Monterey County Behavioral Health Policies and Procedures

Policy Number	460
Policy Title	Mobile Crisis Services
References	9-1-1/Monterey County Law Enforcement Standardized Operating Procedures; American Rescue Plan Act (ARPA) of 2021 Section 9813 (42 U.S.C. section 1396w–6); California Code of Regulations (CCR), Title 9, Sections 1810.405 and 1810.410; Centers for Medicare and Medicaid Services State Health Official (SHO) #21-008; DHCS Behavioral Health Information Notice (BHIN) No. 20-070, 21-003, 21-013, 21-071, 21- 073, 23-001, 22-011, 22-013, 22-019 and 23-025; Department of Mental Health (DMH) Information Notice No. 10-02 and 10-17; Monterey County Behavioral Health Policies 303, 333, 334, 350, 352, 356; Monterey County Cell Phone and Vehicle Use Policies; Monterey County Health Department Policies; Monterey County Information Technology Policies; Social Security Act Section 1905(r) (42 U.S.C. § 1396d) State Plan Amendment (SPA) 20-0006-A, 21-0051, 21-0058, 22-0001 and 22-0043 BHIN 24-023: Standards for Specific Behavioral Health Provider Types and Services; Amends Relevant Sections Within Title 9 and Title 22 of the California Code of Regulations (CCR)
Effective	January 28, 2016 Revised: December 31, 2023 Revised: August 16, 2024

Policy

It is the policy of Monterey County Behavioral Health (MCBH) to establish, or contract with providers to establish, qualifying mobile crisis teams (consists of both County and/or Contracted Provider Staff, shall be referenced as MCT throughout the remainder of this policy unless specified otherwise) as defined in State Plan Amendment (SPA) 22-0043 that meet the Department of Health Care Services' (DHCS) training and implementation requirements set forth in Behavioral Health Information Notice (BHIN) 23-025. It is the intent of MCBH to implement a fully integrated approach across mental health and substance use disorder (SUD) delivery systems in which a single mobile crisis services infrastructure serves the entire County. As described in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Best Practice Toolkit, mobile crisis services are a critical component of an effective behavioral health crisis continuum of care. A "behavioral health crisis" refers to any event or situation associated with an actual or potential disruption of stability and safety as a result of behavioral health issues or conditions. A crisis may begin the moment things begin to

fall apart (e.g., running out of psychotropic medications or being overwhelmed by the urge to use a substance they are trying to avoid) and may continue until the beneficiary is stabilized and connected or re-connected to ongoing services and supports.

Additionally, the purpose of this policy is to provide general operating procedures and service delivery guidelines for the delivery of mobile crisis services throughout Monterey County to individuals of all ages. The primary mission of a mobile crisis response is to respond to uncontained behavioral health crisis situations in the community and provide relief to beneficiaries experiencing a behavioral health crisis avoid unnecessary hospitalizations and law enforcement involvement, and provide diversion to appropriate community-based resources, as clinically appropriate.

Program staff will employ culturally competent and best practice approaches to intervening with individuals in the community who are experiencing a behavioral health crisis event. Each mobile crisis service encounter will be provided in the community and will include at minimum: an initial face to face crisis assessment; mobile crisis response; crisis planning; facilitation of a warm handoff, if needed; referrals to ongoing services, if needed; and follow-up check ins.

Mobile Crisis Teams will partner with law enforcement at their request and provide mobile crisis services in response to 911 calls involving a behavioral health crisis. Mobile Crisis Teams will prioritize such emergency calls from law enforcement. Additionally, Mobile Crisis Teams will respond to calls that originate from crisis lines other than 911 (i.e., the Community Crisis Line of Monterey County, Seneca warmline, 988) that meet the established criteria for an in-person mobile response. Mobile Crisis Teams also receive and respond to non-urgent referrals from a variety of system partners. Mobile Crisis Teams will operate with the goal of avoiding the use of involuntary psychiatric hospitalization, when appropriate, by providing alternative treatment resources, which may include consultation, brief crisis intervention and safety planning, referral to outpatient treatment and/or diversion to voluntary psychiatric, medical and/or SUD related services, as appropriate.

This policy does not supersede calling 911 for all emergencies that may be life-threatening or when there is an immediate safety issue. This policy should be followed in conjunction with all Monterey County Health Department (MCHD) and MCBH policies and procedures.

