STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

HEALTH PLANNING COMMITTEE

June 26, 2023
2:00 p.m. – 4:45 p.m.

- ***Empire State Plaza, Concourse Level, Meeting Room 6, Albany***

- **New York State Department of Health Offices at 1565 Jefferson Road, Suite 120, Rochester, NY 14623**

I. Welcome and Introduction

John Rugge, M.D., Chair, Health Planning Committee

The Big Picture: Challenge and Opportunity

II. Summary of Recent Workgroup Sessions

Shaymaa Mousa, M.D., M.P.H., Center for Health Care Policy and Resource Development, Office of Primary Care and Health Systems Management

Michele Griguts, DDS, Dental Director, Division of Medicaid and Dental Directors, Office of Health Insurance Programs

Emergency Department Utilization
- Mental Health Disorders
- Dental Issues

III. Levers of Change
(DOH Staff)

Workforce (Scope of Practice)
Financial
Regulatory
Statutory

IV. Opportunities for Improvement – Policy Proposals

Committee Discussion

V. Future Topics

Committee Suggestions

VI. Making Care Primary

Gene Heslin, M.D., First Deputy Commissioner, DOH

VII. Public Comment

PHHPC Health Planning Committee – 2/8/23

Topic: EMS and ER Wait Times

Introduction and Impact of ER crowding on EMS response – Dr. Morley

The committee is tasked with reviewing data, assessing the problem, and forwarding recommended solutions to PHHPC.

Delays in transfers means that increasingly patients are held in parking lots, etc. No one wants this.

This meeting is not to point fingers. The goal is to listen to EMD and healthcare leaders as they present solutions.

This is a complex problem, and some things are outside our control.

This is the beginning of addressing this problem.

We know there's a worker shortage. They're tired, and we owe them respect and gratitude.

DOH is working on creating the new Office of Workforce Innovation, that will partner with providers, education, unions, and others to expand the healthcare workforce.

Meeting Call to Order – Dr. Rugge

SEMCO has been clear about the stress on EMS and extended offloading times.

The Governor has identified EMS as one of nine items that need an immediate response.

The system is under unprecedented stress - people, financial, patient stress to get timely care.

This investigation will lead us to identify deficiencies in the healthcare system, ER, inpatient units, and long-term care settings.

Primary care wants to be engaged as well.

Looking at EMS will uncover other issues, but we can't tackle all.

Our response is to begin to review data and understand issue raised by EMS providers. We'll likely need more data to properly understand problems. Will likely touch on approaches to help, new training, reimbursement increases, and statute change.

Need to focus on identifying the problem.

Thank you to the stakeholders for attending today.

Description of Supporting Data – Dr. Heslin

Simply put, currently we have a scoop and run approach, but it's a complex system.

We'll define the problem, do a risk analysis, identify solutions, and identify intended and unintended consequences.

Need to balance need for change with the need for safety.

See PPT - Steve Dziura, Deputy Director, DOH Bureau of Emergency Medical Services

Note that dental is not shown related to reasons for ER visits, but it is a significant reason.

2019-2021 decline in ER visits; slight increase in number of admissions.

Long Island rates are higher.

NY rates are 27 percent higher than national average wait time.

70 percent of patients who go through the ER have non emergent issues or could be treated at primary care.

Data doesn't show the whole picture but identifies problems.

Goal is to frame the problem.

Offload is defined as the time a patient arrives at ambulance bay at hospital. That's where clock starts. The clock ends when full care is turned over to the hospital and EMS can leave.

Our focus should be on 2 hours or less wait times.

Result of long wait times is:

- fewer ambulances available
- 911 calls waiting
- increased mutual aid requests
- trickledown effect – increase response time from further distances means the primary area is not covered and it can take 6-8 hours to recover system to normal status.
- fewer ambulances for interfacility transport
- increased EMS complaints (EMS in certain areas will drop patients after 30 mins in any open space they can find in the hospital)

What are boarding patients? Patients that are admitted but are waiting in the ER for a bed.

Patents ready for discharge but have no place to go are not captured in this data.

Most frequent request is to help find ICU beds for patients, sometimes long distances away.

EMS available ambulances range from 600 (FDNY)-1 ambulances.

Can we measure fatalities that are associated with transport delays? We don't have knowledge of any reports of that nature.

The top issue for ambulance services is staffing.

DOH wants to present more years of data but haven't been able to gather that. Data presented should be used as directional.

Mr. Lawrence asks for data on number of people who dies in ambulance. Response was that the person would be declared dead at the hospital, and it would likely be reported as a death at the hospital as the location. DOH would need a call-by-call analysis to determine if transportation delays correlate to fatalities. Dr. Heslin indicated that DOH will investigate this.

Question - Is there triage among ambulances that are waiting? Yes, triage does occur. EMS renders care and assesses patient on the way to the hospital, and reports that to the hospital so they know what is coming. Once arriving at the hospital, the hospital staff get a quick report from EMS on the patient. Patients in ambulances are balanced against patients waiting in in the ER. If EMS drops a patient in any available space, it could displace a patient that is higher need who has been waiting in the ER.

CNY has longer wait times – due to fewer hospitals?

Long Island data needs a deeper dive. It's got a stable population but increase in admissions.

Mohawk Valley – their goal is 20 minutes, considered the gold standard.

NYC data needs a deeper dive – decrease in transports – why? Is screening happening, triage, more medical direction?

Southern Tier – look to see how they've decreased patient offload time.

Dr. Heslin - Is there a problem? Yes. Is it everywhere? No. There are best practices, the back end of the system plays role. There's a significant decrease in number of EMS, increase in calls outside NYC, overall number if ppl seen in ER has been stable, why are people using ambulances more to get to the hospital?

Dr. Torres – In the South Bronx, people believe that if they go to hospital in an ambulance, they'll get seen faster.

There is a belief that if you go to the hospital by ambulance, you'll be seen faster – not true – if issue is low priority, you'll still be waiting.

Dr. Torres – People are waiting 2-3 months to get into their primary care physician, so the reality is people going to the ER.

Where does 30-minute standard come from? Most national reports focus on 30 minutes or less, historically there is less stress in EMS system until wait times exceed 30 minutes.

External Speakers

Mark Phillippy, SEMSCO Member and Former Chair

To give "drop time" context, it is considered from the patient's door to the hospital bed.

EMS drop time defined is entire time until go back in service. It's a number in transfer of care that is not all that reliable.

How do we get better data and define concepts? Data dictionary.

Drop times are 20 minutes to 6 hours. Delays increase preventable deaths, and cause EMS seek other work.

We need to collaborate and strategize solutions. The system is on brink of failure. There are many factors. Not one solution.

Regional differences are key.

Need to look at best practices, including telehealth, alternative destination solutions and changing statutes.

Optimize interfacility transports – coordination where discharges are planned for the day with transport services.

Dr. Cushman, ER physician and paramedic, New York American College of Emergency Physicians

The problem comes down to hospital crowding, that is manifested most in the ER through boarding. It's not a new issue. The practice of boarding has been normalized.

Another problem is misaligned health system financing.

Need to direct patients to better sources of care.

I see more patients in our tent than in the actual ER.

Ambulance diversion should be a last resort.

Wants to work to get more accurate data.

Karen Roach, Vice President of Regulatory Affairs, Healthcare Association of New York State (HANYS)

Workforce pressures come down to staffing and finances.

HANYS has several projects to consider:

Discharge Delay Project – looking at hospitals as long-term care facilities. Discharge response teams work to create stronger relationships with community organizations. It's a three-month data collection pilot. Results will be published in a few weeks. Focused on 115 patients.

Iroquois Project – looking at statewide hospital home care collaborative for Covid and best practices used to manage covid surge and for people to avoid hospital that don't need it.

Will submit official recommendations to DOH soon.

Dr. Erin Dupree, Senior Vice President and Physician Executive/Alison Burke, Vice President of Regulatory and Professional Affairs – Greater New York Hospital Association (GNYHA)

Reasons people use the EDs - primary care, for uninsured, behavioral health, food, housing instability.

Some hospitals are building urgent cares near EDs to reduce stress in the ED.

Certificate of Need process can delay urgent care projects. Suggests streamlining CON system.

Would like to see more funding for ED modernizations projects.

HANYS supports the Governor's proposed CON changes.

Change scope of practice rules – allow nurses to perform certain tasks without doctor's orders.

Gary Fitzgerald, President & CEO – Iroquois Healthcare Association

There is a 20 percent vacancy rate for RNs.

Beds are available but can't be staffed.

Nursing homes are at 60 percent staffing, so those other patients end up staying in the hospital.

We believe there are solutions:

- community paramedicine program,
- county health departments and hospitals need to work together to go into people's homes, making sure patients are taking meds, eating well etc.
- Scope of practice flexibility

Wendy Darwell, President & CEO, Suburban Hospital Alliance of New York

Patients who are admitted are staying longer, consuming more resources.

It's not a capacity problem, it's a workforce problem.

We are short on nurses, patent transport, lab techs, imaging techs. We rely on contract labor that's not as efficient and contributes to backup.

Nonemergent post discharge transportation is an issue as transportation can be arranged until late in the evening, 9pm or 10pm.

Need policy changes, for example, insurance won't authorize discharge over the weekend or holidays. Need to call by Thursday or patients end up remaining in the hospital all weekend.

Inappropriate use of the ER is a problem. Urgent care won't take uninsured, so that's not an option for those people.

Some patients have no better transportation options. One patient called EMS and took an ambulance to an MRI appointment.

Possible solutions:

- community care medicine
- hiring paramedics to work in Eds (done by EO?)
- redesign of triage processes (just buys time)
- technology solutions (expensive)

Post discharge uses of EMS could be to support patients in the home but need incentives for health plans to cover.

Telehealth check ins, alternate care sites could help.

Need flexibility for regional differences.

Dr. Ortiz – suggests partnering more with universities on workforce issues. For example, Binghamton trains paramedics. Can transfer across all SUNYs. We're missing connections between practice and academia, high school BOCES programs.

Case Example - Dr. Gavin, Mount Sinai Vice Chair for Population Health and Clinical Innovation

Working on preventing ER visits, using a digital first, virtual program.

ET3 – EMS is compensated for initiating telehealth visit, for Medicaid patients.

Supports community care medicine concept.

They have a partnership with OPWDD to care for patients in place.

Suggests expanding paramedic scope of practice.

Need to increase Medicaid reimbursement rates.

Committee Role

Periodic reports to the full PHHPC, starting as early as 2/9/23.

Identify models and best practices.

Mark Philippy asks if a SEMSCO or SEMAC representative could sit in at PHHPC, and for PHHPC representative to be present at SEMSCO and SEMAC meetings to enhance ongoing collaboration.

Probably can't meet again before 4/18 PHHPC meeting due to 4/1 state budget deadline.

Open Committee Discussion

For many ER is the only option after hours. Committee should explore the obligation of providers to meet needs to patients on an ongoing basis and possible supports for patients who need care "after hours" when ED-level care is unnecessary.

Would like finer data, such as average age of persons calling for ambulance care. Mark Philippy/SEMSCO: Demographic data is possible; will look into gathering more of this data.

Education is a possible issue. People are not aware that they can call primary care office after hours.

What are the barriers (if any) to licensure for EMTs to engage in community paramedicine, and what is the reimbursement structure? Steve Dziura (DOH):

- Community paramedicine is not currently permitted in NY law, outside of a current Executive Order (EO no. 4).
- Executive Budget FY24 proposal includes community paramedicine provisions
- ET3 (CMS) program is the only funding mechanism for community paramedicine currently. Otherwise, no incentive to alternative methods of treatment or alt transport destinations, because under existing law (outside CMS pilot) only transport to ED is reimbursable. No billing codes directly for community paramedicine.

Dr. Heslin (DOH): Opportunity for patient education regarding availability of primary care. Need to investigate opportunities that currently exist before investigating new solutions.

    - "888 Treat NY" number – H+H urgent care hotline for virtual treatment option to avoid some ED visits. State financial coverage for uninsured.

Dr. Boufford – Problem comes down to inadequate primary care. PHHPC has no regulatory authority over primary care. PHHPC is concerned about this issue and broader health care weaknesses.

Dr. Soffel – Who benefits from the dysfunction? Rational reason consumers are calling 911 is because there is no one else to call. Wondering how many ER spots are occupied by people transitioning from nursing homes and bouncing back to ERs. Also, want to know more about how much behavioral health is a contributing factor. People with behavioral health problems have no place else to go.

Dr. Cushman – We haven't even touched on the behavioral health issue. Need regulatory and operational solutions relating to evaluations to prevent patients from ever coming to the ED.

EMS can't evaluate patients at nursing homes to determine if a trip to the ER is necessary.

Dr. Heslin final thoughts/takeaways/next steps:

Pre-care discussions – telehealth

Alternate model – ambulance vs. ambulette for non-urgent transports

Engage greater number of squads in stressed areas

How do we re-engage licensed EMS who are not practicing, and engage more people to become EMS

Get better data sets

Boarding partnership

Alternate sites – connection between urgent care and insurance, it's an access issue, unregulated industry that serves the wealthy

Community paramedicine and home care - integration

Behavioral health

One size does not fit all

Further explore the Long Island data - are they doing something that could help?

How do we inform, educate, and continue this in a tactical way so that effort doesn't die?

PHHPC Health Planning Committee
Workgroup 1 – Reducing Emergency Department Boarders: Behavioral Health Patients Workgroup

Thursday, May 4, 2023
1 – 3 p.m.

