FRAMEWORK for YELLOWSTONE COUNTY BEHAVIORAL HEALTH CRISIS CONTINUUM

April 2023

Substance Abuse Connect is partnering with crisis stakeholders to transform Yellowstone County Crisis Services in alignment with
National Guidelines for Behavioral Health Crisis Care
and the CRISIS NOW model

The original framework was developed by the following Crisis Continuum Work Group

Jan Begger	Alternatives, Inc.
Matt Lundgren	Billings Leadership Foundation, Montana Rescue Mission
MarCee Farrar Neary	Community Crisis Center
Dean Wells	United Way of Yellowstone County
Katy Easton	Downtown Billings Alliance, MAAP Program
Patti Webster	HomeFront, Continuum of Care
Rod Ostermiller	Mental Health Center
Lenette Kosovich	Rimrock

Substance Abuse Connect staff will provide backbone support for this coordinated approach, including: facilitating communication between partners, collecting and reporting data, engaging neutral expert consultants, securing funding, tracking return on investment.

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CONTACT: Zack Terakedis: 406-696-0149, zack@substanceabuseconnect.com

SAC CRISIS FRAMEWORK

SAC is partnering with other crisis stakeholders to transform YellowstoneCounty Crisis Services in alignment with the National Guidelines for Behavioral Health Crisis Care (see excerpt in Attachment A), and the CRISIS NOW model.

Integrated throughout: Zero Suicide principles/procedures, Trauma Informed Care, Peer Support

Priority 1: End unnecessary ER/Hospitalization and Jail Bookings	
GOAL 1: QUICK HANDOFF	**GOAL 2: LOWER COST STABILIZATION**
Decrease law enforcement time spent on mental health and SUD services and return officers and deputies to public safety duties	Decrease the # of unnecessary jail bookings and ER/hospitalizations by stabilizing individuals in lower cost crisis receiving facilities.
System Components • Crisis Line (988) • Mobile Crisis Response • Crisis Receiving and Stabilization (Outpatient and Inpatient)	
Priority 2: Stop the Revolving Door	
GOAL 3: JAIL TREATMENT	**GOAL 4: SUCCESSFUL STEP DOWN**
Increase the # of individuals in jail who receive mental health and SUD services while incarcerated, and prepare successful transition out of jail.	Decrease the # of individuals who re-enter crisis services, jail, or ER/Hospital by providing recovery supports in step down facilities and programs.
System Components • Jail MH/SUD Services • Connection to STEP DOWN Support	System Components • Transition Support[1] from *any Crisis Service or from Jail/Prison/Warm Springs* • Shelter/Housing[2] • Education/Employment • Life Skills • Pro-social leisure • Recovery Support
GOAL 5: PREVENT GENERATIONAL CYCLES OF ADDICTION AND CRIME	
Increase the # of children Prenatal-Grade 12 who have access to mental health and SUD interventions prior to any engagement with law enforcement.	
System Components • Perinatal intervention programs • Early Identification and Warning System (EIWS) in schools Services for K-12 students and their families who surface as at-risk in EIWS	

[1] Three components: 1) **Inclusion of Step-Down programs in discharge planning** from jail, ER/Hospital, Prison, Behavioral Health Treatment, and Crisis Receiving Facilities; 2) **Relapse/crisis plan** integrated into discharge plan; 3) **Transitional funds** to create opportunities and leverage resources for integration into the community. Examples of how transition funds can be used: obtain license, housing costs (such as short-term hotel stays, rent, and deposits); essential items to support community integration, such as phones, phone minutes, clothing, or transportation costs.

[2] Appropriate for client need: temporary supportive, permanent supportive, independent, recovery housing etc.

RESULTS

- **Quality of life** improves for individuals with mental illness and/or substance use disorder AND for the communities in Yellowstone County
- **Cost Savings**. Need for high cost, short term solutions such as detention, prison, ER, decreases, resulting in cost savings to local government, healthcare system, schools, and state government (Child Protective Services, Dept. of Corrections, Dept. of Justice, DPHHS)
- Results will be measured, reported, displayed on public facing dashboard, and used for continuous quality improvement.

