

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan



Prepared for the Lebanon County Mental Health /  
Intellectual Disabilities / Early Intervention Program  
by The Panto Group, LLC.

December 2025

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## Acknowledgements

The Panto Group, LLC wishes to express deep appreciation to the Lebanon County Office of Mental Health / Intellectual Disabilities / Early Intervention (MH/ID/EI), specifically Holly A. Leahy, Administrator, Melissa Herr, Deputy Administrator, and Kasey E. Felty, Director of Mental Health Services, whose guidance, insight, and support made the research and resulting strategic enhancement plan possible.

We also extend our sincere gratitude to Sarah Eyster and Donald J. Panto, II from The Panto Group, LLC who prepared the strategic plan, whose professional expertise and analytical contributions were essential in shaping the study's findings and recommendations.

We would additionally like to thank the many county and community stakeholders who provided candid descriptions and expert perspectives on how the crisis intervention system has operated within Lebanon County, and their input and recommendations for continued operational improvement, growth, and development (a list of Contributors and Stakeholders is provided in Appendix 1). Their cooperation and professionalism were instrumental to the successful execution of this study.



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### ***About The Panto Group, LLC***

*The Panto Group, LLC (TPG) is a healthcare business analysis, software development and project management consulting firm. We offer specialized expertise in human services administration and strategic program operations and systems development.*

*With deep experience in human services and Medicaid managed care programs, TPG has been involved in state-wide and county-based program implementations for the delivery of behavioral health services, fiscal analysis and financial reporting, and information systems development.*

# EXECUTIVE SUMMARY

- ◆ Overview
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## Executive Summary

### Overview

Lebanon County Mental Health / Intellectual Disabilities / Early Intervention (MH/ID/EI) was awarded funds through the Community Mental Health Services Block Grant, American Rescue Plan Act (ARPA) of 2021 to support community-based crisis services on December 12, 2022.

On April 3, 2023, Lebanon County MH/ID/EI distributed a Request for Proposal (RFP) seeking an experienced Crisis System Consultant. The Panto Group, LLC (TPG) submitted a proposal and was chosen through a selection committee on July 5, 2023. MH/ID/EI awarded the consulting engagement to TPG on July 20, 2023.

### **Creation of a Comprehensive Dynamic Enhancement Plan**

The RFP issued by MH/ID/EI was for the development of a Crisis System Dynamic Enhancement Plan that encompassed the following goals:

- Create an overview of the existing crisis intervention services system in Lebanon County.
- Examine each crisis intervention system modality as published in SAMHSA's National Guidelines for Behavioral Health, Best Practices Toolkit, and to provide concrete action steps / recommendations toward implementation.
- Perform a financial analysis of Lebanon County's current crisis service system, and to offer recommendations regarding best practices and sustainability.
- Examine the feasibility of regional strategies and partnerships with surrounding counties.

- Conduct surveys of local consumers and stakeholders.
- Provide overall recommendations for crisis intervention services.

TPG conducted system-wide analysis of the Lebanon County crisis intervention services system which included the challenges with recruitment and retention of staff, the sustainability of funding, the promotion of community education, reduction of emergency department encounters with the continued development of mobile crisis services, and the diversion of individuals from acute hospitalization.

The resulting development of the Crisis System Dynamic Enhancement Plan (Enhancement Plan) as contained in the remainder of this document fulfills the requirements outlined in the RFP. The Enhancement Plan provides Lebanon County leaders a comprehensive outline for continued evaluation of the crisis intervention system with strategic recommendations measured against national best-practice benchmarks. In addition, the specific recommendations that are aligned with national guidance provides a framework for further program innovation.

### **Lebanon County Pennsylvania**

Lebanon County, Pennsylvania has 361.8 square miles of land area and is the 60th largest county in Pennsylvania by total area. Lebanon County is bordered by Lancaster County, Schuylkill County, Dauphin County, and Berks County, and is approximately 30 miles from the State Capital in Harrisburg.

Lebanon County, a rural, 5th-Class Pennsylvania County (comparable to Adams, Blair, Lawrence Lycoming, Mercer and Northumberland with populations between 90,000 and 144,999), is currently encountering a steady influx of individuals from outside the County seeking employment within the County. Housing capacity and language barriers present challenges to the behavioral health service system.

Furthermore, emerging from the public health emergency (COVID-19) individuals living below the poverty line, as well as those who may also not have health care coverage create elevated conditions for crisis events.

Using the data results from the National Survey on Drug Use and Health (NSDUH) for measurement years 2016 through 2018 we can reasonably infer the following estimations of scale:

- An estimated 27,000 individuals in Lebanon County have mental illness.
- Many of those (approximately 24,000) would have received treatment of some kind.
- An estimated 6,600 individuals have had serious thoughts of suicide.
- An estimated 6,400 individuals have had alcohol use disorders
- And, an estimated 8,700 have had substance use disorders.

Lebanon County Crisis Intervention Services, for state fiscal year (SFY) from July 2023 – June 2024 served 2,756 unduplicated individuals averaging 320 individuals per month.

Early indicators are showing an increase in the average individuals served per month to be 346 for SFY2024-2025.

While services trends are growing slightly overall, there is an increase in County Funded individuals (i.e. not Medicaid funded under the Behavioral HealthChoices Program), while Behavioral HealthChoices utilization has remained relatively flat. This condition has placed an added burden on MH/ID/EI to address the shift in funding mix.

