Louisiana Crisis Response System (LA-CRS) Companion Guide

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I. Definitions

At Risk Population: The population with Serious Mental Illness and co-occurring physical health conditions who are at risk of nursing home placement. LDH is in the process of operationalizing this definition and this will be updated when finalized.

Behavioral Health Crisis Care (BHCC): a facility based service that operates twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term behavioral health crisis intervention, offering a community based voluntary home-like alternative to more restrictive settings

Community Brief Crisis Support (CBCS): a face to face intervention available to individuals subsequent to receipt of MCR, BHCC, or CS. This ongoing crisis intervention response is intended to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers.

Crisis Stabilization (CS): a short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement.

Iatrogenic: Harm caused by treatment.

Mobile Crisis Response (MCR): a mobile service that is available as an initial intervention for individuals in a self-identified crisis, in which teams deploy to where the individual is located in the community. The service is available twenty-four (24) hours a day, seven (7) days a week and includes maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times.

My Choice Louisiana: Transition Coordination initiative operated through OBH and OAAS in which individuals who meet the target population of the DOJ agreement are transitioned into the community from nursing facilities.

II. General Information

In compliance with requirements outlined within LDH's Agreement with the United States Department of Justice (DOJ) related to individuals with serious mental illness in nursing facilities (Case 3:18-cv-00608, Middle District of Louisiana), LDH developed the Louisiana Crisis Response System (LA-CRS). Through this system LDH developed four (4) services which has allowed for the provision of voluntary crisis services along a continuum for individuals experiencing emotional distress. These services are available to Medicaid eligible adults 21 and older; in April 2024, select services will expand to the child/youth population (20 and younger) and their families. These services include:

- Mobile Crisis Response (MCR)

- Available to child/youth population April 2024

- Behavioral Health Crisis Care (BHCC)
- Community Brief Crisis Support (CBCS)
  - Available to child/youth population April 2024
- Crisis Stabilization (CS)

A. Vision:

The Louisiana Department of Health (LDH) is committed to ensuring that individuals in crisis and their families experience treatment and support that is compassionate, effective, resolution-focused, and delivered by a crisis system that is coordinated, responsive and efficient. LDH is committed to addressing the crisis needs of individuals in the target population as detailed in the Agreement. In addition, LDH believes that by addressing the behavioral health crisis needs of all populations, including Louisiana's most vulnerable citizens (e.g. children and youth in crisis and their families, individuals with co-occurring conditions, and those who are at risk of institutionalization), we can maximize the use of voluntary treatment, reduce the need for law enforcement involvement and mitigate iatrogenic harm caused by involuntary interventions. In addition, it will allow people to remain in their communities and reduce the need for restrictive levels of care including nursing homes, residential care centers, out of home placements, jails, intermediate care facilities for individuals with intellectual/developmental disabilities, and hospitals. It is LDH's goal to develop a statewide model for crisis response that maintains regional and geographic relevance and builds upon the unique and varied strengths, resources, and needs of Louisiana's individual communities.

To achieve this vision, LDH, in consultation with service recipients and key system partners, developed a modern, innovative and coordinated crisis system. LDH's vision is a crisis system that:

- Values and incorporates "lived experience" in designing a crisis system and in crisis service delivery;
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports;
- Is built on principles of recovery and resiliency, delivering services that are individualized and person-centered;
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings;
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response;

- Provides stabilizing interventions and supports that allow individuals to recover as quickly as possible;

- Delivers resolution-focused interventions and assists individuals in problem-solving and in developing strategies to prevent future crises and enhance their ability to recognize and deal with situations that may otherwise result in crises;

- Supports individuals to increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention;

- Continuously improves its processes to assure seamless and efficient care;

- Collaborates and innovates with partner systems including healthcare systems, judicial systems, law enforcement, child protective services, educational systems, homeless coalitions, as well as any other system that touches individuals who may experience a behavioral health crisis; and

- Collaborates with the individual's existing behavioral health service providers, or links individuals to new behavioral health service providers for longer-term treatment when appropriate and desired by the recipient.

A crisis is self-defined and can best be labeled as "need help now" determined by the individual. Therefore, the system, and management of the system, must be flexible and responsive to needs.

B. MCO Role:

MCOs have a crucial role in the success of the LA-CRS system, and shall comply with all portions of Attachment A, *Model Contract* and Crisis Care Coordination Protocols as they relate to implementation of these services. This includes, but is not limited to, the following:

- The development and maintenance of a LA-CRS provider network that meets the needs of its enrollees and maintains standards related to quality provision of services

- The appropriate identification of members in crisis which occurs through:

    - The operation of the 24 Hour Behavioral Health Crisis Line, providing telephonic support to individuals in crisis and triaging/dispatching calls to the appropriate services;

    - Routine education about the LA-CRS targeted to:

        - Enrollees

        - Provider network

        - Community networks

    - Targeted education about the LA-CRS to enrollees:

        - Who have utilized inpatient hospitalization and/or emergency department presentations due to behavioral health conditions
        - Who are at risk of such presentations, such as
            - The At Risk population
            - Individuals served through the My Choice Louisiana program
- Rapid authorization of LA-CRS services
- Rapid linkage to alternate services necessary to meet the individuals needs subsequent to LA-CRS intervention, this includes warm transfer to
    - Higher levels of interventions when warranted
    - Community brief crisis support services when warranted
    - Community based resources for ongoing support subsequent to the crisis experience during traditional hours of operations or, if the crisis occurs after working hours, linkage the next business day
- Ensure staff is educated about the LA-CRS and 24 Hour Behavioral Health Call Center staff process and track calls in congruence with the Crisis Care Coordination Protocols
- Participate in ongoing meetings related to the readiness and implementation of LA-CRS services including regional and statewide crisis coalitions.

