Mobile Crisis Teams Context: Integration & Coordination

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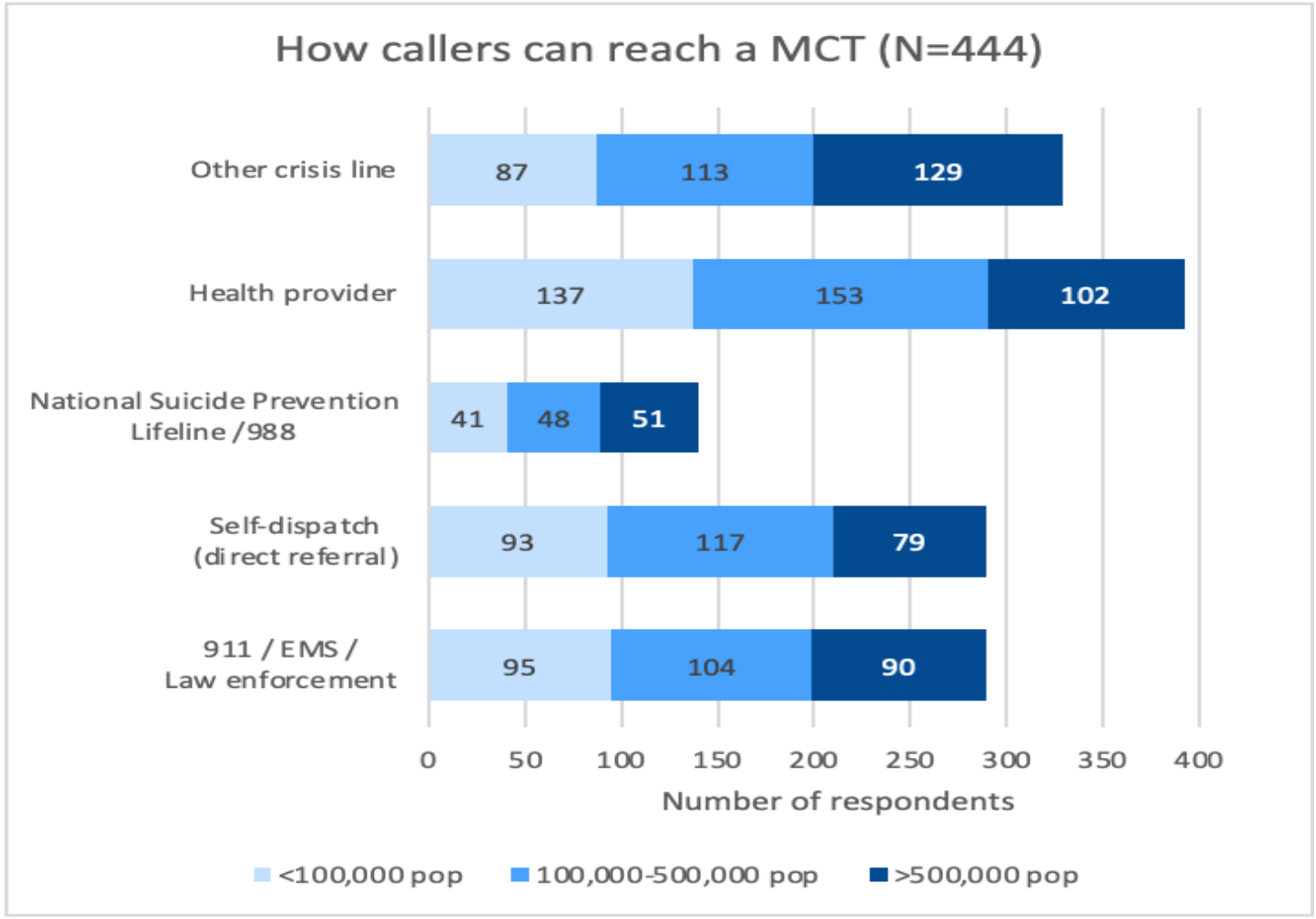
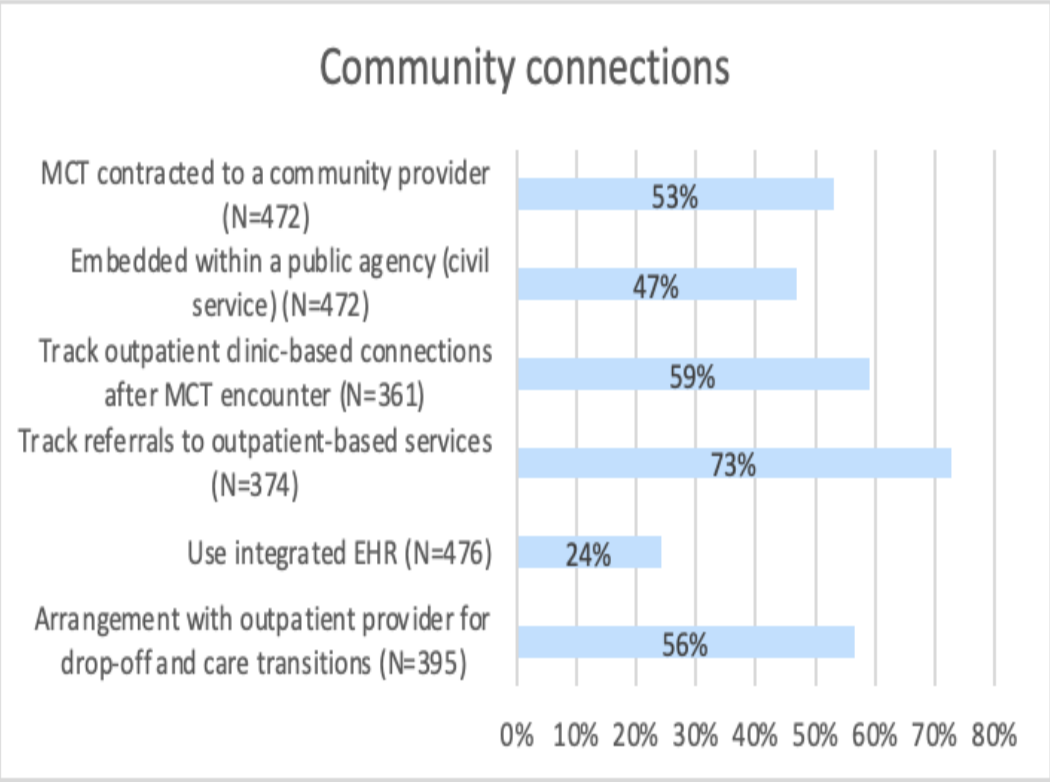
MCT is a component within a system

