

Crisis Redesign Questions and Answers-11/30/07

A. Crisis Redesign Communication

1. Can we post all of the most recent documents on the crisis redesign webpage of the DSHS website?
Yes, questions and answers will be posted on the intranet.
2. Can we have additional comnets so we can cover additional topics?
Yes, Broadcast Message # 0507B was sent out extending the Comnets through November with topic areas for each outlined. We also anticipate some program specific ongoing Comnets (i.e. mobile outreach) to deal with ongoing implementation and coordination issues

B. Crisis Service Planning

1. Can Crisis funds remaining, after ensuring the level of Hotline and MCOT required, be used to purchase local hospital beds and associated services that would provide alternatives to state hospitalization?
Yes. All documentation will need to show that the “associated services” are crisis-related.
2. Can televideo equipment be purchased with new crisis funds and be placed in the jails to allow QMHP-CS’s to do crisis screening and assessment via televideo, rather than face to face?
Yes, with the adoption of new Mental Health Community Services Standards, the QMHP-CS crisis screening and assessment can be performed via tele-health. The current anticipated adoption date is mid-August 2008.
3. Are we still developing a Form Z?
No. DSHS has revised Information Item I to DSHS’s Performance Contract, but the final version has not been posted. Attached is the most recent draft of Information Item I, which no longer includes a reference to Form Z. Information Item I will be posted at the following address once the contract amendment is executed:<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>
4. Can we propose to enhance our existing Crisis Respite Program with some of these funds? I was under the impression these dollars would only be available through the competitive bidding process.
If you have allocation money left over after you meet the requirements for the Hotline and MCOT, then you may use the remaining funds for this purpose. Any remaining funds may be used to enhance, expand, or create any of the crisis services listed in Information Item V.
5. I understand we are to capture expenses for crisis services prior to this initiative to demonstrate the use of new dollars to enhance and enlarge the service. Must the projected

budget reflect the total allocation amount as the difference between existing costs and projected costs for enhancement? In some cases they overlap.

See Broadcast Message #0516. DSHS has removed the requirement for LMHAs to report the First Billed Payer Code CRD when submitting encounters. This means that DSHS is relying solely on CARE Report III expenditure data to accurately report, to the LBB, on the impact of the crisis redesign initiative. Thus it is imperative that quarterly CARE Report III expenditure reports be submitted to DSHS in a timely manner.

6. What are the timelines for LMHAs to implement Crisis Redesign Services?

It is anticipated that the following implementation timelines will be met by the LMHAs/LBHA:

- **October 31, 2007 Initial Crisis Service Plans due to DSHS**
- **December 1, 2007 Begin implementation of initial Crisis Redesign Services**
- **December 31, 2007 Submit updated Crisis Service Plans to DSHS**
- **January 18, 2008 LMHA/LBHAs that wish to provide Outpatient Competency Restoration submit proposals for amendment to their FY2008 Performance Contract**
- **February 29, 2008 LMHAs that wish to provide Psychiatric Emergency Service Center (PESC) or hospital or pre-booking jail diversion project (Projects) using the Community Investment Incentive Funds submit proposals for amendment to their FY2008 Performance Contract.**
- **March 1, 2008 Begin implementation of Outpatient Competency Restoration**
- **June 1, 2008 All Hotlines in Texas achieve accreditation by American Association of Suicidology**
- **June 1, 2008 Begin implementation of PESC and Projects**

7. I would like to confirm my understanding that we could go ahead and hire two additional staff for our mobile crisis outreach team and apply this cost retroactive to the funding we will receive. Additionally I would like to confirm that the cost of sending staff to the required AAS accreditation training will also be applied retroactive to the funding we receive once the contract has been amended.

Yes, to both questions.

8. Can any remaining Crisis Redesign funds be used for contracting for local psychiatric hospital beds?

Contracting with local hospitals for psychiatric beds and associated services is a viable diversionary activity, and will meet the legislative intent of diverting individuals from jail and finding appropriate alternatives to State hospitalization. DSHS is amenable to the use of remaining equity and proportional funding for the purchase of local hospital beds. Please ensure inclusion of any plan to purchase local psychiatric hospital beds in the LMHA's Crisis Service Plan update.

