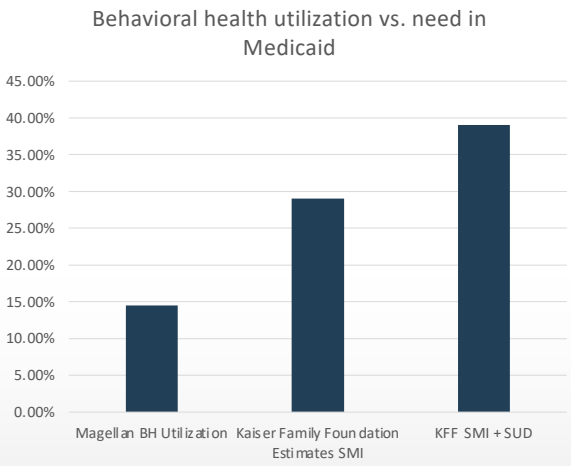
- The county has many resources, though they could be better coordinated
- The county would benefit from improved collection and use of data
- A crisis resource center would help fill a gap in the system, but it will not be a panacea.
  - Montgomery County should define what a center will and will not solve for
- The county should develop distinct strategies to address unique needs of special populations, including children and families, people with limited English proficiency, and people with co-morbid conditions

The outpatient behavioral health delivery system needs to be strengthened, to help keep people from getting into crisis, and get into care quickly after a crisis- "Key Considerations for Investing in a Crisis Center," THS, 2022.

5

There Appear to be Unmet Needs for Services

- Magellan reports that in 2021, 14.5% of beneficiaries in Montgomery County (20,183/138,661) received behavioral health services.
- Typical penetration rate is 17% +/-. Rapid growth in Medicaid beneficiaries during the pandemic likely impacted the behavioral health penetration rate.
- THS attempted to find comparison data to gauge the rate of penetration.
- According to a Kaiser Family Foundation 2020 report,
  - An estimated 29% of Medicaid enrollees have a serious mental illness
  - Combined, 39% of Medicaid enrollees have a mental illness and/or substance use disorder (SUD)
- During 2017–2019, the annual average prevalence of past-year mental health service use among those with any mental illness in Pennsylvania was 47.6%.
- Anecdotally, THS heard that there are many people seeking outpatient services that are put on waitlists or otherwise do not receive care.



6

THS' Analysis

Strengths, Challenges, and Opportunities

7

System Strengths

- **Extensive resources and capacity**
  - Six CBHCs and two FQHCs
  - Administrative Case Management program
  - Peer supports exist in both clinical and non-clinical settings
  - Student Assistance Program offers evidence-based screening, prevention, and treatment programming and other school-based supports
- **Key components of a crisis system in place, and operating effectively**
  - County-specific 9-8-8 Call Center: MCES
  - County-specific mobile crisis: Access
  - County-specific Crisis Intervention training (CIS) for law enforcement and first responders
  - Magellan hospital bed tracking
- **Ability to braid and creatively invest funding**
  - County retains control of Medicaid managed care dollars in partnership with Magellan
  - County leverages human services, mental health, and SAPT block grants
  - BJA Grant
  - ARPA funds
  - Reinvestment funds, earned under the Medicaid BH program, used to start up or expand programs and fund supportive services (e.g., housing)
  - One time request fund (end of year unspent county dollars)
- **Strong collaborations**
  - Key stakeholders including law enforcement, public safety, providers, community-based organizations, and peers/family advocates are actively engaged
  - County-specific and regional groups and forums are convened on a regular basis
  - Innovative pilots have emerged organically
    - Access's Hub and Bridges models
    - Creative Health's co-responder approach
    - Methacton School District's REACH program

8

System Strengths, continued

- **County support during COVID-19 pandemic**
  - Designed an alternative payment structure for provider reimbursement under Medicaid to provide financial stability
  - Issued $12 million Workforce Stability Funds under Medicaid to providers for recruitment and retention efforts
  - Increased Medicaid provider rate reimbursements
  - Increased advocacy supports; opened a Recovery Center run by Recovery Specialist & increased Parent Partner supports
  - Provided a $2 million Reinvestment Fund opportunity for providers to improve their technology platforms to expand telehealth opportunities
  - Collaborated with Career Link to target behavioral health workforce needs in their activities
  - Advocated for changes in state regulations that would address workforce deficiencies
- **Child and family support**
  - Successfully wove values and principles of the systems of care initiative into the county's behavioral health delivery system
    - Included in child-focused RFPs
    - Incorporated into system training
  - Developed a dedicated bi-weekly meeting with system partners (Youth Services Integrated Team) to discuss children with high needs and collaborate on their treatment.
  - Included the voices of families and peers when developing new programs and supports by consult with FamilyWorx
    - Obtained additional family input via surveys

9

Montgomery County Crisis System Resources– Adults

Synopsis only; Not intended to be exhaustive of all resources

10

Potential Montgomery County Crisis Barriers - Adult

THIRD HORIZON STRATEGIES

Before crisis happens or escalates

- CBHC & community treatment waitlists
- Limited services in Spanish
- Services not designed for people with multiple complex conditions

During crisis

- Mobile crisis wait times
- Limited transportation
- Medical clearance at ED prior to psychiatric hospitalization
- ED boarding if no bed available

After crisis

- Limited follow-up if in ED for SUD; or if permission not granted
- CBHC & community treatment waitlists
- Community residential & transitional residential waitlists

Synopsis of major barriers only; not intended to be exhaustive

11

Montgomery County Crisis System Resources– Youth and Families

THIRD HORIZON STRATEGIES

Before crisis

- Student Assistance Program
- Family Worx and other family supports
- CBHCs and other community treatment providers
- Other school and community - based resources