## Methodology

### Field Work and Analysis Period

Project orientation and goal setting was conducted at the commencement of the project with the majority of the field work (as described in the sections below) being conducted from approximately January 2024 through December 2024. The observations and recommendations provided in this report have been made based on analysis of the field work conducted from January 2025 through June 2025.

Research in the development of the Enhancement Plan employed a mixed-methods approach to investigate the Lebanon County crisis intervention service system. Quantitative data was collected and examined from financial and utilization data reports as well as applied assessment scores for measured criteria used in the management of crisis intervention services.

Qualitative data was gathered through semi-structured interviews with a host of community leaders and stakeholders (See Appendix 1- Crisis System Dynamic Enhancement Plan Contributors / Stakeholders) to gain a deeper understanding of their personal experiences and professional guidance. Qualitative data results were analyzed using thematic analysis to identify common patterns.

The combination of data analysis methods was chosen because it provided a comprehensive perspective, with the quantitative component offering generalizable results and the qualitative component offering rich contextual insights.

### Project Management Method

The methods used by TPG in the production of the Enhancement Plan were based on the methods contained in A Guide to the Project Management Body of Knowledge (PMBOK® Guide) – Seventh Edition, published by the

Project Management Institute (PMI). The PMBOK guide is based upon The Standard for Project Management – a standard approved by the American National Standards Institute (ANSI). PMBOK knowledge areas were customized to meet the specific needs of the Enhancement Plan.

## **Stakeholders / Consumers**

TPG conducted interviews with over 95 stakeholders throughout the crisis intervention services system to elicit responses and perspective through a “question and answer” format. Simply stated, the primary question of each stakeholder was “from your perspective, what is working, and what is not?” A follow-up question then asked for input of what each stakeholder felt the optimal local system would look like, and what challenges are you facing in pursuit of the optimal?

Stakeholders and Consumers were constructive and candid, generously sharing their perspectives and recommendations for system improvement.

## **Regulatory Materials and National Guidance**

The National Guidelines for Behavioral Health Crisis Care (Best Practices Toolkit) published by SAMHSA in 2020, and the updated National Guidelines for a Behavioral Health Coordinated System of Care in 2025 were used as the basis of research. In addition, the Roadmap to the Ideal Crisis System; Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response; published by the National Council for Behavioral Health in 2021 provided detailed guidelines, measured criteria definitions, and a report card format that was incorporated to establish a baseline measure for the local crisis intervention system as compared to optimal guidelines.

Other local guidance was taken from the following:

- System Analysis and Recommendations to Reduce Psychiatric Boarding and to Support Persons in Emergency Departments; A Whitepaper prepared by the Emergency Department Boarding Workgroup (October 2023)
- Report of Findings and Recommendations; Comprehensive Behavioral Health Task Force; A guide for counties seeking alternatives to incarcerating mentally ill and substance abusing offenders. County Commissioner’s Association of Pennsylvania; (August 2016). Also referenced was the Year One Implementation Report (August 2017).

## **Examination / Analysis Methods**

A variety of examination methods were employed to elicit stakeholder input and to compile a comprehensive profile of current and potential crisis intervention system conditions. The examination / analysis methods used included:

- SWOT / Gap Analysis to identify current conditions.
- Tabletop Exercises to assess emergency department workflows.
- Themes (data model summaries) were created to categorize responses.
- Law enforcement survey was conducted to elicit input from county police departments.
- Measurable criteria were scored to assess condition and establish prioritization.
- Analysis of current operating budgets and service utilization, identifying sustainability.
- Examination of regional / state-wide environmental factors and lessons learned.

## Development of Recommendations and Plans

Throughout the field work and analysis conducted from approximately January 2024 through June 2025 for the development of the Enhancement Plan, TPG consultants compiled source documentation and project notes that have been referenced and summarized to draw clear observations, highlighting conditions and constraints, and forming recommendations to build a comprehensive strategic plan that will provide guidance for Lebanon County program managers.

## Limitations to Analysis

The Enhancement Plan project was made possible through the financial support of Lebanon County MH/ID/EI, who provided funding through the Community Mental Health Services Block Grant, American Rescue Plan Act (ARPA) of 2021. MH/ID/EI staff, as project sponsors, provided guidance and responded to TPG questions for clarification throughout the project. TPG consultants maintained full control over all aspects of the investigation, including the framing of the research questions, the development of the survey instruments, and the selection of analytical methods. MH/ID/EI Project Sponsors placed no limitations on the design and execution of the project consulting engagement.

## Overview of Existing Crisis Intervention System

### System Partners / Ecosystem

An optimal behavioral health crisis intervention system is a necessary community service, just like police, fire, and emergency medical services (EMS). Lebanon County is to be commended on their desire to identify what an optimal behavioral health crisis intervention system looks like, and to build towards that model with all the resources available to meet the needs of its citizens. While “optimal” is the goal, there are very real

limitations facing a small, rural Pennsylvania County like Lebanon County.

A behavioral health crisis system is part of the much larger ecosystem of community health care and human services, cutting across many governmental bodies and jurisdictions, and in all categories of life (culture, income levels, education, etc.). It is more than just a single program. Rather it is a dynamic organized set of structures, processes, and services that must work together to meet all types of urgent and emergent crises quickly, safely, and successfully.