III. Staffing and Training

A. Staffing:

The MCO shall maintain adequate staffing to ensure compliance with the requirements contained within Attachment A, *Model Contract*, the LA-CRS Companion Guide and the processes outlined within the LDH Crisis Care Coordination Protocols. This includes:

- **Behavioral Health Coordinator**: shall meet the requirements for a LMHP and have at least seven (7) years' experience in managing behavioral healthcare operations. The Behavioral Health Coordinator shall have responsibility for clinical program development and oversight of staff and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness and/or with substance use disorders in compliance with federal and state laws and the requirements set forth in this contract, including the 24-hour behavioral health crisis line, and all documents incorporated by reference. The Behavioral Health Coordinator will share responsibility to manage the specialized behavioral health services delivery system, including crisis response services implemented via the Louisiana Crisis Response System, with the Behavioral Health Medical Director. The Behavioral Health Coordinator shall

regularly review integration performance, performance improvement projects, and surveys related to integration and shall work closely with the Performance/Quality Improvement Coordinator and Quality Management Coordinator and Behavioral Health Quality Management Coordinator. Additionally, the Behavioral Health Coordinator shall participate in Statewide coalitions regarding the implementation of crisis response services through the Louisiana Crisis Response System and ensure MCO participation in regional coalitions developed through this initiative.

- **Liaisons to work with Regional Crisis Coalitions:** developed in conjunction with the Louisiana Crisis Response System.

- **24-Hour Behavioral Health Crisis Line staff:** whether through subcontract, if prior approved by OBH/LDH, or direct employment, the MCO shall have an adequate number of staff to answer the behavioral health crisis line twenty-four (24) hours per day, seven (7) days per week, with sufficient capacity to preclude the use of answering machines, third-party answering services, and voicemail. Staff shall participate in OBH approved trainings. These employees do not need to be LMHPs.

- **Licensed Mental Health Professionals (LMHP):** staff must be trained to determine the medical necessity criteria as established by the State. LMHPs shall be certified in administering the Level of Care Utilization System (LOCUS). LMHPs shall be available to accept and respond to calls via warm transfer from the 24-hour behavioral health crisis line.

B. Training:

In addition to any other training requirements outlined within Attachment A, *Model Contract*, 24 Hour Behavioral Health Crisis Line staff shall participate in the crisis training provided by Louisiana State University Health Science Center (LSUHSC) Center for Evidence to Practice (E2P), hereafter referred to as the Center. This includes both pre-training asynchronous and in-person online (remote) training in accordance with the training delivery matrix, completed prior to answering calls via the 24 hour behavioral health crisis line.

The MCO shall maintain enrollment and participation standards, including use of the Training Adherence Tracker monthly, as outlined by LSUHSC.

IV. Appendices

A. Crisis Care Coordination Protocols

Appendix A

Louisiana Department of Health (LDH)

Crisis Care Coordination Protocols

Purpose and Content of the Protocol

The purpose of this protocol is to convey expectations for ***coordinating*** crisis care across the continuum of crisis care including:

- Managed Care Organization (MCO) Crisis Line
- Mobile Crisis Response (MCR)
- Community Brief Crisis Support (CBCS)
- Behavioral Health Crisis Care (BHCC) Centers
- Crisis Stabilization (CS)

The protocol content will address:

- Crisis Care Coordination is essential to resolving crisis and achieving outcomes
- Role of the MCO Related to Crisis Services
- Role of the MCO Crisis Line
    - Guidance on decisions to dispatch MCR
- Coordination Expectations between MCO Crisis Line, MCRs, and other crisis services
    - How to identify mobile crisis providers to dispatch
    - Dispatching process including closing the loop processes
        - Information to be verbally shared between the Crisis Line and with MCR providers
        - MCR providers back to the crisis line
    - Expectations for MCR services
        - MCR coordination of next level of care
    - Expectations for CBCS services
        - Processing CBCS referrals
        - CBCS coordination of next level of care
    - Expectations for BHCC services
        - Accessing BHCC services
        - BHCC coordination of next level of care
    - Expectations for CS services
        - Accessing CS services
        - CS coordination of next level of care
- Guidance on effective strategies for caller empowerment and avoiding involuntary or coercive processes
    - Guidance on effective strategies for caller empowerment and avoiding involuntary or coercive processes
    - Guidance for involving police and/or EMS
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- Crisis Services Reporting

- Attachment A – Monthly Reporting
- Appendix A – Excerpts – National Standards for Processing Crisis Calls
- Appendix B – Louisiana Crisis Response System: Overview
- Appendix C – Excerpts from the LDH Crisis Response System: Services Overview