During crisis

- Access phone lines
- Lifeline/ 9-8-8
- Mobile Crisis
- Psychiatric hospitals

After crisis

- CBHCs and other community treatment providers
- Residential programs
- Other school and community - based resources

Synopsis only; Not intended to be exhaustive of all resources

12

Potential Montgomery County Crisis System Barriers – Youth and Families

Synopsis of major barriers only; not intended to be exhaustive

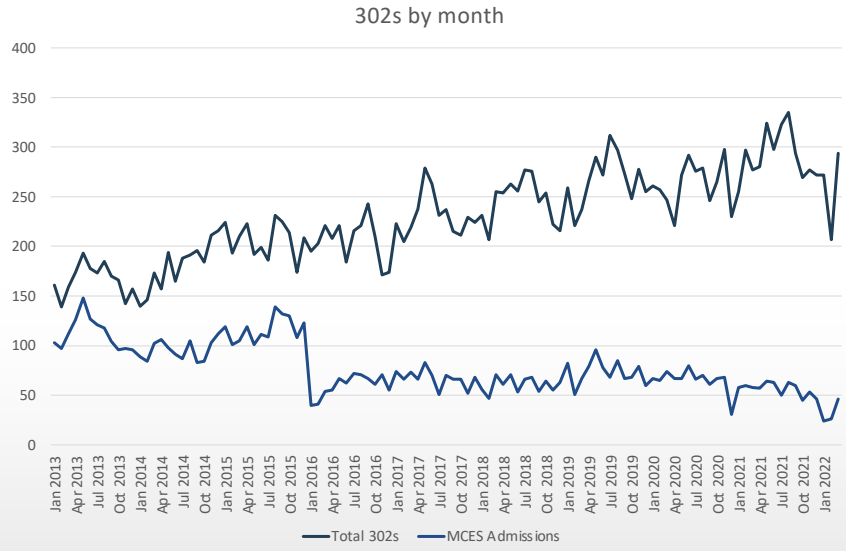
13

System Challenges: Part One

- **Impact of COVID-19 pandemic**
  - 14.5% increase in Medicaid membership
    - What happens after the end of the PHE to folks disenrolled?
  - Decrease in service utilization across all levels of care may be due to workforce issues and impact of the pandemic on membership
  - Inpatient facilities struggle to keep hospital beds open and available due to COVID spread in congregant facilities and workforce issues.
- **Needs increasing**
  - There is a higher volume of 302s
  - Magellan reports utilization is increasing over time
  - Providers and schools report levels of acuity and symptom severity have increased
- **Capacity challenges**
  - Staff vacancies impact access to care at all community-based levels of care
  - Waitlists for outpatient treatment
  - Residential occupancy is not meeting facility capacity, yet there are waitlists for this level of care as well
  - ER "boarding" while waiting for a psychiatric bed
  - Perception of long wait for mobile crisis to arrive
  - MCES walk-in is very small and cannot serve children
- **Data limitations**
  - No commercial data
  - Limited hospital data outside of MCES
  - Outpatient waitlist data is only self-report and not longitudinal
  - No data on mobile crisis response time
  - The system has increasing information loss
    - 302s with "pending" cases
    - NA dispositions

14

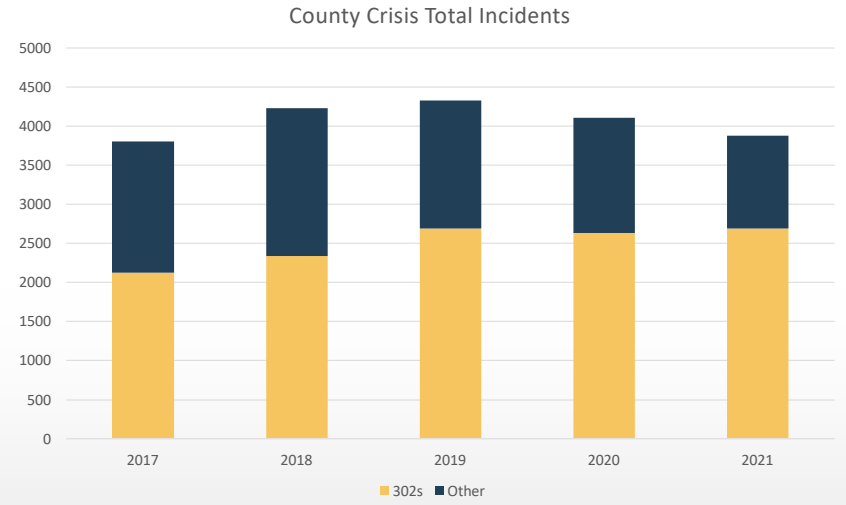
302 Warrants: Total Volume Increased Nearly 100% Over a Decade



- 302s warrants are issued in the most severe cases (highest level of acuity); psychiatric holds are preferable to incarceration
- 2016 system change: started sending more 302s to other hospitals besides MCES
- MCES admissions since 2016 are essentially flat until some dips that likely resulted from the pandemic

15

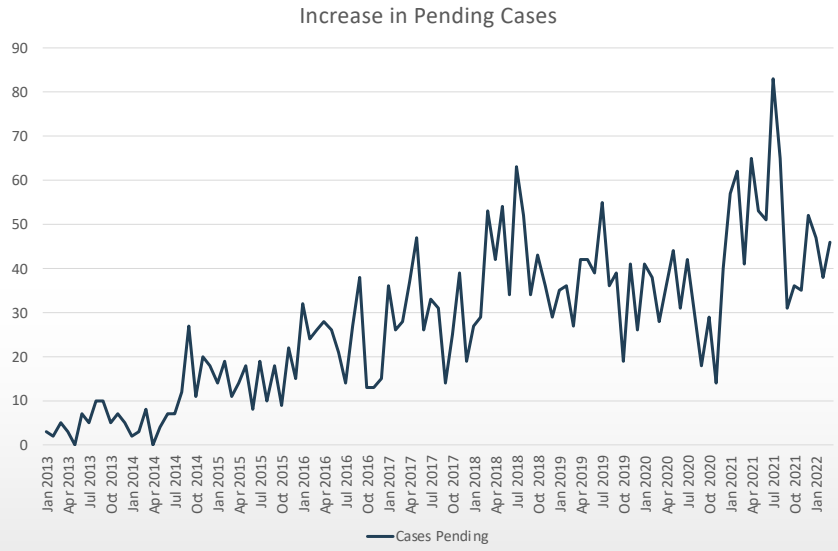
County Composite Crisis Data 2017-2021: 302s Comprise an Increasing Percentage of all Crisis Services