## System Strengths and Accomplishments

Lebanon County MH/ID/EI has developed a number of early system accomplishments that form a foundation for continued growth and innovation. The Enhancement Plan outlines the following accomplishments:

- Expanded Crisis Intervention Staffing
- Improved Location for Crisis Walk-in and Mobile Crisis Services
- Improved Community Awareness / Culture with a Community Liaison
- Implemented the use of Certified Peer Specialists
- Crisis System Coordination – Establishment of the Mobile Crisis Collaboration Team
- Community Relationship Building with System Partners
- Development of Crisis System Dynamic Enhancement Plan
- Implementation of Communication Technology
- Performed an Operation Framework Assessment, using the National Council’s Roadmap
- Used Steps for Communities, System Leaders, and Advocates as benchmark measures

## Structure of the Enhancement Plan

The Crisis System Dynamic Enhancement Plan (Enhancement Plan) is organized using the following outline:

- Each section will outline the environmental conditions impacting the respective area of analysis and then cite applicable National Guideline references as taken from the National Council Roadmap, showing the section and page of the reference.
- Observations are provided from the field work and analysis conducted during development of the Enhancement Plan, and where applicable are cross-referenced with scoring categories from the Roadmap Report Card.
- Finally, each section closes with detailed recommendations for action or consideration by the Lebanon County Office of MH/ID/EI and their collaborative stakeholder partners.

The Enhancement Plan provides detailed observations and recommendations for each of the following analysis areas for continued growth and development (7 analysis areas):

1. Funding Strategies – The constraints of limited resources require heightened attention and collaboration of those involved. The practical solution is in how the process is managed, the accountability and collaboration of the stakeholders, and a persistently optimistic mindset. While more funding is an answer, it is not the only answer necessary to drive system improvement.
2. Accountable Entity Strategic Planning – The development of a Crisis System Dynamic Enhancement Plan (Enhancement Plan) for Lebanon County marks a significant action step by MH/ID/EI to develop the County crisis intervention system and establish a baseline assessment of crisis services.
3. Mobile Crisis Collaboration Team (MCCT) – Aligned with previous recommendations to perform ongoing evaluation using the baseline assessment in the Enhancement Plan, expansion and continued development of the MCCT will improve system-wide coordination. Recommendations and areas of further investigation are provided as an outline for MCCT consideration.
4. Mapping Workflows – The current crisis intervention system of care is not fully documented with clearly defined workflow maps showing action steps, decision points, resulting actions, and participants in the service delivery system, and descriptions of roles and responsibilities. Establishing a process map for each of the respective parts of the crisis intervention service delivery system will aid MH/ID/EI and other key stakeholders to better understand the workflow of action steps involved in serving an individual who needs crisis intervention services.
5. Law Enforcement Engagement – Recommendations outline the need for improved overall system coordination. Law enforcement is very closely aligned with crisis intervention services and may be the most significant and impactful partner with WellSpan Philhaven staff in the delivery of crisis intervention services. Focus should be given to promote the concept that the police must be viewed as “priority customers” to the crisis intervention system.
6. School District Engagement – Crisis intervention services should continue to reach out to the local school districts to leverage the capabilities and resources of both systems to develop effective forms of community education and family support. Efforts in this area will facilitate greater communication and

planning on ways to develop and implement preventative services.

7. Information Systems and Technology – Development of an integrated data repository for crisis intervention services, built upon the current capabilities (i.e. data elements and infrastructure) of the existing systems. At the most basic level, the establishment of a data platform (infrastructure, database, and business intelligence) to contain a crisis system data warehouse is achievable.

## Conclusion

Lebanon County's investment in a comprehensive Crisis System Dynamic Enhancement Plan reflects a clear commitment to strengthening the behavioral health safety net for its residents. The findings of this report show a system with meaningful early accomplishments, dedicated partners, and a strong foundation from which to grow, while also highlighting the operational, financial, and workforce challenges that must be addressed to meet rising community needs.

The recommendations presented throughout the plan offer a structured path forward—one grounded in national best practices, informed by extensive stakeholder input, and tailored to the realities of a rural county navigating rapid change.

Success from this point forward will depend on steady collaboration, transparent communication, and a shared willingness among County leadership, providers, law enforcement, schools, and community organizations to align around common priorities. By approaching implementation with discipline and maintaining a data-informed mindset, Lebanon County can not only enhance crisis response capabilities but also strengthen prevention, reduce avoidable emergency encounters, and improve overall continuity of care.

With focused effort and sustained partnership, the County is well-positioned to build a more responsive, resilient, and person-centered crisis intervention system that meets the needs of its residents today and in the years ahead.

As a society, we do not view behavioral health crisis services as an essential community service, as we view police, fire, emergency medical services (EMS) and emergency medical care. Historically, the problems of people with mental illnesses, substance use disorders and cognitive disabilities (e.g., acquired brain injury) were not the responsibility of the community. Those were things that happened to “other people.” “Someone else” funds these services. Fortunately, as noted above, society is beginning to recognize that behavioral health crises are common and can happen to anyone – to any individual or family – just like crime, fire, flood and emergency medical events. Communities are further recognizing that failure to respond properly to these crises is dramatic in its personal, social and economic cost, resulting in incarceration, devastation, homelessness and death. As a society, therefore, our collective perspective is changing about how behavioral health crisis services should be prioritized. An excellent behavioral health crisis system is an essential community service, just like police, fire and EMS. Every community should expect a highly effective behavioral health crisis response system to meet the needs of its population, just as it expects for other essential community services. *Source: National Council for Behavioral Health, Roadmap to the Ideal Crisis System, page 13*

# INTRODUCTION

- ◆ Lebanon County Statistics
- ◆ Regional Statistics
- ◆ Data Assumptions
- ◆ Overcoming Collaboration Challenges
- ◆ Optimistic View



## Introduction

Lebanon County Mental Health / Intellectual Disabilities / Early Intervention (MH/ID/EI) was awarded funds through the Community Mental Health Services Block Grant, American Rescue Plan Act (ARPA) of 2021 to support community-based crisis services on December 12, 2022.