Mobile Crisis Services Benefit

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to Medi-Cal beneficiaries who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; to reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile crisis services are intended to support an integrated approach to responding to both mental health and substance use related crises. Mobile Crisis

Teams (MCTs) will be carrying, trained, and able to administer naloxone. This benefit is not intended to replace emergency medical services for medical emergencies.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services. To include coordination with and referrals to appropriate health, social and other services and supports when appropriate; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restoring the beneficiary to the highest possible functional level. For children and youth, in particular, MCTs shall work extensively with parents, caretakers and guardians, as appropriate and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary MCT at the location where the beneficiary is experiencing the behavioral health crisis. Locations may include, but are not limited to, the beneficiary's home, school, or workplace, on the street, or where a beneficiary socializes. Pursuant to federal law, mobile crisis services claimed under this benefit cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

Existing Crisis Intervention Services

DHCS is not making any changes to the existing crisis intervention services and SUD crisis intervention services benefits covered under the SMHS and DMC-ODS delivery systems. MCBH shall continue covering these services in accordance with existing federal and state, and contractual requirements. To the extent already allowed, MCBH may provide crisis intervention services in settings or in a manner not allowed under the mobile crisis services benefit. For example, MCBH may allow MCTs to provide qualifying crisis intervention services in a Residential SUD treatment facility (see pgs. 12-13 for comprehensive list of service setting restrictions). However, these services shall not qualify for the enhanced matching rate available for mobile crisis services, and, as applicable, MCBH would remain responsible for the County share of the cost.

Access Criteria for Mobile Crisis Services

Consistent with policies outlined in BHIN 22-011 and BHIN 22-013 (or superseding guidance), and given the unique nature of behavioral health crises, mobile crisis services are covered and reimbursable prior to determination of a mental health or SUD diagnosis, or a determination that the beneficiary meets access criteria for SMHS or DMC-ODS services. MCBH should refer to BHINs 21-071, 21-073 and 23-001 (or superseding guidance) for criteria for beneficiary access to the SMHS and DMC-ODS delivery systems.

Background

The American Rescue Plan Act (ARPA) of 2021 section 9813 (42 U.S.C. section 1396w– 6) allows states to add qualifying community-based mobile crisis intervention services as a covered Medicaid benefit for a five-year period, beginning April 1, 2022, and ending March 31, 2027. In addition, ARPA provides an opportunity to receive an enhanced 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which a state meets the conditions outlined in statute.

Pursuant to Section 14132.57 of the Welfare and Institutions Code (W&I), the Department of Health Care Services (DHCS) intends to seek all necessary federal approvals to provide qualifying community-based mobile crisis intervention services ("mobile crisis services") to eligible Medi-Cal beneficiaries experiencing a mental health and/or SUD crisis ("behavioral health crisis"). Accordingly, DHCS submitted to the Centers for Medicare and Medicaid Services (CMS) State Plan Amendment (SPA) 22-0043 that establishes mobile crisis services as a new benefit in the Medi-Cal program. DHCS is not making any changes to the existing crisis intervention services and SUD crisis intervention services benefits covered under the Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS). MCBH shall continue covering these services in accordance with existing federal and state, and contractual requirements.

No sooner than January 1, 2023, and upon receiving approval from DHCS, MCBH shall provide, or arrange for the provision of, qualifying mobile crisis services in accordance with the requirements set forth in BHIN 23-025. Mobile crisis services are an integral part of California's efforts to strengthen the continuum of community-based care for individuals who experience behavioral health crises, including through implementation of the 988 Suicide and Crisis Lifeline and the Crisis Care Mobile Units Program Grant.

Procedure

1. Dispatch of Mobile Crisis Team

    A. Community Crisis Line of Monterey County

        i. The Community Crisis Line of Monterey County (866-615-1060) allows callers to connect to a real person, in real time to receive support for a behavioral health crisis. This line provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. The public can call for support for themselves or someone else. This line will link callers, when appropriate, to Mobile Crisis Dispatch to activate an in-person field response from a County and/or County contracted provider mobile crisis team.

        ii. MCBH shall coordinate with the 988 Suicide and Crisis Lifeline, local law enforcement and 911 systems, the Family Urgent Response System (FURS), and community partners to ensure beneficiaries have information about mobile crisis services.

B. Standardized Dispatch Tool and Procedures

i. MCBH shall require County-operated or County-contracted mobile crisis dispatch operators to use the DHCS standardized dispatch screening tool and set of procedures to determine when a MCT should be dispatched versus when a beneficiary's needs can be addressed via alternative means (e.g., de-escalation by operator, connection to other services, etc.) or referred to 911 dispatch.