MEETING SUMMARY AND NOTES

Please Note:

- *This outline captures a high-level summary of the PHHPC Health Planning Committee Workgroup on May 4, 2023; the summary of questions and responses is generally a paraphrased version of what was said at the meeting.*
- *The full meeting transcript and archived video are available at:* New York State Department of Health (totalwebcasting.com)

I. Attendees:

OMH:

- Commissioner Ann Sullivan
- Chris Smith, Associate Commissioner for Adult Community Care

DOH:

- Dr. Jim McDonald, Acting Commissioner
- Dr. Gene Heslin, First Deputy Commissioner
- Maclain Berhaupt, Deputy Chief of Staff
- Dr. John Morley, Deputy Commissioner, OPCHSM
- Jen Treacy, Deputy Director, OPCHSM
- Karen Madden
- Jackie Sheltry
- Carrie Roseamelia, Director, Center for Workforce Innovation

PHHPC Members:

- Jeff Kraut, PHHPC Chair
- Dr. John Rugge, Committee Chair
- Ann Monroe, Committee Vice-Chair
- Dr. Sabina Lim
- Peter Robinson
- Dr. Denise Soffel
- Dr. Theodore Strange
- Dr. Kevin Watkins
- Harvey Lawrence

Hospital Associations:

- HANYS: Sarah DuVall, HANYS Director of Behavioral Health
- Suburban Hospital Alliance: Wendy Darwell, President and CEO
- GNYHA: Alison Burke, Vice President of Regulatory and Professional Affairs, and Scott Gaffney

- Iroquois Healthcare Assn: Kevin Kerwin, Vice President for Advocacy and Legislative Counsel

II. Commissioner Sullivan's (OMH) Presentation

a. Identified 3 Key Issues Creating the Psychiatric/Behavioral Health ED Problem:
    i. #1- Getting the right assessment in the ED, and right person to do the assessment.
        1. Telehealth consult (with psychiatrist, social workers) can help
        2. Workforce shortage currently impacting appropriate assessment
            a. Ideally need psychiatric staff to conduct a good assessment. Or telehealth consult with psychiatrist as an alternative.
    ii. #2 - Complex patients in EDs
        1. Often these patients have a dual diagnosis (e.g., development disability and behavioral health) or patients who are experiencing housing difficulties or are unhoused
            a. OMH and OPWDD "**Residential Treatment Facilities**" (RTFs) are a model for helping put dual-diagnosis patients in the right setting. Step-down model for pediatric cases.
            b. **Home-Based Crisis Intervention Services**: in-home treatment services for dual-diagnosis pediatric patients are another model. OMH recently submitted 2 RFPs to develop these models. They are State-funded and available to anyone who qualifies, regardless of insurance (i.e., not Medicaid-only limited).
    iii. #3 - Difficult access to psych beds
        1. Pre-pandemic, psych bed occupancy was 70-80 percent, but post-pandemic occupancy rate is high 80 to low 90 percent due to increased demand and closed beds. 850 beds were offline until early this year out of about 6,000, which is significant. The State/Governor Hochul administration is pushing to get all those beds back online by the end of this

year and so far 200 beds are back online and there were 150 new beds created.
2. There is a perception that psych beds lose money, so distressed hospitals put those beds in jeopardy. We need to change this.
3. Additional capital has helped for hospitals that want to add additional psych beds (adult and/or pediatric)
4. Recently OMH issued an RFP for "home-based crisis intervention services" related to children and families (referenced above). These are services for children where providers do very intensive in-home services for up to 2 or 3 months, depending upon what the child and family needs and care is provided right there in their home.
5. Adding 12 CPEPs across State through FY24 budget.

b. Other central issues to behavioral health patients boarding in the ED/disproportionately seeking ED-level care:
   i. One of the biggest issues is that the workforce isn't as well trained on either side, whether OPWDD or healthcare staff, to manage complex pediatric and adult cases.
   ii. We need to fix the "revolving door" of cases and connect patients *upon discharge* to behavioral health services that will stay connected to that patient for a period after discharge.
   iii. Payment for services must come from both Medicaid and commercial insurance carriers. Behavioral health is one area where Medicaid pays better than commercial insurance. That needs to change.
   iv. Workforce challenges: the State does not have all the workforce yet to assist in all the services that we have the money for.

c. Possible solutions/ideas in progress:
   i. OMH and OPWDD will work on appropriate settings for dual-diagnosed patients and transitional beds, which in Commissioner Sullivan's view greatly contribute to boarding in the ED.
   ii. Mobile crisis teams will be expanding.

III. **Q&A with Committee Members, Participants, and Dr. Sullivan (OMH)**
a. ***Dr. Soffel Question:***

i. How will OMH's new crisis intervention overlay/interface with health homes?
ii. Dr. Sullivan Response: The stabilization centers will contact people who are connected to health homes to make sure that those health home coordinators know where they are, what crises they are in, how they can be helpful.

b. Dr. Lim Questions/Comments:

i. Huge proponent of CPEP.
ii. Reminder to Committee: CPEP is not just psychiatric ED component. Also includes mobile crisis teams and 72-hr observation beds.
iii. Don't see big problem with boarding psych patients in ED at Mt Sinai due to ***continuum of care*** OMH helped them set up at Mt Sinai, including inpatient psych beds, CPEP unit, and outpatient behavioral health care
iv. Dr. Lim: Has there been any consideration for creating broken-down versions of CPEPs, e.g., "CPEP lite", to help incentivize more hospitals to incorporate at least some of the triad of services included in a full CPEP.
    1. Dr. Sullivan: Yes; looking at this now, especially in more rural areas, and how to be more flexible. CPEPs were designed with big urban centers in mind, but not always ideal for non-urban or smaller centers.
v. Dr. Lim: Mt Sinai's issue currently is less with behavioral health boarders but more so with patients who have a primary diagnosis of "SUD" (Substance Use Disorder), so we need to make sure that OASAS is involved in reform discussion

c. ***Dr. Heslin Question/Comments:***

i. Psychiatric medical patients appear to be a growing issue – hard to find appropriate unit due to dually of needs. Perhaps we need to think about a specialized bed for "psychiatric medical" beds. May begin to see these increasingly complex cases grow in number. Important because these are the kinds of patients who may never leave the ED because there is not really an appropriate bed in the acute care floor.

ii. Need to start thinking of the whole patient, not separate beds for specific issues, i.e., med surge beds, substance use beds, etc. For example, med psych beds are limited in what they can provide in terms of medical support. What some hospitals are beginning to do is to cohort some of the clients on the med surge side. They need increased staffing and increased ability to work with those clients. How can we get appropriate beds out of the ED and over to the in-patient side?
    1. Dr Sullivan Response: Agrees that there is a sub-group. Would also need to consider whether an enhanced rate is needed.

d. ***Harvey Lawrence Question/Comment:***
    i. What additional role do you see in FQHCs or other primary care providers to help mitigate the need/demand for sending behavioral health patients to ED?
        1. Dr. Sullivan: Primary care often was where people with depression and anxiety come. It's the assessment, but also the treatment can be very well done in primary care. We know that the anxiety disorders and the depression were doubled or tripled, both for adults and kids across the state. A lot of that could really assessed and then, if possible, I think treated successfully in primary care. Urgent care should be integrated too.

e. ***Ann Monroe Commentary:***
    i. Would like more data that details the problem and shows the landscape of the issue. Is it as serious a problem across the state? Is it a more serious problem, a dual diagnosis, whether that's SUD and mental health or developmental disability and mental health? What are the numbers? What is the data? I think between the two departments [DOH and OMH], there should be data to begin to help us [the Committee members] get a handle on the scope of the problem.
    ii. Suggested that a health plan rep be added to this workgroup to explain what commercial plans pay for and what they don't pay for.
    iii. We need to look not just at new models, but at barriers to existing models being implemented effectively.

1. E.g., look at limited license to allow Art 28s and Art 31s to be *on site* at the same time. This never came to fruition.

f. Dr. Heslin Follow-up Commentary:

i. Comment: The North Country-based organization, "Citizens Advocates," run some behavioral health urgent care centers that are specifically for behavioral health. That could be a model to look at.
ii. Need a better definition of what urgent care is. We've seen from this discussion how important that service is, but we don't have a very good definition regulation what urgency means.

g. Harvey Lawrence Question/Comment:

i. What additional role do you see for primary care providers or FQHCs around the state to play a greater role? I think in intervention or assessing and being sort of a gatekeeper, because it seems like the scale of the problem is so large.
ii. We may never have enough beds, so what mitigation can we do to maybe slow down the need or demand, and at the same time maybe triage and provide people with opportunities that don't necessarily result in them having to be in hospital beds or boarded in the ER?
iii. Dr. Sullivan Response:
    1. So much can be done in primary care, especially with depression and anxiety disorders. It's often important to remember depression is the second largest disability worldwide. The assessment, but also the treatment can be very well done in primary care. We've done this the collaborative clinics across the state, and the FQHCs I've worked with have done this too. In sum, primary care can be a place to, first, be open to hearing what the problems are so that you can find new issues, especially for depression, anxiety disorders they trust their primary care doctor.
    2. As an example model to use primary care to address behavioral health issues before they reach the ED: "Project Teach" was used to address the shortage of child psychiatrists. We (OMH) funded a consultation service for any pediatrician who wanted to call a child psychiatrist and

get some assistance in working with a family or child. Free of charge. A similar model is being used for maternal health and intersection with mental health (e.g., using antidepressants while pregnant).

iv. Harvey Lawrence Follow Up Question:
    1. Some FQHC health centers are establishing urgent care centers. Is there some role the State can have to help stand up these urgent care centers in this space so that they could serve as an intervention because many of them are operating after hours?

v. Dr. Sullivan Response: OMH has thought about this and it's a great idea, but we haven't gone too far with it, but it could help with establishing more integrated care in urgent care centers. Currently urgent care centers are emerging across the country, but many are isolated off and that's not necessarily the best scenario. For example, NYC Health + Hospitals has done some work on doing urgent care centers or behavioral health urgent care as well. I think that we haven't done enough of that but it's a great idea because I think that they could be an access point for people to get help, and they wouldn't need a referral anyplace else if we set up the system right.

h. ***Dr. Strange Commentary:***
    i. We need to consider workforce issues. Urgent care is a band-aid. Primary care is the standard, but many clinicians feel that they have no quality of life, and they are "paid by the numbers". Need to look at quality of life and the way medical care is provided to retain those already in practice.
    ii. Liability reform is also part of this issue, since NY is "pushing the envelope" in what primary care providers are being asked to provide. E.g., some primary care docs will only prescribe up to a certain level before licensed psychiatrist is necessary.

i. ***Maclain Berhaupt (DOH) Commentary:***
    i. Has there been any consideration for how to specifically target this small subset of patients who go to ED because they cannot find or haven't found other services for them?
    ii. Dr. Sullivan Response:

1. OMH has utilized critical intervention programs to target complex, special need and high-risk individuals, such as those involved in the criminal justice system. For instance, OMH now has teams to intervene and is working to establish criminal-justice-focused CTI teams to address the needs of special needs individuals who have managed to get caught into the criminal justice system and have complex health needs.
2. The budget funding will help expand other community and preventative care programs to target special need communities and specialized programs. For example, money for expanded school-based services.
3. All the budget goes to prevention through what's called middle level care all the way to the high end. There's a lot of investment in the high end.

j. Ann Monroe Commentary:

i. PHHPC needs to look at barriers to current models being more effective. You may remember that a long time ago John Rugge and I chaired a group with Jennifer [Treacy, DOH] with the staff to look at a limited integrated license that would allow behavioral health, Article 31 and Article 28 to be on the premises at the same time. It is counterintuitive that you can't have the staff on site at the same time.

k. Sarah Duvall (HANYS):

i. When looking at capacity, what can be done? Is it possible to start looking at some of those community settings and the waitlists and some of the barriers there? We also found eligibility process for services and referral processes being contributors of delay, particularly in the emergency department.

l. ***Alison Burke (GNYHA):***

i. i. One thing that we're hearing from our members right now is that the problem exists across sectors. It's community based. It's hospital based. It's county based. Several the high intensity programs and services in the community are having the same workforce challenge. They're not operating at 100% capacity.

ii. One would hope, given the unprecedented need, we might be able to increase caseload, relax some of the documentation or other things so that we're seeing more people. We're seeing more people before they get to the emergency room.
iii. There's not been a lot of discussion yet about shoring up the existing programs and providers.

IV. Resources mentioned on call

a. ***From HANYS:*** HANYS has conducted a data collection pilot with hospitals on discharge delays in 2022. Here is a report that provides a high level overview of the data collected for EDs and inpatient units: https://www.hanys.org/communications/publications/scope_of_complex_case/docs/complex_case_discharge_delays_survey.pdf.
    i. Note that 'mental health' was high on the list of declined services
    ii. Hospitals are the place of last resort for the community. What can be done to help connect more people with community-based services and reduce wait lists. What is the data showing about access availability for outpatient/community-based services?
        1. Dr. Sullivan: data is variable, but for community clinics where data is available there are long wait lists. We are dealing with mental health and substance use systems that have been underfunded for years, so it will take work to increase access. However, note that CCHCs (Certified Community Behavioral Health Clinics) did not have wait lists before the pandemic, and are only now beginning to have waitlists, so that is a good place to start.

From Denise Soffel + Ann Monroe

Questions for the Emergency Department Behavioral Health Work Group

1. Are we looking to have an immediate and/or long-term impact? What is the timeline for all of these new behavioral health innovations that Commissioner Sullivan discussed to come into fruition? What steps could be taken in the immediate term to ease the pressure on emergency departments?
2. Are there patterns of payment for behavioral health services that contribute to this ED problem? If so, what are they? Age-related? Commercial v. public programs?
3. How wide-spread are inpatient behavioral beds across the state? Urban vs. rural? What is the trend?
4. To what extent is a lack of inpatient psych beds contributing to the problem? To what extent is lack of capacity in community-based care contributing to the problem?
5. What do we know about people being brought to hospital EDs due to a behavioral health crisis? How many people? For what types of conditions? Demographics (age, race, payer)? Regions across the state? How long do they stay in the emergency department? What happens to them next (sent home, hospitalized, referred for care)?
6. How effective are crisis intervention team at diverting individuals in crisis away from EDs?
7. How many children/youths are sent to the ED from a school because the school does not have the capacity to manage disruptive behavior?
8. Has the health home model been effective in identifying individuals with serious mental illness and providing them the supports and services they need to keep them stable? What have we learned from the health home model?
9. Where are C-PEPs and how are they managing capacity? Are behavioral health patients in the ED waiting for beds within the hospital's own C-PEP? What are the restrictions on C-PePs that are not on other hospitals, resulting in most severe cases packing C-PEPs?
10. Are there regulatory restrictions on Article 28s that are not on Article 31s that make community-based care in FQHC's more difficult? (Harvey Lawrence talked about unreasonable payment restrictions on telehealth in Article 28s, but not in Article 31s.)

NEW YORK STATE | Office of Mental Health

Coordinated Behavioral Health Crisis Response System

October 2022

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MOIRA TASHJIAN, MPA
Executive Deputy Commissioner

Dear Fellow New Yorker,

Under Governor Hochul's leadership, New York State is expanding mental health services for all New York residents, and has invested an unprecedented amount of funding into New York's public mental health system. The mission of the New York State Office of Mental Health (OMH) is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbance. Working to make this mission a reality, OMH is pleased to present this statewide comprehensive plan for the provision of state and local services*. In order to accomplish this broad challenge, we need to examine the mental health of our state at multiple levels, including service systems, individual programs, diverse communities, and most importantly, the impact on the individuals we serve and their families.

OMH envisions a future for the public mental health system that will result in:

- Integrated, accessible, and sustainable systems of high quality, person-centered, resiliency- and recovery-focused health and behavioral health supports and services
- Mental and physical wellbeing, and community and social environments that reduce the incidence of disorders, eliminate stigma, and foster community inclusion
- Population health, without disparities

Informing the vast portfolio of work under the Office of Mental Health is a set of core values that are infused in all our functions: the funding, regulation and direct provision of services, research, planning, consumer empowerment, and quality advancement. These values help OMH and our stakeholders at all levels come together around a basic set of principles to drive excellence in a modern, progressive mental health system:

- Person-centered care and systems where recovery is individualized and possible for everyone
- Excellence in the design and delivery of mental health services and supports
- Cultural competence and reduction of disparities in care and health status
- Respect for the worth and dignity of every person, including the prevention and rejection of stigma and promoting full community inclusion and resiliency for those living with mental illness
- Promotion of mental and physical wellness and illness prevention
- Scientific discovery and the translation of science to practice
- Health, engagement, and competence in the workforce

Throughout this plan we will address key issues and strategies: statewide priorities and measurable goals to achieve those priorities; proposing strategies to reach those goals; identifying specific services and supports to promote behavioral health and wellness; analyzing service utilization trends across levels of care and promoting recovery-oriented State and local service development.