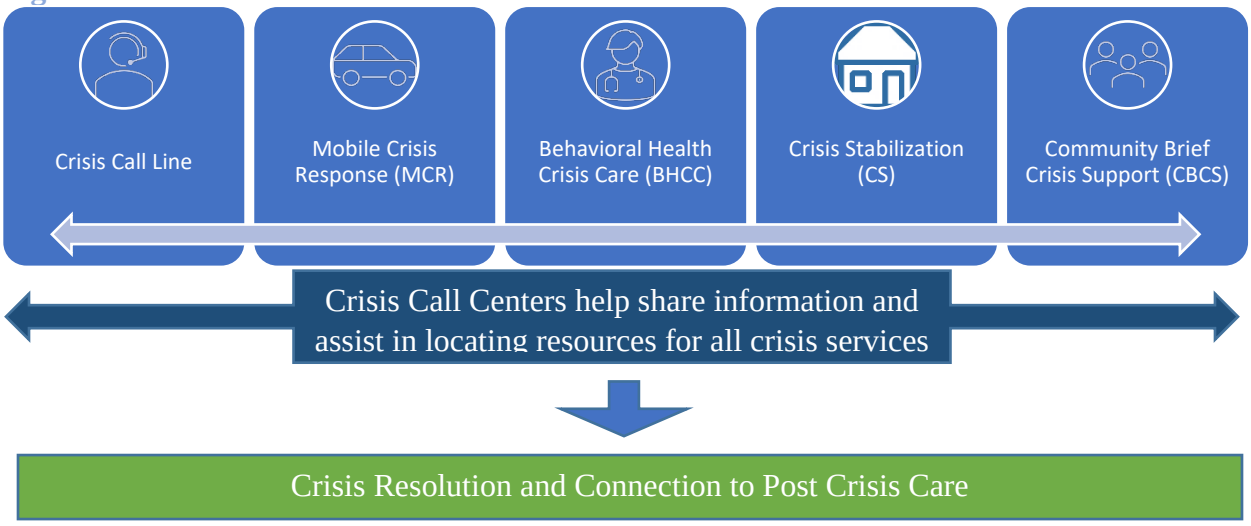
The Louisiana Crisis Response System

In addition to the crisis intervention service offered within the Mental Health Rehabilitation (MHR) array of services, a new set of voluntary crisis services were developed via the implementation of the Louisiana Crisis Response System. These services began with availability for Medicaid adults age 21 and older, with expansion of two of the services to Medicaid members under 21 as well. These services are provided to form a continuum of care offering relief, resolution and intervention through crisis supports and services to decrease the unnecessary use of emergency departments and inpatient hospitalizations for members whose needs are better met in the community. These services are comprised of Mobile Crisis Response (MCR) (all members), Behavioral Health Crisis Care (BHCC) (21+), Community Brief Crisis Support (CBCS) (all members), and Crisis Stabilization for Adults (CS) (21+), which were implemented via a phased in implementation in State Fiscal Year (SFY) 22, and with MCR and CBCS expansion to youth in SFY 24. Beyond the soft launch period, effective 4/1/2024, these services will be available twenty-four (24) hours a day, seven (7) days a week, though during initial implementation lesser hours and days of operation were approved by LDH.

Crisis Care Coordination is Essential to Resolve Crisis and Achieving Outcomes

Crisis care coordination is critical to achieving crisis resolution for members in crisis. The goal of providing crisis services is to provide intervention *and* support ***to resolve the crisis and connect to post crisis care.*** Often times in order to resolve the crisis, individuals and families need to be connected timely to other crisis services or supports. All crisis providers need to ensure all actions are taken to *adequately* address an individual or families' need to have their care coordinated with other crisis services or other support services. Crisis resolution sometimes requires also addressing social determinates. *Figure 1 – Crisis Care Coordination and Crisis Resolution* depicts the expectations for the coordination of crisis care across the continuum and the role of the crisis line to support the sharing of information.

Figure 1 – Crisis Care Coordination and Crisis Resolution



Role of the MCO Related to Crisis Services

The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline to provide crisis counseling, crisis intervention and follow up, linkage to ongoing behavioral health management and intervention. The MCO may also coordinate with community resources to expand the crisis response. The community based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement, and crisis stabilization/crisis walk in centers for adults.

Role of the MCO Crisis Line

The MCO shall maintain a 24-hour toll-free crisis response center to respond to specialized behavioral health needs. The call center must provide the following:

- 24-hour, 7-day a week access to staff
- Answered by a live voice at all times
- Have sufficient telephone lines to answer incoming calls

The MCO shall ensure operation of 24-Hour Behavioral Health Crisis Line in a manner congruent with contract standards. The MCO's 24-Hour Behavioral Health Crisis Lines are critical to supporting individuals and families in crisis and helping them to connect with crisis providers and other supports to help resolve the crisis in the midst of the crisis experience. Additionally, the MCOs are responsible for connecting these members post crisis with timely behavioral health services, physical health services, and other social services.

Guidance on Decisions to Dispatch MCR:

Examples of the types of calls to dispatch a MCR team:

- For calls about a minor youth (under 18) in crisis, the default choice shall be to dispatch the MCR team, unless the caller refuses the dispatch.
- Unable to work with the person or other involved individuals to resolve the crisis over the phone
- Call taker decides that an in person connect could help further resolve an issue
- Call taker perceives the crisis is mostly resolved but thinks a face-to-face interaction could ensure the resolution
- Call taker perceives the crisis as mostly resolved but thinks that a face-to-face interaction would help to see the environment to ensure resolution when there are no other actors affecting the situation.
- Call taker is unsure of the need for dispatch but given the knowledge that the use of additional supports and intervention prevents high levels of care, decides to default to "send" decisions as opposed to "not send" decisions
- Dispatch team if the individual wants the service and there are no medical conditions which warrant a higher or alternate level of care
- Dispatch is requested by a DCFS worker or foster parent/kinship caregiver, on behalf of a child experiencing a sudden change in their living situation such as removal from a family/foster family home and move to a new family/foster family home.

Additionally, refer to the MCO's clinical protocols for managing risk for callers in crisis.