EVIDENCE BASED MODELS

- Sequential Intercept Model
- Crisis Now
- SAMHSA National Guidelines for Behavioral Health Crisis Care
- Risk Need Responsivity Model
- National Association of Counties' Stepping up Initiative
- Others TBD

PAYING for THE CRISIS SYSTEM (see Attachment for more detail)

Current Status

Local government, nonprofits, schools, healthcare bear cost of the crisis system.

- Our system is disconnected, high cost, and not getting the results we desire.
- We are not alone. Most of the country is in the same boat.
- The National Guidelines for Behavioral Health Crisis Care and the Crisis Now model provide a roadmap to transform Crisis Systems in order to promote significant cost savings to local government AND increased efficacy for individuals using the system.
- The U.S. and Montana Departments of Health and Human Services are realigning funding with the research-based guidelines in these models.

Future Status

- Communities that are aligned with the National Guidelines for Behavioral Health Crisis Care will be able to receive state and federal funds to support these services: Crisis Line, Mobile Crisis Response, Crisis Receiving
- This will free up local tax dollars and nonprofit donors to cover essential but unbillable services.
- The system-approach will result in cost savings to all by decreasing the need for the highest cost services (ER, Jail, Prison, Child Protective Services etc.).

SAC BELIEVES

- Yellowstone County cannot afford to continue to do business as usual with the crisis continuum.
- This would be a disservice to tax-payers and non-profit donors.
- Costs may temporarily rise while we transformation takes place, but they will decrease significantly over time
- Connecting the dots between public and private Crisis Services is essential to reducing costs and closing the revolving door into high costs crisis services.

Paradigm

Comparable to physical healthcare system: crisis services are designed to connect individuals as quickly as possible through a systemic approach.

Emergency and Crisis Services Analogies[3]

Services for Responding to a Health Crisis		
	Physical Health	**Mental Health & Substance Use**
Emergency Call Center	911	Crisis Line
Community-Based Response	Ambulance/Fire	Mobile Crisis Response
Emergent Facility Care	Emergency Dept.	Crisis Receiving & Stabilization Facility

After receiving emergency services

Services for Preventing Re-Entry to Crisis		
Care Coordinators and Housing Navigators facilitate connection to		
↓		
	Physical Health	**Mental Health & Substance Use**
Appropriate Housing	Long Term Care facility Therapeutic Care facility Own Home Own Home with home health	Inpatient Treatment Facility Group Home Shelter with transition supports Recovery housing Own Home
Services	Primary Care Provider Physical Therapy Occupational Therapy Nutritionist Community Resources (fitness, bus, employment services, childcare…) Peer Support (for example Grief Group, Diabetes Support Group, Cancer Survivors) *Transportation to get to follow-up appointments* *Notices to employers*	SUD and MH Treatment in community or residential setting Psychiatric Rehabilitation Nutritionist Community Resources (fitness, bus, employment services, childcare…) Peer Support *Transportation to get to follow-up appointments* *Notices to employers*

[3] National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit: p. 39

Funding Crisis Care

Approaches to fund mental health and substance use crisis services vary widely from state to state. In many cases, funding is cobbled together, inconsistently supported and inadequate when not aligned with best practices. One of the greatest factors contributing to these funding challenges is the inconsistent expectations around crisis provider service delivery; allowing providers who staff and operate in very different ways to utilize the same crisis stabilization service coding.

Consider the nature of crisis care in systems with multiple payers. If a provider commits to fully align their practices to the *National Guidelines for Crisis Care* contained in this toolkit, then that provider is poorly positioned to negotiate reimbursement with each of those multiple funders in a region simply because the funder knows the provider will accept all referrals and serve them even if they do not reimburse in a manner that covers the cost of care. In these cases, it is often local jurisdictions who are paying part of the bill for legally or contractually responsible payer health plans that fall short in reimbursement. The solution is to create rate reimbursement structures that sustain delivery of services that align with best practice guidelines and secure capacity funding for community members who otherwise do not have insurance to cover critical care. This is not a new concept given the funding streams that exist in support of 911, fire, ambulance and emergency department services but it is one that must be extended for mental health and substance use crisis care for parity to be realized.

