Sacramento County Mental Health Board
Community Wellness Response Team (CWRT) Advisory Committee
ANNOUNCEMENT – IN PERSON MEETING
HYBRID PARTICIPATION OPTION
Tuesday, April 9, 2024
6:00 PM – 8:00 PM

Members Present: Corrine Sako, Adam Wills, Severine Hollingsworth, Elijah Orr (staff: Korlany Roche)
Absent: Katie Houston, Kaino Hopper, Mykel Gayent

Agenda Item

I. Welcome and Introductions

- Introductions:
  - Committee Members
  - CWRT Partners
- Review MHB Conduct Agreement
- Announcements by CWRT Advisory Committee Members

- Chair Sako commenced the meeting at 6:06pm. Introductions were made and MHB Conduct Agreement was reviewed.
- Chair Sako announced that Member Evan Minton has stepped down from this Advisory Committee and will be sitting on the Justice Committee.
- Individuals interested in participating on this Advisory Committee can apply on the Boards and Commission webpage.
- Chair Sako announced that there is a change to the timeframe in which the CWRT monthly data will be updated and published, due to the increase in data elements being requested. Goal is to post the data close of business the Monday prior this meeting.

II. Public Comments related to the Community Wellness Response Team (CWRT)

- Public Comment 1: Concern that CWRT is screening callers and situations for history of violence and refusing to go out on calls if there is a history of violence, regardless of the current situation. If there is no current violence, then there should be an attempt to de-escalate the crisis. Appreciate the CWRT Advisory board in addressing this question. If we don't want police involvement, then we need to go out and assess the situation.
- Public Comment 2: Question regarding what type of training is happening. I was assisting someone to call CWRT and got transferred to a bunch of places, and persistently being redirected. We tried to access the service via 911 and they were uncertain about how to get us routed. What is happening with the phone issue and getting transferred to Access? We got a hold of CWRT but they weren't sure on the type of response that should happen. We called 911, 988 and the direct line.

Member Comments:

- Member Wills clarified that the individual called from a 619 area code and got transferred to San Diego. Public member shared the local number to 988 is 916-368-3111. It will say it's the old suicide hotline, but stay on hold and it'll connect you to 988. The HOPE line is 916-999-HOPE.

III. Discussion/Action Item: Approve Nomination for CWRT Advisory Committee Member Elijah Orr as CWRT Advisory Committee Co-Chair

- Chair Sako motioned to approve Member Elijah Orr as CWRT Advisory Committee Co-Chair, with a second by Member Hollingsworth. A unanimous vote to approve Member Orr was called.

IV. Presentation on Medi-Cal Mobile Crisis Benefit

- Korlany Roche, Human Services Program Planner, provided information on the Medi-Cal Mobile Crisis Benefit. See attached presentation.

Member Questions/Comments:

- Is the benefit adding another program? Is the benefit using the same dispatch call center or a separate team?
  - No, CWRT meets the DHCS BHIN benefit requirement. There are no changes to the workflow.

- There are so many numbers to call and this can cause confusion to the community. How do I know which number to call?
  - We are encouraging the community to continue calling 988 to receive support and can still access CWRT by that call line. The HOPE line is the direct line for triaging mobile crisis response, and calling the HOPE line with lower risk calls ties up the triage operator. The purpose of 988 is to de-escalate over the phone and provide resource linkage, so the best place to call first is 988. We are intending for callers to use the proper workflow so that calls coming into the HOPE line that aren't crisis, can be provided with a quick response through 988. 988 is also better staffed and equipped to handle a higher volume of calls.

- Are the standardized dispatch screening tool questions available and are they used in addition to the BHS Crisis Matrix?
  - CWRT has opted in to use the DHCS standardized dispatch screening tool, which can be found on the M-TAC website: M-TAC Standardized Tools (camobilecrisis.org). The BHS Crisis Matrix is used to triage calls based on level of risk. See attached.

- Another community member died at the hands of Law Enforcement, Christopher Gilmore, at the time that CWRT was available and operating at 24/7. It is disheartening to see another life taken that could have been avoided with proper mental health response. Where is the sense of urgency with Law Enforcement?
- What is the timeframe to pilot the bi-lateral process?
  - We are in the process of identifying the timeframe it would take to pilot the bi-lateral process. We smaller jurisdictions that have agreed to participate in the pilot. There is also time needed to establish policies and procedures after the MOU agreements, along with training staff.