C. Mobile Crisis Service Providers' Response to Dispatch Requests

i. MCBH shall ensure that mobile crisis service providers have staff readily available to receive and respond to calls that require mobile crisis response coming through the Community Crisis Line, and emergency calls for service requested by law enforcement / 911 dispatch. Mobile crisis service providers shall not use an answering service. If a beneficiary has been screened either directly, or through an individual calling on their behalf to request assistance, and the DHCS standardized dispatch screening tool has been used to determine that the beneficiary requires mobile crisis services, the mobile crisis service provider shall dispatch a team to respond to the beneficiary. When dispatched, the MCT shall meet the beneficiary who is experiencing the behavioral health crisis in the location where the crisis occurs, unless the beneficiary requests to be met in an alternate location in the community or cannot be located.

a. The MCBH mobile crisis team will continue to receive and respond to calls for service from County Communications Dispatch via the CAD page text and/or County issued radio. As MCBH's liaisons with local law enforcement partners, they may also respond to non-emergency calls from peace officers and other referral sources through direct contact or when contacted on a County issued cell phone. The mobile crisis personnel will inform Mobile Crisis Dispatch of their service response before or while on scene for safety purposes.

b. The MCTs can also receive non-urgent referrals and requests for assistance to provide support to other treatment providers (e.g., MCBH outpatient service providers, Adult Protective Services, Child Protective Services, County contracted mental health and SUD providers). A Mobile Crisis Referral may be submitted via encrypted email to MobileCrisis@countyofmonterey.gov to coordinate accompaniment with a current treatment team member.

2. Mobile Crisis Team Requirements for Initial Crisis Response

A. The initial mobile crisis response shall be provided at the beneficiary's location or at an alternate location of the beneficiary's choice in the community ("onsite") by a multidisciplinary MCT. MCTs shall meet the following standards:

i. At least two qualified mobile crisis team providers (as indicated in Enclosure 1) shall be available for the duration of the initial mobile crisis response. It is a best practice for at least two providers to be physically present onsite, but MCBH may allow one of the two required team members to participate via

telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions. MCTs may provide services in this manner only if MCBH determines that such an arrangement:

a. Is necessary because it otherwise would result in a marked delay in a MCT's response time; and
b. The use of such an arrangement poses no safety concerns for the beneficiary or the single MCT member who is physically onsite during the initial mobile crisis response.

ii. At least one onsite MCT member shall be carrying, trained, and able to administer naloxone;
iii. At least one onsite MCT member shall be able to conduct a crisis assessment;
iv. The MCT providing the initial mobile crisis response shall include or have access to a Licensed Practitioner of the Healing Arts (LPHA) as defined in the "SUD Treatment Services" or "Expanded SUD Treatment Services" section of Supplement 3 to Attachment 3.1-A of the State Plan, or a Licensed Mental Health Professional, including a licensed physician, licensed psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurse, or licensed psychiatric technician.

B. Use of Telehealth to Supplement Mobile Crisis Teams

i. The use of telehealth (which includes both synchronous audio-only (e.g., telephone) and video interactions) can offer an important avenue for expanding the expertise available to an onsite MCT. In addition to the staffing requirements listed above, MCTs may utilize telehealth to:
   a. Connect the beneficiary with highly trained and specialized practitioners, including psychiatrists and psychiatric nurse practitioners;
   b. Connect the beneficiary with a provider who can prescribe medications;
   c. Deliver follow-up services;
   d. Consult with appropriate specialists for beneficiaries who have intellectual and/or developmental disabilities (I/DD); and/or
   e. Engage translators or interpreters for beneficiaries who may need American Sign Language or other interpretation or translation services.

C. Role of Peer Support Specialists

i. It is considered a national best practice to include individuals with lived experience as members of MCTs. In December 2021, CMS approved SPA 20-0006-A, SPA 21-0058 and SPA 21-0051, which added Peer Support Services as a distinct service type and Peer Support Specialists as a Medi-Cal provider type in counties opting to implement these services.
ii. A Peer Support Specialist may participate as a MCT member if they have a current, State-approved Medi-Cal Peer Support Specialist certification, as outlined in BHIN 21-041, provide services under the direction of a Behavioral Health Professional, and meet all other mobile crisis services requirements, including required mobile crisis services training.
iii. Including Peer Support Specialists on MCTs may give beneficiaries

experiencing behavioral health crises greater opportunity to see and interact with someone they can relate to while they are receiving services.

iv. In many cases, Peer Support Specialists may be better equipped than other team members to lead client engagement, connect beneficiaries with ongoing supports, and follow-up.

v. Peer Support Specialists may establish a rapport, share experiences, and engage with family members or other significant support collaterals to educate them about self-care and ways to provide further support.

D. Role of Community Health Workers

i. In July 2022, CMS approved SPA 22-0001, which added Community Health Worker (CHW) services as a Medi-Cal benefit. CHWs may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. A CHW that meets the minimum qualifications through the certificate pathway or the work experience pathway as set forth in the California State Medicaid Plan and also completes required mobile crisis services training may provide mobile crisis services as part of a MCT contracted with MCBH.

ii. Like Peer Support Specialists, CHWs are trusted members of their communities who may be best positioned to help serve as cultural liaisons or assist behavioral health professionals in developing a crisis plan or connecting a beneficiary to ongoing services and supports.