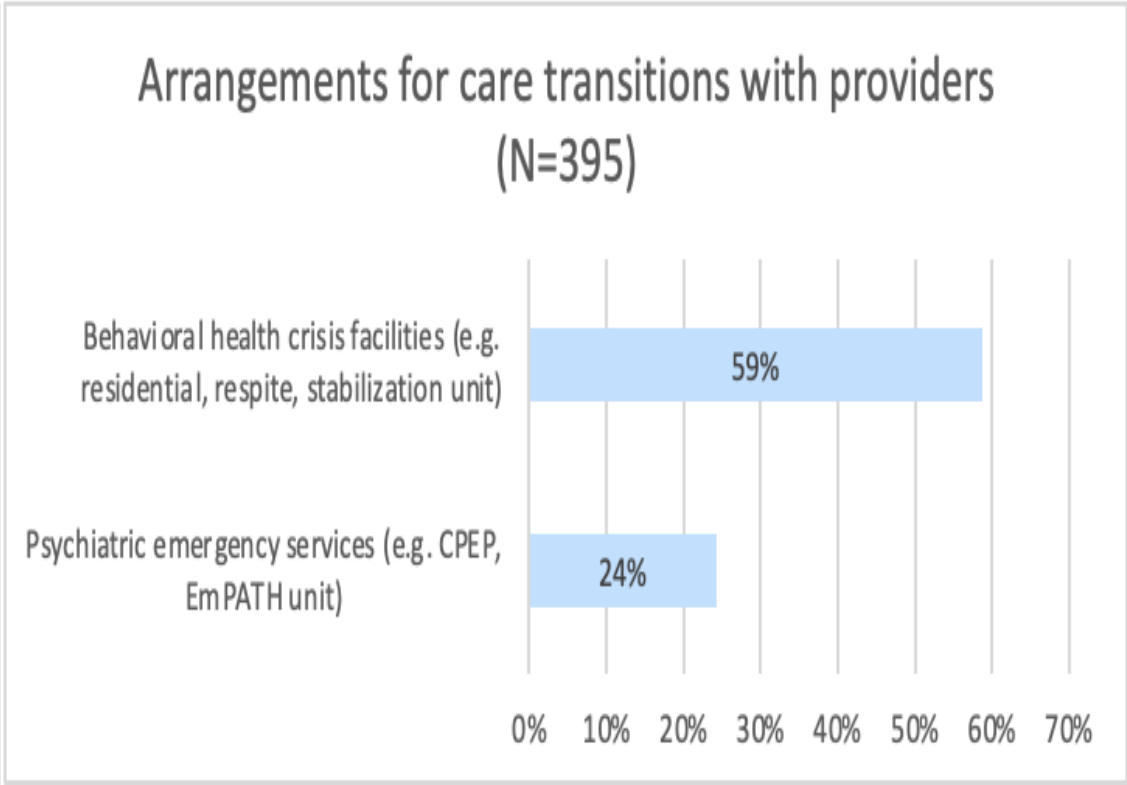
- MCT is dependent upon upstream referral sources and downstream resources and providers
- MCT efficiency and impact is influenced by the degree of integration-coordination
- Fragmentation and operational silos...
  - Create friction and increase inter-agency conflict
  - Reduces MCT efficiency and effectiveness
  - Adversely impacts consumer and provider experience
- Conversely, efficiency, effectiveness, and consumer-provider experience are positively correlated with the degree of integration-coordination with fellow crisis and safety net providers
- Many payors, oversite organizations, and accreditation bodies are requiring formal agreements to drive integration

FINDING #4: Operational Integration Between MCTs and the Crisis Continuum is Limited