9. Of the 82 million appropriated through the legislature, how was it allocated to each authority? Specifically, what was the formula used? How much did DSHS retain?

The crisis allocation methodology is consistent with the proposed use of funds described in DSHS's Legislative Appropriation Request. The new funds will be divided into four portions.

Equity Contribution: A total of \$ 26,506,058 (32%) will be used to improve equity in DSHS funding allocations among LMHAs, as required by the State legislature. Under the DSHS's long term plan, new funds are to be allocated in a way that improves equity.

Funds in this category will be directed only to LMHAs with below average per capita funding levels, and will be distributed in proportion to each LMHA's level of need.

Proportional Allocation: A total of \$ 29,805,802 (36%) will be divided proportionally among LMHAs. The proportional allocation includes a basic allocation to ensure sufficient funding for each LMHA to implement the initial crisis service requirements (i.e., Hotline, and Mobile Crisis Outreach). This basic allocation includes modeled allocations for Hotline (Urban: \$ 364,325, Rural: 1.66% x local service area population x 12 months) and Mobile Crisis Outreach Teams (Urban: \$ 313,800, Rural: \$ 209,050). The proportional allocation also includes a redistribution of funds greater than the amount that each LMHA would need to implement the initial crisis service requirements. This redistribution of funds is targeted toward LMHAs with densely populated local service areas, and will be redistributed based upon population.

Community Investment Incentive: A total of 21,446,250 (30%) will be offered to communities/regions willing to invest a significant level of local resources in the development of emergency psychiatric hub sites, projects that focus on jail diversion or alternatives to State hospitalization, and outpatient competency restoration services.

These funds will require a minimum 25% local match and will be awarded to LMHAs offering the best value to the State of Texas.

State Expenditures: DSHS will reserve \$ 1,241,890 (1.5%) of the funds to cover State costs for crisis redesign implementation (e.g. training, certification, 4 state positions, external evaluation).

The allocation for NorthSTAR is on the Allocation Table shared with the Texas Council of MHMR Centers. See B. 9. for the percentages.

The breakouts for the competitive portion of the new crisis appropriation are as follows:

	PESC/Project Allocation	Outpatient Competency Allocation	Total
FY2008	\$4,289,250	\$1,000,000	\$5,289,250
FY2009	\$17,157,000	\$2,000,000	\$19,157,000
TOTALS	\$21,446,250	\$3,000,000	\$24,446,250
	26.15%	3.66%	29.81%

- One of the options we had considered was someone (another community MHMR) that has an AAS accredited crisis hotline, but is not staffed 100% yet with QMHP's. It is my understanding that they are working towards having all QMHP's but may not be in compliance by 12/31/07. In other words, it may be a few months into 2008 before they have

transitioned to all trained QMHP's on staff. Might we still be able to contract with this Center, given these circumstances?

The hotline standard in Information Item V allows trained and competent paraprofessionals to answer the hotline and provide information and non-crisis referrals, however, a trained and competent QMHP-CS is required to provide crisis screening and assessment of the nature and seriousness of the call (TAC 412G). Your obligation as an LMHA is to assure your contractor is in compliance with applicable departmental rules.

11. Will we be able to use any CR funds that lapse in FY08 in FY09?
No, see General Provisions of your Performance Contract Section 4.09 Return of Funds. Upon expiration or termination of this Contract, Contractor shall return to DSHS all funds this Contract that have not been encumbered for purposes authorized by this allocated under Contract. A transfer to Contractor's fund balance or reserves is not a purpose authorized by this Contract.

12. What is the difference in the Crisis Service Plan and the Network Development Plan?
The Crisis plan will be incorporated into the Local Services Plan (the Network Development Plan is a major component of the Local Services Plan) in FY 2008. (For additional information, refer to the Broadcast Message #0515). In future planning cycles, the Crisis Services Plan will be a component of the Local Services Plan.