E. Role of Emergency Medical Technicians, Paramedics, and Community Paramedics

i. Emergency Medical Technicians (EMTs), Advanced Emergency Medical Technicians (AEMTs), Paramedics, and Community Paramedics that are licensed, certified, and/or accredited in accordance with applicable State of California requirements and who complete required mobile crisis services training may provide mobile crisis services as part of a MCT contracted with MCBH.

ii. EMTs, AEMTs, Paramedics and Community Paramedics may be best positioned to support physical examinations, when needed, and provide individualized care to beneficiaries who are at risk of preventable hospital admission or re-admission due to chronic care or acute physical needs.

iii. These providers may also support a behavioral health professional's assessment to determine if a beneficiary requires emergency transport to an alternative setting for continued care.

3. Mobile Crisis Service Encounter

A. SPA 22-0043 covers the following mobile crisis service components:

i. Initial face-to-face crisis assessment;

ii. Mobile crisis response;

iii. Crisis planning;

iv. Facilitation of a warm handoff, if needed;

v. Referrals to ongoing services, if needed; and
vi. Follow-up check-ins.

B. Each mobile crisis services encounter shall include, at minimum:
i. Initial face-to-face crisis assessment;
ii. Mobile crisis response;
iii. Crisis planning, as appropriate, or documentation in the beneficiary's progress note of the rationale for not engaging the beneficiary in crisis planning; and
iv. A follow-up check-in, or documentation in the beneficiary's progress note that the beneficiary could not be contacted for follow-up despite reasonably diligent efforts by the MCT.

C. When appropriate, each mobile crisis services encounter shall also include:
i. Referrals to ongoing services; and/or
ii. Facilitation of a warm handoff.

D. MCTs shall be able to deliver all mobile crisis service components, even though there may be some circumstances in which it is not necessary or appropriate to provide all components (e.g., if the MCT can de-escalate a situation onsite, it may not be necessary to facilitate a warm handoff to a higher level of care).

E. MCBH shall not require prior authorization for the delivery of mobile crisis services. Consistent with the dispatch procedures, MCBH may de-escalate and stabilize an individual via telephone and make a determination that mobile crisis services are not appropriate or necessary.

F. <u>Initial Face-to-Face Crisis Assessment</u>
i. The MCT shall provide a brief, face-to-face crisis assessment to evaluate the current status of the beneficiary experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger to self or others, determining a short-term strategy for restoring stability, and identifying follow-up care, as appropriate. The crisis assessment is distinct from a comprehensive SMHS or DMC-ODS assessment as described in BHIN 22-019 (or superseding guidance) or a non-specialty mental health assessment as described in APL 22-006.
ii. If a beneficiary is referred to MCBH and/or SUD services for further behavioral health treatment, MCBH and its Contracted Providers, shall ensure the beneficiary receives a comprehensive SMHS or SUD assessment when required.
iii. Any team member that has been trained to conduct a crisis assessment as part of required mobile crisis services training can deliver the initial face-to-face crisis assessment.
iv. When delivering a crisis assessment, MCTs shall use the DHCS standardized crisis assessment tool. MCBH shall ensure that the crisis assessment tool is responsive to youth and adult beneficiaries from culturally diverse backgrounds, including but not limited to tribal communities, LGBTQ+

youth and adults, beneficiaries with limited English proficiencies and beneficiaries with disabilities, including co-morbid disabilities, I/DD, serious mental illness, traumatic brain injury, and beneficiaries who are deaf or hard of hearing.

v. Consistent with the SAMHSA National Guidelines for Behavioral Health Crisis Care, the crisis assessment tool may include information available from the beneficiary or their significant support collateral(s) about:
   a. Causes leading to the crisis; including psychiatric, social, familial, legal factors and substance use;
   b. Safety and risk for the beneficiary and others involved, including an explicit assessment of suicide risk, and access to any weapons or firearms;
   c. Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
   d. Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
   e. Medications prescribed as well as information on the beneficiary's use of prescribed medication;
   f. A rapid determination as to whether the crisis requires coordination with emergency medical services (EMS) or law enforcement; and
   g. Medical history as it may relate to the crisis.

G. Mobile Crisis Response

i. During the mobile crisis service encounter, the MCT shall intervene to de-escalate the behavioral health crisis and stabilize the beneficiary at the location where the crisis occurs, unless the beneficiary requests to be met in an alternate location in the community. The mobile crisis response may include, but is not limited to:
   a. Trauma-informed on-site intervention for immediate de-escalation of behavioral health crises;
   b. Skill development, psychosocial education and initial identification of resources needed to stabilize the beneficiary;
   c. Immediate coordination with other providers involved in the beneficiary's care;
   d. Immediate coordination with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, general acute care hospitals, crisis residential treatment programs, etc.); and
   e. Provision of harm reduction interventions, including the administration of naloxone to reverse an opioid overdose, as needed.