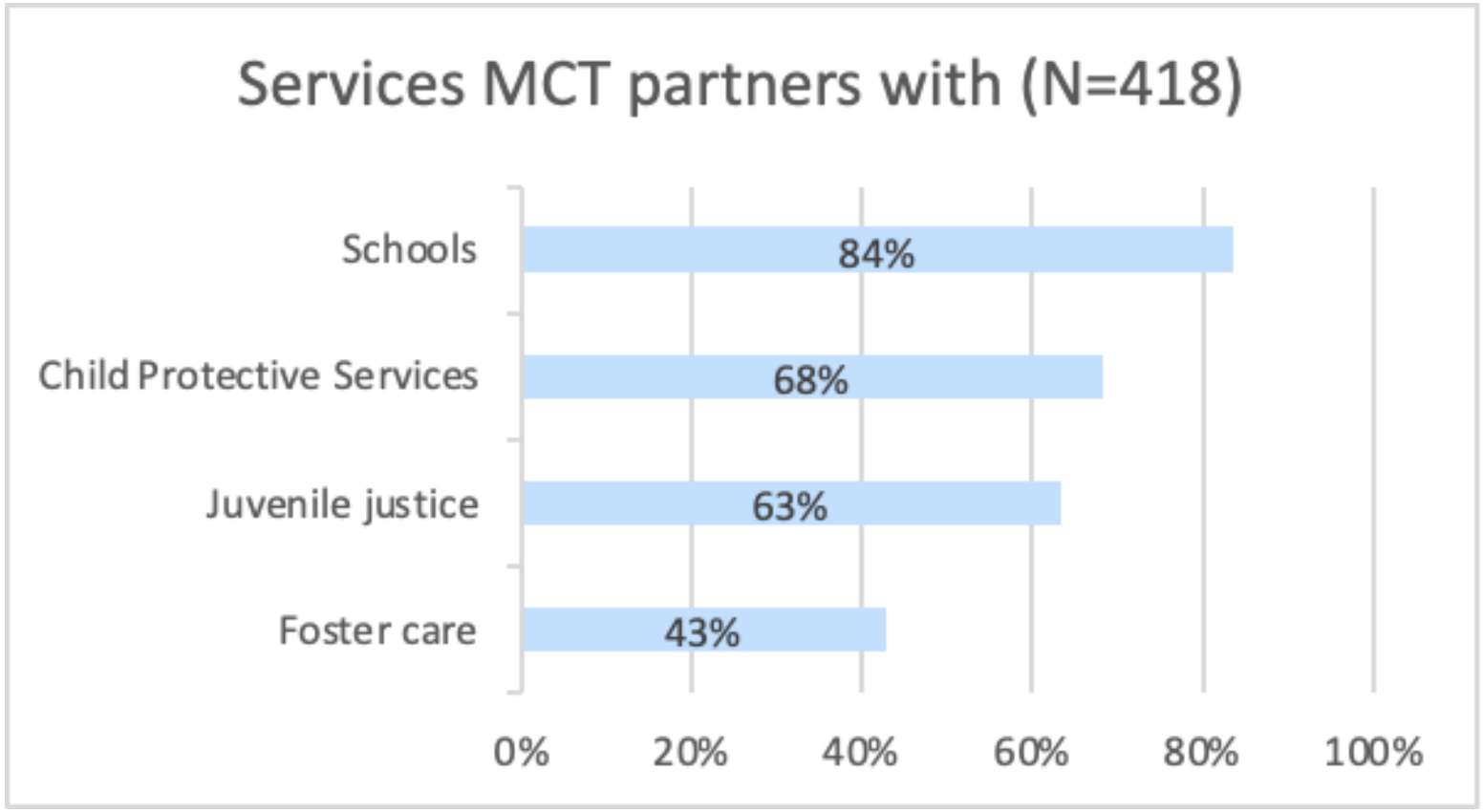


FINDING #4: Operational Integration Between MCTs and the Crisis Continuum is Limited





FINDING #7: Clinical Best Practices and Partnerships are Unevenly Adopted Across MCTs



Essential Community Partners for MCT

- Crisis Hotlines & Warm lines
- 911
- Law Enforcement
- Fire-EMS
- Psych-SUD-IDD outpatient providers
- Peer services organizations
- Psych-SUD Urgent Care
- Psych-SUD Crisis Residential
- Psych-SUD Emergency Services
- Psych-SUD inpatient
- Psych-SUD-IDD Authorities & MCOs
- Emergency Departments
- Jails & Juvenile Detention Centers
- Specialty courts and jail diversion programs
- Probation & parole departments
- Schools: pre-K, K-12, community college, universities
- Child-Adult Protection & Foster Care
- Shelters: homeless, DV/sexual abuse, youth-runaway, other
- Advocacy organizations
- Food pantries, etc.
- 211, 311, etc.
- Transportation providers
- Others?

Levels of Integration-Coordination

- None
- MCT provides education-outreach and develops informal understanding regarding bi-directional referrals
- MOU regarding referral protocols and dispute management
- Advisory role for design, implementation, and ongoing oversite
- Bi-directional shadowing
- MCT co-location and consultation-liaison model
- Data sharing agreements
- Digital integration for data sharing
- Shared language and clinical-operational protocols
- Shared training
- Shared digital platform
- Shared staffing
- Same parent organization with shared...
  - Staffing-training
  - digital platforms
  - language-definitions
  - clinical-operational protocols

911 & Behavioral Health

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Current-historical state of 911's behavioral health response

- Behavioral health events have been framed as public safety (police) vs health emergencies
- Limited collaboration, coordination, and integration with behavioral health providers, organizations, & systems
- 911 has not prioritized detection of behavioral health call types
- Metrics-analytics are inadequate to drive quality and transformation initiatives
- 911 has not adopted evidence-informed triage protocols for behavioral health calls
- Lack of standardization = highly variable approaches
- Need for speed has been prioritized over quality and consumer-provider experience
  - "We don't have time" ***to do things right or do the right thing***

Impacts and Concerns with Current-Historical State

- Escalation vs de-escalation of callers
- Unnecessary involvement with law enforcement
- Unnecessary use of hands on and hand cuffs
- Unnecessary confinement-detention (involuntary inpatient and incarceration)
- Unnecessary deaths
- Oftentimes rushed & sometimes rude experience with 911
- Oftentimes rushed & sometimes rude experience with first responders
- Adverse impacts (inequality & injustice) abound and are worse for racial-ethnic-sexual minorities and other dis-enfranchised groups

Transformation expectations (nationally and locally) for 911

- Perceive-respond to behavioral emergencies and crises as healthcare events
- Improved consumer experience
- Reduce unnecessary involvement with law enforcement
- Reduce unnecessary restrictive and coercive interventions
- Harmonized approach with 988 (crisis hotline and mobile crisis)
- Adoption of evidence-informed triage protocols
- Increased collaboration, coordination, and integration with behavioral health systems

Assessment Domains

- Detection of Behavioral Health "events"
- Violence
- Lethal Means
- Suicide
- Medical

911 "Innovations"

- Detection of behavioral health events:
  - 911 staff or co-located behavioral health providers "listen to the radio"
  - 911 staff utilize 4-pronged initial prompt..."are you calling about a police, medical, fire, or mental health related emergency?"
  - 911 organization utilizes an automated attendant to deliver the standard prompt...which digitally informs the call taker of the caller selected "pathway"
- Triage of identified callers experiencing a behavioral health emergency provided by:
  - Any/all 911 dispatchers
  - Subset of 911 dispatchers
  - Either above with co-located or virtual behavioral health provider listening and coaching
  - Co-located or virtual behavioral health providers manage calls
- Dispositions:
  - Warm handoff to 988
  - "Dispatch" to MCT
  - Dispatch to Fire-EMS as lead responder

911 Triage Protocol Considerations

- Detection of behavioral health events via new standard prompt, caller spontaneous reports, and/or call taker recognizes verbal signs/symptoms and/or prior history
- Assessment domains..."is there immediate danger due to?"
  - Violence
  - Lethal Means (especially guns) "in play"/possession
  - Suicide
  - Medical condition
- If no immediate danger, then warm handoff to 988 or dispatch MCT
- If immediate danger due to suicide but not violence, lethal means in play/possession, or medical condition then dispatch MCT as lead responder
- If immediate danger due to medical and no immediate danger due to violence or lethal means in play/possession, then dispatch to Fire-EMS as the lead responder
- If immediate danger due to violence or lethal means in play/possession, then dispatch law enforcement as the lead responder

988 (Crisis Hotline) and MCT "Dispatch"

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988 Triage Considerations

- Assessment domains...
  - Immediate danger due to
    - Violence
    - Lethal Means (especially guns) "in play"/possession
    - Suicide
    - Medical condition
  - Nature of problem, services history, resources, readiness to change, consumer preferences, etc.
- If caller in crisis and needs-will benefit from MCT vs 988s ability to de-escalate the caller, then dispatch MCT as lead responder
    - Children & families in crisis
    - Persons needing evidence-based brief interventions for suicide
    - Persons with complex problems who have or will likely struggled to engage with services/resources
    - Persons in crisis who request MCT services
- If immediate danger due to medical and no immediate danger due to violence or lethal means in play/possession, then 911 referral
- If immediate danger due to violence or lethal means in play/possession, then 911 referral