- The pandemic likely impacted the total number of crisis services. It will be important to review 2022 data
- 302s are increasing and make up a greater proportion of the total, reflecting higher levels of acuity.

16

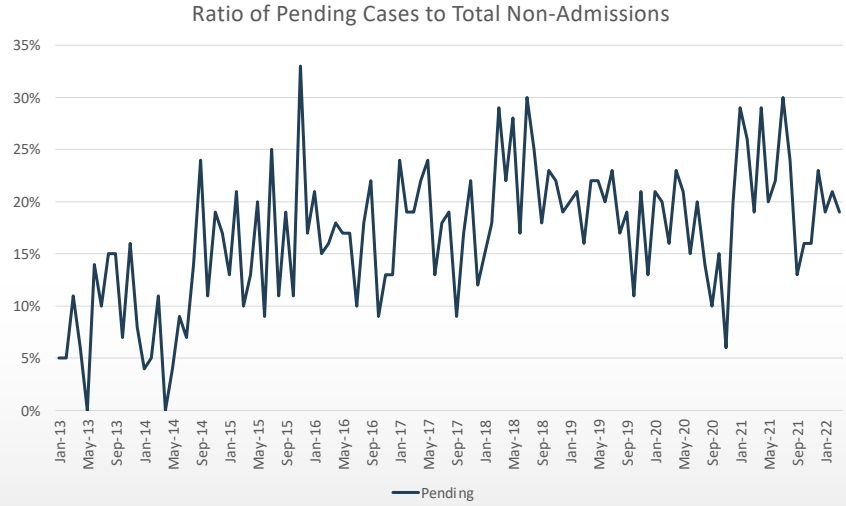
302 Warrants Data Shows Increases in People Awaiting Disposition



- The system's ability to know what is happening with people is decreasing.
- Delays in disposition reduce real time understanding of changes (good or bad) in a client's condition.

17

302 Warrants Data Shows Pending is Becoming Larger Share of Non-Admits (20-30% of Cases)



18

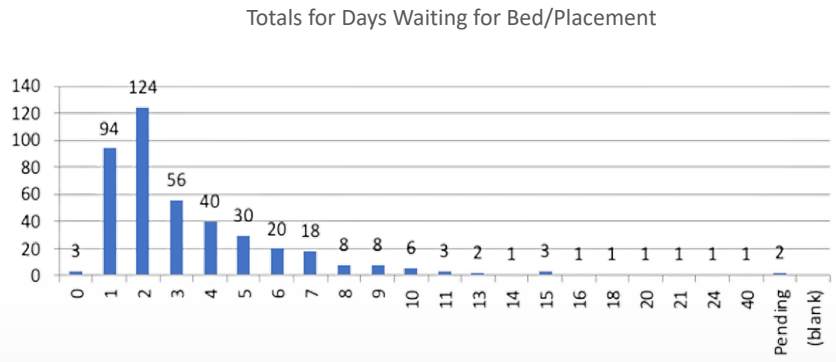
Top 10 Final Disposition, County Composite Crisis Stats 2017-2021

Final Disposition	Count	% Total	% Valid
Not Available (N/A)	6470	32%	
MCES	5670	28%	41%
HORSHAM CLINIC	1061	5%	8%
POTTSTOWN MEMORIAL MEDICAL	715	4%	5%
ABINGTON HOSPITAL	536	3%	4%
BROOKE GLEN BEHAVIORAL HOSPITAL	452	2%	3%
EAGLEVILLE HOSPITAL	416	2%	3%
BRYN MAWR HOSPITAL	389	2%	3%
NON-DISCLOSED OUTPT MH	317	2%	2%
ACCESS SRV--MOBILE CRISIS	304	1%	2%

- Nearly one-third of all people in crisis (32%) had N/A data, meaning we don't know where they ended up. This represents a big gap in understanding.

19

Montgomery County MCS AIP Tracking Data, January 2019 Through June 2022



- The majority (52.1%) of members since 2019 spent 2 days or less waiting for placement, while most (90.3%) members were placed within a week.
- However, one week is a long time if person is stuck in ED
- 9.7% had longer wait times, up to 40 days.

20

2021 AIP Bed Search Data Shows Average Wait Times

	Number of Member Admitted <18	Number of Member Admitted 18+	# of Members Referred for Bed Search <18	# of Members Referred for Bed Search 18+	Average Wait Time Until Placement (hours) <18	Average Wait Time Until Placement (hours) 18+	Number of Incomplete Searches for AIP <18	Number of Incomplete Searches for AIP 18+	% incomplete Searches <18	% incomplete Searches18+
Jan-21	35	171	14	16	72.68	27.74	2	5	14.28%	31.25%
Feb-21	39	174	14	21	45.65	17.48	3	3	7.14%	14.30%
Mar-21	37	177	15	18	29.51	29.37	3	1	20.00%	5.55%
Apr-21	51	178	13	19	32.6	55.59	1	5	7.69%	26.31%
May-21	52	191	14	13	76.75	30.02	2	2	14.29%	15.38%
Jun-21	45	198	4	20	52.37	16.8	1	6	25.00%	30.00%
Jul-21	38	189	12	22	35.1	20.31	3	3	25.00%	13.64%
Aug-21	38	182	11	22	48.85	19.77	3	4	27.27%	18.18%
Sep-21	33	193	11	20	66.82	12.52	2	8	18.18%	40.00%
Oct-21	47	204	14	29	38.45	25.05	5	8	35.71%	27.59%
Nov-21	65	171	23	18	52.19	24.35	7	4	30.43%	22.22%
Dec-21	52	157	14	25	77.25	39.45	3	5	21.43%	20.00%