H. Crisis Planning

i. As appropriate during the mobile crisis services encounter, the MCT shall engage the beneficiary and their significant support collateral(s), if appropriate, in a crisis planning process to avert future crises. Crisis planning may include:
   a. Identifying conditions and factors that contribute to a crisis;

b. Reviewing alternative ways of responding to such conditions and factors; and
c. Identifying steps that the beneficiary and their significant support collateral(s) can take to avert or address a crisis.

ii. When appropriate, crisis planning may include the development of a written crisis safety plan. MCTs will use the DHCS standardized safety plan tool. To the extent information is available and appropriate, the written crisis safety plan shall include, but is not limited to:
a. A review of any immediate threats to the individual's or others' safety and well-being, such as accessible firearms or medications which could be used in a plan for self-harm or harm to others;
b. Conditions and factors that contribute to a crisis;
c. Alternative ways of responding to such conditions and factors;
d. Additional skill development and psychosocial education;
e. A psychiatric advanced directive;
f. Short and long-term prevention and strategies and resources the beneficiary can use to avert or address a future crisis, including harm reduction strategies.

iii. A copy of the crisis safety plan, if one is developed, shall be documented in the beneficiary's clinical record, and provided to the beneficiary and to their significant support collateral(s) if it is feasible and would benefit the beneficiary's treatment.

iv. The MCT shall note in the beneficiary's progress notes if crisis planning was appropriate and if the beneficiary was or was not able to engage in crisis planning. The MCT may continue crisis planning and create or update a written crisis safety plan with the beneficiary as part of follow-up check-ins.

I. <u>Facilitation of a Warm Handoff</u>

i. In some cases, the beneficiary may need to be transported to a higher level of care, such as a sobering center, crisis respite, crisis stabilization unit, psychiatric health facility (PHF), psychiatric inpatient hospital, general acute care hospital, or crisis residential treatment program.

ii. If the beneficiary requires further treatment at a higher level of care, the MCT shall connect the beneficiary with the appropriate care option by facilitating a warm handoff.

iii. The MCT shall also arrange for or provide transportation to effectuate the warm handoff, if needed.

J. <u>Referrals to Ongoing Services</u>

i. MCBH shall ensure that MCTs refer beneficiaries, as appropriate, to available ongoing mental health and/or SUD treatment, community- based supports, social services, and/or other supports to help mitigate the risk of future crises. MCTs shall identify appropriate services and make referrals or appointments during the initial mobile crisis response if appropriate, or as part of follow-up check-ins, as needed. Referral sources may include, but are not limited to:
a. Primary care providers;
b. Outpatient behavioral health treatment providers, including providers that

may offer further support with care coordination/case management;
c. Prescribers for mental health or SUD medications;
d. Providers serving individuals with disabilities, including individuals with I/DD, including but not limited to Regional Centers;
e. Programs offering Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) services;
f. Crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, general acute care hospitals, crisis residential treatment programs, etc.);
g. Community support and mutual aid groups (e.g., National Alliance on Mental Illness, Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery);
h. Care coordination supports identified by the beneficiary's Managed Care Plan (MCP) or other sources (e.g., Enhanced Care Management (ECM) services); and
i. Other housing and community supports for assistance with obtaining housing, utility, and rent (e.g., housing shelters and providers to facilitate coordinated entry, places of worship, food pantries, soup kitchens, recreation centers, community centers).
j. MCTs shall document all referrals in the beneficiary's progress note. MCTs shall coordinate with other providers serving the beneficiary in crisis when appropriate.

K. Follow-up Check-Ins

i. Medi-Cal behavioral health delivery systems shall ensure that beneficiaries receive a follow-up check-in within 72 hours of the initial mobile crisis response. The purpose of the follow-up check-in is to support continued resolution of the crisis, as appropriate, and should include the creation of or updates to the beneficiary's crisis safety plan, or additional referrals to ongoing supports, as needed. If the beneficiary received a referral to ongoing supports during the initial mobile crisis response, as part of follow-up the MCT shall check on the status of appointments and continue to support scheduling, arrange for transportation, and provide reminders as needed.

ii. Follow-up may be conducted by any MCT member who meets DHCS' core training requirements (see Enclosure 2) and may be conducted in-person or via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions. Follow-up may be conducted by a MCT member that did not participate in the initial mobile crisis response. If the MCT member conducting follow-up is not part of the MCT that provided the initial crisis response, the individual providing follow-up shall coordinate with the team members that participated in the initial mobile crisis response to gather information on the recent crisis and any other relevant information about the beneficiary. There may be times when the MCT is unable to engage the beneficiary in follow-up.
    a. Examples include but are not limited to the beneficiary is in inpatient treatment, otherwise incapacitated, unwilling to engage, or cannot be

reached despite reasonably diligent efforts. The MCT shall document those instances where the beneficiary cannot be engaged for follow-up.