Dispatch

- The term "dispatch" is overused in the civilian crisis response space
- Dispatch requires shared use of a digital "engine" that drives workflow adherence, provides various analytics: time interval metrics, dispositions, etc.
- In addition, the term "dispatch" pre-supposes that... when I say, you go "no questions asked"
- Most of what we see across the nation is a low or no tech "negotiated referral" in which insufficiently resourced MCTs are channeling "The 3 Bears"...most often too cold or too hot and sometimes just right
- Civilian provider organization obtaining 911 CAD privileges is a big lift with numerous challenges
- MCT typically does not have the capacity for an on demand, rapid response wanted/needed by 911 & 988
- Most often MCTs have internal dedicated capacity to receive, process, accept or not, and assign cases
  - They are often reluctant to relinquish dispatch/case assignment authority
  - They also receive referrals from sources other than 911 & 988 and need to process those events as well
- TrekMedics (Beacon Crisis Response Platform), Harris Logic, Behavioral Health Link, Bamboo Health and Solari have solutions in this space

Estimating Need
Staffing Formulas & Estimating Capacity

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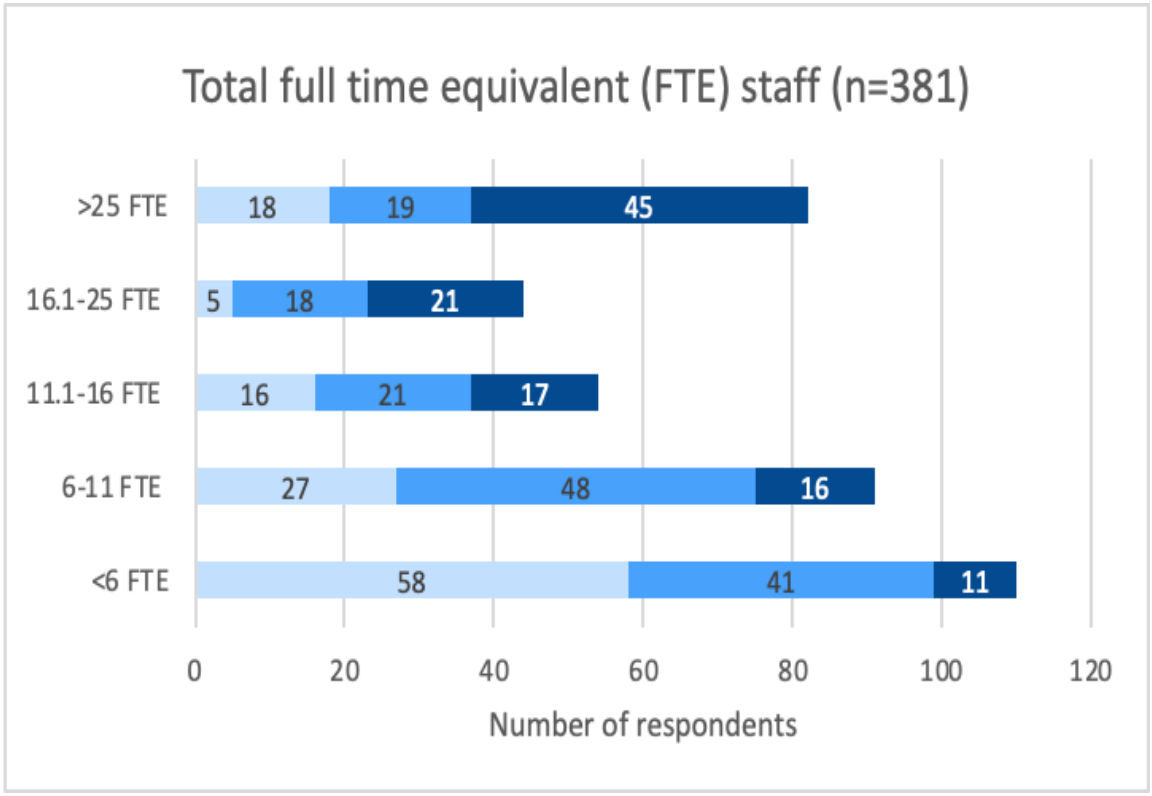
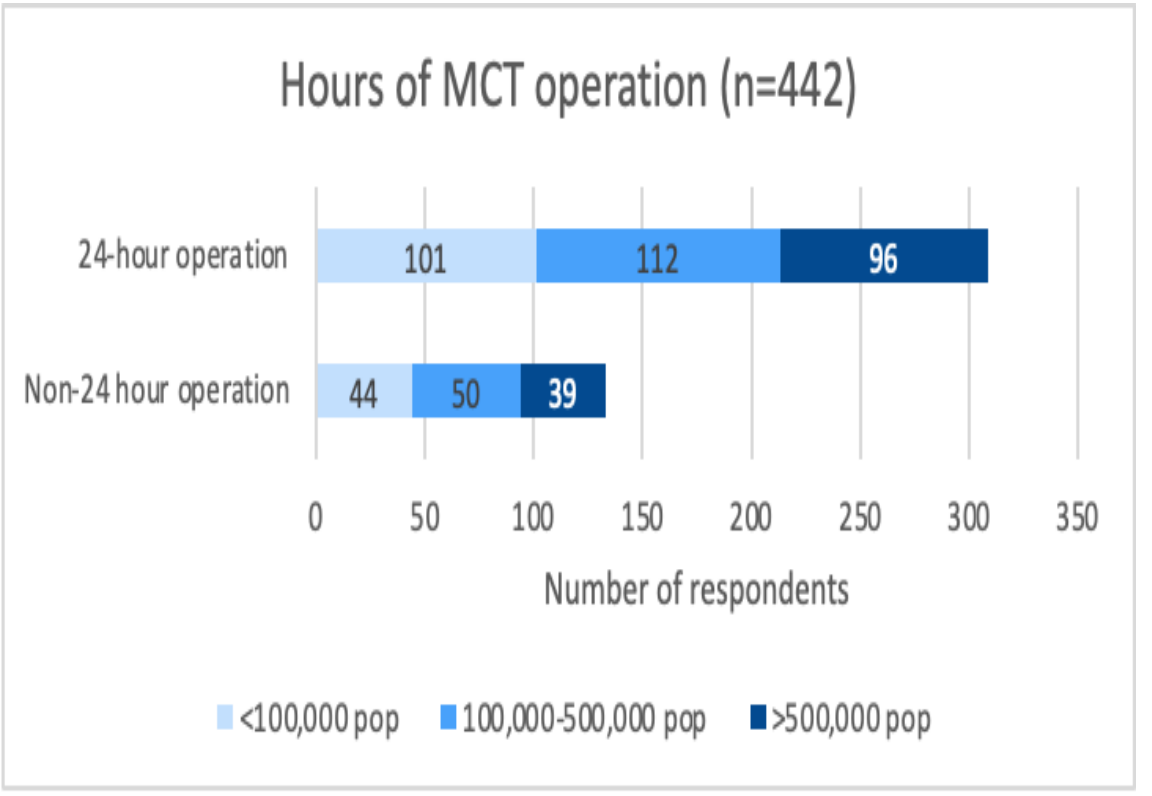
Estimating Need