13. How should we provide Crisis Service Plan updates?
DSHS requests that the first update of the Crisis Service Plan due on December 31, 2007 be submitted to the Performance Contract mailbox performance.contract@dshs.state.tx.us Any subsequent updates, please notify your Contract Manager and send the update to the Performance Contract mailbox. DSHS explored other options to streamline the process, but all would require more work on the part of the LMHA to accomplish.

14. Once the specific crisis allocation is determined, is it that amount only that should be addressed in the Local Crisis Plan? If not, why not and what is your statutory authority for making that determination?
The Crisis Service Plan should reflect the local planning process and overall scope of the new crisis delivery system. It is the clear intent of the legislature as expressed in Rider 69 of the Appropriations Act that Crisis Redesign funds be used to improve crisis services in each local service area. DSHS is requesting that LMHAs describe the total picture of those services including current and planned funding.

C. Crisis Redesign Service Standards

1. Extended Observation, Crisis Residential, Crisis Respite with 4 + persons: There seems to be a big concern about the licensing "regulations" around physical plant requirements for these types of facilities. Do we have a set of standards we are suggesting or requiring regarding physical plant (e.g., pull away shower heads, fire life safety code issues, etc)?

DSHS anticipates providing a list of examples of safety measures. No list is comprehensive due to the range of issues the different environments may face in each level of care. It remains the responsibility of the LMHA to ensure and maintain a safe environment of care appropriate to the acuity of the individuals served in that service environment. Please reference the Texas Administrative Code Chapter 412 Subchapter G 412.308 related to Environment of Care and Safety which has required LMHAs to comply with the appropriate Life Safety Code for the occupancy, ensure the environment is safe and free of hazards.

2. Extended Observation – Harris County states that common practice for people only placed on precaution to be reassessed (Section IV D. IV. C. 4) a)) every 15 minutes, and that people not on precaution are assessed every 30 minutes. Is this something that we want to revisit? **DSHS modified Information Item V to read “allow for reassessment every 15 minutes” rather than “ensure reassessment every 15 minutes” and it is consistent with Appendix III of the Crisis Redesign Committee’s Report. This means you must have the capacity to provide reassessment every 15 minutes if it is clinically indicated.**

3. Is CBT the only Counseling model one can use in a crisis as well? CBT as a model is often not indicated nor clinically appropriate for persons in crisis. (Comments by several clinicians).

Brief solution-focused therapy is a form of CBT and may be used in as little as one session. DSHS intends to address the types of CBT that may be needed in a crisis setting. When we speak of “Cognitive Behavioral Therapy” as a specific treatment model, we’re generally speaking of a treatment model that emphasizes teaching clients a specific set of tools to use to master challenges that arise in that client’s life. Different skills/tools may be taught depending on the diagnosis and behavioral presentation. The learning is generally both didactic and experiential in nature. When we speak of “cognitive behavioral therapies” we’re generally speaking of a continuum of treatment models that involve cognitive functioning (thinking, processing information) and behavioral functioning (actions, activities, behavioral responses). Sometimes the models emphasize changing cognitions (thoughts/beliefs) in order to shift behavior, and sometimes changing behaviors to shift cognitions. Feelings related to both behaviors and cognitions are also emphasized in the treatment methodologies. Accepted cognitive behavioral therapies include Cognitive Behavior Therapy, Solution-Focused Therapy, Dialectical Behavior Therapy, EMDR, NLP, Reality Therapy and others. “Cognitive Behavioral Therapy” (ala the Monica Basco protocol taught to LMHA clinicians to address Major Depression) and “Solution-Focused Therapy” are both cognitive behavioral therapies with very similar treatment components but slightly different philosophies. In both treatment models very similar conversations occur between the therapist and client/family including variables of (but not remotely limited to):

- **Always looking for and pointing out (whether directly or Socratically) thinking errors and social (or concrete) misperceptions**
- **Encouraging curiosity to take different perspectives of a given situation**
- **Encouraging the “scientific method”, i.e. examine the data, create a hypothesis, develop a strategy and test it out, evaluate the effectiveness of the strategy and either adopt or discard it and move on**

- **Developing an understanding and awareness of the interplay between thoughts, feelings and actions and the ability to differentiate between the three**

The CBT therapist works with the client using a methodical protocol to “teach” the understanding and use of the above variables (and more) and will often see the protocol through so that each CBT knowledge point/item/variable has a chance to be learned and mastered.