The Office of Mental Health (OMH) has developed a phased approach to updating the Statewide Comprehensive Plan to provide the most current available data and inform New Yorkers about our most relevant projects and priorities. This phased approach presents discrete sections by topic and/or focus area and the following section describes OMH's efforts in preventing suicide across New York State.

OMH has collaborated with county leadership to develop a shared vision of a coordinated behavioral health crisis response system available to all New Yorkers, regardless of ability to pay. The crisis response system goals are to: reduce unnecessary emergency room visits and inpatient hospitalizations; maintain people safely in the community; reduce risk of future crises; and coordinate information sharing among clinicians, recipients, and involved family members to reflect recipients' preferences. These services are meant to be delivered in trauma-informed, recovery-oriented, and culturally and linguistically competent ways.

Thank you for your interest in the mental health of New Yorkers!

Sincerely,

Ann Marie T. Sullivan, M.D.
Commissioner
New York State Office of Mental Health

*Section 5.07 of Mental Hygiene Law requires OMH to develop a statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness.

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OMH Coordinated Crisis Response System

The New York State Office of Mental Health (OMH) Coordinated Crisis Response System is charged with providing a comprehensive, coordinated behavioral health crisis response continuum to every New Yorker regardless of their ability to pay. Successful delivery of such a system will save more lives while improving access to critical services during and after a behavioral health crisis.

Expected outcomes of a cohesive crisis response system include:

- Improved safety for individuals experiencing a crisis
- Decreased suicide, overdose, and early death
- More referrals to affordable community support services
- Lowered costs as a result of reducing the use of hospital emergency departments and long-term hospital stays
- Reduction of law enforcement and encounters with the criminal justice system for those experiencing a mental health crisis

New York State's Current Crisis Response System

New York State's crisis system already has several key components in place to create a coordinated crisis response system for all New Yorkers. This includes Mobile Crisis services, Crisis Residence programs, and Comprehensive Psychiatric Emergency Programs (CPEPs). These services will be fortified through funding opportunities and coordination efforts. A statewide behavioral health crisis hotline and Crisis Stabilization Centers will also be established within the next year.

Together, these programs provide all the components necessary to create an effective behavioral health crisis response system. The task at hand is coordinating all aspects of crisis response to build a robust continuum of care that effectively responds and provides supports to all New Yorkers.

The goals of the coordinated crisis response system are to:

- Maintain people safely in the community
- Reduce unnecessary emergency room visits and inpatient hospitalizations
- Reduce risk of future crises
- Coordinate information sharing among clinicians, recipients, and involved family members to reflect recipients' preferences

As New York State develops a coordinated crisis response system, data reporting is also receiving special focus. OMH is currently working to coordinate a crisis data council that will identify and track key data points across the crisis care continuum. At this time, the data that is currently collected is linked to Medicaid Managed Care utilization, which is not reflective of the full breadth of crisis services utilization in New York State.

The Future of Behavioral Health Crisis Response in New York State

OMH is committed to providing a high-quality crisis response system to all New Yorkers with strong supports that can assist individuals when an emergency occurs, quickly respond to and stabilize a person when they do experience a crisis, and connect them to community-based treatment and support services. These are critical components to creating a successful crisis system and improving the way we address behavioral health crises in New York. By providing all New Yorkers with a robust, coordinated behavioral crisis response system, OMH hopes to save more lives while improving access to critical services during and after a behavioral health crisis.

This crisis system relies on the fortification of the three pillars of crisis care:

- Someone to Call
- Someone to Come
- Somewhere to Go

When an individual is experiencing a mental health or substance use crisis, these three pillars are vital to that individual's immediate safety and a healthy recovery. New York State's crisis system will include: telephonic triage and support through the 988 Suicide Prevention and Behavioral Health Crisis Hotline, connection to Mobile Crisis and follow-up services, Crisis Residence programs, Crisis Stabilization Centers, CPEPs, and access to community treatment and services. All crisis services are delivered in a trauma-informed, recovery-oriented, and culturally and linguistically competent way. While New York State focuses on strengthening the pillars of our crisis care system, OMH is also in ongoing conversations with local governmental units (LGUs), community advocates, consumers of behavioral health services, providers, and other stakeholders to identify opportunities for continued crisis service development.

Someone to Call

The first step of the crisis care system is to provide a telephonic triage and response line that New Yorker's can call when experiencing a behavioral health crisis. This is a crucial first step, as 80% of behavioral health crises can be resolved over the phone without the need for a higher level of care.[1]

988 – A New Three-Digit Number for New York's Behavioral Health Crisis Hotline

In October of 2020, the National Suicide Hotline Designation Act was signed into law, designating 988 as the three-digit crisis line for immediate access to the National Suicide Prevention Lifeline (Lifeline). The intention of this transition is to easily connect callers with trained behavioral health counselors that can help defuse a crisis and link individuals to mental health and substance use services in their own community. The Lifeline provides emotional support, information, and resources to callers looking for immediate assistance for mental health crises and suicide prevention.

OMH received a planning grant in 2020 through Vibrant Emotional Health and the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop an implementation plan for 988.

The top five priorities of New York's 988 implementation are:

1. Assigning in-state 988 coverage for the remaining uncovered counties in NYS through an RFA process
2. Ensuring primary and back-up centers have capacity to operate 24/7 with capacity to be able to meet the needs of NYS callers, chatters, and texters contacting 988
3. Ensuring all 988 Call Centers have access to a database of culturally and regionally competent resources spanning NYS to be able to seamlessly assist callers, regardless of their geographical position
4. Programming the new operational and start-up funding resources to support the launch of 988 in July 2022 for call center volume growth and 988-related crisis services
5. Ensuring that 988 is a service for all New Yorkers, regardless of age, race, ethnicity, religion, sexual orientation, or socioeconomic status

This implementation plan was successfully created and submitted on January 31, 2022, thanks to a strong collaboration between OMH and a statewide, multi-stakeholder coalition of more than 150 individuals representing the needs and interests of New Yorkers. The coalition will continue to meet throughout the 988 implementation process to provide support and feedback on the evolving process.

988 launches nationally and will be available to the public on July 16, 2022. New Yorkers will be able to reach the Lifeline via text, chat, or call. When individuals dial 988, their call will be routed to the New York Lifeline Crisis Center that is closest to the caller's area code. There are currently 12 active and one onboarding Lifeline Crisis Centers in New York State, with plans to add two additional centers by the end of 2022.

In 2019, there were 137,481 calls to the Lifeline that originated from a New York State area code – a 73% increase from 2016. Call volume is expected to increase by more than 300% over the next five years. Therefore, enhancing call center capacity is a crucial step of New York State's 988 planning process. Creating additional Lifeline crisis centers, hiring more crisis staff, and ensuring a strong network of backup centers is in place will prepare New York State for a successful launch of 988 in July of 2022. The State has also been collaborating with 911 coordinators, law enforcement, and emergency responders to help identify areas for partnership and provide even more support to those experiencing a crisis. Such collaborations can lessen the response of unnecessary law enforcement dispatch and reduce the burden on hospital emergency departments, where individuals experiencing a behavioral health crisis are often sent.

[1] Balfour, M. E., Hahn Stephenson, A., Delany-Brumsey, A., Winsky, J., & Goldman, M. L. (2021). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric services (Washington, D.C.)*, appips202000721. Advance online publication. https://doi.org/10.1176/appi.ps.202000721.

988 - More Than Just A Number

988 will be a resource that any New Yorker can access 24/7 to be connected to the most appropriate and least restrictive behavioral health crisis care. In its advanced state, 988 will serve as the single point of access for support and connection to the expanded crisis services continuum in New York. 988 crisis counselors will receive training in how to interact with special populations, with both a specialized Veterans crisis line and a Spanish language line available.

Diversity and Inclusion in Crisis Response

New York State is committed to providing linguistically and culturally competent care to all individuals who contact 988. OMH's Office of Diversity and Inclusion (ODI) has worked with 988 stakeholders to ensure linguistically and culturally competent care training standards will be in place for all Lifeline Crisis Centers. On January 20, 2022, ODI presented to the Lifeline Crisis Centers in NYS on the specific initiatives OMH is taking to ensure equity and access. During this meeting, centers had an opportunity to ask questions and develop strategies specific to their regional/county needs. All 988 Contact Centers will be required to demonstrate the following:

- Commitment to equity and the reduction of disparities in access, quality, and treatment outcomes for marginalized populations
- Organizational equity structure
- Equity training activities and topics related to diversity, inclusion, cultural competence, and the reduction of disparities in access, quality, and treatment outcomes for marginalized/underserved populations
- Workforce Diversity and Inclusion
- Language access, including efforts to meet the language access needs of the client's served by 988 (e.g., limited English proficient, Deaf/ASL)

Trainings will focus on topics such as implicit bias, diversity recruitment, creating inclusive work environments, and providing language access services. This shall include the use of data to identify the most prevalent language access needs, availability of direct care staff who speak the most prevalent languages and the provision of best practice approaches to provide language access services (i.e., phone, video interpretation). Centers will also include information about efforts to ensure all staff with direct contact with clients are knowledgeable about using these resources. Additionally, the Centers will provide information about the plan to provide key documents and forms in the languages of the most prevalent cultural groups of its service users (consent forms, releases of information, medication information, rights, and grievances procedures).

Funding

New York State is providing substantial funding for the development and implementation of 988. The Governor's enacted Executive Budget for FY 2022-23 includes $35 million dedicated to funding the 988-crisis response system, growing to $60 million annually. This critical investment will more than double the current funding available for NYS 988 in 2022-23 and will further assist Lifeline Crisis Centers in developing, sustaining, and expanding their ability to respond to the most vulnerable New Yorkers in their time of crisis and beyond, supporting operations and resources for enhanced technology, follow-up, and community linkages.

OMH is also contributing $10 million in current year start-up funds from the supplemental Mental Health Block Grant to assist Lifeline Crisis Centers with building capacity to be responsive to the projected volume increases of 988. This $10 million allocation is a critical investment for FY 2021-2022 as this one-time funding is dedicated to preparing for 988 implementation and assuring New Yorkers have access to the 988-crisis system. Using funds from this source, OMH released a 988 Contact Center Request for Applications (RFA) in February 2022 to establish up to two new contact centers in NYS, one in the North Country Region and the other in the Capital Region, to ensure expansive local coverage in areas without a current in-state contact center.

Additionally, on December 20, 2021, SAMHSA announced a Notice of Funding Opportunity (NOFO): "FY 2022 Cooperative Agreements for States and Territories to Build Local 988 Capacity". Through this opportunity, NYS has been identified as eligible to receive $7,280,460 over two years to support workforce capacity building at the local/state level. OMH responded to this NOFO with an application to support additional start-up investments required to hire staff for the call centers and was notified of receipt of the award on April 20, 2022.

The implementation of 988 is a watershed moment in the history of crisis and behavioral health care in the United States. It presents an opportunity to reach millions in emotional distress while de-stigmatizing help-seeking. New York State seeks to be a national leader in coordinated crisis services during this pivotal point in time.

Someone to Come

Mobile crisis services are the second pillar of a well-established crisis response system. The purpose of Mobile Crisis services is to deliver person-centered, trauma-informed, culturally and linguistically competent behavioral health crisis services in the community. These services promote resiliency, rehabilitation, and recovery, and aim to provide immediate support and offer alternatives to hospitalization when appropriate.

Mobile Crisis

Mobile Crisis teams offer community-based crisis intervention services to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. The mission of Mobile Crisis providers is to deliver person-centered, trauma-informed services that are culturally and linguistically competent in order to promote resiliency, rehabilitation, and recovery.

Ideally, Mobile Crisis services are available 24/7 in the community to children and adults who are experiencing or are at imminent risk of experiencing a behavioral health crisis. These services aim to provide immediate support and offer alternatives to hospitalization when appropriate. For safety and optimal engagement, Mobile Crisis teams consist of two people, usually a licensed staff member and a licensed or non-licensed staff member, that support the individual's emergent needs, as well as emergency department and justice system diversion, while partnering with EMS service as warranted.

Mobile Crisis encompasses three specific crisis services:

1. **Telephonic Crisis Triage**: Telephonic crisis triage services include 988, local call centers, behavioral health providers, Mobile Crisis staff, and other emergency lines. This service includes a preliminary assessment to determine the need for further evaluation and to make treatment recommendations and/or referrals to other health and/or behavioral health services as clinically indicated.
2. **Mobile Crisis Response**: Mobile Crisis staff is dispatched to an individual's home or any community setting following the preliminary telephonic triage when it is determined a face-to-face comprehensive crisis assessment is warranted. It is expected that Mobile Crisis teams arrive within 3 hours of an initial referral.
3. **Mobile and Telephonic Follow-Up**: These services consist of a short-term reassessment of symptoms via therapeutic communication and interactions with the recipient and collaterals, when available, to maintain stabilization in the community. Follow-up contact between the Mobile Crisis staff and the recipient, service providers, and identified supports must be initiated within 24 hours of the initial behavioral health crisis or by the next business day.

Currently, State-designated Mobile Crisis providers use the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) as a tool for data sharing and mobile access to individuals' medical history, treatment information, and crisis response plan, when available. PSYCKES is a HIPAA-compliant web-based application designed to support clinical decision making, care coordination, and quality improvement in NYS.

In 2018, OMH required county mental hygiene directors to create Mobile Crisis Response plans that identified providers who would be eligible for reimbursement through the 1115 Medicaid Managed Care Crisis Intervention benefit. In addition, the implementation of the Children's Crisis Intervention Benefit through Children and Family Treatment and Support Services (CFTSS) was coordinated with this effort to allow for consistency in response and access. This planning has laid the foundation for future Mobile Crisis planning and coordination with telephonic triage services, including 988 and 911.

As of February 2022, 50 out of 62 counties in New York have access to Mobile Crisis services and there were a total of 57 approved Mobile Crisis programs throughout the state. In early 2022, opportunities for expansion of Mobile Crisis services were made available through Mental Health Block Grant funding. Eligible Mobile Crisis providers were approved to receive $25,000 to expand services through purchasing equipment, upgrading technology, and other means. Opportunities to improve Mobile Crisis response include 988 planning and community input, the identification and implementation of standards and best practices in Mobile Crisis care, and the expansion of peer services.

Still, there may be barriers to access, most frequently in rural areas of the state. With the support of the same Mental Health Block Grant and other resources, OMH is in the process of developing funding opportunities to establish Mobile Crisis services in counties where there currently are none. Development will be expected to address disparities in access, staffing demands and needed levels of expertise, technology, equipment, integration with local services and each county and/or region's developing system of crisis intervention and care.

OMH has forged a unique three-year relationship with Coordinated Care Services, Inc. (CCSI) to promptly respond to the complexities and challenges of existing and developing Mobile Crisis services across the state. CCSI and OMH have already begun partnering to provide comprehensive, inclusive and program-specific technical assistance regarding program design and billing practices (including revenue cycle management, financial modeling 1:1 program consultation) that focus on the enhancement of an integrated system of crisis services statewide while assuring person-centered, trauma-informed timely and effective response and intervention. CCSI is an organization uniquely positioned to understand the complexities of billing in a mobile crisis environment outside of the traditional office setting due to its extensive experience in designing, implementing and managing community-based behavioral health services, including mobile crisis. This experience is critical to be able to respond quickly to what is a time-limited federal funding opportunity to expand mobile crisis services from August 1, 2021 to July 31, 2024.