L. Documentation

i. MCTs shall document problems identified during the mobile crisis services encounter on the beneficiary's problem list within the beneficiary's medical record, consistent with documentation requirements outlined in BHIN 22-019 (or superseding guidance). In addition, MCTs shall create a progress note that describes all service components delivered to the beneficiary, including any follow-up check-ins, referrals to ongoing supports, crisis planning, or facilitation of a warm handoff made as part of the mobile crisis services encounter.

M. Coordination with Other Delivery Systems

A mobile crisis response is a powerful indicator that a beneficiary needs additional services or that something is not working well with their current array of services; it warrants an alert to other providers who are involved in the beneficiary's care and coordinated follow-up.

i. MCBH and MCTs shall document in the client electronic medical record if they are aware the beneficiary is receiving care management through targeted case management, ICC, ECM, or any other benefit including non-Medi-Cal benefits such as Full-Service Partnership;
   a. If a MCT receives information that a beneficiary is receiving services from a care manager, it shall alert the beneficiary's care manager(s) of the behavioral health crisis, as applicable, and coordinate referrals and follow-up consistent with privacy and confidentiality requirements.

MCTs shall ensure that they have the beneficiary's consent for these disclosures in cases where consent is required by applicable law.

N. Service Setting Restrictions

i. With the exception of the settings listed in the next paragraph, the initial mobile crisis response shall be provided where the beneficiary is in crisis, or at an alternate location of the beneficiary's choosing. Examples of settings include, but are not limited to:
   a. Houses and multi-unit housing;
   b. Workplaces;
   c. Public libraries;
   d. Parks;
   e. Schools;
   f. Homeless shelters;
   g. Outpatient clinics;
   h. Assisted living facilities; and
   i. Primary care provider settings.

Mobile crisis services shall not be provided in the following settings due to

restrictions in federal law and/or because these facilities and settings are already required to provide other crisis services:

a. Inpatient Hospital;
b. Inpatient Psychiatric Hospital;
c. Emergency Department;
d. Mental Health Rehabilitation Center;
e. Skilled Nursing Facility;
f. Intermediate Care Facility;
g. Settings subject to the inmate exclusion such as jails, prisons, and juvenile detention facilities;
h. Other crisis stabilization and receiving facilities (e.g., , crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, , etc.).

4. Standards

A. Response Times

i. MCTs shall arrive at the community-based location where a crisis occurs in a timely manner. Specifically, MCTs shall arrive:
   a. Within 60 minutes of the beneficiary being determined to require mobile crisis services in urban areas; and
   b. Within 120 minutes of the beneficiary being determined to require mobile crisis services in rural areas.

   Timeliness standards are not included in network adequacy requirements or certification.

B. Community Partnerships

ii. MCBH shall maintain relationships with key community partners to support community engagement with mobile crisis services, coordination, and system navigation. MCBH shall ensure that:
   a. Community partners are aware of the availability of mobile crisis services as a community resource; and
   b. Community partners understand how to request mobile crisis services to assist beneficiaries experiencing behavioral health crises.

iii. Community partners may include, but are not limited to:
   a. Medical and behavioral health providers;
   b. Primary care providers (including pediatric providers for children);
   c. Social services providers;
   d. Community health centers;
   e. Federally qualified health centers;
   f. Crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, crisis residential treatment programs, etc.);
   g. Hospitals;
   h. Schools;
   i. Regional Centers;
   j. Carelon;

k. Local courts;
l. Local departments of social services; and
m. Law enforcement.

C. Law Enforcement

i. When a MCT is dispatched, it is considered a national best practice for the team to respond without law enforcement accompaniment unless special safety concerns warrant inclusion. When not required for safety reasons, law enforcement involvement in a behavioral health crisis can lead to an increase in unnecessary arrests and incarceration of beneficiaries living with acute behavioral health needs.

ii. MCBH shall coordinate with law enforcement and share information with law enforcement officers about how to request or coordinate mobile crisis dispatch, when appropriate.

iii. MCBH shall also work with law enforcement to determine how MCTs and law enforcement can best work together to safely resolve and de-escalate behavioral health crises, minimizing the role of law enforcement except when necessary and appropriate for safety reasons.

iv. While law enforcement officers may accompany a MCT when necessary for safety reasons, they shall not qualify as a member of the MCT for purposes of meeting MCT requirements. Similarly, Crisis Intervention Teams (CIT), which include specially trained law enforcement officers who have undergone designated CIT training may not provide or be reimbursed for mobile crisis services, unless they meet the MCT requirements.