The Solution-focused therapist works very similarly with the same variables, but the day the client feels/states/agrees the specific problem for which they came to treatment has been solved or mastered, the treatment is considered complete. The S-F therapist believes the tenet that any day the client/family come in for a session may well be the day the sought-for solution is realized and therefore the last day of treatment (related to that problem).

4. Are behavioral health techs appropriate for overnight in a crisis residential or are we still requiring that a QMHP be there at all times?

Information Item V was modified to say paraprofessionals may be on site during the overnight shift.

5. Please clarify what comprises a “full RN evaluation” and what is the difference between a full RN evaluation/full nursing assessment and when the physical assessment begins.

The term “full RN evaluation/full nursing assessment” was revised to read “comprehensive nursing assessment.” The definition from the Texas State Board of Nursing is as follows: “Registered nurses conduct “comprehensive nursing assessments of the health status of clients.” A comprehensive nursing assessment is an extensive data collection (initial and ongoing) for individuals, families, groups and communities addressing anticipated changes in client conditions as well as emergent changes in a client’s health status; recognizing alterations to previous client conditions; synthesizing the biological, psychological, spiritual and social aspects of the client’s condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnoses; plan nursing interventions, evaluate need for different interventions, and the need to communicate and consult with other health team members.

6. Can we add the word “imminent” in front of the “risk of harm” statements in the Extended Observation, Crisis Residential and Crisis Respite Standards?

DSHS modified the language of Information Item V to state “low risk of harm” in the Crisis Respite Standards.

7. It was stated that the CSU requirements allow for psychiatric technicians as opposed to QMHP-CSs on-site 24/7. Do we want to revisit the standards for Crisis Residential if this is the case?

DSHS has modified Information Item V to state trained and competent paraprofessionals may be used on the overnight shift.

The Texas Administrative Code §411.623 for Crisis Stabilization Units states,

(1) The chief nursing supervisor shall develop and implement a written staffing plan that:

(A) describes the number of RNs, LVNs, and UAPs on each unit for each shift;

(B) provides for at least one LVN or one RN to be physically present and on-duty at all times on each unit when a patient is present on the unit;

(C) if an RN is not physically present and on-duty at all times on each unit when a patient is present on the unit, provides for an RN to be physically present at the CSU within 10 minutes of being contacted by a staff member;

(D) if the CSU has only one unit, in addition to one LVN or one RN required by subparagraph (B) of this paragraph, at least two staff members who provide direct patient care to be physically present and on-duty at all times on the unit when a patient is present on the unit; and

(E) provides for an adequate number of RNs on each unit to supervise all UAPs

8. If the Respite is run by the LMHA do they still need to meet DADS' Assisted Living Facility Standards?

Yes, if it is an assisted living facility that is used for crisis respite. See web site

<http://www.dads.state.tx.us/handbooks/lis-alf/>

9. Can we include APNs and PAs to the documents when we mention "Physicians, preferably psychiatrists?"

DSHS modified Information Item V in the situations where inclusion is permissible in the standards.

10. In the event that an LPHA is on the deployed Mobile Crisis Outreach Team, can a paraprofessional be the other member?

No. Information Item V with the Crisis Redesign Standards state "A MCOT, at a minimum, is comprised of 2 QMHP-CSs or where appropriate 1 QMHP-CS and law enforcement.

11. Why is DSHS requiring "higher standards" than AAS for Accreditation?

AAS accredits both grassroots and professional hotlines thus the range in scoring in each area, the expectations of DSHS is that LMHAs and their contractors are professional organizations. DSHS expects LMHAs and their contractors to abide by the Texas Administrative Code Chapter 412 Subchapter G.

DSHS is not requiring higher standards than AAS Accreditation. AAS does not accredit at a level. AAS accredits based upon the elements listed within the 8th Edition of AAS's [Organization Accreditation Standards Manual](#). The standards recommended by the Clinical Subcommittee of the Crisis Redesign Task Force, and promulgated by DSHS include operational standards for accredited LMHAs that are greater than the lower levels (i.e., Level I and Level II in the AAS accreditation scoring table). These operational standards are reflected in the table located in Information Item V.

