MENTAL HEALTH BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

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SUBJECT
Mental Health Crisis Intervention Services Guidelines

BY
Deputy Secretary for Mental Health

SCOPE:

County MH/MR Administrators
Mental Health Crisis Intervention Service Providers

PURPOSE:

This bulletin supplements Mental Health Bulletin Number OMH-92-16 which provides guidelines for agencies that wish to be licensed and enrolled providers of Mental Health Crisis Intervention (MHCI) Services prior to the publication of final regulations. These guidelines are provided to assure the consistency of service delivery across the Commonwealth.

BACKGROUND:

Following the publication of the proposed regulation, 55 Pa. Code 5240, on March 6, 1993, there was a formal comment period during which several issues were presented. There was also a conference on June 7 and 8, 1993, in Harrisburg relating to MHCI service implementation. These forums raised several issues of statewide significance that require prompt guidance. The publication of 55 Pa. Code 5240 in the Pennsylvania Bulletin as a final regulation will supersede the guidelines set forth in this bulletin.

ISSUES AND GUIDELINES:

Issue 1:

What is expected of providers in terms of obtaining a liability and billing for MHCI services? Because of the nature of the services, especially the telephone service, it is very difficult to obtain the liability and/or payment resources of consumers and sometimes even to identify them.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Your Area Office of Mental Health

Guidelines:

Providers are not required to obtain a formal liability determination for MHCI services provided during a crisis event. A crisis event is an initial contact made by a consumer or a collateral and follow-up. One purpose of follow-up should be to make a verbal inquiry as to third party resources and the consumer's ability to pay. The inquiry is secondary to the provision of services and should be made in a manner that is not disruptive. The effort to obtain information on payment resources should be documented. Sometimes a provider knows the consumer and the consumer's payment resources. The Office of Mental Health (OMH) intends to require that the provider must bill for any MHCI service if there is a known payment resource.

Follow-up MHCI services should not be a substitute for existing case management services such as Intensive Case Management and Resource Coordination or for intensive outpatient services regardless of whether or not these services are immediately available to consumers.

Issue 2:

How may MHCI services be authorized or reauthorized to continue beyond the crisis event as a reimbursable service?

Guidelines:

Only MHCI residential services may be reauthorized under the conditions as set forth in Mental Health Bulletin OMH #92-16, Attachment C, Subsection E. Costs of reauthorizations should be included in the MHCI provider's service rate.

Issue 3:

What constitutes a "crisis event?"

Guidelines:

A crisis event consists of the initial MHCI contact by a consumer or collateral and up to two follow-up contacts made within 14 calendar days and any reauthorized-period in a MHCI residential service. MHCI services are considered to be terminated at the end of the crisis event. An initial contact for a MHCI residential services provider includes up to 120 hours of consecutive service. This service may be briefly interrupted by necessary examination or medical treatments outside the facility provided the interruption does not exceed 4 hours.

If one MHCI provider component service transfers service to another, these services are considered as parts of a single crisis event and the last MHCI service component provider has responsibility for follow-up. For example, if a consumer calls the telephone service and the telephone staff person determines that the mobile provider should go to the consumer's

location and it, in turn, gets the consumer to a crisis residence, all three services are involved in the crisis event. The telephone service provider may contact the mobile service provider to determine disposition and the - mobile service provider may contact the crisis residence to determine disposition. However, only the last MHCI provider to serve the consumer, in this example the residential service, may provide follow-up with the consumer.

Issue 4:

What is "follow-up?"

Guidelines:

Follow-up are contacts made with the consumer or parents, if the consumer is a child or adolescent, which aTe initiated by a MHCI service provider after the initial contact. The purpose of follow-up is to assess the status of the consumer and the effectiveness of services provided in the initial contact. Inquiry should be made to determine third party payment resources and, if there are none, the consumer's stated ability to pay.

Providers of MHCI telephone and residential services will be reimbursed for up to two provider initiated follow-up telephone contacts made within 14 days after the initial contact. MHCI telephone providers may bill for follow-up services at the accepted rate.