- Average wait times for children (52.33 hours) under 18 were significantly higher than wait times for adults 26.36 hours)
- The discrepancy is likely due to outliers: there are few child cases per month (small N), so one case where someone is waitlisted for a long time can disproportionately impact the average.
- Data fails to capture commercially insured and those who choose not to go on a waitlist because of long wait times.

21

Magellan Collected Outpatient Waitlist Data Through Provider Self- Report

	Level of Care	2019	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Montgomery County Total	Outpatient Therapy	354	773	905	1067	966	865	1030	1140	1162
	Outpatient Medication Management	50	185	338	293	259	127	211	177	42
	Family Based Services	21	237	120	103	86	100	108	132	78
	Blended Case Management	82	289	241	229	193	207	241	234	213
	Peer Support	27	104	118	99	58	91	89	115	130

- This data offers a very limited picture as it is not collected longitudinally, does not account for duplication, and is based on self-report.
- May 2022 waitlist numbers (1162) for outpatient therapy is striking.

22

County Crisis Residential Waitlist Data Shows Occupancy is Not Meeting Facility Capacity

	COUNTY ONLY LTSR	Licensed CRR / Enhanced CRR	Licensed Specialized Personal Care Homes
Capacity	32	104	46
Current Occupancy	27	93	45
Waitlist #	6	26	50
Average Length of Wait of waitlist	16.5 months	2 months	50 months
Longest on Waitlist	42 months	7 Months	36 months
Shortest on Waitlist	1 month	Less than on month	Less than one month
Average Length of Stay (Current)	41.34 months	18.5 months	44
Funding by - MA, BASE, HealthChoices	Base		

- Conjecture: This may be due to workforce limitations or COVID-19 restrictions
- Regardless of why, the impact is unmet need

23

Child Residential Waitlist Data is Maintained Separately: Here is What THS Was Given

- As of 8/23/22 we have 37 children currently in RTF
- As of 8/26/2022 we have 6 kids on the RTF bed search
  - 1 – 82 days since approval
  - 1 – 57 days since approval
  - 1 – 314 days since approval
  - 1 – 1 days since approval
  - 1 – 295 days since approval
  - 1 – 97 since approval
- As of 8/23/2022 we have one child on the RTF Transfer list
  - 1 – 104 days since transfer approved
- As of 8/23/2022 we have 1 child on the CRR/Host Home list
  - 1 – 287 days since approval

24

System Challenges: Part Two

- **Fragmentation**
  - Primary care providers are considered secondary to or separate from the system
  - Commercial carriers are not at the table
  - Mental health and substance use disorder treatment is often viewed as distinct
- **Confusion around roles and responsibilities**
  - When to call which agency
  - What to expect of a CBHC
    - After hours care
    - Role in crisis care
  - What to expect of an FQHC
- **Overarching workforce issues**
  - Workforce shortages contribute to wait times
    - Burnout and pay issues impact retention
    - Recruitment pipeline
    - Competition with telehealth companies and hospitals
  - Licensure and credentialing issues
  - Limited availability of bilingual workforce

25

System Challenges: Fragmentation of Mental Health and Drug and Alcohol Services

Co-occurring disorders are common…

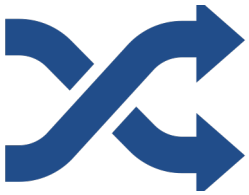
- According to the National Institute on Drug Abuse, about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa.
- Over 60 percent of adolescents in community-based substance use disorder treatment programs also meet diagnostic criteria for another mental illness.

…Yet in Montgomery County, system design, service delivery, and funding are often distinct.

- Mental health is separate from the drug and alcohol division.
- Separate contracting mechanisms
- Separate regulatory framework, including screening and assessment requirements
- D&A contractors not referring to mobile crisis
- 9-8-8 is not being used for SUD
- When someone presents in the ED with an SUD concern or overdose, there is often no referral pathway to treatment

26

System Challenges: Part Three
Special Populations or People with Complex Needs



People in a behavioral health crisis with acute or chronic physical health needs may get turned away from psychiatric hospitals until they are "medically cleared."

People with co-occurring mental health and substance use disorders may get shuffled between providers.

Children in behavioral health crises have fewer options for care.

They cannot be served by MCES' walk-in facility, have long wait times for in-patient and residential levels of care, and may be sent out of the county.

People with limited English proficiency may get turned away or put on waiting lists.

There are a limited (unknown) number of bilingual clinicians and many program materials are not available in Spanish.