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## Lebanon County Statistics

Lebanon County, Pennsylvania has 361.8 square miles of land area and is the 60th largest county in Pennsylvania by total area. Lebanon County is bordered by Lancaster County, Schuylkill County, Dauphin County, and Berks County, and is approximately 30 miles from the State Capital in Harrisburg.

The United States Census Bureau report estimated population of Lebanon County is 145,319 as of July 2024, up from 143,257 in April 2020, an increase of 2,062, or 1.4%. Roughly 14.9% of the language spoken at home is other than English, and 5.1% of the population are foreign-born. Movement of new individuals from a different state into Lebanon County is trending at approximately 1.0% during calendar year 2023. Median household income is \$78,824 with 7.5% of County residents living in poverty. Housing capacity remains a challenge with median gross rental values at \$1,186 with only about 0.5% of the housing stock vacant (59,084 total housing units with 55,808 occupied; 3,276 vacant as of the 2020 Decennial Census).

Lebanon County shows that 9.2% of the population lives without health care coverage, higher than the State level of 5.4%<sup>(1)</sup>

Lebanon County, a rural, 5<sup>th</sup>-Class Pennsylvania County (comparable to Adams, Blair, Lawrence Lycoming, Mercer and Northumberland with populations between 90,000 and 144,999), is currently encountering a steady influx of individuals from outside the County seeking employment within the County. Housing capacity and language barriers present challenges to the behavioral health service system. Furthermore, emerging from the public health emergency (COVID-19) individuals living below the poverty line, as well as those who may also not have health care coverage create elevated conditions for crisis events.

## Regional Statistics

The Pennsylvania Behavioral Health Commission noted in their special report released in October 2022 that adults with any mental illness (AMI) has been increasing in recent years and nearly 34% of Pennsylvanians have a mental illness or substance use disorder, above the national average of 31%. The Commission identified the need to stabilize and expand the workforce, improve the criminal justice and public safety systems, and expand the capacity for services and supports as their top 3 priorities. These three priorities also specifically impact the service delivery system in Lebanon County for crisis intervention and behavioral health services.<sup>(2)</sup>

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

The National Survey on Drug Use and Health (NSDUH), conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides nationally representative data on the use of tobacco, alcohol, and drugs; substance use disorders; mental health issues; and receipt of substance use and mental health treatment among the civilian, noninstitutionalized population aged 12 or older in the United States.

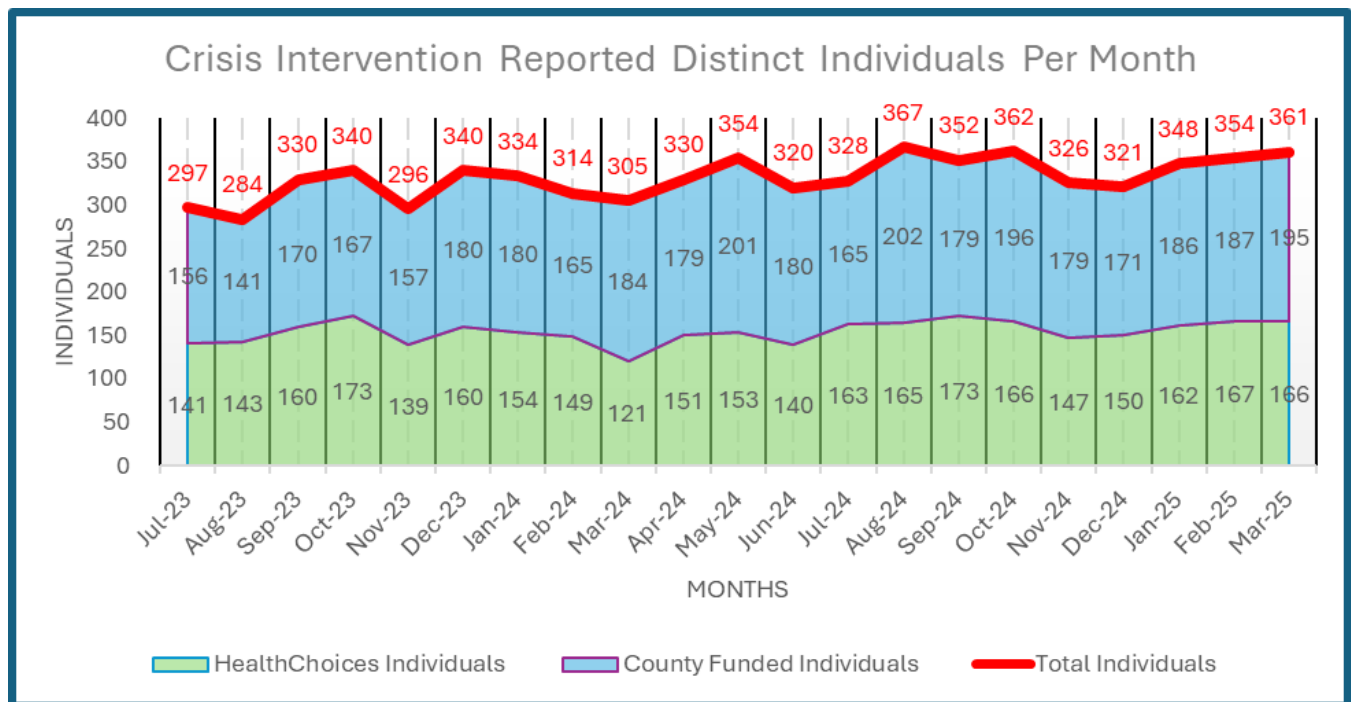
NSDUH provides Substate data which show results for county regions within Pennsylvania. The data measures provided in the table below are for Lebanon, Dauphin, Lancaster, Adams and York Counties for the measurement years 2016, 2017, and 2018. As of the release of this report, SAMHSA has not yet published substate data for the combined years from 2021 to 2023 which are expected to be released in 2025.<sup>(3)</sup>