Coordination Expectations for MCO Crisis Line

How to access providers and dispatch a mobile crisis response (closed-loop process):

Crisis lines and mobile teams shall use the Louisiana Crisis Care Coordination Contact List to identify providers by areas and access contact information.

Dispatching process:

- Once a decision is made to dispatch a mobile team, the crisis line calls the mobile team contact number, conveys the information to the call taker.
- The crisis line staff shall initiatite a warm transfer to the MCR program staff. Once the warm transfer has occurred, the MCO crisis line can disconnect.
  - The mobile team will provide an estimated time of arrival, determine if there are any imminent needs, and provide telephonic support if clinically necessary.
- Mobile team goes to the location and provides crisis intervention and supports.
- If needed, the mobile team calls the crisis line to obtain support in identifying resources.
- Mobile team calls back the crisis line and conveys information regarding resolution and recommendations for follow-up including accessing CBCS.
- **Though the service is not prior authorized and deployment should not be predicated on the approval of MCO for service delivery, if the mobile team becomes aware of an individual in need of mobile crisis response in the community and has triaged the referral internally to verify need for service, they shall make the MCO aware of the dispatch to ensure tracking occurs appropriately. In order to ensure this occurs, the provider will call the crisis line concurrent to deployment, providing information pertinent to the person in crisis to enable the crisis line to complete the MCO Crisis Line Tracking/Ad Hoc reporting Template. This includes the data elements listed below.**

Information to be verbally shared by the Crisis Line to the MCR providers when initiating dispatch:

Crisis Line to the MCR provider:

- Name of the caller,
- Relationship of the caller to the individual in crisis (i.e. self, parent, family member, teacher, etc.)
- *(If the caller for a minor youth in crisis, is not a parent or otherwise a person with legal authority to act on behalf of the minor)* Name and contact information for the parent or person with legal authority to act on behalf of the minor, and efforts made by the caller to contact the parent/person with legal authority.
- Name of the individual in crisis (if not the caller)
- Address
- Contact number of the caller where they can be reached if disconnected

- Demographics and Medicaid ID number
- Presenting circumstances – plain language
- What challenges are current for the person/family – (e.g., feeling sad and unable to stop crying, feeling lost, have not eaten, can't drive to the grocery store)
- What resources might have been tried and/or are available to the person/family
- What context information – (e.g., lost job 6 months ago, lost family member to COVID, impact from hurricane)
- Preferences and unique needs that were communicated
    - Is the person aware that a MCR team has been dispatched to their home/environment
- Connection to treatment providers and last seen
- Name and relationship of other individuals who are at the location
- Environmental safety items (e.g., weapons, dog in back yard)
- Referral source if other than the individual (e.g., medical providers, school, 911, police officer)
- Name and contact information for treatment providers
- Dispatch time (time information was communicated)

Coordination Expectations for MCR Services

When dispatched by the MCO crisis line, the MCR providers will respond to the individual within the community, providing supportive and person centered interventions to mitigate the crisis in the community. Beyond the initial response, MCR teams should provide support for up to 72 hours to monitor stability and evaluate the individual's needs. See the Louisiana Medicaid Behavioral Health Services Provider Manual for further details and requirements.

MCR providers verbally provide back to the crisis line after deployment and the initial crisis response has occurred:

- Name
- Disposition
    - Remain in the community with follow-up
    - Remain in the community declined follow-up
    - Referred to higher level of crisis care
    - BH treatment facility
    - Emergency
- Dangerous situation and MCR involved police
- Follow-up recommendations for the MCO crisis line
- Location arrival time
- Completion time of activity at the location
- If applicable, based on the individual's needs, refer to CBCS

MCR coordination of next level of care:

During the intervention, MCR teams should coordinate with MCO crisis line, ensuring linkage to alternate services and resources necessary for the individual to remain in the

community. This includes linking with an existing provider or providing a bridge to a new provider. For those who require ongoing support beyond that which MCR can provide and would benefit from CBCS services, the MCR team should initiate a referral to this intervention. See the Louisiana Medicaid Behavioral Health Services Provider Manual for further details and requirements.

Coordination Expectations for CBCS Services

Individuals eligible for CBCS must have received MCR, BHCC, or CS. One of these providers must determine the need for ongoing follow up beyond 72 hours. CBCS must be prior authorized by the MCO.

Processing CBCS referrals:

To make a referral to CBCS, the MCR, BHCC, or CS staff contacts the CBCS providers using the Louisiana Crisis Care Coordination Contact List to inform of need for services. Through this process, they convey the following:

- Name of the individual
- Demographics and ID#
- Presenting circumstances – plain language
    - What challenges are current for the person/family – (e.g., feeling sad and unable to stop crying, feeling lost, have not eaten, can't drive to the grocery store)
    - What resources might have been tried and/or are available to the person/family
    - What context information – (e.g., lost job 6 months ago, lost family member to COVID, impact from hurricane)
- Why the referral is being made; this information should include why CBCS is needed
- Preferences and unique needs that were identified/communicated
- Connection to treatment providers and the date they were last seen
    - Name and contact information for treatment providers

The CBCS program communicates with the MCO prior authorization department per the different communication approaches outlined on the Louisiana Crisis Care Coordination Contact List. The CBCS conveys to the MCO prior authorization department the information that supports the need for CBCS given the information obtained from the referring provider. The MCO PA Department shall process the request as expeditiously as the individual's condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation. The MCO PA Department will communicate the approved/disapproved authorization to the individual/representative, CBCS provider and the referring provider using their existing processes.