- When will you have a deadline of when the MOU with Law Enforcement Agencies will be completed? We need a timeframe to track the progress and make adjustments as needed.
  - We will bring this back to the Bi-lateral Referral Process group and add to the agenda to establish a timeframe. Collaborating with the various agencies can very complex as we have different policies, different familiarity with processes, need to find common language to have a shared understanding, and go through our respective counsel and risk management. We can certainly put the pressure on counsel and risk management. It is a big lift and there is a sense of urgency.

- How can we put pressure on Law Enforcement Agencies to make it more urgent? Do we need to go to a city council meeting or Board of Supervisor meeting?
  - We can put on the agenda for next month to discuss what options we want to take to carry that sense of urgency.

- As a follow up from last month's meeting, does the Sheriff's Department have the list of prompts to screen callers for mental health needs?
- Yes, Chief Deputy Matt Petersen shared list of prompts for call takers to screen. Matt also added the agency have a desire to shift outcomes, we are engaged in the process of collaboration and want what is best for the community. We have the same sense of urgency.

V. Discussion: CWRT Program Implementation, Including Data & Response Outcomes

a. Sacramento County Behavioral Health Services CWRT

b. 988/WellSpace Health

c. Bay Area Community Services (BACS)

d. 4/8/24 CWRT Program Update here: https://dhs.saccounty.gov/BHS/SiteAssets/Pages/Community-Wellness-Response-Team/CWRT%20Timeline%20March%202024%20Draft%20%28003%29.pdf

Alondra/BHS

- Shared success story: Grandparents called about minor grandchild perceived as gay, bullied at school, became suicidal and disclosed suicidal ideation. CWRT provided services to youth and grandparents, provided resources on bullying.
- Monthly updates: Received 1411 calls to 988, we had 48 mobile responses in February. 29 were stabilized in the community, 10 were transported MHUCC voluntarily, no hospitalizations, unable to locate 8 times, and 1 refused linkage to services.

Terri/WellSpace

- Shared success story: CWRT team arrived at residence for support and depression death of husband. Individual had thoughts of suicide and rated suicidality at 4.5/5. She had difficulties meeting her basic needs due to a medical condition, and this was the first time she reached out for help. The team provided resources to meet basic needs, and even helped her to schedule an appointment with Kaiser and hair dresser. At the end she reported her suicide ideation went from 4.5 to 1.
- We had 1,411 calls and warm transferred 81 calls, which is the highest we've had by far. We had 19 missed opportunities due to lunch time and staffing. 95% of calls were resolved by phone.
- Hope that people understand that we've worked hard to ensure system works for the community. We have 75 staff and will be increasing that to 90 so that the community has someone to talk to and we will always be available. We have been working hard to build a partnership and there should not be a workaround to the HOPE line.

Harjit/BACS –

- No updates. As the teams are emerging, I have been monitoring and getting to know the teams. I have been seeing great communication, teamwork and comradery. They are detail oriented in their communication and getting the information needed to respond. I am happy with the progress so far

Member Comments:

- Chair Sako shared there is a 95-100% retention rate with BACS. There are 22 allocated position, 20 are filled, with 2 vacancies. While BHS vacancy rate is 42%. Why is BACS able to fill positions? Why is it hard for BHS to fill positions? Budget season is also upon us, is the issue about pay, salary, benefits or working conditions? Why is there a higher vacancy rate?
- Stephanie shared we just added two Mental Health Counselor positions that added to the vacancy rate, otherwise we have been consistently at the 40% vacancy rate. The government is more slow moving and to ensure we are hiring good stewards of tax dollars, the hiring process is slower. I can only speak to speed, not interest. We also only have 19 filled positions because we have more allocated positions, but we definitely need more.
- Alondra shared we are trying to increase our dispatch teams and hiring Mental Health Counselors to also accommodate the higher call volume. We are hiring licensed LMFTs and LCSW and working on hiring efforts.
- Chair Sako shared there is a Sacramento Valley Psychological Association conference in May that will have hiring opportunities. What can we do to help support hiring efforts?
- Alondra shared we will also have a one-day job fair that is coming up. I will share job descriptions and announcements.

