Crisis Services – Mobile, Telephone, and Site Based

Magellan Behavioral Health of Pennsylvania (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the HealthChoices program, with a goal to promote the utilization and progress toward providing best practices performances, to increase the quality of services and to improve outcomes for members.

Current Version Information

Substantive changes in most recent update:

1. Description of Best Practices tool kit
2. Information regarding telephonic billable unit requirements
3. Removed Encounter verification requirement

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania regulations and requirements including, but not limited to, The Pennsylvania Code Title 55, Chapter 1101 General Provisions and Proposed Rulemaking Crisis Intervention Services as well as all associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan in order to be eligible for payment for services.

Please routinely visit the link below to stay up to date on Compliance Alerts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

Mental Health Crisis Intervention services are immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress which are provided to adults, adolescents, and children and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The services provide rapid response to crisis situations which threaten the well-being of the individual or others.

Scope of Services

Mental Health Crisis Intervention (MHCI) includes intervention, assessment, counseling, screening and disposition services which are commonly considered appropriate to the provision of mental health crisis intervention. MCHI is provided to any individual of any age and is available 24 hours per day, 7 days per week. MHCI can be provided by telephone, walk-in, or on a mobile basis.

Service Description

Mental Health Crisis Intervention (MHCI) can be staffed by three levels of qualification. A Mental Health Professional is one who has a graduate degree in medicine, osteopathy, social work, psychology, rehabilitation, activity therapies, counseling, education, or a related field and has at least one year of mental health direct care experience. A Crisis Worker II is one who meets at least one of the following criteria: 1) has at least a bachelor's degree in sociology, social work, psychology, gerontology, criminal justice, theology, nursing, counseling, education or a related field and at least two years' experience in public or private human services, one of which must in mental health direct care or 2) six years of experience as a Crisis Worker I. A Crisis Worker I is one who has a high school diploma or equivalency.

Telephonic Crisis Service is a 24-hour a day, 7 days a week "hot-line" service available in each Mental Health (MH)/Intellectual Disability (ID) catchment area throughout the state. This service screens incoming calls and provides appropriate counseling, consultation, and referral to individuals who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. Service is also provided to callers who represent or seek assistance for individuals who are exhibiting these problems. Telephonic crisis calls shall only be answered by a person who has been trained to answer crisis calls and not by a recording or other mechanical device. At least one staff person who meets the requirements of a Mental Health Professional or Crisis Worker II shall be available at all times on-site or able to be reached via conference calling. Telephonic Crisis Services are a required component of Mental Health Crisis Intervention Services.

Walk-in Crisis Service is provided at a provider site in face-to-face contact with individuals in crisis or with individuals seeking help for persons in crisis. Service is available at a licensed facility and includes assessment, information and referral, crisis counseling, crisis resolution, accessing community resources and back-up, including emergency services and psychiatric or medical consultation. This service also provides intake, documentation, evaluation, and follow-up. Walk-in Crisis Services are provided by Mental Health Professionals or a Crisis Worker II and at least one staff member must be on site during the posted hours of operation. If a walk-in site is also the location providing Telephonic Crisis Services, the site must have a dedicated individual for each type of service offered.

Mobile Crisis Services are provided at a community site that is the place where the crisis is occurring or a place where a person in crisis is located. The service shall be available with prompt response and may be delivered by an individual or a team of Mental Health Professionals and Crisis Workers. Services include crisis intervention, assessment, counseling, resolution, referral and follow up. This service also provides back up and linkages with other services and referrals. Extended service by a Crisis Worker I staff member can also occur.

Service Exclusions

There are no service exclusions for the provision of Mental Health Crisis Intervention Services for individuals in the community.

Referral Process

Mental Health Crisis Intervention is provided to an individual of any age and is available 24 hours per day, 7 days per week. Mental Health Crisis Intervention can be provided by telephone, walk-in, or on a mobile basis. Referrals can be made either via telephone or "walk-in" or via text/chat where available. Mental Health Crisis Intervention does not require a prior authorization from Magellan. Members may go to any Emergency Department or Crisis Center for emergency care and do not need to call Magellan first.

Admission Process

Mental Health Crisis Intervention Services are provided to adults or children and their families who exhibit an acute problem of disturbed thought, behavior, mood, or social relationships. Similar to the referral process noted above, individuals may seek crisis intervention services by telephone or walk-in or via text/chat where available. A Crisis Worker will complete an initial assessment, which includes screening for suicide, complete a comprehensive suicide risk assessment and screen for violence risk. This assessment should address the causes leading to the crisis event, safety and risk for the individual and others involved, strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports, recent inpatient hospitalizations and/or any current relationship with a mental health provider, medications prescribed, as well as information on the individual's compliance with the medication regimen and medical history as it may relate to the crisis.