12. Having read the Crisis Redesign from DSHS, we noticed it is requiring at least two counselors be on duty at the Crisis Line during any given period of the day. We are wanting to know if DSHS is using the word "counselor" in a manner as one which is a qualified

mental health professional (QMHP) or as wanting a licensed counselor on the phone lines.
What is DSHS interpretation of counselor for crisis redesign?

By a counselor we mean a QMHP-CS. Please reference FY2008 Information Item V for staffing requirements related to the 24-hour hotline.

13. May we use televideo for the QMHP-CS crisis assessment in jails?

See answer in B.2.

14. If the Hotline tells caller to meet the crisis screener at the MH Clinic Crisis screener sees caller and assures crisis intervention and documents intervention and resolution, does Hotline need to follow-up? Same situation but the person never shows. Does the Hotline call as follow-up?

The Hotline should assure that the caller has been seen by the crisis screener and the link was effectively made. Same situation but the person never shows. Does the Hotline call as follow-up?

Yes

15. If a 3rd party e.g. girlfriend or wife etc, calls with a concern regarding husband , boyfriend who seems to be a danger to self or others, and Hotline works with the 3rd party and tells them options, does the Hotline do follow-up to see what happened?

Yes, 3rd party caller should be made aware that you intend to check back to see what happened.

16. Will residential facilities operated by the LMHA require a license?

This is currently under evaluation.

17. Would a CSSP, as currently defined in TAC 412 I, qualify as a trained and competent paraprofessional in the standards that are part of Information Item V?

D. Crisis Redesign Service Reporting

1. ATCMHMR stated that sometimes they get people that, when they complete a crisis trag and it computes as a "0" if they complete a full intake trag later on the same day, they are no longer a "0." Stated that 2 TRAGS cannot be entered on the same day. Then asked if they could make it appear as though there was a day delay between the two.

You may enter a TRAG on the same day but the Crisis TRAG needs to be both entered first and in the event that the center is batching, the batching stream needs to be in that order, as well. (E.g.: SP0 then SP3, not the other way around)

2. Continuity of Care: Do phone contacts count as an encounter for crisis follow-up?

Yes.

3. Will there be a hold harmless period for data sanctions?

There can be no hold harmless period for any Medicaid billing data. DSHS will evaluate the data after the 3 rd quarter and decide on other data sanctions at that time.

4. What time can be billed to crisis transportation?

Only the time in which staff members are transporting an individual can be counted in crisis transportation. Crisis transportation does not include travel to the crisis location by the crisis worker.

5. I may be missing the obvious, but when "CRD" as First Billed Payer goes away, and as there is not a distinct Service Grid Code for CRD funds, how will DSHS be able to report the numbers of persons served through CRD Funding? (I realize the Funding will be reported through Report III)

DSHS will use percentages based upon numbers served and apply them to the expenditure data in CARE Report III, or will use percentages based upon expenditure data in CARE Report III, and will apply them to the total number of individuals served in each category of service(e.g. outpatient). DSHS provides similar calculations when reporting substance abuse performance measures to the LBB. For example, DSHS reports the average cost per adult and youth served in substance abuse treatment programs. All of the funding allocated, and spent on substance abuse treatment is lumped together (i.e., adult and youth). To report the average cost per adult and youth served, DSHS adds the total number of adults and the total number of youth served together and calculates the total percentage of adults and youth served. These percentages are then applied to the lumped expenditure data for substance abuse treatment programs to provide an approximate amount spent on adults and youth. This approximate amount is used to calculate the average cost per adult and youth served. The same logic will be applied to the new crisis funding depending upon DSHS reporting requirements. See also B.5.

6. What does DSHS require as far as documentation for safety monitoring? In the psychiatric emergency room there may be thousands upon thousands of 1 minute events for safety monitoring.