Public Comments

- Public Comment 1: From the Office of Patients' Rights of Sacramento County. We work and meet with clients in LPS designated facilities and in the ERs. Where are you advertising 988 number? We meet with over 4000 people and only staff of 8. No one they've worked with has said they've seen 988 advertisement. Regarding CWRT and warm handoffs, when it's necessary to go to the ER, what is the education in the ER, they're immediately being placed on 5150 involuntary when they had gone somewhere voluntarily. There is miscommunication and misinformation, saying if you go here willingly, you'll get home but that is causing the community to be hesitant to call and their experience is not as positive as it is being advertised. How do we keep the process less traumatizing.
- Alondra shared that CWRT works with the MHUCC and MHTC and provide voluntary transportation. They contact staff ahead of time to give them information, so they know we are coming and transport voluntarily.
- Member Wills shared MHUCC will provide respite and take care of them but they won't put them on a 5150 right away. If you need a doctor for a refill, you will still need to wait. CWRT is less institutionalized which is one of many reasons why I support the team.
- Terri shared that for 988, less than 1% of callers in Sacramento County have required a welfare response. Welfare responses are also voluntary welfare checks when the risk is high and imminent when 5150 would be activated. Using the ER is only for cases where it is critical and necessary.

- Public Comment 2: There are some individuals who go to the ER because they want medication. How does the program support that?
- Terri responded that would be a potential CWRT referral if they need services and need to connect

with MHUCC for medication. We are trying to design the system to only use ER for emergencies. We have had no reports of transferring to ER. We also have an ER program, 988 will provide 30 days of follow up where people have been in the ER and need follow up services.

- Alondra shared we can link back to the provider to provide follow up if they're already receiving services.
- Member Wills asked how is this information being disseminated? How much of a budget is there to do the marketing for 988?
- Chair Sako shared we had a presentation by Edelman Marketing and we need to rush the promotion. They're starting to roll it out. I can attest to seeing transit shelters and there are radio ads. NAMI did a survey that found 4 out of 5 Americans had strong support of 988 nationwide, and that 2% nationwide are individuals unfamiliar with 988. Maybe have Edelman come back or get a status update.
- Alondra shared the marketing plan started February 18th and will run for 8 weeks. There is also a lot of free materials that can be printed and ordered.
- Member Wills shared we need to put pamphlets in fire stations and hospitals.

VI. Adjournment

Next CWRT Advisory Committee Meeting Scheduled for Tuesday May 14, 2024 6pm-8pm

Chair Sako adjourned the meeting at 8:08pm.

SACRAMENTO COUNTY

MEDI-CAL MOBILE CRISIS SERVICES BENEFIT

BHIN No. 23-025

CWRT ADVISORY COMMITTEE MEETING
APRIL 9, 2024

Presented by: Korlany Roche, PsyD, LMFT
Human Services Program Planner

SUMMARY

- Medi-Cal behavioral health delivery systems shall establish, or contract with providers to establish, qualifying mobile crisis teams that meet DHCS' training and implementation requirements set forth in this BHIN.
- All mobile crisis teams, regardless of delivery system, shall meet the same requirements.
- Counties may implement a fully integrated approach across mental health and substance use disorder (SUD) delivery system in which a single mobile crisis services infrastructure serves the entire county.
- A single integrated system may include multiple mobile crisis teams that are equipped to respond to beneficiaries regardless of whether they otherwise are served by the MHP or the county's SUD delivery system.