Treatment or Service Plan

MHCI Services include crisis intervention, assessment, counseling, screening, resolution, referral and follow up. The primary responsibility of the MHCI provider is to respond to and seek to resolve a crisis situation. As noted in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit, crisis stabilization is a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental disorder. The service should provide "back-up" and linkages with other services and referrals such as short-term crisis residential programs. When indicated, Mobile Crisis Service Providers should also follow up with the individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs.

Expectations of Service Delivery

As noted in SAMHSA's National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit, crisis services should not be viewed as stand-alone resources operating independent of the local community mental health system and hospital systems, but rather an integrated part of a coordinated continuum of care. Services, needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode. Additionally, SAMHSA's toolkit references the following core principles/best practices for crisis care: addressing recovery needs, significant role for peers, trauma-informed care, Zero Suicide/Suicide Safer Care, safety/security for staff and people in crisis, and crisis response partnerships with law enforcement, dispatch and emergency medical services. The Best Practice Toolkit also outlines best practices for a mobile crisis team which includes incorporation of peers within the mobile crisis team, respond without law enforcement accompaniment unless special circumstances warrant inclusion, implement real-time GPS technology in partnership with the regions' crisis call center hub, schedule outpatient follow-up appointments in a manner synonymous with a warm hand-off in order to support connection to ongoing care. The Department of Human Services' Crisis Intervention Services

Implementation Medical Assistance Bulletin also references Community Support Programs (CSP) and Children, Adolescent Service System Program (CASSP) as additional core principles in Mental Health Crisis Intervention Services.

Only the time spent in direct telephone contact with a person in crisis or a parent if the person is a child may be billed at the unit rate. Costs necessary for all other activities required for the service are built into the rate. A unit of service is 15 minutes or a major portion thereof (i.e., at least 8 minutes).

Documentation

The documentation in the individual's behavioral health record allows mental health professionals to evaluate and plan for treatment, monitor health care over time, and facilitate communication and continuity of care among healthcare professionals involved in the individual's care. It ensures accurate and timely claims review and payment, promotes appropriate utilization review and quality of care evaluations, and can be used for research and education.

- The record must be legible throughout.
- The record must identify the individual on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.
- The documentation of treatment or progress notes for all services, at a minimum, must include:
  - The specific services rendered;
  - The date the service was provided;
  - The name(s) of the individual(s) who rendered the services;
  - The place where the services were rendered;
  - The relationship of the services to the treatment plan – specifically, any goals, objectives and interventions;
  - Progress at each session, any change in diagnosis, changes in treatment and response to treatment; and
  - The actual clock hours that services were rendered.

Records for each MHCI service shall be specifically identified and may be integrated with the consumer's other service records which are maintained by the provider so long as there is a copy of services rendered at the MHCI component provider's facility.

Care Coordination

It is best practice for crisis intervention staff to coordinate with natural and professional supports as appropriate in order to gather necessary information to complete their assessment and make recommendations for medically necessary behavioral health services. Natural and professional supports should also be included in the discharge planning, resource linkage, and transition processes.

SAMHSA Best Practice Toolkit also notes that agreements or protocols for frequently used referral sources such as community behavioral health centers, police, hospitals, and other crisis intervention providers are recommended. Agency-to-agency collaboration is essential and may manifest through personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols or more advanced high-tech solutions such as real-time bed registries, shared GPS-enabled communication to support dispatch and outpatient appointment setting through the call center hub (SAMHSA National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit, 2020).

Discharge Planning and Transition

Crisis services should identify all referrals and linkages to medically necessary behavioral health services needed to resolve the current episode and prevent future crises. These services may include, but are not limited to, acute inpatient hospitalization, crisis residential services or treatment in the community (e.g., community behavioral health clinics and/or mobile support services such as case management or peer support). The crisis intervention staff is responsible to assist the individual in transitioning to the level of care recommended. There should be evidence of the individual and their supports being involved in the crisis planning process, both in the transition to the next level of care and in safety planning for the future.

As noted in SAMHSA's Best Practice Toolkit, responding to mental health crises should also include prevention. This includes "evaluating and considering factors that contributed to the current episode and that will prevent future relapse" (SAMHSA National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit, 2020). A complete crisis response is a whole person approach including consideration of physical health and social determinants of health, such as housing and income. Discharge planning should therefore include identifying community resources, in addition to treatment, that will assist in addressing unmet needs.

If the individual is not agreeable to the recommended level of care, there should be documentation that they were educated regarding their options and given information regarding relevant resources. If there is a concern for the individual's safety or the safety of others, the crisis intervention staff should consider an involuntary commitment and follow the procedures in the link below.
http://www.pacodeandbulletin.gov/Display/pacodefile=/secure/pacode/data/055/chapter5100/chap5100toc.html&d=

If a member is referred to community-based treatment, follow-up calls to the individual should be completed to determine if the recommendations and referrals are meeting their needs. A face-to-face

contact may be warranted if unable to connect via phone; if this is completed there should be documentation that this was deemed medically necessary by a mental health or medical professional.