- 988 / Other hotlines
  - Historically, 80% diversion for hotline, MCT, and crisis rez has been an anchor
    - That is, 20+% of hotline callers warrant an MCT dispatch-referral
    - High variability given lack of standardized triage protocols, global insufficient MCT capacity, and priorities (send MCT as often as reasonable vs only when necessary)
- 911: 8-20+% of 911 callers are experiencing a behavioral health crisis / emergency
  - High variability given lack of standardized detection protocols
  - Data from integrated 911, law enforcement, and fire-EMS suggests % of time in which hands on and/or hand cuffs is "required" during behavioral emergencies is overall low (<10%) but varies based upon context
  - 50+% of 911 calls involving BH would be appropriate for MCT
- Schools, jails, shelters, child/adult protection, etc. have some capacity to estimate # of BH crisis events per month/year

FINDING #3: There is a Gap Between the Vision and Reality for MCT Scale and Reach





24/7 on duty staffing

- Majority of MCTs across the nation do not have capacity for a 24/7 on duty model
- If 2-person teams are required, then for ***base staffing*** you need 3 persons on duty for each hour, therefore...
  - 3 persons per hour * 24 hours per day * 7 days per week * 52 weeks per year =
    - 3 * 24 * 7 * 52 = 26,208 direct service person hours per year
    - 2080 = # annual hours for a FTE
    - 26,208 / 2080 = 12.6 direct service FTEs
    - This does not count executive, admin, supervisors/quality staff, business intelligence, etc.
  - Add capacity @ 3 persons per hour
    - Peak times (10A-10P)

Estimating Capacity

Multiple Caveats....

- Peak hour, on duty teams: 2-5 encounters / 8-hour shift
- Off Peak hour, on duty teams: 1-3 encounters / 8-hour shift

Base Staffing Model (12.6 FTE's): 12 hours on and 12 hours off peak

12/8 = 1.5; 2 * 1.5 = 3
12/8 = 1.5; 5 * 1.5 = 7.5

- 3 – 7.5 peak encounters per day

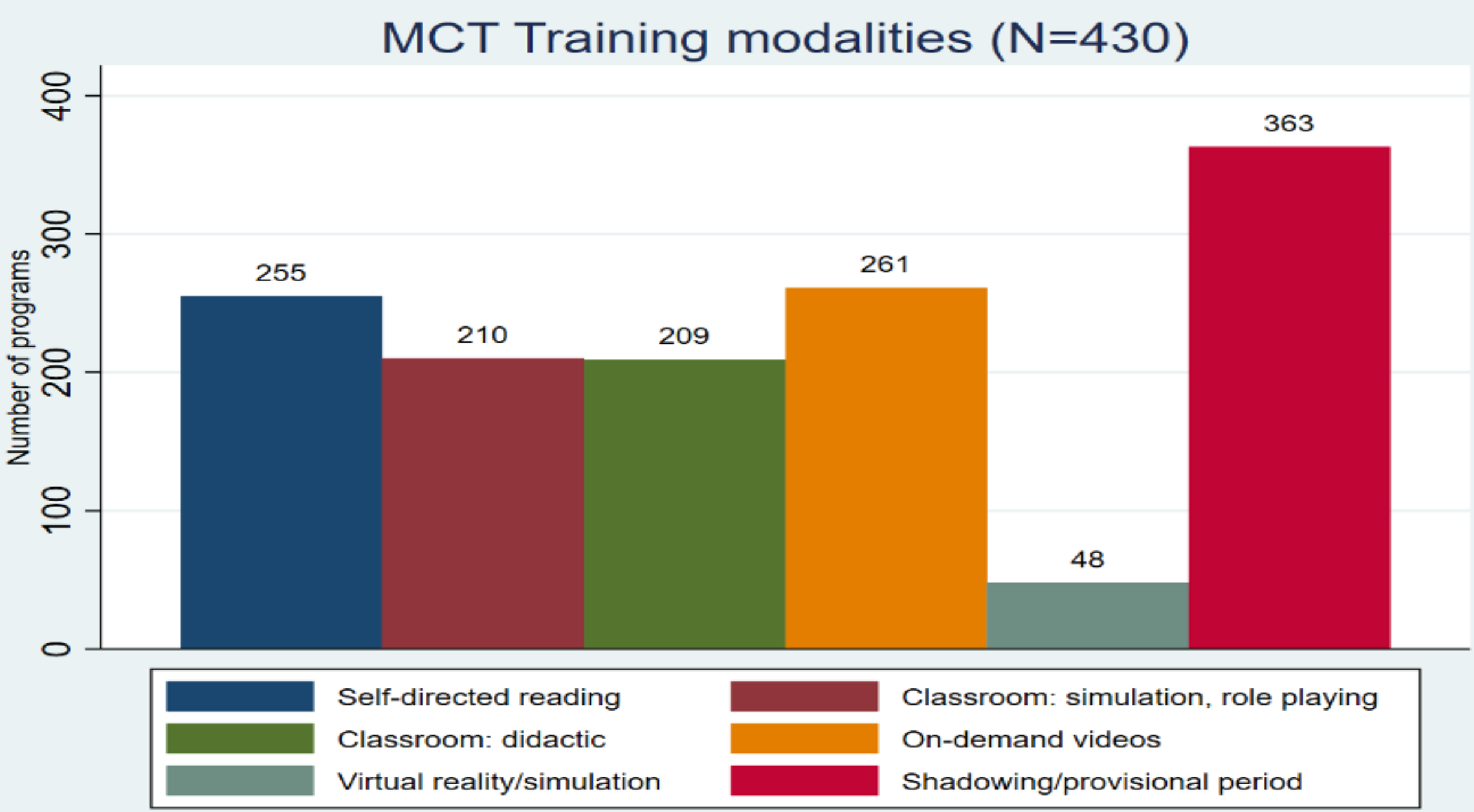
12/8 = 1.5; 1 * 1.5 = 1.5
12/8 = 1.5; 3 * 1.5 = 4.5