27

Opportunities: Improve Services for Immigrants and Non-Native English Speakers

- Promote the CLAS Standards
- Incentivize or require providers to have adequate bilingual capabilities and translation services available
- Make county resources available in Spanish
- Increase culturally relevant support through community-based organizations such as ACLAMO

28

Opportunities: Address the Unique Needs of Children and Families

- Focus on children and families when designing a crisis resource center
- Seek opportunities to strengthen relationships between CBHCs and schools
- Utilize the August 2022 CMS bulletin on Medicaid and CHIP authorities to assess if there are additional ways PA could design a comprehensive array of services and supports to meet the unique needs of children and youth with behavioral health needs
- There is also a new opportunity for states to offer health homes for medically complex kids

29

Opportunities: Behavioral Health Workforce

Strategies the county has used and should continue

- Advocate with state for rate increases, cost of living adjustments, and hiring or retention bonuses (See CA Behavioral Health Workforce Revitalization Act)
- Encourage or incentivize innovative use of peers and other non-licensed behavioral health staff
- Promote pipeline through collaborations with Career Link and other organizations and universities
- Advocate with the state for regulatory change that modifies the scope of practice requirements (e.g., Nursing coverage and medication distribution in residential programs)

Potential new strategies to attract and retain workforce

- Consolidate regulations and/or provide waivers to reduce providers' administrative burden. See National Council on Mental Well-Being/HMA report
- Support and incentivize non-licensed BA level workforce to achieve licensure (this is timely given forthcoming reimbursement changes)
- Form a behavioral health workforce task force to further explore strategies. See CO report
- Develop targeted strategies to attract bilingual/bicultural workforce

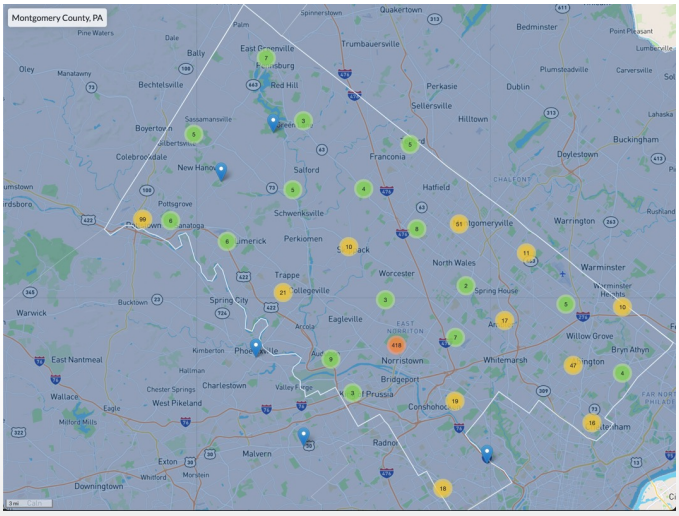
30

Opportunities: Crisis Resource Center

- Use guidance from case studies brief
- Articulate goals, and clearly define what a center will and will NOT solve for
- Design resource center to address the needs of both children and adults
- Design resource center to address both MH and SUD
  - Combined functioning as a 24/7 assessment center
  - Leverage opioid settlement funding
- Select location for ease of access, reduced stigma
- Do not "under-resource" the center
- Ensure the center seamlessly coordinates care
- Continue to include diverse stakeholders in the planning, design, and RFP process

31

Utilize 305 Ambulance Data to Determine the Ideal location for Crisis Resource Center(s)



Where are they dispatched?

- **418** in the Norristown-Bridgeport area
- **105** in the Pottstown area

Where do they go?

- **54%** of persons are taken to Montgomery County Emergency Services
- **29%** of persons are taken to a hospital or care facility
- **8.4%** are discharged home or to a residence or public place
- **8%** are NA for final disposition

32

Opportunities: County Can Advocate with State for Needed Policy Changes

- Seek 85% enhanced match from CMS for mobile crisis and ensure the state shares resources with the county
- Identify opportunities to consolidate regulations and reduce the administrative burden on providers
- Continue to pursue increased flexibility in funding, COLAs, and rate increases
- Seek flexibility in psychiatric evaluation requirements for therapy, medication management, partial hospitalization
  - Federal guidelines provide broad state discretion in establishing medical necessity and utilization management criterion 42 CFR 440.230
  - Elevate mid-level clinicians' ability to approve treatment plans, diagnosis

33

Policy Changes Continued

- Revisit Certified Community Behavioral Health Clinics
  - Bipartisan Safer Communities Act creates new incentives and opportunities
  - PA was in the Demonstration before, but the state found the reporting requirements burdensome. There is some negotiation happening with CMS
- Align state regulatory frameworks for MH and D&A, including ensuring there are adequate crisis responses for people in crisis due to SUD or overdose
- Assess new opportunities coming from CMS to expand and sustain school-based behavioral health services. CMS recently clarified its policy on how schools can bill Medicaid and will issue additional guidance next year to simplify the process. It will also provide grants to states expanding access to Medicaid-covered services in schools
- Pursue legislative or regulatory action to ensure commercial insurance carriers pay for behavioral health crisis services, with reasonable credentialing requirements. See WA State model

34

Other Opportunities for Enhancement

THIRD HORIZON STRATEGIES

Facilitate a shared understanding of the behavioral health delivery system and clarify roles and responsibilities
- Align contract language and SOW with RFP expectations

Promote spread/dissemination of best practices and promising pilots

- Maximize the internal county data dashboard (under development) for business intelligence and planning
- Collaboratively establish new data measures on wait times

Establish relationships with commercial carriers
- Explore partnership opportunities to benefit people with private insurance
- Seek aggregate data

Integrate operations between MH and D&A
- Streamline county RFP and contracting processes to the extent possible within the regulatory framework
- Continue to advocate with state for integration