## Data Assumptions

Using the data results from the NSDUH for measurement years 2016 through 2018 we can reasonably infer the following estimations of scale:

- An estimated 27,000 individuals in Lebanon County have mental illness.
- Many of those (approximately 24,000) would have received treatment of some kind.
- An estimated 6,600 individuals have had serious thoughts of suicide.
- An estimated 6,400 individuals have had alcohol use disorders
- And, an estimated 8,700 have had substance use disorders.

The estimated measures provided above set the background conditions contributing to the current levels of utilization of Crisis Intervention Services.



# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

Lebanon County Crisis Intervention Services, for state fiscal year (SFY) from July 2023 – June 2024 served 2,756 unduplicated individuals averaging 320 individuals per month.

- Early indicators are showing an increase in the average individuals served per month to be 346 for SFY2024-2025.
- While services trends are growing slightly overall, there is an increase in County Funded individuals (i.e. not Medicaid funded under the Behavioral HealthChoices Program), while Behavioral HealthChoices utilization has remained relatively flat. This condition has placed an added burden on MH/ID/EI to address the shift in funding mix.

Utilization patterns are directly impacted by local conditions. Currently there is simply not enough community capacity for housing and community based behavioral health services available as a resource for diversion or discharge from crisis intervention events.

- The resource shortage then places a compounded burden on the mental health, substance abuse, and crisis intervention staff to find emergent solutions.
- The issue is further compounded by placing a broader burden on the local criminal justice system, local police departments, and local school systems.

## Overcoming Collaboration Challenges

The challenge to Lebanon County is to develop optimal crisis intervention services as part of the overall behavioral health system. While there appear to be no quick or easy solutions, the County MH/ID/EI leaders have assembled the Mobile Crisis Collaboration Team (MCCT) as the administrative body to assess and develop the County crisis intervention system.

Lebanon County's regional 988 call center is administered by the Lancaster County Crisis Intervention Office as the regional call center for Lebanon County, and the 717 and 223 area codes. Lebanon County MH/ID/EI coordinated a meeting in November 2023 to create an operational agreement through a memorandum of understanding between the Lancaster County Office of Behavioral Health / Developmental Services (LCBH/DS) and the Lebanon County Department of Emergency Services (LCDES) to define and clarify the processes and responsibilities of each agency to manage 988 calls.

As an outcome of this first meeting, Lebanon County MH/ID/EI, Lebanon County Crisis Intervention (operated by subcontract with WellSpan), and the Lebanon County DES continued to meet to identify developmental needs for coordinated crisis intervention services. Their initial goal was to establish Lebanon County Crisis Intervention as a dispatchable entity, either alongside first responders or independently as a mental health first responder. Currently, Lebanon County Crisis Intervention (LCCI) is dispatched at the request of the 911 caller or first responder on the scene.

The MCCT has continued to meet as a coordinated body regularly, at a minimum of every 3 months and has incorporated local law enforcement and emergency medical services / ambulance to join in the collaboration and planning. Expansion plans for future meetings will include participants from the local school systems within Lebanon County.

Lebanon County MH/ID/EI understands that building collaborative systems necessitates government and community partners to build and maintain effective cooperative relationships to continually assess need, and to actively participate in creative solutions.

## Optimistic View

We have approached the identified findings and recommendations in this strategic plan using a “yes / if” mindset. The mindset was used by Walt Disney to drive his visionary development of Walt Disney World. The yes/if mindset embraces that “yes, things are possible, if conditions are right”. It is proactive, optimistically focusing on opportunities, and how to overcome obstacles. By contrast, a “no/because” mindset is a deal killer, limiting possibilities and stifling creativity.

We have also incorporated a forward-looking 5-year window for our recommendations. Our hope is that when some recommendations may not be feasible now or within a year or two, this report will serve as a strategic plan to base development should some of the current constraints (such as financial resources) find a remedy within the 5-year window.

We believe this report will afford Lebanon County Leaders the ability to strategically and optimistically identify what program design changes are possible in a systematic manner, stretching for the best options available, and pushing all stakeholders toward innovative alternatives.

# METHODOLOGY

- ◆ Field Work and Analysis Period
- ◆ Project Management Method
- ◆ Identify Stakeholders
- ◆ Stakeholder Interviews
- ◆ Consumer Interviews
- ◆ Regulatory Materials and National Guidance
- ◆ SWOT / Gap Analysis
- ◆ Themes (Data Model)
- ◆ Tabletop Exercise
- ◆ Law Enforcement Survey
- ◆ Roadmap to the Ideal Crisis System—Measurable Criteria
- ◆ Analysis of Current Budget and Utilization
- ◆ Examination of Regional / State-Wide Environmental Factors
- ◆ Development of Recommendations and Plans
- ◆ Limitations to Analysis



## Methodology

### Field Work and Analysis Period

Project orientation and goal setting was conducted at the commencement of the project with the majority of the field work (as described in the sections below) being conducted from approximately January 2024 through December 2024. The observations and recommendations provided in this report have been made based on analysis of the field work conducted from January 2025 through June 2025.