Home Based Crisis Intervention

Home Based Crisis Intervention (HBCI) programs are utilized to prevent in-patient admissions and help children and their families to establish stability within the community. Youth and their families are typically enrolled for up to 6 weeks with a single identified clinician who meets with the family multiple times a week. This intense, in-home level of involvement and collaboration is utilized to help families create and practice de-escalation skills, identify a support network and to ensure connection to appropriate community-based services. Families are provided with 24/7 access for crisis de-escalation.

The FY22-23 Executive Budget includes an increase in funding for HBCI programs; $7.5 million for 22-23 and then $10 million full annual with the goal of increasing the volume of families served. Other plans for HBCI include the development of 12 new HBCI teams, 2 of which will focus on the I/DD population, and the opportunity to improve staff recruitment and retention as well as provide technical assistance and to create uniformity amongst existing HBCI teams. Current HBCI programs and LGUs will assist in the revitalization of HBCI and the development of unified service delivery across the State.

Somewhere to Go

When someone has experienced a behavioral health crisis and requires further assistance, crisis facilities provide these individuals with a safe place to go. Crisis Stabilization Centers provide short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment. Meanwhile Crisis Residences provide individuals with short-term (up to 28 days) residential support to individuals who are exhibiting symptoms of mental illness or experiencing a psychiatric crisis. These services are a critical component in providing somewhere to go for emotional support and crisis stabilization during a moment of crisis.

Crisis Stabilization Centers

Crisis Stabilization Centers are an additional component of the comprehensive crisis response system, providing New Yorkers with a safe place to go when experiencing a behavioral health crisis. In 2021, MHL Article 36 established the authority for the development of Crisis Stabilization Centers to be jointly licensed by OMH and the Office of Addiction Services and Supports (OASAS). Since then, OMH and OASAS have been working collaboratively to develop Crisis Stabilization Center Regulations, Title 14 NYCRR Part 600, Program Guidance, and other joint processes for the development and implementation of Crisis Stabilization Centers.

Crisis Stabilization Centers provide voluntary urgent care services for individuals experiencing symptoms of mental health and/or substance use crises that need immediate stabilization or treatment. Centers will be operational 24/7/365 and available to children, adolescents, adults, and families. Services may be provided to each individual for up to 24 hours. All services are person-centered, and trauma-informed, with an emphasis on using peers and recovery-oriented support. Crisis Stabilization Centers will coordinate and collaborate with local Mobile Crisis providers, law enforcement, telephonic triage lines, and community treatment and support services. If further treatment is needed, staff will connect individuals to resources within their community to provide continued support, including Crisis Residences.

There will be two types of Crisis Stabilization Centers in New York:

1. **Supportive Crisis Stabilization Centers (SCSC)** are similar to the living room model[1], providing support and assistance to individuals with mental health and/or substance use crisis symptoms. Services are for recipients experiencing challenges in daily life that do not pose the likelihood of serious harm to self or others.
2. **Intensive Crisis Stabilization Centers (ICSC)** provide urgent treatment to recipients experiencing an acute mental health and/or substance use crisis. ICSCs offer all services provided at an SCSC while also providing rapid access to services for acute symptoms, assisting in diversion from a higher level of care, and prescribing medications to manage substance use and mental health symptoms.

Table 1. Services Provided by Crisis Stabilization Center Type

Services Provided	Supportive Crisis Stabilization Center (SCSC)	Intensive Crisis Stabilization Center (ICSC)
Triage, screening, and assessment	♦	♦
Therapeutic interventions	♦	♦
Peer support	♦	♦
Ongoing observation	♦	♦
Care collaboration with a recipient's identified collaterals	♦	♦
Discharge, aftercare planning and follow-up	♦	♦
Psychiatric diagnostic evaluation and plan		♦
Psychosocial assessment		♦
Medication management		♦
Medication for addiction treatment (MAT)		♦
Medication administration and monitoring		♦
Mild to moderate detoxification services		♦

[1] Saxon, V., Mukherjee, D., and Thomas, D. (2018). Behavioral Health Crisis Stabilization Centers: A New Normal. Journal of Mental Health and Clinical Psychology. https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.pdf

Crisis Stabilization Centers will be required to report data to OMH and OASAS. Collected data will be used to improve quality of care and recipient satisfaction, identify trends to inform community planning, analyze the effectiveness of crisis stabilization within the overall crisis system, inform future policy decisions, and ensure coordination and utilization of services within the crisis services system.

Article 9 of Mental Hygiene Law was recently amended to authorize the diversion of individuals experiencing a mental health crisis to Crisis Stabilization Centers instead of hospital emergency departments if they voluntarily agree and the Center determines care there is appropriate.

The development of Crisis Stabilization Centers was included in the Governor's Executive Budget for FY 2022-23 (Part AA of Chapter 57 of the laws of 2021). Over $100 million was offered towards the development of 12 Intensive Crisis Stabilization Centers across New York State.[1] A Request for Proposal (RFP) for the development of these centers was published on January 28, 2022, with proposals due by the summer of 2022. The 12 centers will be distributed throughout the State, with three in the New York City Region and nine outside of New York City. It is expected that these newly developed Intensive Crisis Stabilization Centers will be active, licensed, and providing services by early 2023. An RFP will be published for the development and licensing of Supportive Crisis Stabilization Centers later in 2022.

Crisis Residences

In October 2019, OMH updated Part 589 Crisis Residence regulations to bring programs in line with current practices and standardize crisis residential services for children and adults. Crisis Residence programs are an integral part of the behavioral health continuum of care and a coordinated crisis response system. Located in the community and providing a home-like setting, Crisis Residence programs offer a safe place for the stabilization of symptoms related to mental health and/or emotional crises. They operate 24/7 and provide a range of services for children and adults, including respite, peer support, safety planning, medication management and monitory, case management, assistance in personal care and activities of daily living, facilitated engagement with natural supports and providers, linkages to community services, and comprehensive assessments. Participation in a Crisis Residence program is voluntary on behalf of the care recipient.

OMH requires Crisis Residence programs to be recovery oriented, person-centered, trauma informed, and culturally and linguistically competent. Services are strengths-based and provided on the basis that all individuals have the capacity to recover. All individuals must have individualized service plans that accurately reflect their strengths, needs, preferences, rehabilitative goals, experiences, and personal backgrounds. At the organizational level, Crisis Residences are encouraged to implement policies and practices aimed at advancing health equity, improving quality, and eliminating health care disparities for special/marginalized populations using the framework provided by the National Culturally and Linguistically Appropriate (CLAS) Standards.

Adult Crisis Residence programs utilize a multi-disciplinary staff that includes a Program Director, Supervisor, and other clinical and qualified mental health staff, including credentialed peer specialist. NYS also uses certified or credentialed peer specialists to deliver Crisis Residence services. A strong peer workforce has been shown to provide diversion from higher levels of care and connections to community resources.

Crisis Residence options include Children's Crisis Residences, which are available to individuals up to age 21, and two Adult Crisis Residence programs: Intensive Crisis Residence and Residential Crisis Support, which are available for people ages 18 years and older who are currently experiencing a mental health crisis. Both the children and adult Crisis Residence programs provide a level of short-term support (up to 28 days) with the goal of having individuals return to their home and prevent the need for a more intensive level of care.

Programs that are currently operating as children's Crisis Residences have transitioned to the updated Part 589 regulation and currently operating adult programs are applying for licensure as Crisis Residences, which allows for expansion of reimbursement through Medicaid. Crisis Residence programs serving Medicaid enrolled children are now available under both Medicaid managed care and fee-for-service. As a result, children and their families who are in need of immediate interventions and supports for a child's psychiatric crisis can more easily access this program. In addition, $50 million for capital improvement and development was awarded to providers across New York for the expansion or development of crisis residential programs. These new programs will open between 2022 and 2025.

OMH is in the process of streamlining data reporting for the Crisis Response System. Crisis Residence programs currently report data to Local Government Units (LGUs), and OMH has been working to create a list of metrics for providers that contains the standard data they will need to report and collect for Crisis Residences. It is expected that all Crisis Residence programs will eventually report this data to OMH.

[1] New York State Office of the Governor. (2022, February 2). *Governor Hochul Announces $100 Million for Behavioral Health Crisis Stabilization Centers.* https://www.governor.ny.gov/news/governor-hochul-announces-100-million-behavioral-health-crisis-stabilization-centers

Comprehensive Psychiatric Emergency Program (CPEP)

2021 Annual Summary

The Comprehensive Psychiatric Emergency Program (CPEP) is a set of hospital- and community-based services that include emergency observation, evaluation, and care and treatment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Triage and referral emergency visits require a psychiatric diagnostic examination and may result in further evaluation or treatment activities, or discharge to another level of care. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination.

Program objectives include: providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services. CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. Triage and referral emergency visit services and full emergency visit services are Medicaid reimbursable.

The four CPEP service components are:

1. **Hospital-Based Crisis Intervention Services**: The psychiatric emergency room is the setting for CPEP hospital-based crisis intervention services and is available 24 hours per day, seven days a week. Services offered in the emergency room include triage, referral, evaluation and assessment, stabilization, treatment, and discharge planning. These services are provided by a multi-disciplinary team consistent with CPEP regulations. Enhanced staffing is necessary for timely and thorough assessments and more appropriate clinical decision making, especially as high risk or high cost decisions are frequently made. CPEPs help ensure individual and community safety and appropriate inpatient admissions and outpatient referrals.
2. **Extended Observation Beds** are intended to provide recipients a safe environment where staff can continue to observe, assess, diagnose, treat, and develop plans for continued treatment as needed in the community or in a hospital or other setting. By regulation, CPEPs may be licensed for up to six extended observation beds. The number of beds per site varies based on geographical need and the CPEP's physical plant. Extended observation beds are usually located in or adjacent to the psychiatric emergency room, allowing recipients to remain in the emergency room area for up to 72 hours. Extended observation beds enable staff to assess and treat recipients who need short term care and treatment rather than inpatient hospitalization. In addition, the availability of extended observation beds assists in diverting avoidable short term inpatient admissions.
3. **Crisis Outreach Services** are designed to provide mental health emergency services in the community. The two objectives of this component of service are to provide initial evaluation, assessment and crisis intervention services for individuals in the community who are unable or unwilling to use hospital-based crisis intervention services in the emergency room, and to provide interim crisis services for emergency room recipients who require follow up. Interim crisis services are mental health services provided in the community for recipients who are discharged from a CPEP emergency room, and include immediate face-to-face contacts with mental health professionals to facilitate community tenure while waiting for a first visit with a community-based mental health provider.

In 2020, OMH updated CPEP regulations to strengthen services for individuals requiring psychiatric emergency services and to provide a level of uniformity and consistency throughout CPEPs statewide. Changes to the regulations include revisions to permit psychiatric nurse practitioners to perform triage and referral services within CPEP settings. Additional changes include the development of a voluntary legal status for individuals receiving CPEP services, the addition of an option for CPEPs to develop CPEP satellites, and strengthening the requirements for continuity-of-care after discharge. The revised regulations also encouraged CPEPs to develop relationships with newly licensed crisis residences. OMH worked closely with CPEPs to revise these regulations and anticipates the clarified, updated regulations will improve service delivery across New York State.

CPEP Provider Performance Data

In addition to providing or ensuring the provision of required services, each CPEP is also responsible for submitting quarterly reports to OMH including: the number of visits or admission to each of the four required components of service; timeliness/length of stay and disposition data related to emergency room evaluations and extended observation beds; disposition data related to crisis outreach and crisis residence services; discharge diagnoses; and recipient demographic characteristics. There are 22 CPEPs operating in four OMH Field Office regions; there are no CPEPs in the Hudson River region.

CPEP Regional Count:

- 3 in Western New York
- 2 in Central New York
- 16 in New York City
- 1 on Long Island

Table 2. Statewide Aggregated CPEP Data, 2021

Category		Description	Total 2020 Annual Visits
CPEP Component Use	ER	Brief Visits	26,377
		Full Visits	76,906
		Total Visits	103,283
	Extended Observation Beds (EOBs)	Admissions	11,055
		Total Bed Days Occupied	18,658
	Crisis Outreach	Initial Visits	13,360
		Interim Visits	5,814
		Total Visits	19,174
	Crisis Residence	Admissions	63
		Total Bed Days	720
Waiting and Retention Times	1st Contact with Clinical Staff	Less than 1 Hour	89,605
		1 to 2 Hours	6,691
		More than 2 Hours	2,989
	1st Contact with MD	Less than 2 Hours	87,315
		2 to 4 Hours	10,991
		4+ to 6 Hours	4,447
		More than 6 Hours	4,025
	Entry to Discharge (Non-EOBs)	Less than 8 Hours	36,434
		8 to 16 Hours	17,774
		16+ to 24 Hours	14,093
		More than 24 Hours	17,769
	Entry to Discharge (EOBs)	Less than 24 Hours	2,375
		24 to 48 Hours	4,063
		48+ to 72 Hours	2,929
		More than 72 Hours	1,584
Diagnosis on Discharge from CPEP Services		Schizophrenia, other Psychotic Disorders, and Mood Disorders	56,451
		Substance-Related Disorders	18,953
		Personality Disorders	4,424
		Dementia and other Cognitive Disorders	2,993
		Other	26,823
		TOTAL	109,644
Client Demographics	Age Reported for All CPEP Components	Under 18 Years Old	14,781
		18 - 34 Years Old	42,576
		35 - 64 Years Old	42,052
		65 Years Old or Older	5,262
	Gender Reported for All CPEP Components	Male	59,879
		Female	44,967

PHHPC's Health Planning Committee Educational Workgroup: Dental/Oral Health Care in the Emergency Department

Please Note:

- *This outline captures a high-level summary of the PHHPC Health Planning Committee Workgroup on June 8, 2023; the summary is generally a paraphrased version of what was said at the meeting.*
- *The full meeting transcript and archived video are available at:* New York State Department of Health (totalwebcasting.com)

I. Agenda

a. **Welcome remarks from Dr. Rugge**

b. **Introductions**

i. Health Planning Committee (HPC) participants
ii. Presenters:
1. Dr. Eni Obadan-Udoh, Associate Professor and Director, Dental Public Health Postgraduate Program at University of California San Francisco School of Dentistry
2. Dr. Dionne Richardson, Dental Director, Office of Public Health, Center for Community Health
3. Jean Moore, Director, Center for Health Workforce Studies at UAlbany

c. **Problem Summary and Data Supporting Non-Traumatic/Preventable ED Visits for Dental Care (Dr. Morley)**

Delays in the ER have been a problem since 1989. Patients can be held up to 3 hours because ER staff overwhelmed. SEMSCO met with us a few months ago. This is a public health issue, affecting EMS and response time.

This educational meeting is to focus on oral health and impacts on the ER. A large percentage of these types of visits don't require emergency medicine, they should be seen by primary care etc.