Advocate for the investment of opioid settlement funds in the broader system

35

Biggest Takeaways

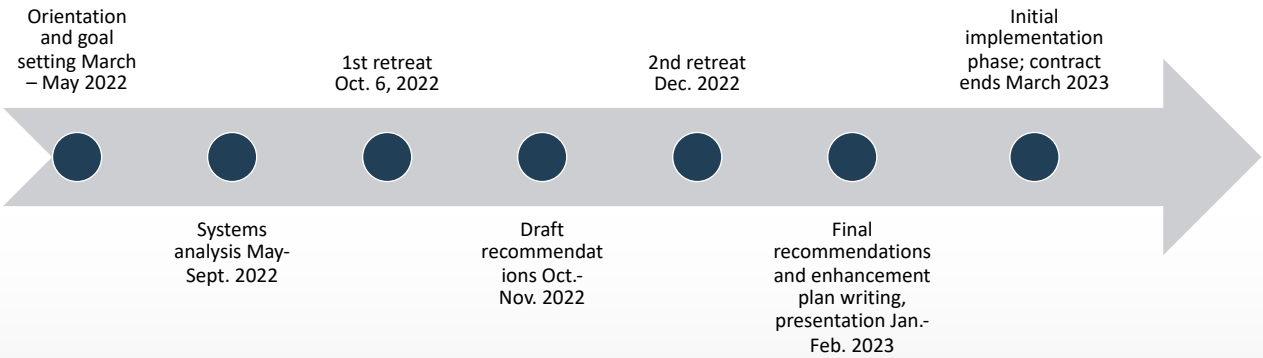
THIRD HORIZON STRATEGIES

- The county has many resources, though they could be better coordinated
- The county would benefit from improved collection and use of data
- A crisis resource center would help fill a gap in the system, but it will not be a panacea.
  - Montgomery County should define what a center will and will not solve for.
- The county should develop distinct strategies to address unique needs of special populations, including children and families, people with limited English proficiency, and people with co-morbid conditions

The outpatient behavioral health delivery system needs to be strengthened, to help keep people from getting into crisis, and get into care quickly after a crisis- "Key Considerations for Investing in a Crisis Center," THS, 2022.

36

Crisis System Enhancement Plan Timeline



37

Thank you!

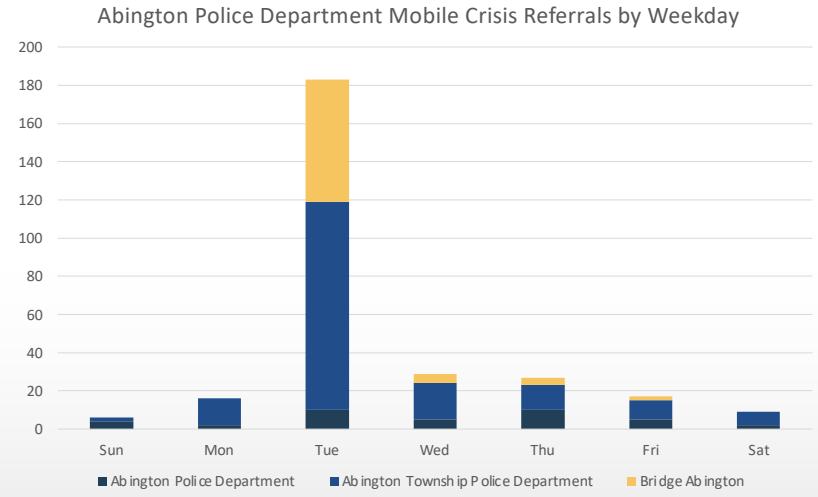
Mindy Klowden, MNM, Senior Director
Mindy@thirdhorizonstrategies.com
(303) 884-2670

38

Appendices

39

Referrals to Mobile Crisis, 2021



- Abington Police Department has a Tuesday bridge meeting that accounts for the high volume of Tuesday police department referrals.
  - It could be a good strategy to manage high volume referral sources on different days to spread the workload.

40

Age of Referrals to Mobile Crisis, 2021

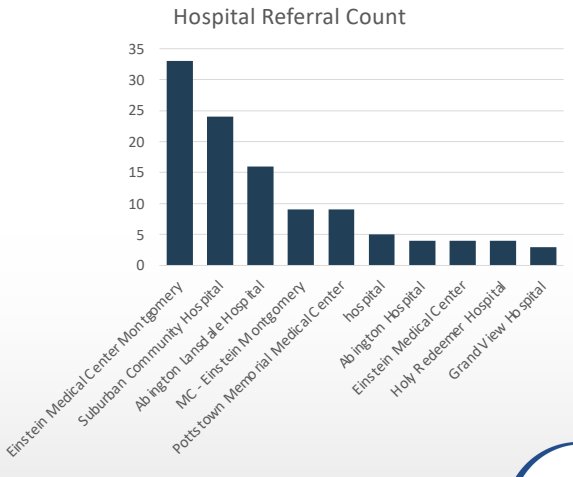
Age	Freq	% Valid	% Total
<17 yrs	577	32.93	31.86
17-25	241	13.76	13.31
26-35	249	14.21	13.75
36-45	204	11.64	11.26
46-55	159	9.08	8.78
56-65	153	8.73	8.45
66+	169	9.65	9.33
<NA>	59		3.26
Total	1811	100	100

Source	Median Age
Hospital – ER	33.2
Police	39.3
School	13.9

41

Top 10 Hospitals Making Referrals to Mobile Crisis, 2021

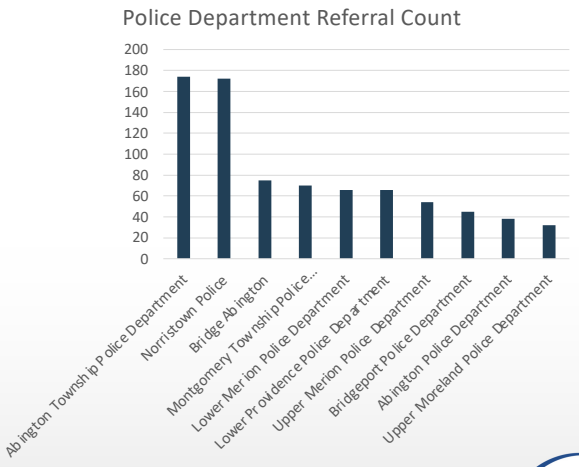
Hospital	N	%
Einstein Medical Center Montgomery	33	25.38%
Suburban Community Hospital	24	18.46%
Abington Lansdale Hospital	16	12.31%
MC - Einstein Montgomery	9	6.92%
Pottstown Memorial Medical Center	9	6.92%
Hospital	5	3.85%
Abington Hospital	4	3.08%
Einstein Medical Center	4	3.08%
Holy Redeemer Hospital	4	3.08%
Grand View Hospital	3	2.31%