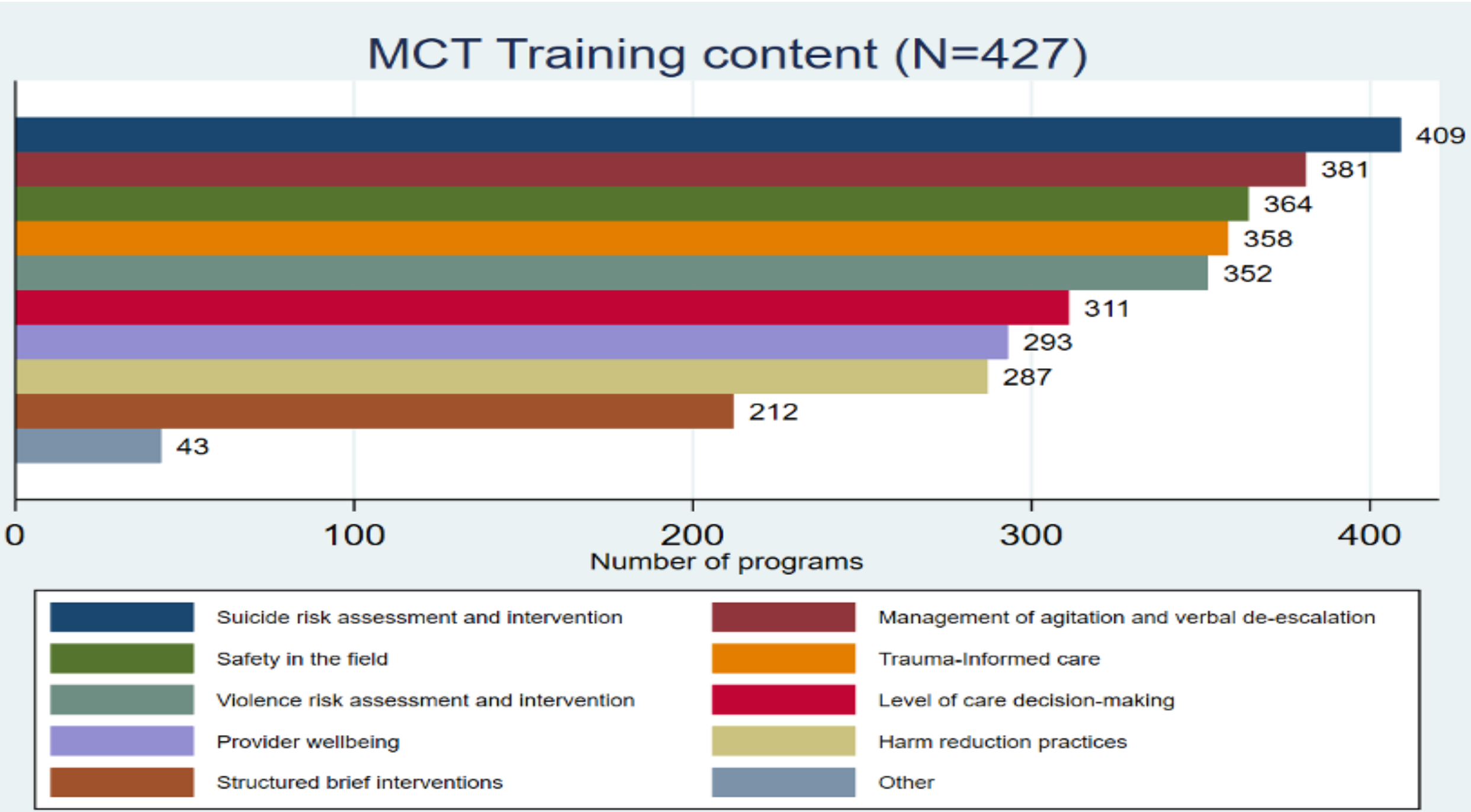
- 1.5 - 4.5 off peak encounters per day

12.6 FTE on duty staffing model can produce

- 3 + 1.5 = 4.5 & 7.5 + 4.5 = 12
- 4.5 - 12 encounters per day

MCT Training


MCT Training modalities (N=430)
Number of programs
0
100
200
300
400
255
210
209
261
48
363
Self-directed reading
Classroom: simulation, role playing
Classroom: didactic
On-demand videos
Virtual reality/simulation
Shadowing/provisional period


MCT Training content (N=427)
409
381
364
358
352
311
293
287
212
43
0
100
200
300
400
Number of programs
Suicide risk assessment and intervention
Management of agitation and verbal de-escalation
Safety in the field
Trauma-Informed care
Violence risk assessment and intervention
Level of care decision-making
Provider wellbeing
Harm reduction practices
Structured brief interventions
Other

40-hour curriculum

- Drivers of Demand for Crisis Care
- Mobile Crisis as a Specialty
- Culture of Safety & Safety in the Field
- Provider Wellness
- Crisis Theory, Stress Theory, and Crisis Intervention
- Interprofessional Collaboration, Team Science and Team-Based Care
- Psychotherapy Integration: Principles of Optimal Change
- Crisis Psychotherapy: blending narrative-social constructionistic & structured approaches
- Managing bias and negative countertransference via Humanizing Language
- Challenging Interactions
- Reporting Veracity
- Decision-Making in Behavioral Emergencies
- Agitation and Verbal De-escalation
- Violence Overview
- Violence Assessment and Intervention
- Suicide Overview
- Suicide Theories and Risk Factors
- Suicidal Ideation
- Cultural Considerations in Suicide
- Suicide Risk Formulation
- Common Case Types
- Structured Brief Interventions
- Level of Care Decision Making
- Care Transitions and Follow Up

Pathway to Expertise

- Memorize foundational knowledge and skills
- Graduated exposure and modeling of live services by an expert
- Mental practice and simulation (reacting to vignettes and recordings)
- Successive approximation toward full speed with an expert shadow
- Real-time consultation and debriefing with an expert
- Adopt structured clinical judgement tools
- Frequent objective feedback: efficiency and effectiveness
- No substitute for trials at speed under pressure. It just takes time.