70 percent of patients presenting to the ED do not need ED care; 15 percent are dental patients. They get help as safety net, and get help with pain, but they really need dentists.

Dr. Rugge – Non-traumatic Dental is a category of care that is inappropriate for the ED. Patients can get medicine for pain and antibiotics, but there should be alternatives to the ED for these patients.

d. **Current Landscape: Research and possible models to increase preventative care and divert certain oral health patients from ED (Presenters)**

i. **Dr. Obadan-Udoh:** ***Diversion of Non-Traumatic Dental Patients from the ED Utilizing a Telehealth Triage Model***

Problem

Looking at demographics for ER visits for non-traumatic dental conditions (NTDC): younger adults, disparities by race, health status, day of the week, time of day, rural more than urban, general access, economic influences – Medicaid/uninsured, inability to afford dental care, stable home, etc.; 60 percent of ED visits are covered by Medicaid and the majority of the rest are uninsured.

Patients who use the ER are often repeat users and receive antibiotics or opioids but don't get care they need.

This results in EMS delays, waste resources, and adds to ED overcrowding and wait times. People with Substance Use Disorder also come to the ED which is limited in the help that can be provided.

Dental Quality Alliance looked at Medicaid data:

2 measures:

- Assess ED visits
- How many people after ED visits went to a dental office?
    - Only 30 percent had a dental visit within 30 days
    - 60 percent returned to the ED

Prevention Measures

- Good oral hygiene; regular dental checkups, a healthy diet
- Insurance – help sign up, get connect to dental clinic
- School based programs – visit kids in school w preventive care
- Regular dental homes

If past the point of prevention, ED diversion programs should be used:

- Teledentistry triage platform
- Mobile dental vans (schools, shelters, park in ED lot)
- Co-located dental office-partner w urgent care
- Referral and care-connect to dental home

Tele-dentistry – calls to 911 are transferred to a hotline, where patients speak to a nurse who decides urgency, and send the patient to the ED or notifies the on call dentist. Care coordinator arranges follow up care.

Mobile dental vans – increases access, lower cost, can park anywhere, builds community outreach, can reach the homeless population.

Co-located office-urgent care – different models, for example, a patient-volunteer model, partnering with specialty clinics, corporate franchises, academic model, retainer model

For effective referrals, a care coordinator is key. Many people have insurance but

don't know how to navigate system.

Questions/Comments:

Dental therapists serving as midlevel providers are useful, but don't exist in NYS. There are a few states that have that.
Dr. Bufford – Indian Health Service has been successful with midlevel providers.
Telehealth offers room as a solution.
CA has made a push to get more dental type providers.

Are there states or systems that have succeeded in diverting from ER? Several states tried voucher model for example (MN, MD) the problem is that many solutions are grant funded and when the funding is gone then the program is gone.
CA-care coordination has been a huge success.
Mobile van models have challenges, but have been successful in schools for prevention, and in rural counties in CA.
No studies have been conducted yet to determine the savings from dental diversions.

Dr. Soffel – Medicaid managed care plans should be helping to overcome barriers to dental. OR has been somewhat successful; as a state we should see that ED can link people back to plans.

Dr. Morley – Regarding the impact of dental health on general medical health, for states that have been successful, are they seeing improvements? Generally, we know that health will improve, not much data linking both.

Ms. Bray – Medicaid managed care plans in theory would be perfect but have contributed to this issue with weak provider panels. On paper they look good, but often people have to travel far to see a provider. They have some solutions; Medicaid managed care plans need more regulation; they've been described as wild west, and many dental members are dropping out because the reimbursement is not sustainable.

Dr. Bufford – referenced the Santa Fe Group of Dentists, an oral health benefit provider under Medicare trying to find solutions. It's a global problem that dentists don't want to participate in public health insurance as well as resistance to expanding scope of practice for midlevel practitioners.

ii. **Dr. Richardson:** ***Public Health Measures to Improve and Increase Access to Oral Health Care***

One of 39 State Dental directors across the U.S. who oversee dental health initiatives and programs.

Strategies to address oral health
Access to oral health care is essential as prevention is key.
Goal is to have oral health services integrated into other services provided by the Division of Family Health.
School based initiatives (dental programs and sealant intervention) as well as drinking water fluoridation are some of the main initiatives the Department is currently undertaking.
Dental school based health centers mainly utilize portable equipment as well as

a number of mobile vans (have traditionally been the least cost effective but there has been increased interest in this modality since COVID). There are few fixed school sites.

The decision to provide water fluoridation is a local one, there is no state mandate.

iii. **Ms. Moore:** ***Strategies to Decrease Oral Health Disparities and Increase the Availability of an Oral Health Workforce Equipped to Provide Preventive and Basic Restorative Services***

What can we do?

- Integrating oral health with primary care
- FQHCs are well suited for integration - HRSA supported expansion of dental services for FQHCs (2016)
- Case studies – best practices, hygienist sit in on well baby/child visits to advise parents on preventative oral care for baby.
- Deploy new oral health service delivery strategies – mobile and portable dentistry, teledentistry, mobile vans

Hygienists as a workforce:

- Can improve oral health literacy – promote prevention, advise parents
- Need better data on state's oral health workforce, there is a law passed for a survey (2021) but there was no funding attached. We need to understand supply, distribution, aging workforce.
- Offering provider incentives to practice in underserved areas, loan repayment programs (currently for 115 dentists and 22 hygienists).
- Provide training opportunities for students, interdisciplinary collaboration. For example, the feasibility of hospital-based dental residency.
- Dental hygiene scope of practice – allow hygienists to do more. Dental therapy legislature has been introduced for a few years now.
- Need community health coordinators, expand functional dental assistants; dental therapist?

Questions/Comments:

Ms. Duhan (CHCANYS) – 90 percent of FQHCs offer dental services; would love to see dental therapist model; workforce is a barrier to expanding dental services; expand hygienist training by partnering with community colleges, especially in rural areas; Medicaid managed care plans - create incentives for establishment of dental homes; dental home should be matched with a patient's primary care provider/medical home.

Mr. Hill (NYS Dental Assoc) – not seeing the impact of dental therapists in rural areas so we have been more focused on reducing barriers. It will take time, if enacted, for dental therapist model to be effective.

Dr. Robinson – suggests academic dental schools (5) should be involved in solutions, for the ED problem and for workforce issues.

Dr. Richardson – DOH is looking closely at mobile providers, some of which are non-school based, that may be connected with hospitals.

e. **Reform Possibilities: Discussion of possible avenues for reform (HPC members Q&A with meeting participants)**

Ms. Bray – NYS Dental Association:
Dental Demonstration Project – looking at free mission of mercy events. They'd like to go further, by quantifying what types of people come to those events and their reasons:

- 52 percent cite a financial barrier
- 48 percent – why don't they go to the dentist:
    - 13 percent do not have a dental problem, so don't go to the dentist
    - 13 percent cite fear as a reason
    - 22 percent cite other reasons (transportation, physical ailments, childcare)
    - Care coordination can help address that 48 percent.

Tele-dentistry and triaging can help, especially in rural areas which need more incentives. Need to train more care coordinators, certificate on completion – extra training for hygienists, other states have done this. NYS has 20 hygienists who are care coordinators training more can help fill the void. Create regions that correlate with local health departments to target regional issues as well as partnering with local hospitals. Working on medical-dental integration.

Dr. McLaren – Community health workers are vital, combined with telehealth services rates go up for complete treatment plans. Agrees we need to engage academic dental centers in this discussion.

Dr. Soffel – Suggests Dentists Across NY loan repayment program; can we incentivize or penalize Medicaid managed care plans?

Dr. Roseamelia – Recruiting rural students through dental admissions policies.
NYU, Buffalo, Stoney Brook, Touro, Columbia have dental schools, Rochester has large post-doc training (~144 dental residents) is also considered one of the academic centers.
NYU takes students to Hudson NY, Poughkeepsie for outreach programs which are being reinstated after COVID.

NYS Education Department is also needed as they handle scope of practice and licensure.

f. **Closing Remarks and Next Steps (Dr. Rugge)**
    i. Full Committee Meeting Date (TBD; tentatively June 26, 2023)
    ii. Assignment for HPC members: Come to Full Committee Meeting with preliminary draft reform suggestions on this Workgroup topic

Emergency Department Utilization for Non-traumatic Dental Conditions: Potential Solutions

Eni Obadan-Udoh, DDS, MPH, Dr.Med.Sc.

Associate Professor and Residency Director

Oral Epidemiology and Dental Public Health

University of California San Francisco

UCSF
University of California San Francisco

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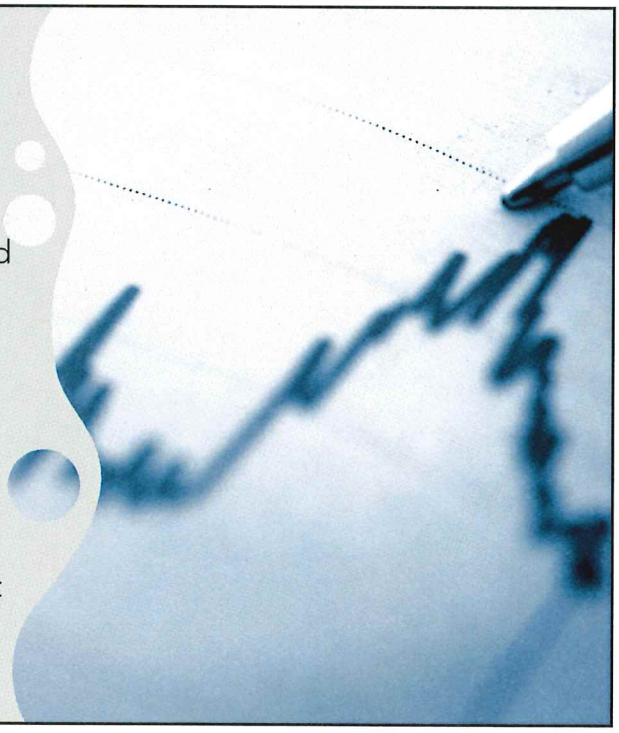
FINANCIAL DISCLOSURES

Funding Sources:

- Robert Wood Johnson Foundation (Harold Amos Medical Faculty Development Program); 2020-2024; PI (Obadan-Udoh)
- Health Resources and Services Administration (HRSA); Postdoctoral Training in Dental Public Health; 2020-2025; PI (Obadan-Udoh)

No conflicts of interest to disclose; Views presented are those of the author and do not represent an endorsement by the sponsors.



2

Factors Associated with ED Use for NTDCs

1. **Patient Demographics**
   Age, gender, race/ethnicity, comorbidities, oral health status were key factors
2. **Accessibility**
   Time of day, day of week, geographic location, access to dental practitioner
3. **Economic Influences**
   Insurance, inability to afford dental care, income
4. **Social Demographics**
   Community language, homelessness, repeat use

3

3

Nearly 60% of ED Visits for NTDCs Expected to Be Covered by Medicaid

1. **Coverage**
   Medicaid was expected to cover about 60% of all ED visits for NTDCs
2. **Uninsured**
   The remaining ED visits for NTDCs were attributed to uninsured patients

4

4

Prescription Fill Rates within 7 Days of a Dental-Related ED Visit

Beneficiary

Antibiotic

54.9% of Medicaid patients and 55.0% of commercially insured patients filled a prescription for an antibiotic

Opioid

39.6% of Medicaid patients and 42.0% of commercially insured patients filled an opioid prescription

Costs

Limitations on prescriptions can reduce costs for both beneficiaries and insurance providers. Increased awareness of oral care can reduce ED visits, decreasing healthcare costs for all

5

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Effect of ED Utilization for NTDCs

Ambulance Delays

ED Overcrowding and Long wait times

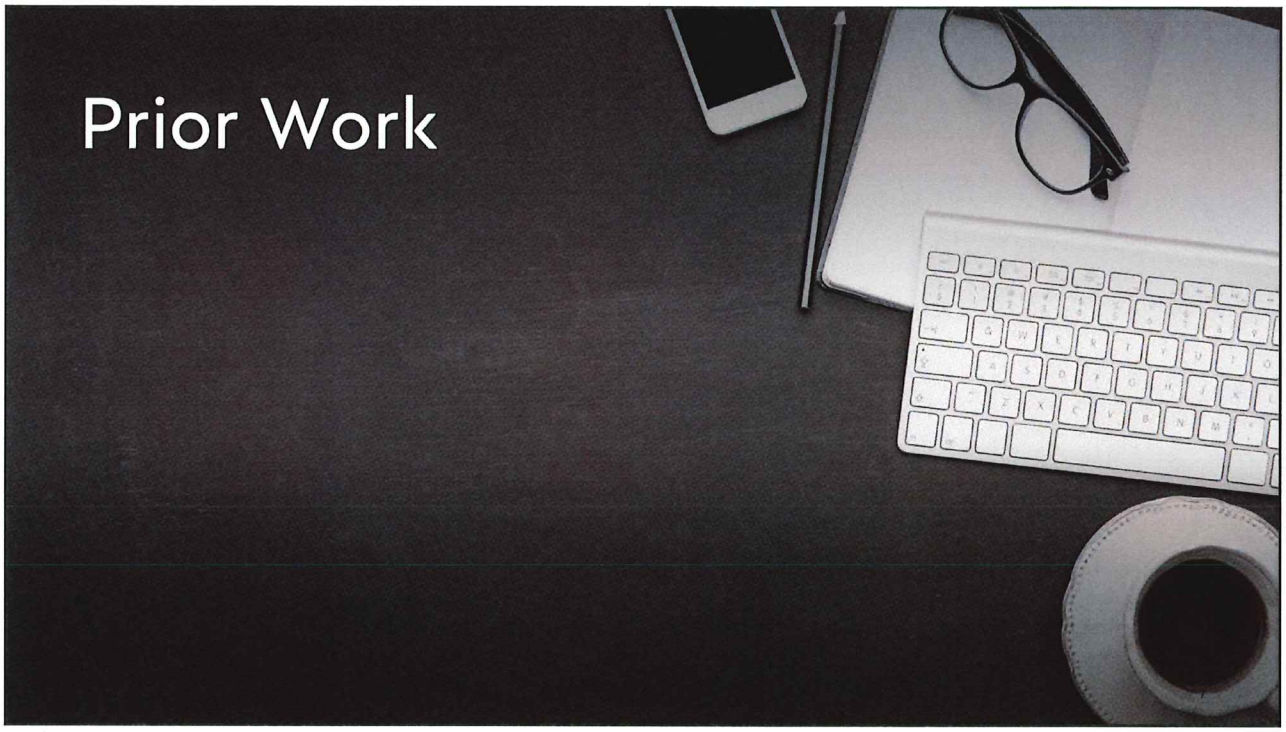
Wasted Resources

Substance Use Disorder

6

6

Prior Work



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ED Quality Measures

ELSEVIER

The Journal of the American Dental Association

Available online 2 May 2023

In Press, Corrected Proof ⓘ What's this? ↗

Investigation

Testing dental quality measures: Emergency department visits for nontraumatic dental conditions and subsequent follow-up dental visits