Throughout the field work and analysis phases of the Enhancement Plan project, Lebanon County MH/ID/EI had already begun implementing several significant crisis intervention system structural and operational improvements. We will highlight where appropriate that observations and recommendations made in this report are already being addressed by initiatives currently being implemented by Lebanon County MH/ID/EI.

### Project Management Method

The methods used by TPG in the production of MH/ID/EI's Crisis System Dynamic Enhancement Plan (referenced later in this document as Enhancement Plan) Project were based on the methods contained in A Guide to the Project Management Body of Knowledge (PMBOK® Guide) – Seventh Edition, published by the Project Management Institute (PMI). The PMBOK guide is based upon The Standard for Project Management – a standard approved by the American National Standards Institute (ANSI). PMBOK knowledge areas were customized to meet the specific needs of the Enhancement Plan.

MH/ID/EI's over-arching goal was to assess the condition of and improve / create value in the current crisis intervention system. The system must meet the needs of people in need, those delivering services, and community responders and stakeholders. The crisis intervention system must be efficient, effective and responsive. It must also be able to accommodate changes needed to support growth.

### Identify Stakeholders

The first task was to identify key stakeholders related to the Enhancement Plan. MH/ID/EI Project Sponsors included Holly A. Leahy, Administrator, and Melissa Herr, Deputy Administrator and Commitment Coordinator, and Kasey E. Felty, Director of Mental Health Services. Throughout the life cycle of the Enhancement Plan Holly and her team provided instruction to guide TPG Consultants on orientation to the current ("as-is") crisis system. As well, they identified a broad list of county and community stakeholders for us to gather their perspectives and recommendations about the existing crisis system.

TPG established routine update meetings on a bi-weekly basis to maintain communication of Enhancement Plan status, and to address questions and seek guidance or approval. Once the Enhancement Plan Stakeholder Register was compiled and reviewed by MH/ID/EI Project Sponsors, TPG Consultants were given the freedom to establish interviews with a significant number of community stakeholders / subject matter experts (SMEs). [See Appendix 1 – Crisis System Dynamic Enhancement Plan Contributors / Stakeholders.](#)

## Stakeholder Interviews

TPG conducted interviews with over 95 stakeholders representing the expertise and valuable input from:

- County MH/ID/EI Project Sponsors
- County Officials from Human Services
- Criminal Justice and the Courts
- WellSpan Philhaven Crisis Intervention
- WellSpan Good Samaritan Hospital
- Community Mental Health and Substance Abuse Providers
- Municipal Police Departments
- County School Districts
- Other Community Social Service Providers, and
- Expert program leaders from the Behavioral HealthChoices Managed Care Program.

Interviews were designed to elicit responses and perspective from each stakeholder through a “question and answer” format. The questions we discussed with each stakeholder followed the outline of the questions provided below:

- What is your / your agency’s level of involvement with the Lebanon County Crisis Intervention System?
- From your perspective, what is working or not working? (System successes or challenges).
- What would the “Optimal” Crisis Intervention System look like? (needs; desires?).
- What do you see as possible or practical? (given known constraints).
- What are some of the unique challenges (barriers) or victories you see?
- What do you feel we should know about or focus on for further examination?

Interviewed stakeholders were all very generous with their impressions of the current (“as-is”) Crisis System. They also were very candid in their identification of challenges and barriers they see with the current system. They were equally generous with their recommendations for ways the system can be improved or enhanced to promote quality and efficiency. Along these lines nearly all of the stakeholder respondents identified that the changes being made to the Crisis Intervention System have made a marked improvement overall.

Stakeholders’ responses from each of the interview sessions were kept confidential, with their recommendations de-identified to allow them the fullest freedom to be un-inhibited and candid in their responses. We found all of the input, even where criticisms were voiced, to be constructive, in an effort to help us compile a full profile of both strengths and weaknesses. The weight of the stakeholders input was invaluable to the findings and recommendations provided in this strategic plan.

## Consumer Interviews

Collection of comments and perspective from crisis intervention users of service was a requirement of the Enhancement Plan Sponsors. TPG conducted 3 consumer groups through the Community Services Group, Psychiatric Rehabilitation Program location. We also created a very short consumer survey distributed by the Lebanon County Christian Ministries. While the participation / response rate was very small, the information shared by the group participants (who were users of crisis intervention services) was favorable. A notable comment from one consumer was, "...having the crisis location outside, next to the hospital has really helped out. When walking around, and I feel I need to talk to someone, I know I can pop in. Nothing negative to say."

## Regulatory Materials and National Guidance

Early in the Enhancement Plan life cycle, TPG reviewed industry literature to establish a framework for mapping and aligning the stakeholder responses we collected with National, State, and County standards. We also wanted to assure that we were incorporating, as broadly as possible, published guidance to any conclusions drawn from our analysis.