Idealized new employee training: 1st 90 days

- Self-directed videos & reading @ 40 hours
- Shadowing live services @ 40 hours
  - Mobile Crisis with a super-user
  - Frequent debriefing
- Shadowed and tethered services @ 80 hours
  - Mobile Crisis with a super-user
  - Supervisory consults
  - Quality reviews
  - Simulation via recorded calls and vignettes
  - Frequent debriefing and objective feedback
- Classroom training @ 40 hours
- Shadowed-increased autonomy @ 380 hours
- Formal performance evaluation-vetting at 90 days

MCT Workflow & Protocols

Mobile Crisis Team Workflow

- Initial plan based upon dispatch data, system look ups, reports from clinical home, call with client-collaterals en route, and ecosystem assessment
- Engagement and de-escalation
- Rule out emergency medical conditions
- Therapeutic interviewing: narrative and semi-structured
  - Social context & determinants
  - Suicide assessment
  - Violence assessment
  - Functional capacities & available support
  - Reporting veracity
  - Readiness to change
- Safety Planning Intervention
- Lethal Means Restriction
- Evaluate impact of engagement & brief intervention
- Collaborative Care Planning
- Referral-Linkage / Continuity of Care
- Follow Up

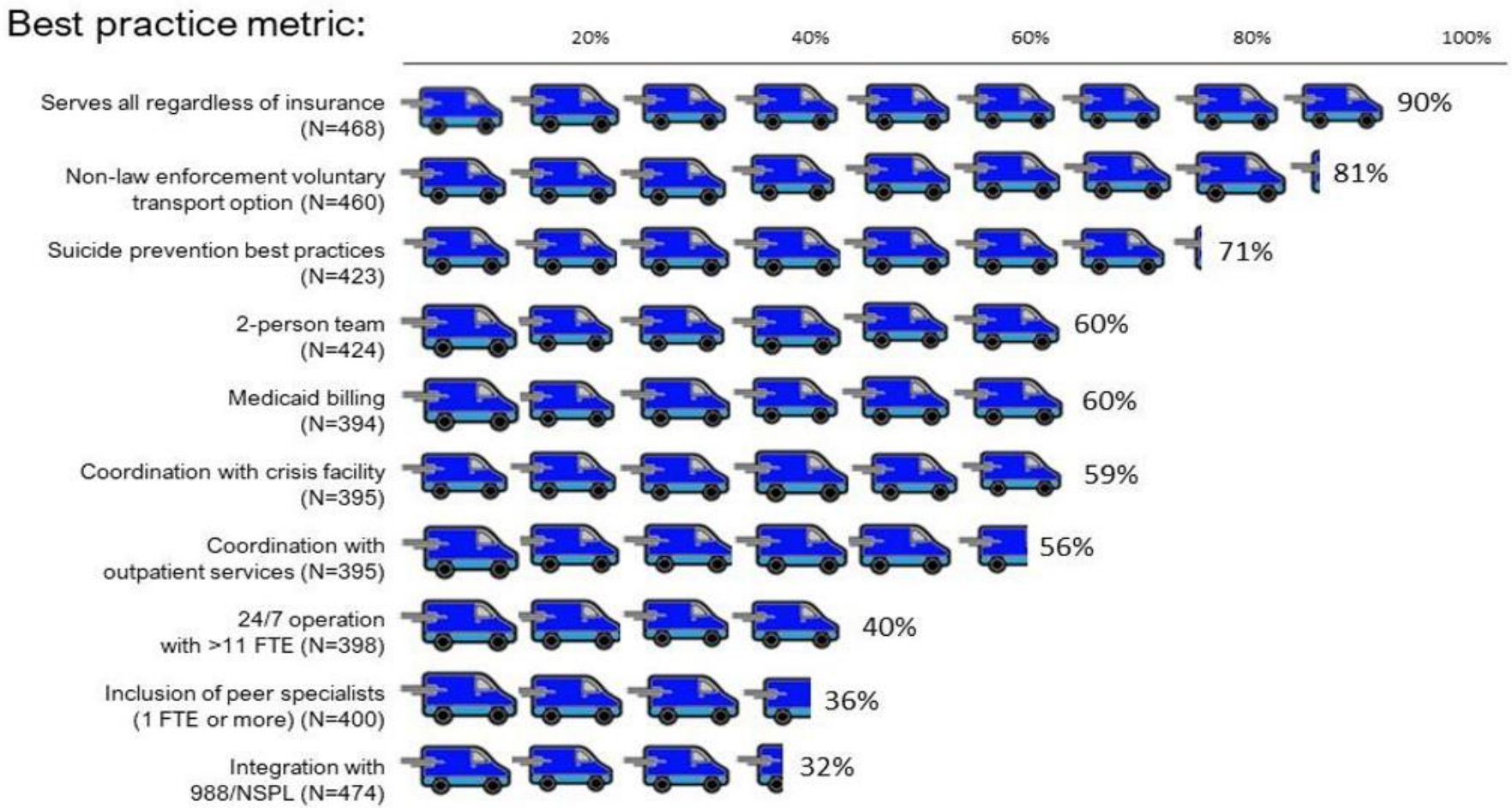
Suicide Care Workflow: Ideal

- Checklists: drivers, risk factors, ACEs, SDOH, and protective factors
- Standardized self-report measures: PHQ-9, GAD-7, MDQ, PCL, AUDIT, DAST
- Established interview protocols: C-SSRS
- Readiness to change protocol
- Structured clinical judgement tools for
  - Reporting veracity
  - Risk formulation: IRRS & R-CTRS
- Lethal means restriction protocol
- Collaborative safety planning protocol: SPI or CRP
- Pre-and post-intervention assessment of dynamic states: SCS-S & S-VAS
- Continuity of care
- Follow up protocols: 24 & 72 hours, 1-week, weekly X 3; monthly non-demand caring contacts for 12 months
- Suicide-specific evidence-based treatment: CAMS

Best Practice Dashboard

We propose that a key step towards this objective is to develop a dashboard that can track uptake of MCT best practices

- Drawing on recent federal and local legislative and regulatory definitions of MCTs
- Using questions from the survey as an initial iteration
- Demonstrate how regions across the US states are performing in terms of the number of MCT programs that report implementing 7 or more of these 10 best practices