I. 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.
- Utilize de-escalation and stabilization techniques, reduce the immediate risk of danger and subsequent harm, avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.
- Services include:
  - Warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services
  - Coordination with, and referrals to, appropriate health, social and other services and supports, as needed
  - Short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care

II. DISPATCH OF MOBILE CRISIS TEAMS

- Counties shall establish a system for dispatching mobile crisis teams and develop policies and procedures that shall include, but are not limited to:
  - A single telephone number to serve as a crisis services hotline connected to the dispatch of mobile crisis teams to receive and triage beneficiary calls;
  - A standardized dispatch tool and procedures to determine when to dispatch a mobile crisis team; and
  - Procedures identifying how mobile crisis teams will respond to dispatch requests

III. MOBILE CRISIS TEAM REQUIREMENTS FOR INITIAL CRISIS RESPONSE

- 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 by a multidisciplinary mobile crisis team.
- Mobile crisis teams shall meet the following standards:
  - At least 2 providers shall be available for the duration of the initial mobile crisis response.
  - At least 1 onsite mobile crisis team member shall be carrying, trained, and able to administer naloxone.
  - At least 1 onsite mobile crisis team member shall be able to conduct a crisis assessment.
  - The mobile crisis team providing the initial mobile crisis response shall include or have access to an LPHA. *Example: a mobile crisis team could consist of 2 peer specialists who have access to an LPHA via telehealth.*

IV. MOBILE CRISIS SERVICE ENCOUNTER

Each mobile crisis services ***encounter*** shall include, at minimum:

- **Initial face-to-face crisis assessment**;
- **Mobile crisis response**;
- **Crisis planning**, as appropriate, or documentation in the beneficiary's progress note of the rationale for not engaging the beneficiary in crisis planning; and
- **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 mobile crisis team.

When appropriate, each mobile crisis services ***encounter*** shall also include:

- Referrals to ongoing services; and/or
- Facilitation of a warm handoff.

*Mobile crisis teams 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.

INITIAL FACE-TO-FACE CRISIS ASSESSMENT

The mobile crisis team 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.

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.

When delivering a crisis assessment, mobile crisis tams shall use a standardized crisis assessment tool.

MOBILE CRISIS RESPONSE

During the mobile crisis service encounter, the mobile crisis team 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:

- Trauma-informed on-site intervention for immediate de-escalation of behavioral health crises;
- Skill development, psychosocial education and initial identification of resources needed to stabilize the beneficiary;
- Immediate coordination with other providers involved in the beneficiary's care'
- Immediate coordination with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, etc.); and
- Provision of harm reduction interventions, including the administration of naloxone to reverse an opioid overdose, as needed.

CRISIS PLANNING

As appropriate during the mobile crisis services encounter, the mobile crisis team 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:

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

When appropriate, crisis planning may include the development of a written crisis safety plan. To the extent information is available and appropriate, the written crisis safety plan shall include, but is not limited to:

- 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;
- Conditions and factors that contribute to a crisis;
- Alternative ways of responding to such conditions and factors;
- Additional skill development and psychosocial education;
- Short and long-term prevention and strategies and resources the beneficiary can use to avert or address a future crisis, including harm reduction strategies.

FOLLOW-UP CHECK-INS

Counties 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 mobile crisis team shall check on the status of appointments and continue to support scheduling, arrange for transportation, and provide reminders as needed.
- Follow-up may be conducted by any mobile crisis team member who meets DHCS' core training requirements and may be conducted in-person or via telehealth.
- Follow-up may be conducted by a mobile crisis team member that did not participate in the initial mobile crisis response.

SERVICE SETTING RESTRICTIONS

Mobile crisis services shall not be provided in the following settings due to restrictions in federal law and/or because facilities and settings are already required to provide other crisis services:

- Inpatient Hospital;
- Inpatient Psychiatric Hospital;
- Emergency Department;
- Residential SUD treatment and withdrawal management facility;
- Mental Health Rehabilitation Center;
- Psychiatric Health Facility (PHF);
- Special Treatment Program;
- Skilled Nursing Facility;
- Intermediate Care Facility;
- Settings subject to the inmate exclusion such as jails, prisons, and juvenile detention facilities;
- Other crisis stabilization and receiving facilities (e.g., sobering centers, crisis respite, crisis stabilization units, crisis residential treatment programs, etc.).

V. STANDARDS: RESPONSE TIMES

Mobile crisis teams shall arrive:

- Within 60 minutes of the beneficiary being determined to require mobile crisis services in urban areas; and
- Within 120 minutes of the beneficiary being determined to require mobile crisis services in rural areas.

V. STANDARDS: LAW ENFORCEMENT

When a mobile crisis team is dispatched, it is considered a national best practice for the team to respond without law enforcement accompaniment unless special safety concerns warrant inclusion.