We provide a listing of foundational documents used for reference in the field work, analysis, and goal alignment conducted throughout the Enhancement Plan:

- The National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit; produced for the Substance Abuse and Mental Health Services Administration (SAMHSA). (2020)
- 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care; produced for the Substance Abuse and Mental Health Services Administration (SAMHSA). (2025)
- National Guidelines for Child and Youth Behavioral Health Crisis Care; produced for the Substance Abuse and Mental Health Services Administration (SAMHSA). (2022)
- Roadmap to the Ideal Crisis System; Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response; published by the National Council for Behavioral Health (March 2021).
- Department of Justice and Department of Health & Human Services Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities. U.S. Department of Justice (May 2023)
- System Analysis and Recommendations to Reduce Psychiatric Boarding and to Support Persons in Emergency Departments; A Whitepaper prepared by the Emergency Department Boarding Workgroup (October 2023)
- Report of Findings and Recommendations; Comprehensive Behavioral Health Task Force; A guide for counties seeking alternatives to incarcerating mentally ill and substance abusing offenders. County Commissioner's Association of Pennsylvania; (August 2016). Also referenced was the Year One Implementation Report (August 2017).
- Lebanon County Human Services Plan for FY23-24, and FY24-25.
- Lebanon County Criminal Justice Advisory Board (LCCJAB); Strategic Plan for 2024-2025.

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

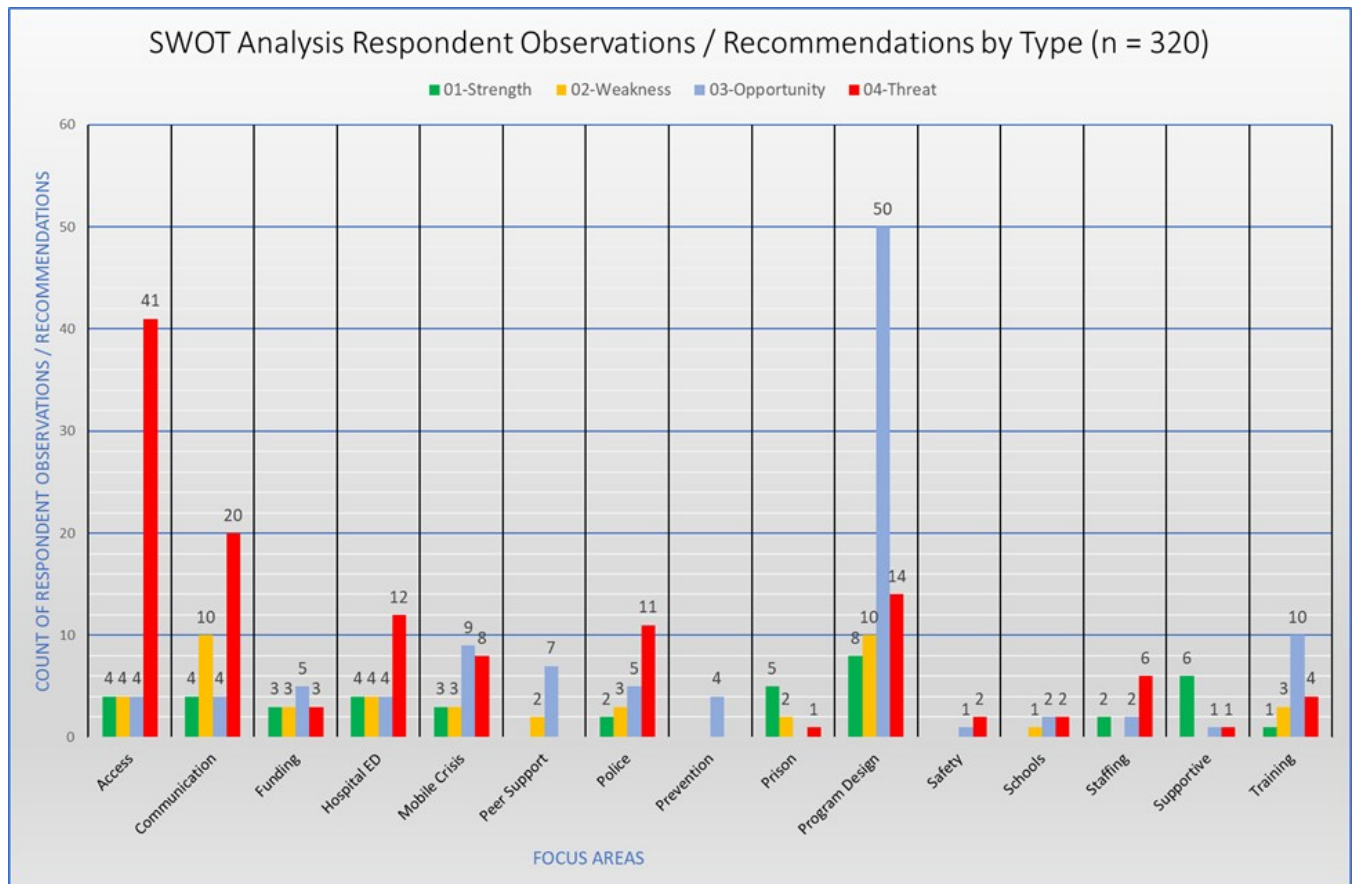
- Lebanon County Intermediate Punishment Treatment Program; Plan for 2024-2025.

Another source of guidance used to build the framework for mapping our collected data to national standards came from information gathered from the presenters at the Behavioral Health Crisis Planning Symposium (held on September 14, 2023), offered by the Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) in partnership with Temple University Harrisburg. The Symposium highlighted best-practice crisis modalities operating in other states. The panel, including Dr. Margie Balfour, Chief of Quality & Clinical Innovation at Connections Health Solution, provided a wealth of expert guidance.