Crisis Care Analytics Framework

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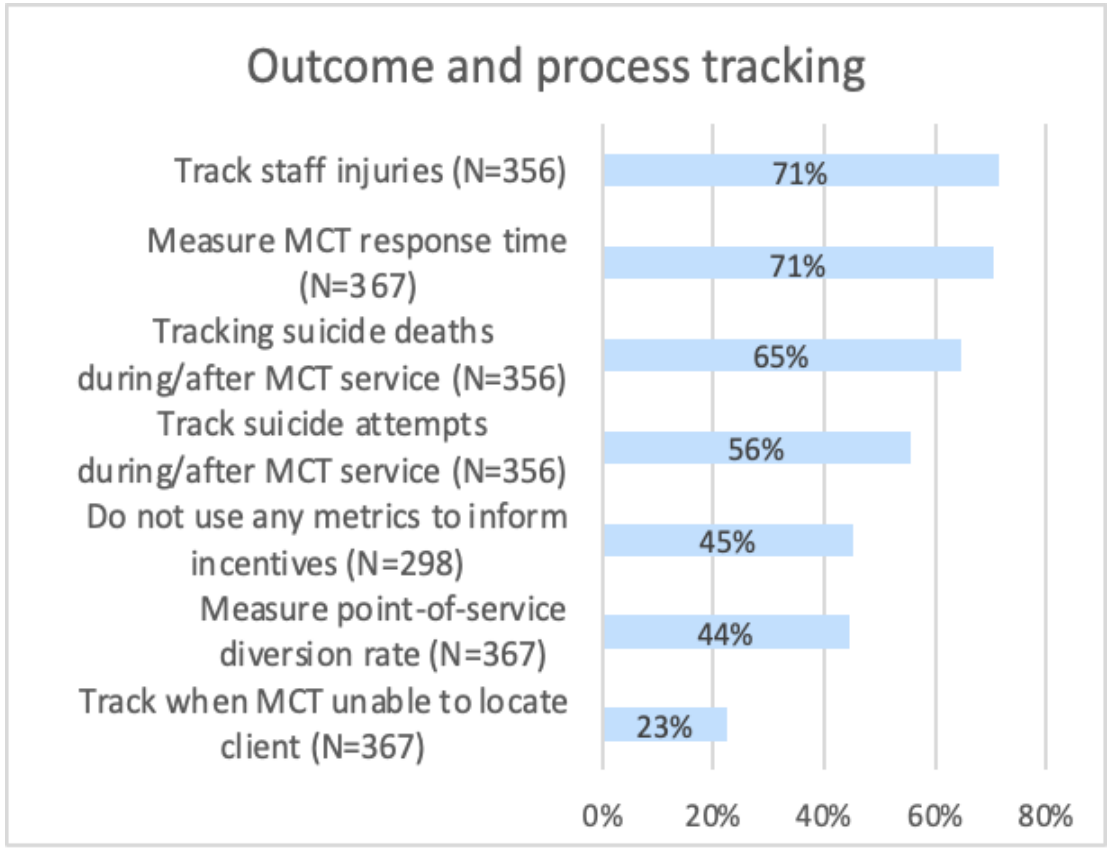
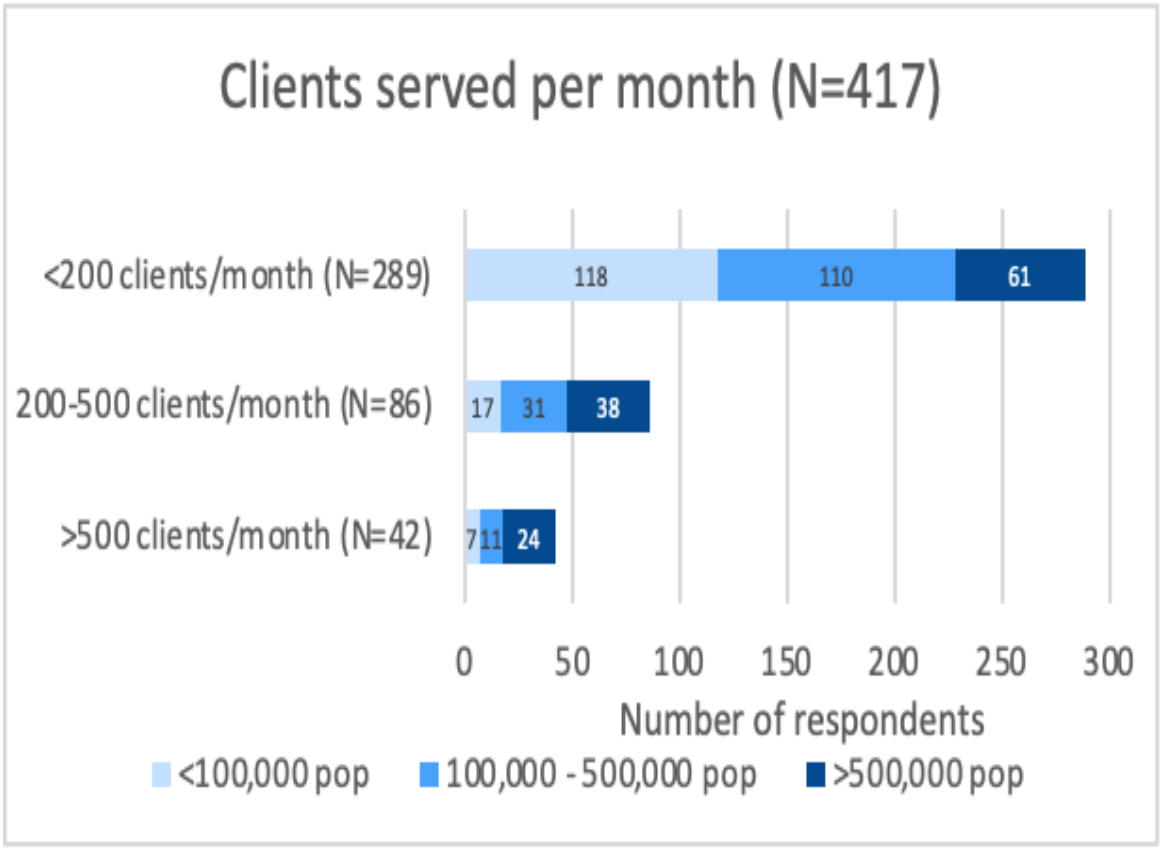
FINDING #6: Metrics Tracked by MCTs are Incomplete





Analytics Framework		
Metric Type	Key Question	Specific example
Production	How much, how many?	# Unique persons served
		# encounter by type
Responsivity (time interval metrics)	How fast?	speed of answer; response time
		time to see provider, provide follow up
Descriptive Stats (referral)	How many & % by category	# 911 vs hotline dispatches
Population Descriptive Stats	How many & % by category	# of 13-17 year olds
Process metrics	How often & % do we adhere utilize various best practices	% of time that performs lethal means restriction
Outcomes (point of service)	What happened by category & #/%	diversion rate
		referral-linkage dispositions
Outcomes (downstream)	What happened & % by category	connection to community-based care
		diversion rate @ 30, 45, 60, etc. days
Failure to connect	What didn't happen & #/% by category?	abandonment rate
		false alarm, unable to locate client
Consumer Experience	How did we do?	Complaints
		Compliments
Safety	Safety events by category & #'s	Near misses
		critical-sentinel events

Thank You!

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