Providers of MHCI walk-in, mobile and medical-mobile services may be reimbursed for follow-up initiated by providers either by telephone or by direct service, depending upon the providers' licensure. Again, two provider-initiated follow-up contacts within 14 days of the initial contact are compensable. Estimated costs of telephone follow-up should be estimated in the rate, and walk-in, mobile or medical mobile follow-up contacts should be billed at the provider's accepted rate.

Providers of MHCI residential services will be reimbursed for up to two provider initiated telephone contacts made within 14 days after the consumer leaves the provider's facility. Providers should include an estimate of the costs to provide follow-up services in their rate.

All MHCI providers should document the justification, purpose, and results of follow-up. There must be a clinical recommendation approved by a mental health or medical professional to justify face to face follow-up contacts. Face to face follow-up contacts are not reimbursable if it is a substitute for a clinically appropriate referral to outpatient services.

Issue 5:

Are there OMH standards for the physical facilities of MHCI walk-in I and residential providers?

Guidelines:

Prior to publication of final regulations, crisis residential facilities may be licensed against the Physical Facilities Standards of the

Community Residential Rehabilitation Services regulation, 55 Pa. Code, 555310.71-73. The facilities of crisis walk-in service providers may be licensed against 55200.45 relating to the physical facility of Psychiatric Outpatient Clinics. These guidelines will be superseded by the published, final regulations, Chapter 5240.

Issue 6:

The OMH has indicated that it will permit on duty MHCI staff to work in other programs when they are not occupied with crisis services. What are the guidelines for staff sharing?

Guidelines:

Although the Office has agreed that a MHCI provider's staff may be shared with other crisis components and other mental health services, there should be at least one staff person available at all times for immediate response for the telephone crisis service either at the facility site or through call forwarding or patch-in. The Office recognizes that this person may be occupied with another call at any particular time. A staff person should also be on site to provide crisis walk-in services during the provider's posted hours of operation. A protocol addressing how these requirements are met should be on file. Back-up staff should be considered on-call with units of service estimated for rate setting purposes. Back-up staff should be qualified under MHCI guidelines.

Issue 7:

How should MHCI residential service providers handle medication administration:

Guidelines:

Persons entering the crisis residence with prescribed medications are to be self-medicating to the greatest degree possible. An individual who is authorized to administer meds must be accessible at all times to assist persons who cannot take their own medication. All medications within the residence must be maintained in their original containers, and stored in a locked cabinet or room.

Issue 8:

How should MHCI residential service providers pay for medications?

Guidelines:

A supply of prescription drugs should not be maintained for dispensing by MHCI residential providers. Self-medicating consumers are responsible to maintain their own supply of medication under conditions set forth in the provider's written protocol. In emergency situations, consumers may be in need of medication, but may not have medical coverage or sufficient funds to obtain the medication. The cost of such medications may be paid by the crisis residential program using 100% state funds if a third

party payment resource is not available. Provider payments for medications should not exceed 2% of the annual budget.

Issue 9:

What are the guidelines for MHCI services in hospitals or by hospital MHCI service providers?

Guidelines:

Non-hospital MHCI programs may locate or provide services in a hospital, but they should not call upon on-duty hospital staff to provide services to the crisis service. This does not preclude the hospital from providing services in its facilities to MHCI consumers (e.g., a physical examination). An independent provider that locates its walk-in facility in a hospital should clearly identify the location as separate from the emergency room or other hospital operation. Independent MHCI providers may be called to provide crisis services to an emergency room patient or to a consumer who is in the emergency room location. A crisis residence located in a hospital should be in a distinct part of the hospital as approved by the Department of Health, Division .of Hospitals.

If the MHCI provider is a hospital, it should locate and provide services either in the community or in a distinct part of the hospital as approved by the Department of Health, Division of Hospitals. Staff or these providers should not bill for crisis services provided in the hospital emergency room or in any area of the hospital except in an approved distinct part. All crisis services provided in the emergency room of a hospital by hospital employees are considered to be hospital outpatient services, not MHCI services.

Crisis residential facilities which are located in a distinct part of a hospital should have a direct access which is not through the hospital. This access must meet required building codes and laws such as the Americans With Disabilities Act.

Private psychiatric hospitals are also subject to this policy.