42

Top 10 Police Departments Making Referrals to Mobile Crisis

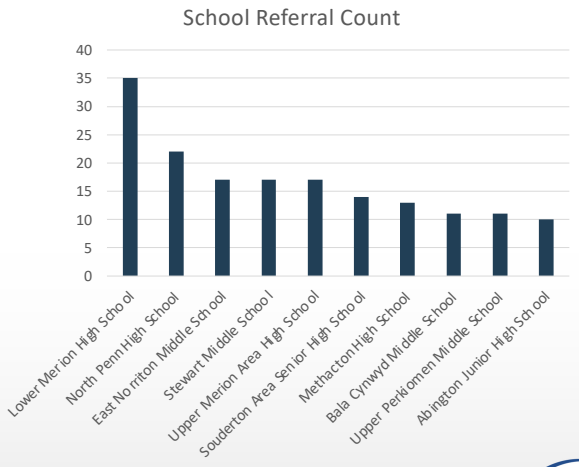
Police Department	N	%
Abington Township Police Department	174	14.88%
Norristown Police	172	14.71%
Bridge Abington	75	6.42%
Montgomery Township Police Department	70	5.99%
Lower Merion Police Department	66	5.65%
Lower Providence Police Department	66	5.65%
Upper Merion Police Department	54	4.62%
Bridgeport Police Department	45	3.85%
Abington Police Department	38	3.25%
Upper Moreland Police Department	32	2.74%



43

Top 10 Schools Making Referrals to Mobile Crisis

School	N	%
Lower Merion High School	35	6.84%
North Penn High School	22	4.30%
East Norriton Middle School	17	3.32%
Stewart Middle School	17	3.32%
Upper Merion Area High School	17	3.32%
Souderton Area Senior High School	14	2.73%
Methacton High School	13	2.54%
Bala Cynwyd Middle School	11	2.15%
Upper Perkiomen Middle School	11	2.15%
Abington Junior High School	10	1.95%



44

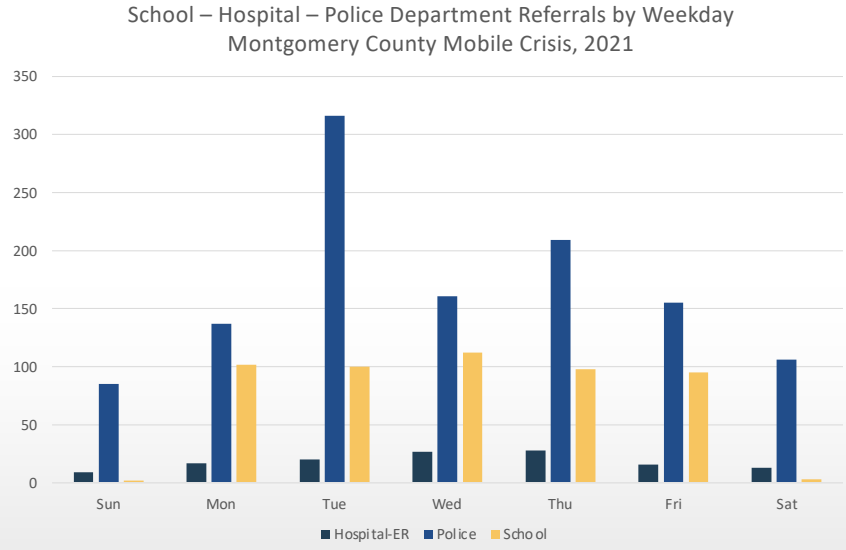
Part VI Final Disposition Data

Part VI Where	Count	% Total
MCES	4640	50%
NA	3359	36%
POTTSTOWN MEMORIAL MEDICAL	737	8%
BRYN MAWR HOSPITAL	643	7%
ABINGTON HOSPITAL	616	7%
Einstein Medical Center Montgomery	430	5%
HORSHAM CLINIC	421	5%
LANKENAU HOSPITAL	243	3%
SUBURBAN COMMUNITY HOSPITAL	182	2%
LANSDALE HOSPITAL	129	1%

- 61% of crisis stats are classified as 302
- From 2017-2021, 77% of individuals who do a Part VI at MCES have a final disposition at MCES