While LE officers may accompany a mobile crisis team when necessary for safety reasons, they shall not qualify as a member of the mobile crisis team for purposes of meeting Mobile Crisis Team Requirements.

V. STANDARDS: TRANSPORTATION

When needed, a mobile crisis team shall arrange for or provide transportation to an appropriate level of care or treatment setting. The mobile crisis team may transport the beneficiary directly as part of providing the mobile crisis service.

If the mobile crisis team provides transportation or accompanies a beneficiary who is being transported by an Non-Medical Transportation (NMT) provider, EMS, or law enforcement, it can receive an add-on reimbursement to reflect the expanded nature of its mobile crisis encounter in such circumstances.

TRAINING

All mobile crisis team members shall meet the State's training requirements. The core training curriculum will include:

- Crisis Intervention and De-escalation Strategies;
- Harm Reduction Strategies;
- Delivering Trauma-informed Care;
- Conducting a Crisis Assessment; and
- Crisis Safety Plan Development.
- Mobile crisis team members must meet core training curriculum requirements before delivering qualifying mobile crisis services.

Mobile crisis team members must also complete required enhanced training curriculum, which will include:

- Provider Safety
- Delivering Culturally Responsive Crisis Care
- Crisis Response Strategies for Special Populations (e.g., children, youth and families, tribal communities, and beneficiaries with I/DD).

BHS MOBILE CRISIS CONTINUUM

IMPLEMENTATION OF MEDI-CAL MOBILE CRISIS SERVICES BENEFIT



CRISIS SERVICES LINE	MOBILE CRISIS TEAMS	FOLLOW UP SERVICES
988	CWRT	CWRT
916-999-HOPE	CWRT	CWRT
FURS/The Source	The Source	The Source
911/Dispatch	CWRT	CWRT
	MCST*	CST*

*Mobile Crisis Support Team (MCST) and Community Support Team (CST)

BHS MOBILE CRISIS CONTINUUM

IMPLEMENTATION OF MEDI-CAL MOBILE CRISIS SERVICES BENEFIT

916-999-HOPE Line vs. 988

- DHCS requires a single telephone number to serve as a crisis services hotline to serve Sacramento County residents under this benefit.
  - BHS utilizes 988 to meet this requirement.
- DHCS also requires a local telephone number to receive and triage beneficiary calls.
  - BHS established the HOPE line to meet this requirement.
- BHS will continue to encourage 988 as the main entry point for crisis calls.
  - Minimizes community confusion by advertising two lines.
  - 988 supports sufficient staffing to manage a high call volume.
- HOPE line allows:
  - Direct access to the CWRT Dispatch Call Center when needed.
  - A bi-lateral referral process with Law Enforcement agencies and Emergency Medical Services/Fire.

BHS MOBILE CRISIS CONTINUUM

WORKFLOW

CRISIS SERVICES LINE

- Provides immediate support through text, chat, or phone
- Assesses need for mobile crisis response
- Provides dispatch referral for mobile crisis response
- Complete risk assessment to assess and link beneficiaries with on-going follow-up care
- Assist beneficiaries in planning for safety including utilizing natural supports
- Provide information and referrals for community resources
- Provide crisis interventions to support callers in resolving their crisis
- Provide referrals after the resolution of the crisis to appropriate resources, including Managed Care Plans and educational resources on school campuses

MOBILE CRISIS TEAMS

- Provides trauma-informed on-site intervention for immediate de-escalation of behavioral health crises
- Provides initial face-to-face crisis assessment
- Provides skill development, harm reduction interventions
- Administer naloxone, as needed
- Immediate coordination with other providers involved in the beneficiary's care
- Immediate coordination with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, etc.)
- Provides crisis and safety planning
- Provides warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services

FOLLOW UP SERVICES

- Provides follow-up check-in within 72 hours of the initial mobile crisis response
- Provides short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care
- Provides referrals to appropriate health, social and other services and supports, as needed
- Create or provide updates to the beneficiary's crisis safety plan, or additional referrals to ongoing supports, as needed
- Check on the status of appointments and continue to support scheduling, arrange for transportation, and provide reminders, as needed