Enihomo Obadan-Udoh DDS, MPH, DrMedSc, Jill Boylston Herndon PhD, Richie Kohli BDS, MS, Susan McKernan DMD, MS, PhD, Matthew Jura, Elizabeth Momany PhD, Garima Arora, Harjit Singh Sehgal BDS, MS, Alfa-Ibrahim Yansane PhD, Elizabeth Mertz PhD, Diptee Ojha BDS, PhD, Craig Amundson DDS

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Measure 1
Number of ED visits for ambulatory care sensitive nontraumatic dental conditions per 100,000 member-months for adults

Measure 2
The percentage of ambulatory care sensitive nontraumatic dental condition ED visits among adults ≥ 18 y in the reporting period for which the member visited a dentist within 7 d and within 30 d of the ED visit

9

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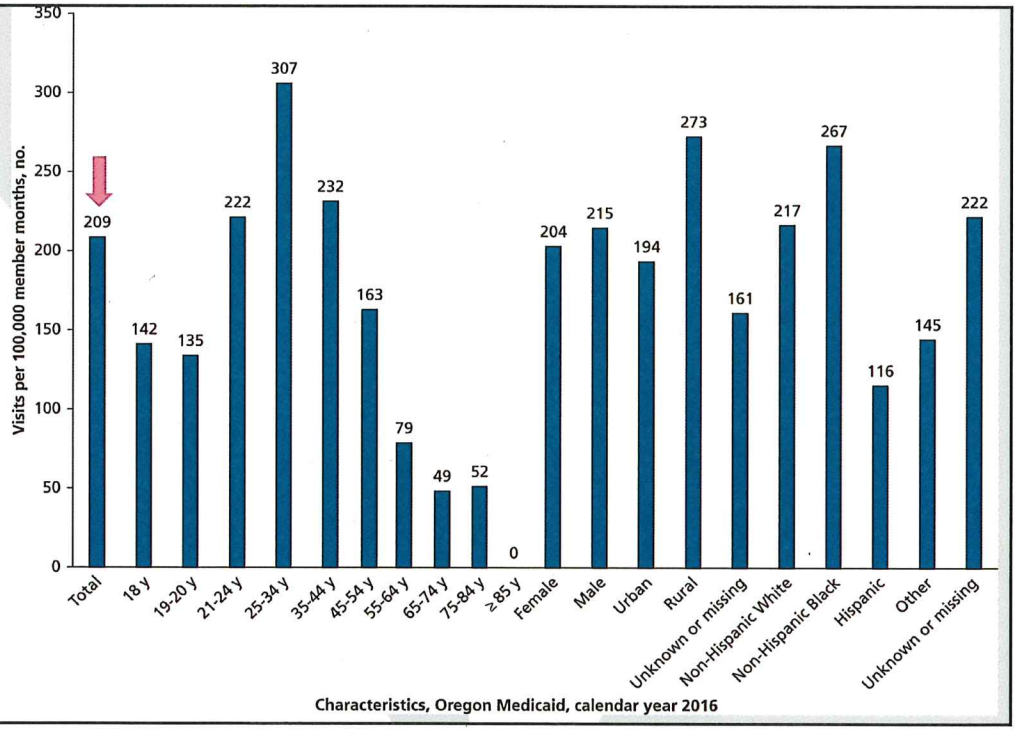
Measure 1



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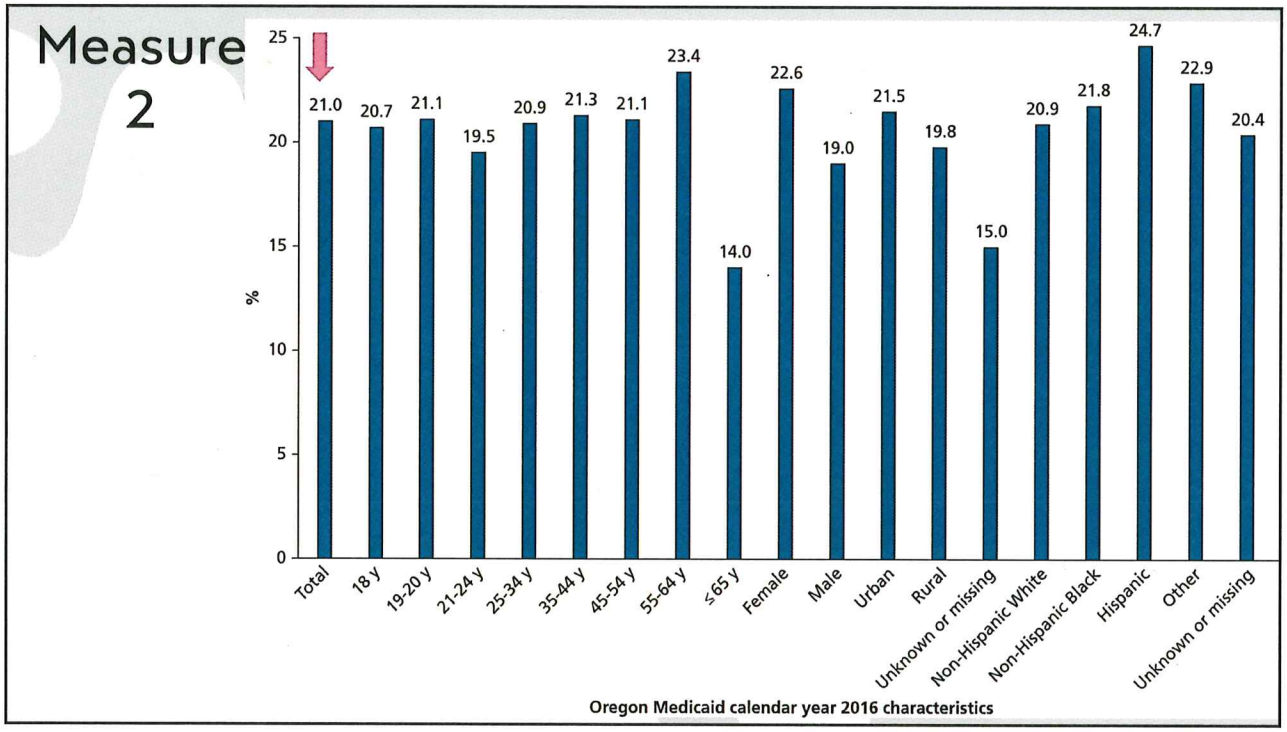
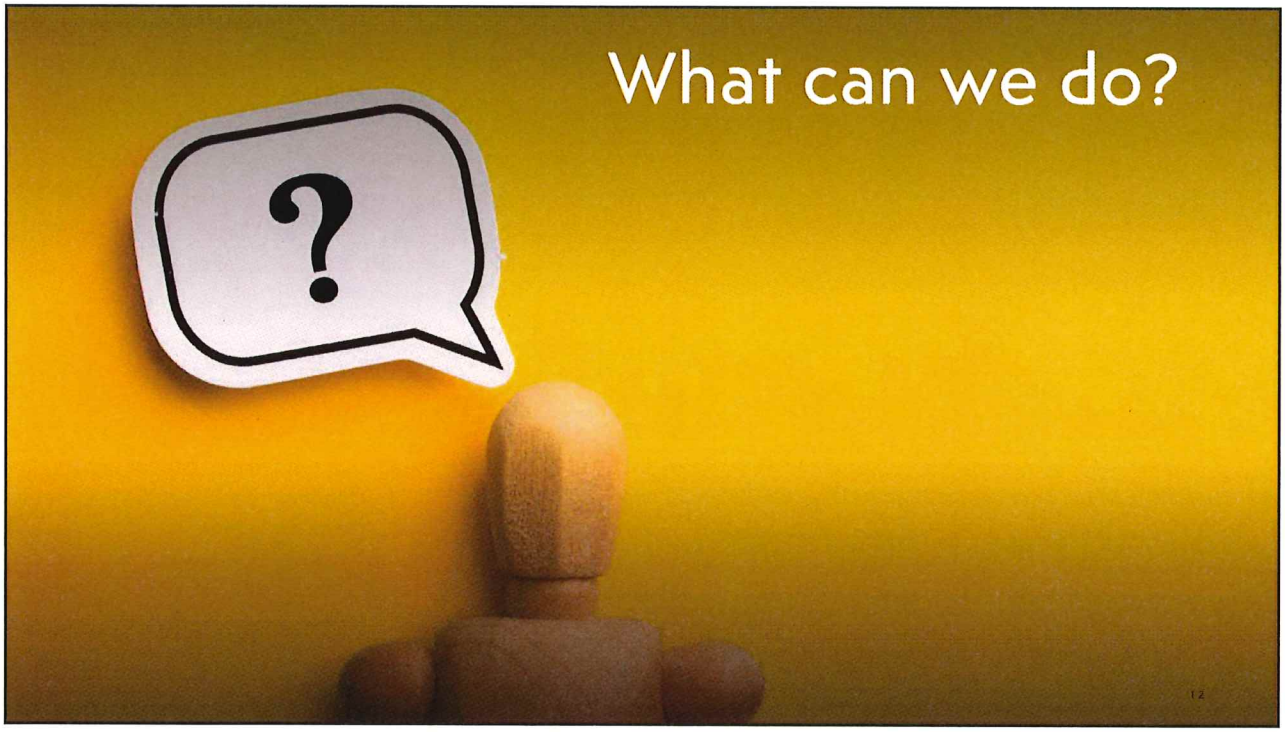

Measure 2
%
25
20
15
10
5
0
21.0
20.7
21.1
19.5
20.9
21.3
21.1
23.4
14.0
22.6
19.0
21.5
19.8
15.0
20.9
21.8
24.7
22.9
20.4
Total
18 y
19-20 y
21-24 y
25-34 y
35-44 y
45-54 y
55-64 y
≤65 y
Female
Male
Urban
Rural
Unknown or missing
Non-Hispanic White
Non-Hispanic Black
Hispanic
Other
Unknown or missing
Oregon Medicaid calendar year 2016 characteristics

11


What can we do?
?

12

Prevention!!!

Oral Hygiene

Encourage good oral hygiene practices, such as brushing and flossing regularly, to prevent cavities and gum disease.

Regular Dental Checkups

Encourage patients to see a dentist regularly for preventive care and to address any dental issues before they become emergencies.

Healthy Diet

Encourage a healthy diet that is low in sugar and high in fruits and vegetables, which can help prevent tooth decay.

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BEFORE THE ED VISIT

INSURANCE

SCHOOL-BASED PROGRAMS

REGULAR DENTAL HOMES

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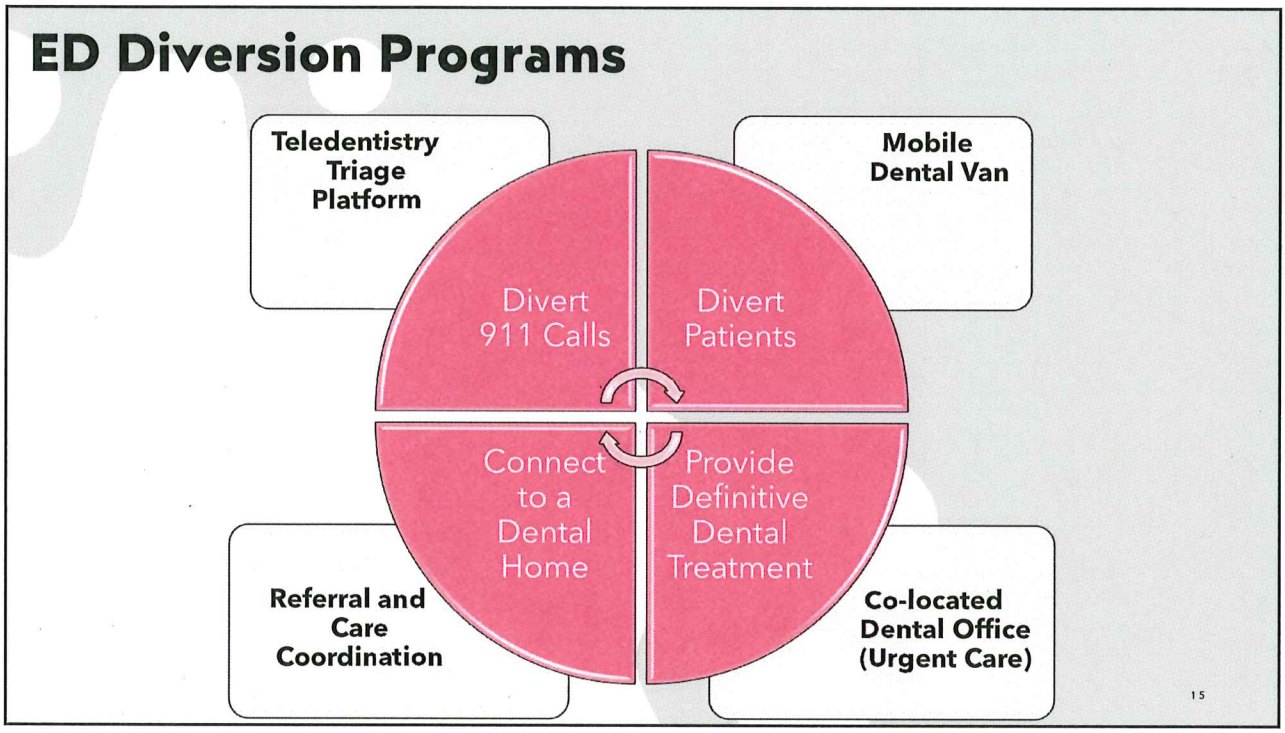
ED Diversion Programs
Teledentistry Triage Platform
Mobile Dental Van
Divert 911 Calls
Divert Patients
Connect to a Dental Home
Provide Definitive Dental Treatment
Referral and Care Coordination
Co-located Dental Office (Urgent Care)
15