CBCS coordination of next level of care:

CBCS providers should ensure ongoing support of individual and coordination with MCOs, ensuring linkage to alternate services and resources necessary for the individual to remain in the community. If referral to BHCC is deemed appropriate and necessary, prior

authorization for this level of care will be initiated using the communication process with the MCO. See the Medicaid Behavioral Health Services Provider Manual for further details and requirements.

Coordination Expectations for BHCC Services

BHCC Centers (BHCCC) operate twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term mental health crisis response, offering a community based voluntary home-like alternative to more restrictive settings. See the Medicaid Behavioral Health Services Provider Manual for further details and requirements.

Referring to BHCC services:

Crisis lines, MCR teams, and CBCS providers shall use the Louisiana Crisis Care Coordination Contact List to identify BHCC providers by areas and access contact information. When making referrals, providers and/or MCO crisis lines shall call the BHCC center and provide them with the following information:

- Name of the individual
- Demographics and ID#
- Presenting circumstances – plain language
  - What challenges are current for the person/family – (e.g., feeling sad and unable to stop crying, feeling lost, have not eaten, can't drive to the grocery store)
  - What resources might have been tried and/or are available to the person/family
  - What context information – (e.g., lost job 6 months ago, lost family member to COVID, impact from hurricane)
- Why the referral is being made (if from MCR/CBCS or crisis line)
- Preferences and unique needs that were identified/communicated
- Connection to treatment providers and last seen
  - Name and contact information for treatment providers
- Referral source if other than the individual (e.g., medical providers, school, 911, police officer)
- Anticipated method and time of arrival at BHCC

Prior authorization for this service is not needed unless referred in from CBCS. The BHCC Center will provide notification to the MCO via their prior authorization pathways as outlined within the MCO tab of the Louisiana Crisis Care Coordination Contact List.

BHCC coordination of next level of care:

BHCC staff should coordinate with MCO, ensuring linkage to alternate services and resources necessary for the individual to remain in the community. This includes linking with an existing provider or providing a bridge to a new provider. For those who require ongoing support in the community beyond that which BHCC can provide and would benefit from CBCS services, the BHCC team should initiate a referral to this intervention, per information outlined previously. For those individuals who require a higher level of intervention to support the individual's persistent behavioral health or acute medical needs,

the BHCC team should work with the individual to link them to that level of care. See the Medicaid Behavioral Health Service Provider Manual for further details and requirements.

Coordination Expectations for CS Services

Individuals eligible for CS must have received MCR, BHCC, CBCS, or Assertive Community Treatment (ACT) services and have been determined by those providers to need ongoing follow up beyond that which their organizations can provide, and be prior authorized for CS by the MCO.

Processing CS referrals:

To make a referral to CS, the MCR, BHCC, CBCS, or ACT staff contacts the CS providers using the Louisiana Crisis Care Coordination Contact List to inform of need for services and determine bed availability. Through this process, they convey the following:

- Name of the individual
- Demographics and ID#
- Presenting circumstances – plain language
  - What challenges are current for the person/family – (e.g., feeling sad and unable to stop crying, feeling lost, have not eaten, can't drive to the grocery store)
  - What resources might have been tried and/or are available to the person/family
  - What context information – (e.g., lost job 6 months ago, lost family member to COVID, impact from hurricane)
- Why the referral is being made; this information should include why CS is needed:
  - as a higher level of care instead of ongoing support in the community
  - as a lower level of care instead of acute psychiatric inpatient treatment or an alternate inpatient setting
- Preferences and unique needs that were identified/communicated
- Connection to treatment providers and the date they were last seen
  - Name and contact information for treatment providers
- Anticipated method and day/time of arrival at CS

CS requires concurrent review after the initial 24-hour period, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved, or until the member can access alternative behavioral health supports and services.

Upon admission, the CS provider must immediately notify the MCE of the member's admission using the different communication approaches outlined on the Louisiana Crisis Care Coordination Contact List. The member's treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider. During the concurrent review, the CS provider shall convey to the MCO PA department the information that supports the need for CS. The MCO PA Department will communicate the approved/disapproved ongoing authorization to the individual/representative, CS provider and the referring provider using their existing processes. If denied, the MCO will

work with CS provider, the individual, community provider and discuss an alternate plan for ongoing interventions.

Guidance on the use of effective engagement approaches and avoidance of involuntary or coercive processes

Guidance on effective strategies to support empowerment of individuals and avoid involuntary or coercive processes

Call takers must use engagement approaches that also explore to uncover the callers strengths and preferences for working through their challenges they are seeking help for. Effective interventions include exploring the caller's options and supporting their selection of resolution. Only in dangerous situations should involvement of police or involuntary processes be invoked (as outlined below). An example of this includes if a call taker determines sending a mobile team would be beneficial, the call taker is to use engagement approaches to introduce the idea of sending a mobile team and converse with the caller so that they feel comfortable and accept a mobile team to come to their location

Guidance for involving police and/or EMS:

If after using engagement approaches to support a person in crisis, and the situation is determined to be of imminent danger for hurting oneself or others consider involving the police and/or EMS. Here are examples of when to consider this:

- Immediate danger of someone using or about to use a weapon
- Immediate danger of someone hurting or about to hurt oneself
- Life threatening event that requires more rapid response time than can be expected by MCR
- When the person voices feeling unable to wait for the MCR team to arrive

Guidance on use of involuntary processes:

The crisis call line and other crisis providers should refer to the state statues and rules on referring someone through an involuntary process.