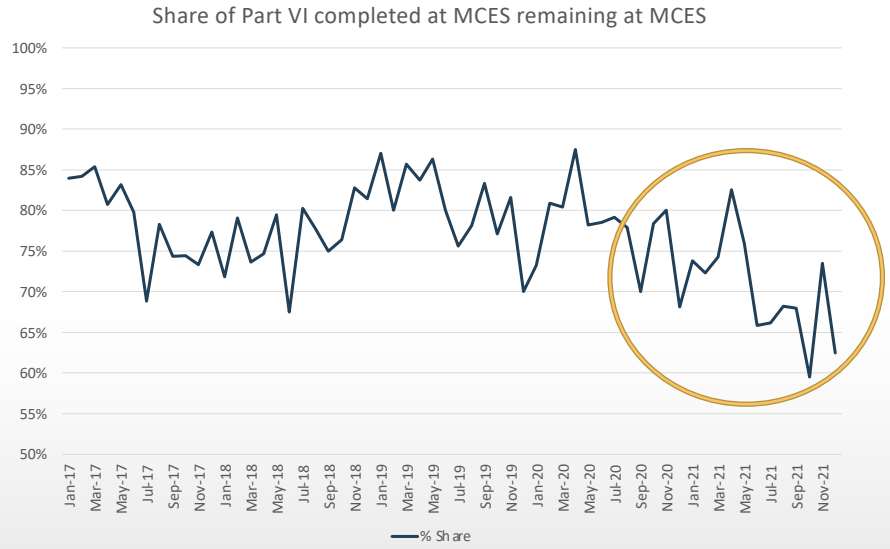
45

Referrals to Mobile Crisis, 2021



46

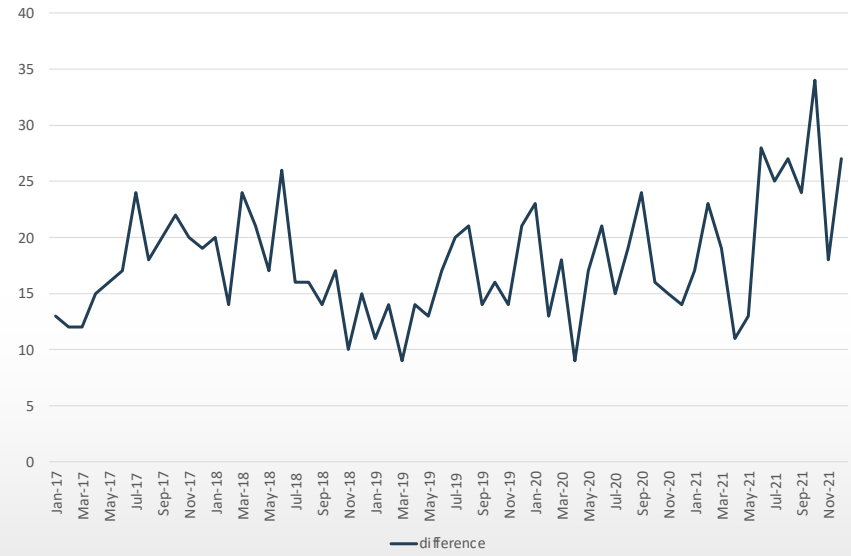
MCES Care for 302 Patients



- Though not necessarily a trend, in the last two years, the share of patients who had a Part VI performed at MCES who stayed at MCES dropped significantly.
- Possible explanations? Either the wrong people are being brought to MCES in the first place, MCES is having to turn more away, COVID-19, or some other issue

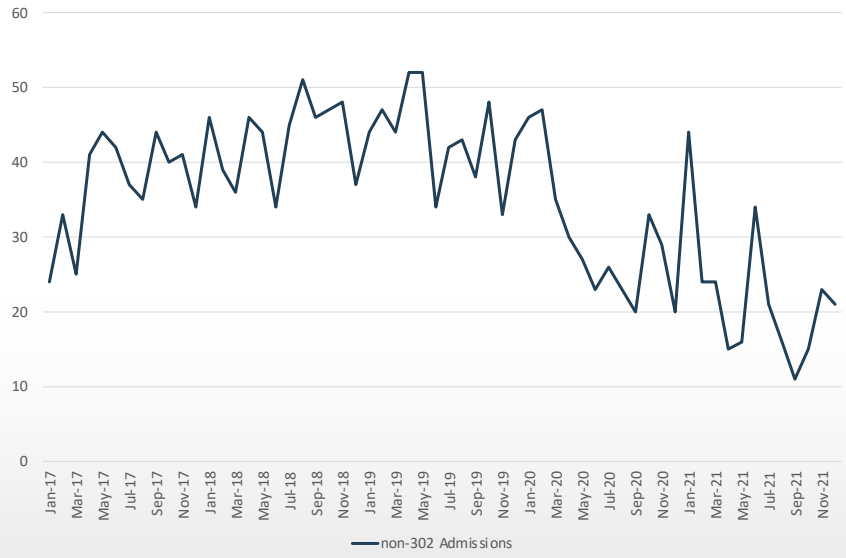
47

Difference Between MCES Part VI and 302 Final Disposition



48

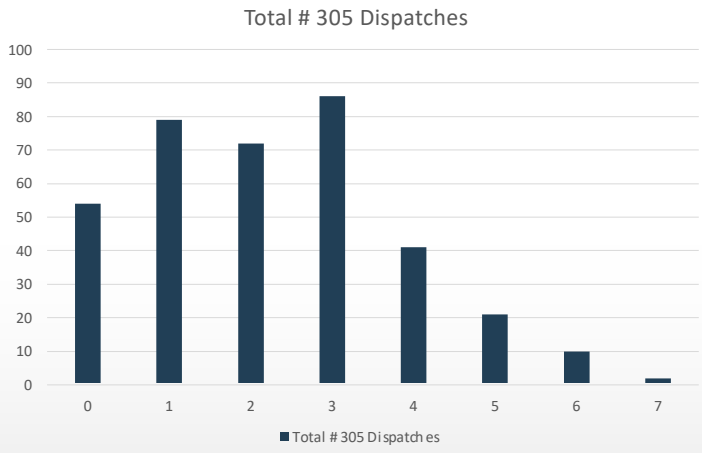
MCES Non-302 Admissions



- This is clearly a COVID-19 issue, given the timeline and closures at MCES.
- Still the data show a diminished capacity from MCES to handle anything other than 302 cases, and an increasing number of Part VI processed at MCES that do not result in an admission there.
- From the 302 data, the reality is that the total number of 302s in Montgomery County remains steadily on the rise and looks unaffected by COVID-19.

49

305 Ambulances Daily Dispatch Data



The average number of dispatches per day is 2.26.

The most dispatches in a single day was 7.

From data, we don't know how many calls are transferred or delayed for lack of capacity, only those that were dispatched.

50

THIRD HORIZON
STRATEGIES