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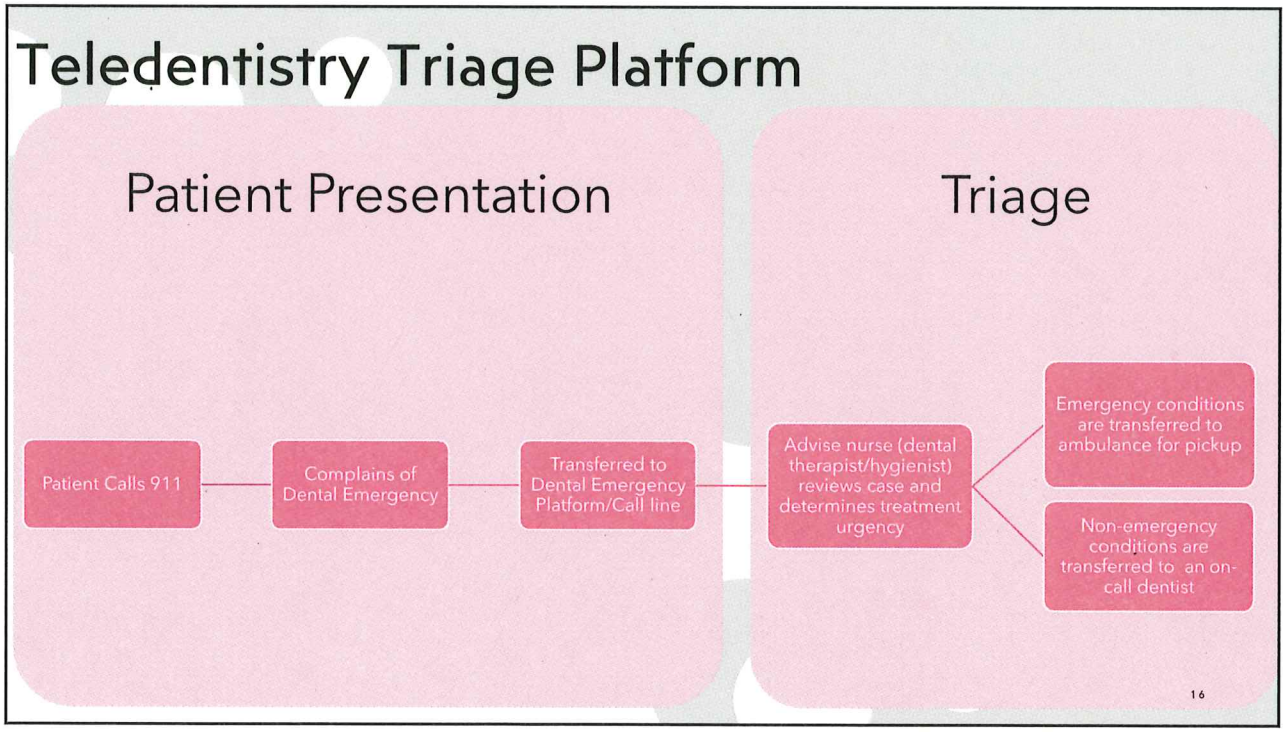
Teledentistry Triage Platform
Patient Presentation
Triage
Patient Calls 911
Complains of Dental Emergency
Transferred to Dental Emergency Platform/Call line
Advise nurse (dental therapist/hygienist) reviews case and determines treatment urgency
Emergency conditions are transferred to ambulance for pickup
Non-emergency conditions are transferred to an on-call dentist
16

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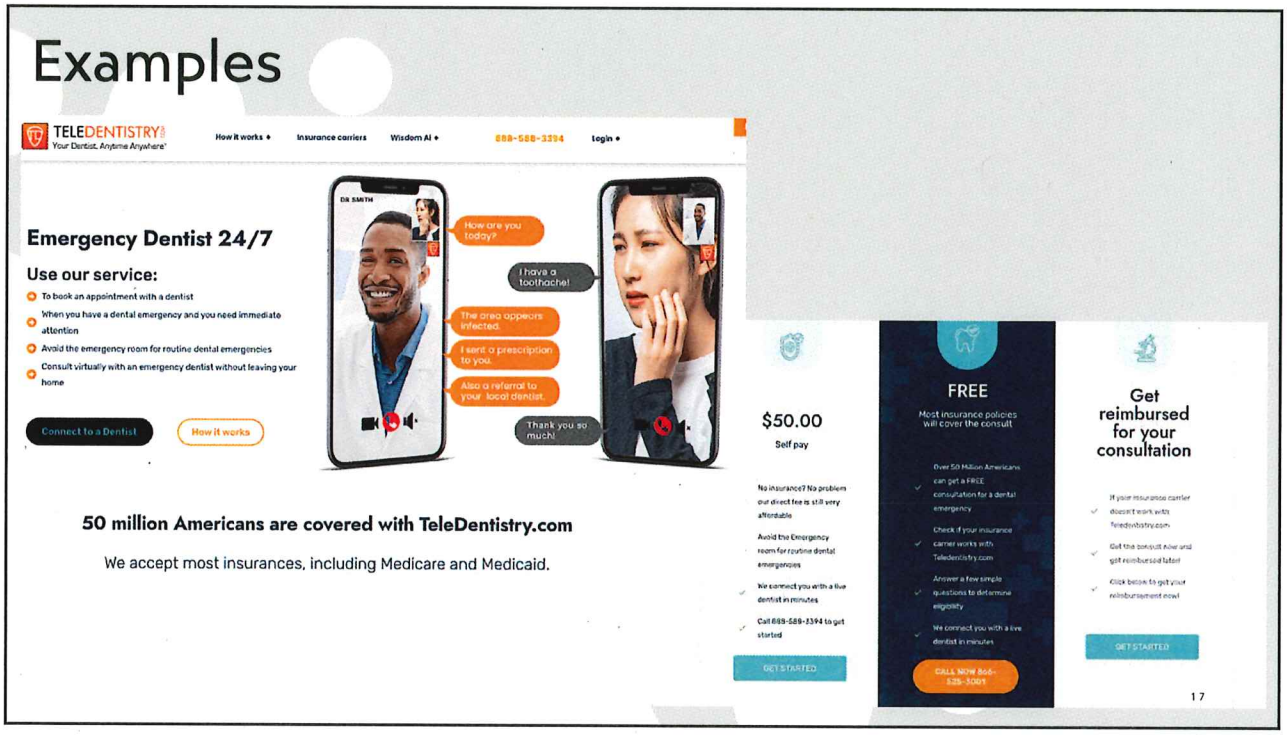
Examples



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Mobile Dental Vans

Increased Access

Mobile dental vans bring care directly to communities, making it easier for people to get the treatment they need.

Lower Cost

Using a van instead of a fixed dental office can lead to significant cost savings that can be passed onto patients.

Flexibility

Mobile dental vans can go where the patients are, removing barriers to care like transportation and limited mobility.

Community Outreach

Mobile dental vans build rapport with local communities and provide a critical healthcare service that can address a major health disparity.

18


Mobile Dental Services
Rural Communities
Mobile dental vans provide a vital service to sparsely populated rural areas with fewer dental offices.
Homeless Populations
Mobile dental vans can provide care directly on the streets, making a real difference for people who have nowhere else to turn.
Schools and Universities
Mobile dental vans can visit schools and universities to provide dental services to children who might not otherwise receive them.
Prison Populations
Mobile dental vans can provide care directly to incarcerated individuals, helping to address the serious dental health disparities in this population.
19

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Co-Located Dental Office/Urgent care
•Patient Volunteer Model
•Specialty Care Model
•Corporate/Franchise Model
•Academic Model
•Retainer Model
•Voucher Model
•Private Practice Model
20

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Referral and Care Coordination

- Identify patients in need of emergency dental care
- Respond to triage referrals
- Help patients sign up for dental insurance
- Find dental appointments within 24 hours in local area
- Follow up with provider and patient to confirm appointment
- Send reminders to patient
- Send follow-up messages after the appointment to confirm symptom resolution
- Help establish a regular dental home

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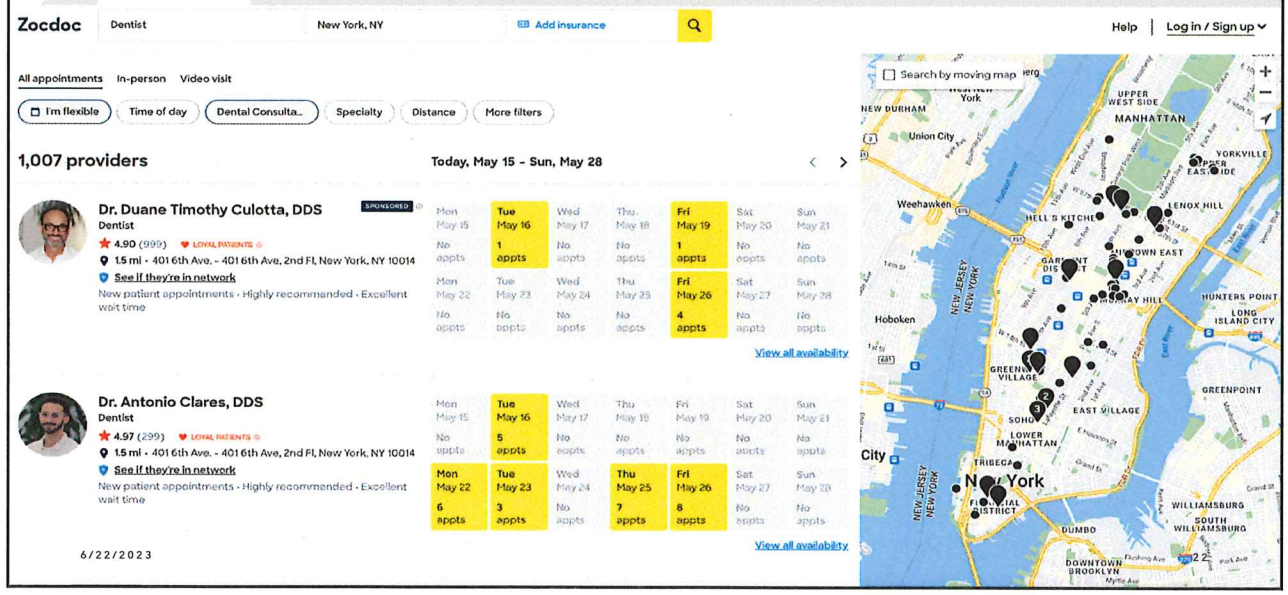
Referral Options



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Resources

https://www.zocdoc.com/

https://teledentistry.com/new-york/

https://www.onlinedoctor.com/best-teledentistry-companies/#Dentist

https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/community-initiatives/action-for-dental-health/emergency-department-referrals/ed_referral_program_models.pdf?rev=8558057b59ff4d37bbfb54e7c8a71f26&hash=E517072B6A4BA7B0399AF38BA28F35E1

https://www.adea.org/legregmap/

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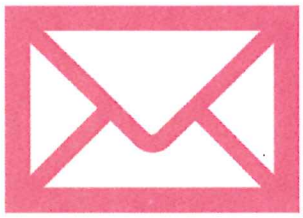
Thank you!!!



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OHWRC
Oral Health Workforce Research Center

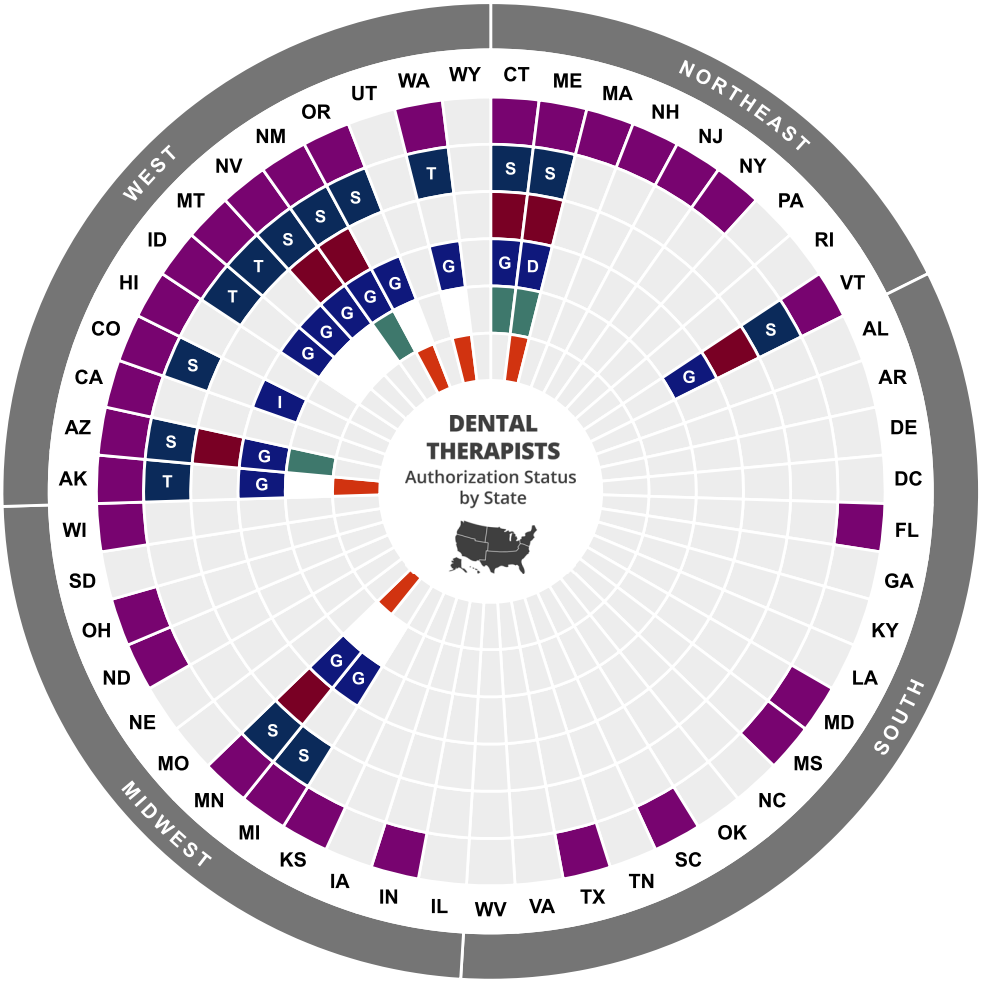
Authorization Status of Dental Therapists By State

This infographic describes the status of dental therapy in the United States (US) and details the specific requirements in state laws and regulations that define dental therapy practice.

Dental therapists (DTs) are primary dental care practitioners that have been deployed in many countries around the world. Dental therapy was first implemented by the Alaska Native Tribal Health Consortium in 2005.[1]

There is increasingly strong evidence supporting the safety and effectiveness of DTs, including their ability to promote community-based services and enhance oral health equity.[2-4]

Following the approval of education standards by the Commission on Dental Accreditation (CODA) in 2015, dental therapy gained increasing acceptance in the US with states and tribal nations authorizing dental therapy. Dental therapy is rapidly becoming an established, growing profession in the US, although there is variation in legal authority across states and jurisdictions.