Outcomes

All providers of Crisis Services should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Inpatient diversion rates
- Outpatient/community-based service engagement rates
- Member satisfaction
- Average response time
- Percent of mobile crisis responses resolved in the community

Complaint Process

Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

The information that is collected through Magellan's investigation is presented to a first level complaint review committee, which makes the first level complaint decision. HealthChoices standards and regulations, contractual standards, and generally accepted standards of care apply those standards to the issue at hand. Magellan is required to make a decision and send a letter to the member explaining the findings and the reasons for the decision within 30 calendar days of receipt of the Complaint.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to

develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Viewing complaints from the member's perspective is critical. If the member feels the concern sufficiently to raise it, the matter should be taken seriously and treated accordingly. If the member is still active with provider's services, attempts to resolve the member's issue or concerns and an internal review of the concerns should occur. As opportunities for improvement are identified, corrective action(s) should be implemented in accordance with provider's internal policies, procedures, and protocols.

Service providers should also have internal written policies and procedures for filing and resolving complaints within their organization. These policies and procedures must comply with state and federal regulations, as well as applicable accreditation standards. Staff should be trained to listen effectively and manage a member's expectations and employ a proactive approach to customer service. Organizations should always try to resolve the member's concerns immediately and informally whenever possible. Complaints/concerns involving minor issues might not require a formal written response. However, even if the matter is addressed quickly and informally, documentation of the member's complaint/concern and actions taken to resolve it should be documented and recorded.

If the member (or their family members or representatives) feel that their concerns have not been addressed, the matter might require a more formal review involving designated staff within provider's organization. Because these reports might be received by a variety of staff, clear definitions, and clearly defined procedures for submission of verbal or written complaints/grievances are essential. The information must be forwarded promptly to the designated staff or department for investigation and follow up.

Persons receiving services should be provided with information explaining the agency's complaint/grievance policies and procedures. Programs often provide this information upon admission to the service; however, it should also be readily accessible throughout the duration of services. Physicians and staff should have adequate training on helping individuals as needed to report, address, and resolve a complaint or grievance.

Grievance Process

Magellan and the Pennsylvania HealthChoices Program Standards and Requirements defines a grievance as a request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.

If a level-of-care request is not authorized at the level, frequency, or duration as requested, Magellan members are entitled to grieve a medical necessity denial. At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Please see the Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information including provider-initiated grievances and filing a provider complaint.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC). Assessment of compliance with these requirements is integrated into our quality improvement activities.

NCQA's accreditation standards for managed behavioral health care organizations (MBHOs) emphasize quality standards and activities in a number of areas. NCQA reviews the quality of care and service we deliver, as well as the direct care provided, particularly in the areas of access and availability to care, utilization management, and continuity of care across behavioral health programs. Magellan has developed a number of performance measurement and quality oversight activities to support these NCQA standards and HealthChoices' requirements.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to any and all portions of the medical record that resulted from member's admission or the services provided.

Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide, safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook
- Provide treatment records as requested for quality of care issues and adhere to clinical practice guidelines and HEDIS®-related measures
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities
- Use evidence-based practices
- Adhere to principles of member safety
- Attend or log on to provider training and orientation sessions
- Participate in the completion of a remediation plan if quality of care concern arises
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information
- Assist in the investigation and timely response of member complaints
- Assist in the investigation and timely response of adverse incidents

Magellan supports a wide range of evidence-based and best practices. Magellan requests that contracted providers and practitioners keep inventory and fidelity of evidence-based or best practices that they offer and incorporate into treatment.

Magellan commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective treatment in a manner that is respectful of individual member preferences, needs and values and sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices that are deeply rooted in cultural competence as well, focusing on continual training and education to support staff.

Cultural Competency and the LGBTQIA+ Tools are available on www.Magellanofpa.com to help with development of provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, non-English languages, or alternative formats of materials or communication approaches. Providers are encouraged to maintain a process of accessibility and training for staff so that when opportunities present to support Members that may have language assistance needs, the team is prepared to fully respond to ensure the best possible treatment outcomes. Magellan offers language assistance service educational resources for network providers. These are located on Magellan's website.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, Other (https://www.magellanprovider.com/media/29919/adverseincidentreporting.pdf).

Appendix A to the Pennsylvania HealthChoices Supplement to the Magellan National Provider Handbook offers an updated Incident Reporting Form, Provider Instructions and Definitions. Magellan also provides an electronic format for incident reporting for submission to ease provider paper burden.