In a November 13, 2018 letter from the Centers for Medicare & Medicaid Services to State Medicaid Directors, a path to receive a waiver on the payment exclusion for Institutions of Mental Disease (IMD) was offered:

"CMS will consider a state's commitment to on-going maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project in order to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Furthermore, CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, ***particularly crisis stabilization services.****"*

The letter clarifies that "*states may receive federal matching funds for Medicaid-coverable services provided to individuals residing in psychiatric hospitals and residential treatment settings that are not ordinarily matchable because these facilities qualify as IMDs"* under an approved demonstration project. This represents an opportunity leverage the additional federal funding in lieu of state payment for these IMD services; freeing up state funding to support local crisis care.

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The Firehouse Model: Crisis Care Funding vs. Emergency Care Funding

It is revealing to compare mental health crisis care to other first responder systems like firefighting or emergency medical services (EMS). There are striking similarities:

- The service is essential and may be needed by anyone in the community;
- The need for it is predictable over time but the timing of individual crises events is not; *and*
- Effective crisis response is lifesaving and much less expensive than the consequences of inadequate care.

One might measure the effectiveness of emergency medical services (EMS) in lives saved because of timely intervention for individuals with acute heart disease. For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief respite stays that might cost $300 per day versus inpatient rates of $1,000 per day. This approach better connects the individual to his or her community while minimizing disruption in the person's community connections.

It is also useful to think about the financing of core crisis services. It would be unthinkable for any community, except frontier or very small ones, to go without their own fire department. Because this is known to be an essential public expenditure, fire stations and fire trucks are simply made available. Sometimes users may pay a fee for service calls but the station and the equipment are available to anyone in need regardless of ability to pay. In most communities, mental health crisis services take a different approach or are not offered at all due to the lack of coverage or reimbursement for this level of care. Health coverage (e.g., Medicaid) will pay for professional fees as if services were delivered as part of a routine office visit but few entities pay for the infrastructure of a crisis system with rates that reflect the "firehouse model" expenses involved in being available for the next call or referral.

For those who have ever experienced a medical emergency and contacted 911 for help, they probably know how this plays out. Fire departments and/or an ambulance respond quickly to deliver emergent care. If they assess a need for further support, they may transport to the emergency department for care. What follows in the subsequent weeks, following care, is the delivery of bills or invoices for the ambulance care and transportation followed by any services received within the emergency department. These bills or invoices total thousands of dollars in most cases; expenses that represent the higher cost of offering emergent care that is accessible to **anyone, anywhere and anytime**. Unfortunately, crisis care reimbursement is often a fraction of that of its physical health counterparts and is, therefore, delivered in a model that falls short of best practice expectations or is simply not offered because there is no mechanism to adequately reimburse the cost of the level of care.

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A Potential Solution

Funding crisis care through a firehouse model may be the best approach for some of these services while other viable options are also evolving with the implementation of parity. A leading solution to the crisis care funding puzzle is to model reimbursement after the physical health service counterparts already in place. Subsequent efforts to enforce parity laws in a manner that removes much of the burden on local communities by shifting the expense to the person's health insurance plan that, by law or contract, is actually responsible for covering this care will position crisis care to have sustainable funding streams in support of best practice care; leading to care that can truly lower health care costs while dramatically improving the experience of people in crisis and the health of communities through justice system and ED diversion.