D. Transportation

i. When needed, a MCT shall arrange for or provide transportation to an appropriate level of care or treatment setting. The MCT may transport the beneficiary directly as part of providing the mobile crisis service.
   a. The MCTs will travel and respond to calls using a designated marked County and/or County contracted provider vehicles and conduct outreach work with known individuals who may be in need of crisis intervention or a referral for other community services. The MCTs will adhere to the Monterey County Vehicle Use Policy and follow the County Fleet recommended routine maintenance schedule.
   b. Individuals not meeting criteria for an involuntary psychiatric hold, who have been evaluated by the MCT may be transported in the MCT County Vehicle to voluntary alternative locations, if deemed appropriate, based on MCTs clinical judgment.

ii. If the MCT cannot provide transportation itself, or if there are outstanding medical or safety concerns, the MCT shall coordinate with non-medical transportation (NMT) providers, EMS, or law enforcement, if necessary, to arrange transportation and ensure the beneficiary is connected with appropriate care.
   a. If the MCT determines the individual in crisis meets the California W&I Section 5150 or 5585 for an involuntary psychiatric hold, the MCT authorized team member will complete the 5150 or 5585 documentation

and facilitate transport to the emergency room for further evaluation. If an individual is placed on an involuntary psychiatric hold by either the MCT or a responding peace officer, the individual will be transported by peace officer or ambulance.

iii. If EMS, NMT, or law enforcement is utilized to transport the beneficiary directly to a higher level of care, the MCT shall remain onsite until the transportation provider arrives to coordinate care.

E. . Cultural Competency, Linguistic Appropriate Care and Accessibility

i. All members of MCTs shall comply with all applicable cultural competence and linguistic requirements in state and federal law, including those in W&I section 14684, subdivision (a)(9); CCR, Title 9, section 1810.410; the contract between the MHP and DHCS and contracts between DMC-ODS counties and DHCS; BHIN 20-070 and 23-001; and DMH Information Notices 10-02 and 10-17.

F. Privacy and Confidentiality

i. MCT shall maintain the privacy and confidentiality of their patient's information in accordance with federal and state law. The MCTs will adhere to all privacy and confidentiality regulations when responding to an event. All MCBH and contracted provider workforce is subject to all rules of confidentiality set forth in all applicable health privacy laws, which apply to the provision of mental health services by the MCT program.

i. MCT are health care providers subject to the privacy and security rules under the Health Insurance Portability and Accountability Act (HIPAA). While MCT and MCBH will often be able to exchange protected health information in compliance with HIPAA, MCBH shall be aware of HIPAA requirements that may limit MCTs' ability to share such information, such as HIPAA's minimum necessary requirement. The minimum necessary of confidential mental health information will be shared for the sole purpose of preventing or causing harm and/or injury to others or to themselves.

ii. In addition, there may be circumstances where MCTs are subject to the federal substance use disorder confidentiality regulation, 42 C.F.R. Part 2. MCBH shall inquire whether any of their MCT are subject to 42 C.F.R. Part 2 and, if so, ensure that workflows are in place to ask beneficiaries for their consent when appropriate.

iii. The MCTs will enter each call for service into the electronic health record system. The MCTs will utilize County/Contracted provider issued encrypted and password protected laptops and follow all County Information Technology (IT) Policies. MCT staff will have readily available or accessible information to provide to individuals about community resources, grievance procedures and problem resolution processes. Handling of protected health information (PHI) by the MCT will be in accordance with all MCHD and MCBH policies, including but not limited to, MCBH policies 303, 350, 352, and 356. MCT staff will utilize a lock box to secure PHI and other health information and shall comply with all MCHD and MCBH policies to safeguard confidentiality of the individual's health information at all times.

5. Other Considerations

A. Children and Youth

i. MCTs shall respond to beneficiaries of all ages, including children and youth experiencing behavioral health crises. Through crisis de-escalation and resolution, MCT may help children, youth and their families avoid hospitalization and emergency out-of-home placements in many circumstances. For some children and youth, accessing crisis services may be their first introduction to the state's behavioral health system, making it a critical moment for early identification of mental health conditions and engagement into treatment.

ii. As part of required training, MCTs shall participate in training on strategies to work effectively with children, youth and young adults experiencing behavioral health crises. Training may include, but is not limited to, delivering culturally responsive care, particularly when working with children, youth and young adults who are LGBTQ+, Black, Indigenous, and People of Color, involved in the child welfare system, or living with Intellectual and/or Developmental Disabilities (I/DD). In addition, MCT shall abide by all state and federal minor consent laws. Required training shall also include an overview of existing minor consent obligations and appropriate protocols for communicating with parents, guardians and other responsible adults who may or may not be present at the time of the crisis.