Crisis Reporting

Each crisis provider shall submit a monthly report to the MCOs using the crisis reporting templates located at https://ldh.la.gov/page/1700; Reference reporting templates 404 (behavioral health crisis care report), 405 (community brief crisis support report) and 406 (crisis stabilization). The MCR report template is sent to the providers from the MCO. Weekly ad hoc Crisis Line/MCR, CBCS, BHCC, and CS reports are due Tuesdays to the MCOs.

The MCO shall submit the monthly Crisis Line/MCR, CBCS, BHCC, and CS reports due on the 15th of the month for the prior month. The tracking/ad hoc reporting templates can be found at https://ldh.la.gov/page/1700. Weekly ad hoc Crisis Line/MCR, CBCS, BHCC, and CS reports are due by close of business every Tuesday.

ATTACHMENT A

Each crisis provider shall submit a monthly report using the crisis reporting templates located at https://ldh.la.gov/page/1700; Reference reporting templates 403 (MCO crisis line), 404 (behavioral health crisis care report), 405 (community brief crisis support report) and 406 (crisis stabilization).

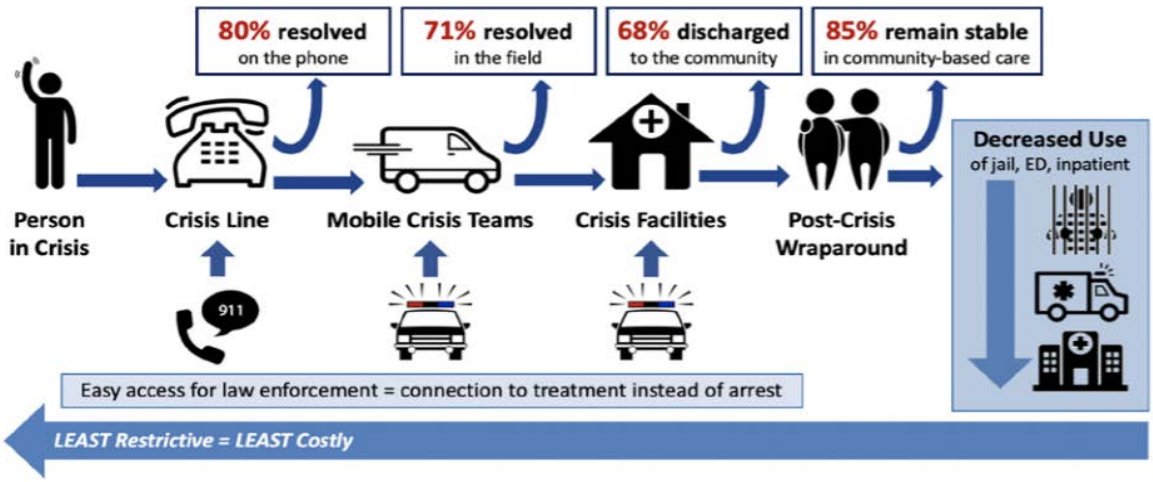
Appendixes

Appendix A - Excerpts – National Guidelines Processing Crisis Calls

Crisis call centers are defined within the National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit published by the Substance Abuse and Mental Health Administration (SAMHSA) as being one of the essential elements of an effective, modern, and comprehensive crisis system. This function is an essential element within a no wrong-door approach to crisis systems. Call centers should operate every moment of every day (24/7/365) with clinical staffing which enables the assessment and engagement of individuals in crisis and offer air traffic control (ATC) quality coordination of crisis care in real time. Ideally, this should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide. Through these efforts, call center staff should:

1. Practice active engagement with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety;
2. Use the least invasive intervention and consider involuntary emergency interventions as a last resort, except for in circumstances as described below;
3. Initiate life-saving services for attempts in progress – in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services;
4. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;
5. Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;
6. Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide; and
7. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.

The visual below is an example of where and how crises can be resolved when operating in congruence with the standards outlined above.



Source: : Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. Figure 1: Alignment of crisis services toward a common goal. Pg. 10

Appendix B- LOUISIANA CRISIS RESPONSE SYSTEM: OVERVIEW

The Louisiana Department of Health (LDH) is committed to ensuring that individuals in crisis and their families experience treatment and support that is compassionate, effective, resolution-focused, and delivered by a crisis system that is coordinated, responsive and efficient. LDH is committed to addressing the crisis needs of individuals in the target population as detailed in the Agreement. In addition, LDH believes that by addressing the behavioral health crisis needs of all populations, including Louisiana's most vulnerable citizens (e.g. individuals with co-occurring conditions, and those who are at risk of institutionalization), we can maximize the use of voluntary treatment and reduce the need for law enforcement involvement. In addition, it will allow people to remain in their communities and reduce the need for restrictive levels of care including nursing homes, residential care centers, out of home placements, jails, intermediate care facilities for individuals with intellectual/developmental disabilities, and hospitals. In order to meet these objectives, LDH has developed a statewide model for crisis response that maintains regional and geographic relevance and builds upon the unique and varied strengths, resources, and needs of Louisiana's individual communities.

Vision

To achieve this vision, LDH, in consultation with service recipients and key system partners, will develop a modern, innovative and coordinated crisis system. LDH's vision is a crisis system that:

- Values and incorporates "lived experience" in designing a crisis system and in crisis service delivery;
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports;
- Is built on principles of recovery and resiliency, delivering services that are individualized and person-centered;
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings;
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response;
- Provides stabilizing interventions and supports that allow individuals to recover as quickly as possible;
- Delivers resolution-focused interventions and assists individuals in problem-solving and in developing strategies to prevent future crises and enhance their ability to recognize and deal with situations that may otherwise result in crises;
- Supports individuals to increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention;
- Continuously improves its processes to assure seamless and efficient care;
- Collaborates and innovates with partner systems including healthcare systems, judicial systems, law enforcement, child protective services, educational systems, homeless coalitions, as well as any other system that touches individuals who may experience a behavioral health crisis; and

- Collaborates with the individual's existing behavioral health service providers, or links individuals to new behavioral health service providers for longer-term treatment when appropriate and desired by the recipient.