Discussed adding a row to 1505 and 2505 documenting the Billing Unit as an Event rather than 15 min. Would there need to be a separate modifier to indicate the distinction? (Pending recommendation from the Service Grid Workgroup)

7. There needs to be a mechanism to report where a center has a crisis contact with an individual who will not ever be part of ongoing services, and does not meet the criteria to place the individual into SP 0 on the Adult-TRAG or CA-TRAG, but does meet the definition of crisis in TAC 412G.

Discussed adding two rows to crisis intervention services (i.e., H2011?? & H2011??GJ) that would help with this. (Pending recommendation from the Service Grid Workgroup)

Can DSHS provide generic birth date for 1505 and 2505, like what was done for local case number?

8. There is concern about reporting the same type of information in different places on an encounter stream. For example, the modifier UK indicates collateral only - services provided on behalf of the client to someone other than the client, but recipient code 2 will indicate the same thing. What is the rationale for reporting the same information in two different places on a data stream?

(Pending recommendation from the Service Grid Workgroup.)

E. Crisis Redesign Training

1. Can we provide training regarding Mobile Crisis Outreach to the LMHAs?
Yes, and DSHS will provide Mobile Crisis Outreach training. DSHS is currently gathering additional information from around the country and are developing a training plan.
2. What kind of training will law enforcement have in relation to Crisis Redesign?
**Please check the TCLEOSE web site <http://www.tcleose.state.tx.us/>
Your suggestions regarding training opportunities for law enforcement in crisis redesign may be directed to Philander Moore at philander.moore@dshs.state.tx.us**
3. Is there helpful reading material to assist crisis workers in their training?
It would be helpful if the mental health workers taking the training try to read Hoff, Lee Ann. (1995). People in crisis: Understanding and helping. New York: Jossey-Bass. It is a fairly easy read and would give them a good overview of crisis management.

F. Crisis Redesign Utilization Management

1. .Define crisis service episode and explain how it relates to authorizations.
A crisis episode represents services provided to an individual within 1-7 days of the initial crisis contact. A crisis authorization may be up to 7 days.
2. If MCOT gives crisis services to active client how is this documented?
It would be documented using the appropriate service code or procedure code as defined in MBOW CA General Warehouse folder under specifications (file names: INFO_Mental_Health_Service_Array_Combined_FY08.xls and INFO_Encounter_Field_Defn_FY08.xls) If you have questions, please contact Christopher Dickinson at christopher.dickinson@dshs.state.tx
3. Should Crisis Respite be included in the Adult UM Guidelines for SP-0?
Yes, since individual with low risk of harm can be served in Crisis Respite.
4. What does the assessment (i.e., Adult-TRAG & CA-TRAG) process look like from service package 0 to service package 5 to service packages 1-4?

Crisis Assessment = SP0 → Intake Assessment = SP5 → Update Assessment = SPs 1-4
5. Is DSHS considering the inclusion of a score of 4 as an indicator for the need for authorization into service package 0 on the Risk of Harm domain on the CA-TRAG?

6. There seems to be a discrepancy between the definition of crisis in TAC 412 G, and the Adult-TRAG & CA-TRAG dimension scores that would indicate placement into service package 0. How will DSHS address this?
7. How will repeated circulation from service package 0 to service package 5 impact the readmission rate contract performance measure?
8. After listening to the Comnet and talking with Crisis Assist Deputy, it seems as though another suggestion in WebCare would better suit Harris County needs. Allowing a Crisis TRAG SP 0 to be overridden into a SP 5 Crisis Follow up would meet our MCOT team needs and purpose. By allowing the MCOT team to resolve the crisis, but then to still be the primary clinicians to provide services to the client they've formed trusting relationship with, until client is engaged in ongoing MHMRA services-SP 0 overridden into SP 5 follow-up would help. The team could then try to engage the client into services at ongoing MHMRA clinics for 30 days. Once successful, the MHMRA team would re-TRAG for ongoing services.

G. Crisis Redesign Evaluation

1. Will there be stakeholder input on satisfaction survey to be used to evaluate the Crisis Redesign project?

Implementation of the Crisis Redesign Initiative will be evaluated by an external evaluator and the request for proposals is underway. One component of this evaluation is anticipated to be a satisfaction survey.