B. Individuals with Intellectual and/or Developmental Disabilities

i. Beneficiaries experiencing behavioral health crises may have co-occurring needs which require additional considerations in the provision of mobile crisis services. People with I/DD and co-occurring mental health conditions may experience sensory or communication challenges that may complicate de-escalation of a behavioral health crisis. MCTs responding to a beneficiary with I/DD shall ensure that natural supports (e.g., familial caregivers, personal attendants) are involved and consulted in the crisis response, if appropriate. To the extent possible, MCTs are encouraged to include a team member with I/DD expertise or have access to an individual with I/DD expertise (e.g., a Board-Certified Behavioral Analyst) via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions.

ii. All members of MCTs shall participate in training on crisis response for beneficiaries with I/DD, which may include, but is not limited to general characteristics of people with intellectual disability and autism spectrum disorder, co-occurrence of I/DD and mental health conditions, and crisis intervention strategies for serving this population (e.g., communication tactics and techniques, strategies to involve caregivers, etc.).

iii. Additionally, MCBH developed a MOU with the San Andreas Regional Center (SARC) to coordinate services, identify dually diagnosed beneficiaries, and develop procedures for Regional Center staff and county mental health staff to collaborate in responding to beneficiaries with co-occurring I/DD and mental health conditions.

Enclosure 1
Qualified Mobile Crisis Team Members by Delivery System

Rehabilitative Mental Health Treatment Providers*	**SUD Treatment Providers****	**Expanded SUD Treatment Providers****	**Other Provider Types**
• Physician • Psychologist • Waivered Psychologist • Licensed Clinical Social Worker • Waivered/Registered Clinical Social Worker • Licensed Professional Clinical Counselor • Waivered/Registered Professional Clinical Counselor • Marriage and Family Therapist • Waivered/Registered Marriage and Family Therapist • Registered Nurse • Certified Nurse Specialist • Licensed Vocational Nurse • Psychiatric Technician • Mental Health Rehabilitation Specialist • Physician Assistant • Nurse Practitioner • Pharmacist • Occupational Therapist • Other Qualified Provider • Peer Support Specialist • Clinical Trainee • Medical Assistant	• Peer Support Specialist • Clinical Trainee • Medical Assistant		• Advanced Emergency Medical Technicians. Advanced Emergency Medical Technicians must be certified in accordable with applicable State of California certification requirements. Paramedics. Paramedics must be licensed in accordance with applicable State of California licensure requirements. • Community Paramedics. Community paramedics must be licensed, certified, and accredited in accordance with applicable State of California licensure requirements.

Notes

*Defined in the “Provider Qualifications” subsection of the “Rehabilitative Mental Health Services” section of this supplement. Rehabilitative Mental Health Treatment services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Rehabilitative Mental Health Services established by the Department of Health Care Services, to the extent authorized under state law.

**Defined in the “Provider Qualifications” subsection of the “SUD Treatment” and “Expanded SUD Treatment” sections of this supplement. SUD and Expanded SUD Treatment services are provided by DMC certified providers that: 1) are licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations; 2) abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and 3) sign a provider agreement with a county or the Department of Health Care Services.

***Other Provider Types are eligible to participate on mobile crisis teams delivering Rehabilitative Mental Health Treatment, SUD Treatment, or Expanded SUD Treatment services as defined above.

Enclosure 2
Medi-Cal Mobile Crisis Services Benefit: Training Courses Overview

Required Core Trainings	Required Enhanced Trainings	Recommended Supplemental Trainings
1. Crisis Intervention and De-escalation Strategies 2. Harm Reduction Strategies 3. Delivering Trauma-Informed Care 4. Conducting a Crisis Assessment 5. Crisis Safety Plan Development	1. Crisis Response Strategies for Special Populations (may be a two-part training) a. Children, Youth and Families b. Tribal Communities c. Individuals with Intellectual and Developmental Disabilities (I/DD) 2. Co-occurring Disorders/Responding to SUD Crises 3. Delivering Culturally Responsive Crisis Care	1. Community Partnership Coordination Strategies 2. Staffing Mobile Crisis Teams and Team Composition 3. Aftercare and/or Post Crisis Follow-up Strategies 4. Motivational Interviewing 5. Suicide Prevention 6. Psychiatric Advance Directives 7. Provider Safety 8. Crisis Response for Rural Areas 9. Accessibility Strategies 10. Service Guidelines and Access to Services Criteria 11. Documentation Requirements for Mobile Crisis Services 12. Medi-Cal Eligibility Verification 13. Claiming/Billing and Reimbursement for Mobile Crisis Services 14. Data Reporting for Mobile Crisis Services 15. Process and Safeguards for Maintaining Privacy and Confidentiality 16. Dispatch and Timely Response of Mobile Crisis Teams 17. Considerations and Strategies for Meeting Timeliness Standards 18. Facilitation of Warm

		Handoffs to Alternative Treatment Settings 19. Transportation Strategies for Beneficiaries Experiencing a Behavioral Health Crisis 20. Appropriate Use of Telehealth for Mobile Crisis Services 21. Coordination with Family Urgent Response System, Regional Centers, and other Dispatch Lines