Multiple Payer Systems

The approach proposed supports reimbursement within multiple payer systems when responsible payers (health plans) each pay for services at rates that support operations. Therefore, it is recommended that states, counties or local jurisdictions establish rates for their communities that can be applied to all payers. Otherwise, local jurisdictions will be forced to cover the shortfall in funding from the legally or contractually responsible payers who offer lower reimbursement for care that is always made available to all community members. In essence, the lead of local government to establish reasonable reimbursement rates for best practice crisis services amongst all responsible payers offers a sustainable model that reduces the demand on communities to cover health care expenses that should be covered by an insurer; supporting the existence of the safety net service that is accessible in real-time when called-upon.

Regional 24/7 Crisis Call Center Hub

This service is really meant to serve entire regions in a manner similar to 911 call responses with SAMHSA delivering some funding to support this valuable resource currently. Although there is some ability to verify certain information identifying the caller, reimbursing for care using the Behavioral Health Hotline code, call center funding might be best served through a population-based funding stream that comes from an assessment on cell phone and/or land line utilization. This approach would more cleanly sustain nationwide funding for this safety net service and implementation of advanced air traffic control-type technology in all parts of the country.

Crisis Mobile Response Services

Crisis mobile response services are analogous to fire and ambulance responses for emergent physical health issues. As such, funding mechanisms should align so that adequate capacity can be in place to serve communities. Given that demand is not completely predictable, there will be some down time for these teams and reimbursement rates must be set so that the health plan still realizes value in the service (largely value realized by avoiding ambulance and emergency department bills) while community members get better access to care. If commercial and Medicaid plans pay at this reasonable rate for quality care, the state, county or city funding of contributions will be relatively low; particularly in states with low uninsured rates.

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Crisis Receiving and Stabilization Facility Services

Crisis receiving and stabilization services are analogous to emergency department services but typically fall under a crisis stabilization coding approach that offers hourly and per diem reimbursement. Facilities are likely licensed outpatient programs that offer flexibility to deliver care to a larger number of people in smaller spaces; necessitating that service duration be limited to under 24 hours (often referred to as 23-hour programs). Professional fees are usually billed in addition to the crisis stabilization service but can be bundled if that approach is preferred. The benefit to separate billing of professional services is that practically all payers currently reimburse for these services while few outside of Medicaid recognize crisis stabilization for reimbursement at this time. Getting some of the expense covered by these payers (pending a better enforcement of the parity law) is better than none when it comes to minimizing the financial cost to the community served.

Crisis Service Coding

Establishing a common definition for "crisis services" is essential to this coding process given the ever-expanding use of the term "crisis" by entities describing offerings that do not truly function as no-wrong-door safety net services accepting all referrals. Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime**. This crisis service coding discussion focuses solely and exclusively on the three essential crisis services. Any other service may offer value within the continuum of care but should not use "crisis service" coding.

Crisis services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical healthcare system. The table below provides a look at similarities between crisis services and their physical health counterparts; offering a framework that can be used to model reimbursement for these similar services in a manner consistent with public expectations of parity.

Table 2 – Emergency and Crisis Service Analogies

Services for Responding to a Health Crisis		
	Physical Health	**Mental Health & Substance Use**
Emergency Call Center	911	Crisis Line
Community-Based Response	Ambulance/Fire	Mobile Crisis Response
Emergent Facility Care	Emergency Dept.	Crisis Receiving & Stabilization Facility

Healthcare Coding of Crisis Services

Coding of crisis services must be standardized to support reimbursement for these important services. Additionally, coding for mobile and facility-based crisis services has a clear to path to reimbursement much like what currently exists for ambulance and emergency department service providers. Although a bit different than the analogous 911 service that largely focuses on dispatching support, crisis line services represent an essential element of improving access to care that includes the delivery of telehealth services. Here's a brief description of these services and a

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straightforward strategy for healthcare coding in each case:

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1. Crisis Call Center: This service represents the incorporation of a readily accessible crisis call center that is equipped to efficiently connect individuals in a mental health crisis to needed care; including telehealth support services delivered by the crisis line itself. Recognizing the provider's limited ability to verify insurance and identification over the phone, these services may be best funded as a safety net resource but reimbursement for services delivered is an option. The most straight-forward option is to bill for services delivered to eligible individuals using the Healthcare Common Procedure Coding System *(HCPCS) code of H0030 - Behavioral Health Hotline Service*.