A crisis is self-defined and can best be labeled as "need help now" determined by the individual. Therefore, the system, and management of the system, must be flexible and responsive to needs.

Appendix C – LOUISIANA CRISIS RESPONSE SYSTEM: SERVICE OVERVIEW

Mobile Crisis Response – Implemented 3/1/2022 for individuals aged 21+, 4/1/2024 expanded to individuals aged under 21.

Mobile Crisis Response (MCR) services are an initial or emergent crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis in the community. MCR is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis until the member experiences sufficient relief/resolution and the member can remain in the community and return to existing services or be linked to alternative behavioral health services which may include higher levels of treatment like inpatient psychiatric hospitalization.

Mobile Crisis providers are dispatched after an initial triage screening determines that MCR is the most appropriate service. MCR services are available twenty-four (24) hours a day, seven (7) days a week and must include maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times.

Components

- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section;
- Provide follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to seventy-two (72) hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:
    - Telephonic or face to face follow-up based on a clinical individualized need, with face to face follow-up highly preferred for service delivery to youth; and
    - Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member aged twenty-one (21) years and over to his/her best age-appropriate functional level. Members in crisis who require this service may be using substances during the crisis, and substance use will not, in and of itself, disqualify them for eligibility for the service.

All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for initial/emergent crisis services as long as medical necessity is met.

For youth, eligibility for initial/emergent crisis services based on "self-identification" that the member is experiencing a crisis includes self-identification by the youth and identification by the current physical caregiver to the youth, under the principle that "the crisis is defined by the caller." The caller, who identifies the crisis and initiates Mobile Crisis Response services for youth, may commonly be an adult currently serving in a caregiving role to the youth in the setting where the crisis is being experienced. This may include, but is not limited to:

1. Caregivers in a home setting, including a parent, legal guardian, foster parent, fictive kin, or other family member serving in a caregiving role in the home or community setting at the time that the youth is experiencing the crisis;
2. Teacher or staff in a school setting where the youth is experiencing a crisis;
3. Care staff at a group home setting where the youth currently resides and where the youth is experiencing the crisis; or
4. A helping professional accompanying the youth at the time of the crisis, such as a pediatrician, FINS worker, or probation officer.

A child experiencing a sudden change in their living situation, such as removal from a family or foster family home and move to a new family or foster family home, may experience this as a crisis that exceeds the abilities and the resources of those involved to effectively resolve it. A youth or their caregiver self-identifying this experience as a crisis is eligible for MCR services.

Consent to MCR services for minors less than 18 years old: When the call is initiated by a caller who is not a parent with parental authority or otherwise a person with legal authority to act on behalf of the minor, the caller must attempt to contact the parent, or person with legal authority, to obtain their consent for the minor in crisis to receive MCR services, during the time when the MCR team is dispatching. (For example, school staff do not have parental authority; therefore school staff must call the parent/guardian during the time when the MCR team is dispatching and attempt to gain their consent). If the parent, guardian, or person with legal authority, is not readily available, continuous efforts must be made by the caller and the MCR team to reach the parent, or person with legal authority, throughout the minor's intervention, to inform them of the situation and to attempt to obtain their consent for treatment.

While un-emancipated minors usually need the consent of a parent or guardian before receiving medical care, including behavioral health care, a minor may receive emergency medical treatment to preserve life and prevent serious impairment without consent from a parent or guardian. Specifically, under Louisiana's Medical Consent Law, consent to treatment for a minor is implied when an emergency exists. La. R.S. § 40:1159.5(A).

An emergency is defined as a situation wherein: (1) the treatment is medically necessary; and (2) a person authorized to consent is not readily available; and (3) any delay in treatment could reasonably be expected to jeopardize the life or health of the minor or could reasonably result in disfigurement or impair faculties. In these emergency situations, services can and should be provided to the minor, even if attempts to obtain the parent or guardian's consent were unsuccessful, while continued attempts are made to contact the parent or guardian in order to obtain their consent for the services. In no event should services be rendered over the expressed objection of the parent or guardian. In the event the parent, or person with legal authority, refuses to consent to the MCR services for the minor, the intervention must cease once all immediate threats to the child's life are resolved. See Louisiana Children's Code article 1554, which provides that while

parents and legal guardians have the right to refuse care for minors, they generally cannot do so if it endangers the child's life.

NOTE: A minor in crisis may consent to the MCR services if they believe they are afflicted with an illness or disease and possess the physical and mental capacity to consent to care. La. R.S. 1079.1(A). Unless otherwise stated by available legal documentation, a youth who is aged 18 years or older can individually consent to MCR services and does not need parental consent. Additionally, a person 18 years of age or older may refuse to consent to medical or surgical treatment as to their own person. La. R.S. § 40:1159.7.

Service Utilization
MCR is an initial crisis response and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify the MCO when its member presents. MCR is intended to provide crisis supports and services during the first 72 hours of a crisis.

Community Brief Crisis Support (CBCS) – Implemented 3/1/2022 for individuals aged 21+, 4/1/2024 expanded to individuals aged under 21.