Campaign for Dental Therapy in the State (Active or Prior)

Authorization of Dental Therapy

- T Tribal Dental Therapy
- S Statewide

Mandated Dual Dental Hygiene and/or Degree Requirement in State Statute

Dental Therapist Supervision Level by Dentist

- D Direct
- I Indirect
- G General

Population/Setting Restrictions on DT Practice

- Setting Only
- Population Only
- Both

Dental Therapists Practicing in the State

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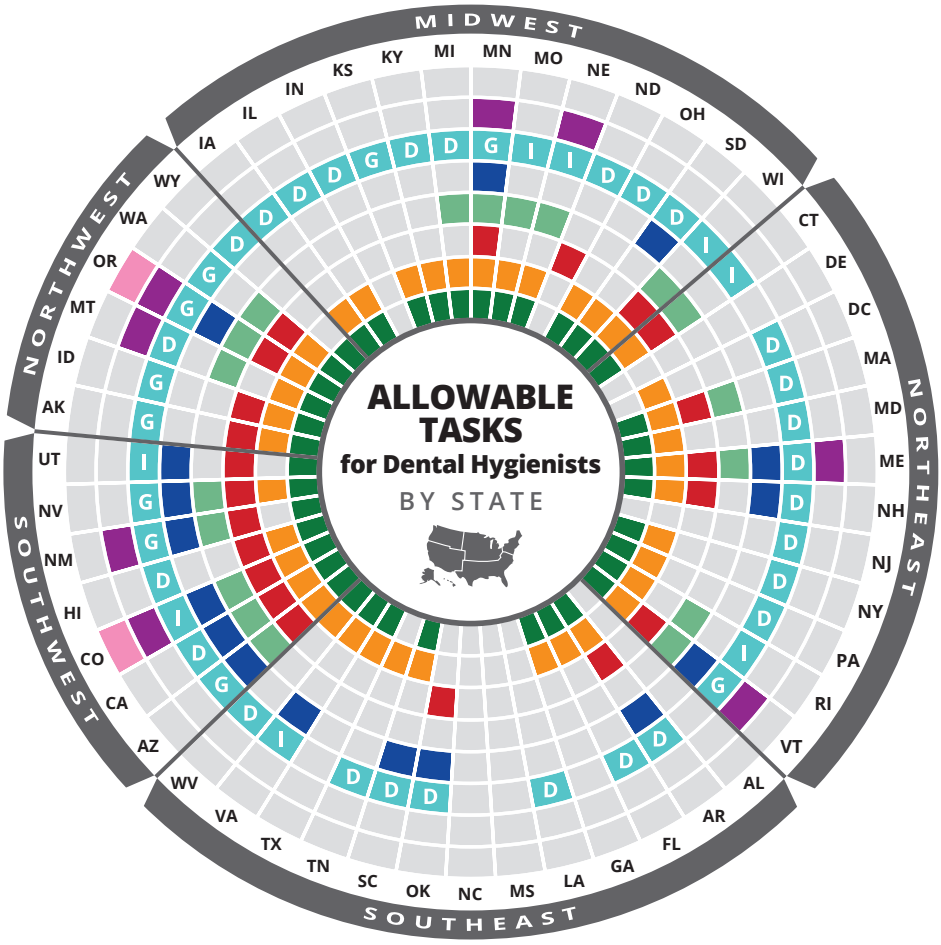
This graphic is for informational purposes only and state level authorization and requirements are subject to change. Contact the applicable dental board or an attorney for specific legal advice.

This graphic was developed by researchers at the Oral Health Workforce Research Center (OHWRC), Center for Health Workforce Studies at the University at Albany's School of Public Health and colleagues at Healthforce Center at the University of California, San Francisco. This work is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $449,943 with 50% financed with non-governmental sources through a grant from the W.K. Kellogg Foundation. The information presented in this infographic is based on research conducted by the authors and does not necessarily represent the official views of, nor an endorsement, by, HRSA, HHS, or the US government. For more information, please visit HRSA.gov.

Last Updated September 2020.

Variation in Dental Hygiene Scope of Practice by State



The purpose of this graphic is to help planners, policymakers, and others understand differences in legal scope of practice across states, particularly in public health settings.

Research has shown that a broader scope of practice for dental hygienists is positively and significantly associated with improved oral health outcomes in a state's population.[1,2]

- Dental Hygiene Diagnosis
- Prescriptive Authority
- Local Anesthesia
  - D Direct
  - I Indirect
  - G General
- Supervision of Dental Assistants
- Direct Medicaid Reimbursement
- Dental Hygiene Treatment Planning
- Provision of Sealants
- Direct Access to Prophylaxis
- Not Allowed / No Law

Dental Hygiene Diagnosis

The identification of oral conditions for which treatment falls within the dental hygiene scope of practice, as part of a dental hygiene treatment plan.

Prescriptive Authority

The ability to prescribe, administer, and dispense fluoride, topical medications, and chlorhexidine.

Local Anesthesia

The administration of local anesthesia.

LEVEL OF SUPERVISION

- **D** **Direct:** The dentist is required to be physically present during the administration of local anesthesia by the dental hygienist.
- **I** **Indirect:** The dentist is required to be on the premises during the administration of local anesthesia by the dental hygienist.
- **G** **General:** The dentist is required to authorize the administration of local anesthesia by the dental hygienist but is not required to be on the premises during the procedure.

Supervision of Dental Assistants

The ability to supervise dental assistants when performing tasks within the dental hygiene scope of practice.

Direct Medicaid Reimbursement

The direct Medicaid reimbursement of dental hygiene services to the dental hygienist.

Dental Hygiene Treatment Planning

The ability of a dental hygienist to assess oral conditions and formulate treatment plans for services within the dental hygiene scope of practice.

Provision of Sealants Without Prior Examination

The ability of a dental hygienist working in a public health setting to provide sealants without prior examination by a dentist.

Direct Access to Prophylaxis from a Dental Hygienist

The ability of a dental hygienist working in a public health setting to provide prophylaxis without prior examination by a dentist.

Not Allowed / No Law

Sources: 1. Langelier M, Baker B, Continelli T. *Development of a New Dental Hygiene Professional Practice Index by State, 2016.* Rensselaer, NY: Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany; November 2016. 2. Langelier M, Continelli T, Moore J, Baker B, Surdu S. Expanded Scopes of Practice for Dental Hygienists Associated With Improved Oral Health Outcomes for Adults. *Health Affairs.* 2016;35(12):2207-2215.

http://www.oralhealthworkforce.org/wp-content/uploads/2017/03/OHWRC_Dental_Hygiene_Scope_of_Practice_2016.pdf

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OHWRC
Oral Health Workforce Research Center

Making Care Primary (MCP) Model

Registration is open for the MCP Model Overview Webinar on June 27, 2023

On June 8, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary primary care model – the Making that will be tested in eight states. Launching July 1, 2024, the 10.5-year model will improve care management and care coordination, with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health n related social needs (HRSNs) such as housing and nutrition. CMS is working with State Medicaid Agencies in the eight states to eng across payers, with plans to engage private payers in the coming months. **CMS will begin accepting applications for the model ir are interested in applying for Making Care Primary, please submit a non-binding Letter of Intent here. This information will l efforts.**

Model Overview

The Making Care Primary (MCP) Model is a 10.5-year multi-payer model with three participation tracks that build upon previous prim Comprehensive Primary Care (CPC), CPC+, and Primary Care First (PCF) models, as well as the Maryland Primary Care Program (improve care for beneficiaries by supporting the delivery of advanced primary care services, which are foundational for a high-perfor Model will provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt pros payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care. Stat commit to designing Medicaid programs to align with MCP in key areas. This model will attempt to strengthen coordination between p clinicians, specialists, social service providers, and behavioral health clinicians, ultimately leading to chronic disease prevention, few better health outcomes.

Highlights

MCP provides primary care clinicians with enhanced model payments, tools, and supports to improve the health outcome provides additional resources and data to help primary care clinicians better coordinate care with specialists. Additionally integration, meaning that clinicians can more seamlessly address physical and behavioral health needs and tap into com health disparities.

MCP will aim to ensure that patients receive care to meet their health goals and social needs. Patients will receive enhan participants to better manage their conditions and improve their overall wellness.

Model Purpose

Primary care clinicians are the first line of defense for prevention, screening, management of chronic conditions, and overall wellnes diagnosed with multiple chronic conditions, which only intensifies the importance of accessible, affordable, high-quality primary care their overall health care. However, care coordination is increasingly challenging as patients see a greater number of specialists more Center for Medicare and Medicaid Innovation (the Innovation Center) increases the investment in primary care so patients can acces quality, whole-person care.

The MCP Model meets primary care organizations where they are through its progressive, three-track approach to begin transformin

outcomes for their patients. This includes several payment innovations to support participants in delivering advanced primary care. T MCP will include prospective payments for primary care that will reduce organizations' reliance on fee-for-service payments. Risk-adj payments, which will also be paid prospectively and represent an additional investment in primary care, will allow participants to expa for health-related social needs, and integrate with specialty care. MCP will include Federally Qualified Health Centers (FQHCs) in a r care model for the first time, as well as other organizations serving Medicare beneficiaries with complex health and social needs to fu participants, the model features upside-only performance incentives that will allow participants to be rewarded for their work to impro for their patients. The quality performance measures included in MCP reflect the work of CMS to streamline measures across prog innovative measures.

The MCP care delivery approach communicates its vision for care delivery through three domains:

> **Care Management**: participants will build their care management and chronic condition self-management support services, managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use
>
> **Care Integration**: in alignment with CMS' Specialty Integration Strategy, participants will strengthen their connections with using evidence-based behavioral health screening and evaluation to improve patient care and coordination.
>
> **Community Connection**: participants will identify and address health-related social needs (HRSNs) and connect patients t services.

Each of these domains has specific care delivery requirements for participating organizations in each track.

Model Design

MCP's **three progressive tracks** are designed to recognize participants' varying experience in value-based care—from under-resou existing advanced primary care experience in alternative payment models. MCP aims to give these organizations flexibility, allowing t participation track and receive payments that reflect each participant's experience towards accountable care. Again, MCP is a three-t reserved for organizations with no prior value-based care experience.

> **Track 1 –Building Infrastructure**: Participants will begin to develop the foundation for implementing advanced primary care stratifying their population, reviewing data, building out workflows, identifying staff for chronic disease management, and cor needs screening and referral. Payment for primary care will remain fee-for-service (FFS), while CMS provides additional fina participants develop care transformation infrastructure and build advanced care delivery capabilities. Participants can begin improving patient health outcomes in this track.
>
> **Track 2 – Implementing Advanced Primary Care**: As participants progress to Track 2, they will build upon the Track 1 requ social service providers and specialists, implementing care management services, and systematically screening for behavio for primary care will shift to a 50/50 blend of prospective, population-based payments and FFS payments. CMS will continue support at a lower level than Track 1, as participants continue to build advanced care delivery capabilities. Participants will b financial rewards for improving patient health outcomes.
>
> **Track 3 – Optimizing Care and Partnerships**: In Track 3, participants will expand upon the requirements of Tracks 1 and 2 frameworks to optimize and improve workflows, address silos to improve care integration, develop social services and speci deepen connections to community resources. Payment for primary care will shift to fully prospective, population-based payn to provide additional financial support, at a lower level than Track 2, to sustain care delivery activities while participants have greater financial rewards for improving patient health outcomes.

Eligibility Criteria

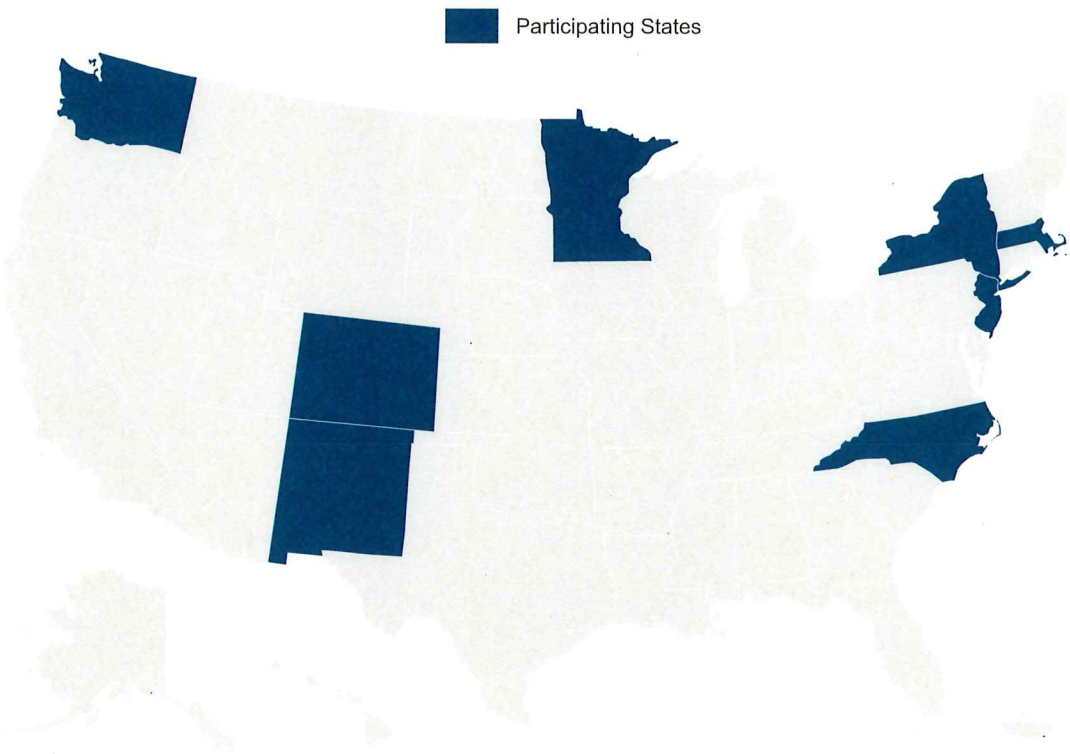
To be eligible to apply to participate in MCP, an organization must:

> Be a legal entity formed under applicable state, federal, or Tribal law authorized to conduct business in each state in which i
> Be Medicare-enrolled.
> Bill for health services furnished to a minimum of 125 attributed Medicare beneficiaries.
> Have the majority (at least 51%) of their primary care sites (physical locations where care is delivered) located in an MCP st

Rural Health Clinics, concierge practices (practices that collect a fee from patients for access to their services), current Primary Care ACO REACH Participant Providers, and Grandfathered Tribal FQHCs are not eligible for MCP. Organizations will not be able to conc Medicare Shared Savings Program and MCP after the first six months of the model.

State Participation in MCP

Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, New York, North Carolina, and Washington were selected after revi geographic diversity, health equity opportunity, population, current CMS Innovation Center footprint, generalizability to the rest of the model evaluation, and the ability to align with state Medicaid agencies. CMS will provide further details about state-specific eligibility Request for Applications (RFA).



Source: Centers for

Multi-Payer Alignment

We are partnering with state Medicaid agencies and other payers in the listed MCP states to align MCP and state programs. While C Medicare beneficiaries as described in the RFA, other payers are encouraged to partner with CMS to realize the goals and elements across all patients, including those covered by Medicaid, commercial, and other payers.

Health Equity Strategy

The Innovation Center believes that equitable care is crucial to achieving high-quality care for Medicare and Medicaid beneficiaries a MCP's success. CMS defines health equity as: "the attainment of the highest level of health for all people, where everyone has a fair their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, pref factors that affect access to care and health outcomes." The term "underserved communities" refers to populations sharing a parti geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civ

MCP includes several model components designed to improve health equity:

- Some payments will be adjusted by clinical indicators and social risk.
- Participants will be required to develop a strategic plan for how they will identify disparities and reduce them.
- Participants will be required to implement HRSN screening and referrals.
- Participants will be allowed to reduce cost-sharing for patients in need.
- CMS will measure the percentage of patients screened for HRSNs
- CMS will collect data on certain demographic information and HRSNs to evaluate health disparities in MCP communities.

What's Next?

CMS plans to release a Request for Applications (RFA) and commence the application period for this model later this summer. More design is forthcoming. **If you are interested in applying for Making Care Primary, please submit a non-binding Letter of Intent help support CMS recruiting efforts.** For information on your state's aligned program, please contact your State Medicaid Agency.

Additional Information

MCP Model Applicant Letter of Intent
MCP Model Overview Webinar - June 27, 2023

How to Contact the MCP Model Team

If you have questions regarding the Model, you can contact the MCP model team by emailing MCP@cms.hhs.gov.

Related Items

Accountable Care Models	Accountable Care Models	Accountable Car
ACO Investment Model	ACO REACH	Advance Payme
Stage:Not Active	Stage:Active	Stage:Not Active
Learn More	Learn More	Learn More

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