The limitation of the direct billing approach is that it can be very difficult to acquire the information adequate to verify healthcare coverage and the identity of the service recipient during the phone interaction. However, some level of direct billing for care could be used to augment the funding received by regional and state government entities to support operations. Crisis line providers do indeed deliver telehealth support to insured callers every day. Data elements such as member phone numbers of Medicaid-enrolled or privately insured individuals can be combined with Caller ID technology to support billing efforts.

2. Mobile Crisis: Mobile crisis services represent community-based support where people in crisis are; either at home or a location in the community. Services should be billed using the nationally recognized *HCPCS code of H2011 Crisis Intervention Service per 15 Minutes*. Limiting the use of this code to only community-based mobile crisis team services positions a funder to set a reimbursement rate that represents the actual cost of delivering this safety net service much as it does for a fire department or ambulance service reimbursement rate. When applicable, transportation services should be billed separately.

3. Crisis Receiving and Stabilization Facility: Crisis receiving and stabilization facility services that meet minimum expectations described in this paper are delivered by a 24/7 staffed multidisciplinary team that includes prescribers (psychiatrists and/or psychiatric nurse practitioners), nurses, clinicians and peers. Nationally recognized HCPCS codes of *S9484 Crisis Intervention Mental Health Services per Hour* and *S9485 Crisis Intervention Mental Health Services per Diem* can be used to reimburse for services delivered. Medications, radiology, laboratory, CPT codes and professional evaluation and treatment services may be billed separately or bundled into reimbursement rates.

Table 3 – Crisis Service Coding

Service	Recommended Coding Option Approach
Crisis Line	**H0030** – Behavioral Health Hotline Service and contract as a safety net resource to augment funding
Mobile Crisis Response	**H2011** - Crisis Intervention Service per 15 minutes *Note: The HT modifier can be utilized in combination with this code to denote a multi-disciplinary team if codes are used for multiple crisis delivery modalities.*
Crisis Stabilization Facility (non-hospital)	**S9484** - Crisis Intervention Mental Health Services per Hour **S9485** - Crisis Intervention Mental Health Services per Diem *Note: The TG modifier can be utilized to denote a complex level of care if these codes are utilized for multiple crisis delivery modalities*

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A Call for Parity

Establishing universally recognized and accepting coding for crisis services is an essential step toward delivering on our nation's promise of parity; moving mental healthcare out of the shadows and into mainstream care of the whole person. Parity should be the expectation. Individuals experiencing a mental health or substance use crisis must have access to timely and effective care, based on the person's needs that aligns with access to care for a person with a physical health emergency.

Unfortunately, access to effective care during a mental health crisis is widely known to be deficient in healthcare settings across the country. "8 in 10 ED Doctors Say Mental Health System is Not Working for Patients" according to a survey by the American College of Emergency Physicians (ACEP). Thousands of Americans are dying from suicide every month and many family members of those coping with serious mental illness or loss of loved ones to suicide are experiencing unspeakable pain. Individuals with limited options are getting the wrong care in the wrong place with jails, EDs and inpatient care substituting for mental health crisis services and law enforcement is functioning as defacto mobile crisis units.

According to the 2019 Treatment Advocacy Center published *Road Runner* study, more than $17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness. If extrapolated to law enforcement agencies nationwide, this number is approximately $918 million or 10% of law enforcement's annual operating budget. Additionally, mental illness is the most prevalent disability in the United States. The time is ripe to solidify better access to crisis care and change these unacceptable outcomes that are adversely impacting communities, filling jails and crowding emergency departments. A nationally recognized framework for delivering a full continuum of crisis care has been established by the National Action Alliance for Suicide Prevention Crisis Services Task Force with resources found on www.crisisnow.com website and healthcare coding, as defined in this document, is available to support reimbursement for that care

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