Community Brief Crisis Support (CBCS) services are an ongoing crisis response intended to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis until the crisis is resolved and the member can return to existing services or be linked to alternative behavioral health services. As determined by the MCO, CBCS can also be provided to individuals who have experienced a presentation to an emergency department for a reason related to emotional distress.

CBCS services are available twenty-four (24) hours a day, seven (7) days a week. CBCS services are not intended for and should not replace existing behavioral health services. Rather referrals for services occur directly from Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), or crisis stabilization (CS) providers as needed for ongoing follow up and care.
This level of care involves supporting and collaborating with the member (and for youth, the member's caregiver) to achieve symptom reduction by problem solving and developing useful safety plans that will assist with community tenure.

Components
- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and
- Providing follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to fifteen (15) days following initial contact with the CBCS provider once the previous CI (MCR, BHCC, CS) provider has discharged the member to ensure continued stability post crisis for those not accessing higher levels of care, including but not limited to:
    - Telephonic or face to face follow-up based on clinical individualized need, with face to face follow-up highly preferred for service delivery to youth; and

- Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Eligibility Criteria
The medical necessity for these rehabilitative services must be determined by and services recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a memberto his/her best age-appropriate functional level. This service will be rendered to eligible members after a referral is made from MCR, BHCC, or CS. Members in crisis who require this service may be using substances during the crisis, and this substance use will not, in and of itself, disqualify them for eligibility for the service.

All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for ongoing crisis services as long as medical necessity is met and the members is not already linked to an existing MHR or ACT provider.

For youth, eligibility for crisis services based on "self-identification" that the member is experiencing a crisis includes identification by the youth's caregiver. CBCS can be requested by any caregiver and delivered in any setting as defined in the MCR section, above, as long as there is consent for treatment from an individual legally allowed to consent to treatment of the youth.

Service Utilization
CBCS requires prior authorization, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved, or until the member can access alternative behavioral health supports and services. The member's treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider. Additional units may be approved with prior authorization.

Behavioral Health Crisis Care – Implemented 4/1/2022
Behavioral Health Crisis Care (BHCC) services are an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults. BHCC Centers (BHCCC) operate twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term mental health crisis response, offering a community based voluntary home-like alternative to more restrictive settings, such as the emergency departments, or coercive approaches, such as Physician Emergency Certificates (PECs), law enforcement holds, or Orders of Protective Custody (OPC). BHCC Centers are designed to offer recovery oriented and time limited services up to twenty-three (23) hours per intervention, generally addressing a single episode that enables a member to return home with community-based services for support or be transitioned to a higher level of care as appropriate if the crisis is unable to be resolved.

Components
- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section;
- A registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for medical stability; and

- Providing follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to seventy-two (72) hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:
    - Telephonic follow-up based on clinical individualized need; and
    - Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Eligibility Criteria
The medical necessity for these rehabilitative services must be determined by and services recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member aged twenty-one (21) years and over to his/her best age-appropriate functional level. Members in crisis who require this service may be using substances during the crisis, and this substance use will not, in and of itself, disqualify them for eligibility for the service. All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for initial/emergent crisis services as long as medical necessity is met.

Service Utilization
BHCC is an initial crisis service and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify the MCO when its member presents. BHCC is intended to provide crisis supports and services during the first twenty-three (23) hours of a crisis.

Crisis Stabilization for Adults– Implemented 8/3/2022

Crisis Stabilization for Adults Crisis Stabilization (CS) for adults is a short-term bed-based crisis treatment and support service for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement. CS is utilized when additional crisis supports are necessary to stabilize the crisis and ensure community tenure in instances in which more intensive inpatient psychiatric care is not warranted or when the member's needs are better met at this level. This service is designed to ameliorate a psychiatric crisis and/or reduce acute symptoms of mental illness and to provide crisis relief, resolution, and intensive supportive resources for adults who need temporary twenty-four (24) hours a day, seven (7) days a week support and is not intended to be a housing placement.

CS assists with deescalating the severity of a member's level of distress and/or need for urgent care associated with a mental health disorder. The goal is to support members in ways that will mitigate the need for higher levels of care, further ensuring the coordination of a successful return to community placement at the earliest possible time. Short-term crisis bed based stabilization services include a range of resources that can meet the needs of the member with an acute psychiatric crisis and provide a safe environment for care and recovery. Care coordination is a key element of crisis services, coordinating across the services and beyond depending on the needs of the member.

Services are provided in an organized bed-based non-medical setting, delivered by appropriately trained staff that provide safe twenty-four (24) hour crisis relieving/resolving intervention and support, medication management, observation and care coordination in a supervised environment where the member is served. While these are not primary substance use treatment facilities, the use of previously initiated medication assisted treatment (MAT) may continue.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. Referrals to CS must be completed by the Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), Community Brief Crisis Support (CBCS) providers or ACT teams. Other referrals will be considered on a case by case basis. This service is intended for any member in mental health crisis, needing immediate intervention to stabilize the situation and needing help now but is whose needs do not meet a higher level of care (examples include not at medical risk or currently violent). While medical clearance will not be required, members admitted to this level of care should be medically stable. Members who have a co-morbid physical condition that requires nursing or hospital level of care or who are a threat to themselves or others and require an inpatient level of care are not eligible for CS services.

Components

- Provide services (assessment, interventions, care coordination and follow-up) as outlined in the manual.

Service Utilization

CS requires prior authorization, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved, or until the member can access alternative behavioral health supports and services. The member's treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider. Additional units may be approved with prior authorization. The LMHP or psychiatrist must be available at all times to provide back up, support and/or consultation through all services delivered during a crisis.