## SWOT / Gap Analysis

Once a significant number of key stakeholders had been interviewed, TPG compiled a strengths and weaknesses, and opportunities and threats (SWOT) analysis on the responses to provide the Enhancement Plan Sponsors with an interim report as of December 2023.

Early findings from the preliminary Enhancement Plan stakeholder respondents showed that perceptions on system strengths and weaknesses varied widely. TPG reviewed the responses with the Enhancement Plan Sponsors who identified that the perceptions of some of the respondents were not accurate or did not align with crisis data. What became clear was a communication disconnect between parts of the overall system, and areas for coordination improvements.



Strongly held opinions expressed by County Managers, WellSpan Philhaven Staff, WellSpan Good Samaritan Hospital Emergency Department (ED) Staff, HealthChoices Program Administration and PerformCare and sample of community providers identified challenges and a system experiencing the pains of growth and change from past culture and conditions.

In general, the opinions and perceptions of core system stakeholders are that crisis intervention service delivery (historically) had been provided within the ED. This caused challenges coordinating care between the ED staff, WellSpan Philhaven crisis intervention staff, the patient and their families. These conditions were known to MH/ID/EI and were some of the root causes that prompted the implementation of Mobile Crisis and the establishment of a new location for the Crisis Walk-In Center, as well as the implementation of Peer Supports. The service delivery changes were the results of HealthChoices Reinvestment Projects already approved and underway at the start of the Enhancement Plan.

So, the SWOT analysis documented the conditions or root causes of past and current operational coordination weaknesses and reinforced the actions already underway by MH/ID/EI to improve the overall process.

Focus areas emerged during the SWOT analysis as displayed in the data graphic on count of respondent observations / recommendations by type. At the time the SWOT analysis was conducted there were 320 total observations / recommendations made by the stakeholders interviewed.

It was apparent at this point of analysis that stakeholders identified service access as a clear threat, along with communication issues between parts of the crisis intervention system. It is no surprise that access to community treatment persists in the recent post-pandemic years. By talking with the ED, we were made aware of operational issues due to staffing, the implementation of Behavioral Health Therapists (BHT), along with some concern for coordination and safety issues.

Conversely, optimism was very high with many highlighting opportunities that either are already being pursued in mobile crisis and peer support, or for improved coordination between parts of the crisis intervention continuum, improved communication, and exploring additional programmatic development.

Enhancement Plan Sponsors reviewed the submitted interim report from TPG and requested further elaboration and clarification on the SWOT report stakeholder observations. TPG provided a follow-up report to address the questions raised by Sponsors in March 2024. (Responses provided below were from 2023. WellSpan is currently working on issues identified) The summarized responses included:

## WellSpan Good Samaritan Hospital Emergency Department (ED)

- ED staff reported that when a person with a mental health crisis lingers in the ED, they often see an increase in behaviors which takes time away from other patients. They described crisis and the ED as a “catch all service” (citing illustrations).
- They also expressed frustration and the feeling of being overwhelmed. [in treating a crisis event].
- They reported that once a care decision is made, the Behavioral Health Therapists (BHT) are no longer involved in treatment.

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

- They described that ED physicians are managing medications, not a psychiatrist, and existing community providers (if known) are not involved / included while awaiting treatment. These connections would be helpful while boarding.
- They feel the ED can be unsafe at times and security is hesitant to get involved. The resulting condition is that clinical staff are expected to manage difficult situations and the BERT response. They did say that there is de-escalation training offered. Emergency Department and Security staff could benefit from Trauma Informed Care training and become a Trauma Informed ED.
- They talked about people in crisis who know what to say to get admitted when they need a place to sleep or food to eat.

They wished there were some educational materials for community resources available as well as therapeutic games / activities for people while awaiting a placement.

## WellSpan Philhaven (Lebanon County Crisis Intervention Services provider)

Philhaven and ED staff had differing opinions of the roles and responsibilities of Crisis Intervention and BHTs regarding the following:

- Bed search responsibility.
- Pre-certification for inpatient
- Transportation coordination
- Services offered when the person “boards” in the ED.
- How existing community resources are incorporated during boarding – if known?
- Behavioral Emergency Response Team (BERT) roles?
- Unclear of how WellSpan physical health patients are moved through the WellSpan system.

Subsequent to the SWOT analysis and follow-up, TPG continued to broaden the stakeholder list to additional community providers, local law enforcement, local school districts, and key state-wide experts in behavioral health within the HealthChoices Behavioral Health Program. The questions remained the same to see what is working or not working. TPG examined other current studies conducted within the State of Pennsylvania to compare findings and recommendations. With the additional stakeholder / subject matter expert input, the focus areas identified in the SWOT analysis grew into a broader set of themes that have been used to categorize our final findings and recommendations.

## Themes (Data Model)

Interview results conducted during the field-work phases of the Enhancement Plan, including stakeholder recommendations, and additional data analysis model results at the conclusion of the SWOT Analysis were mapped into summarized categories, and then further into overarching themes. With an abundance of stakeholder content and data, it was a challenge to align the results with the published National Guidelines and Strategic Plans (referenced above) in a way that was easily usable to provide meaningful guidance to the users of this CIS Strategic Plan.

## Tabletop Exercise

Questions regarding workflow processes in the WellSpan Good Samaritan Hospital Emergency Department (ED) prompted TPG to recommend conducting a Table-Top Exercise with the ED and Well Span Philhaven (WSP) staff to examine how several specific examples of sample cases would be handled as they move through the crisis intervention and emergency department systems. [See Appendix 2 – Table-Top Exercise](#)

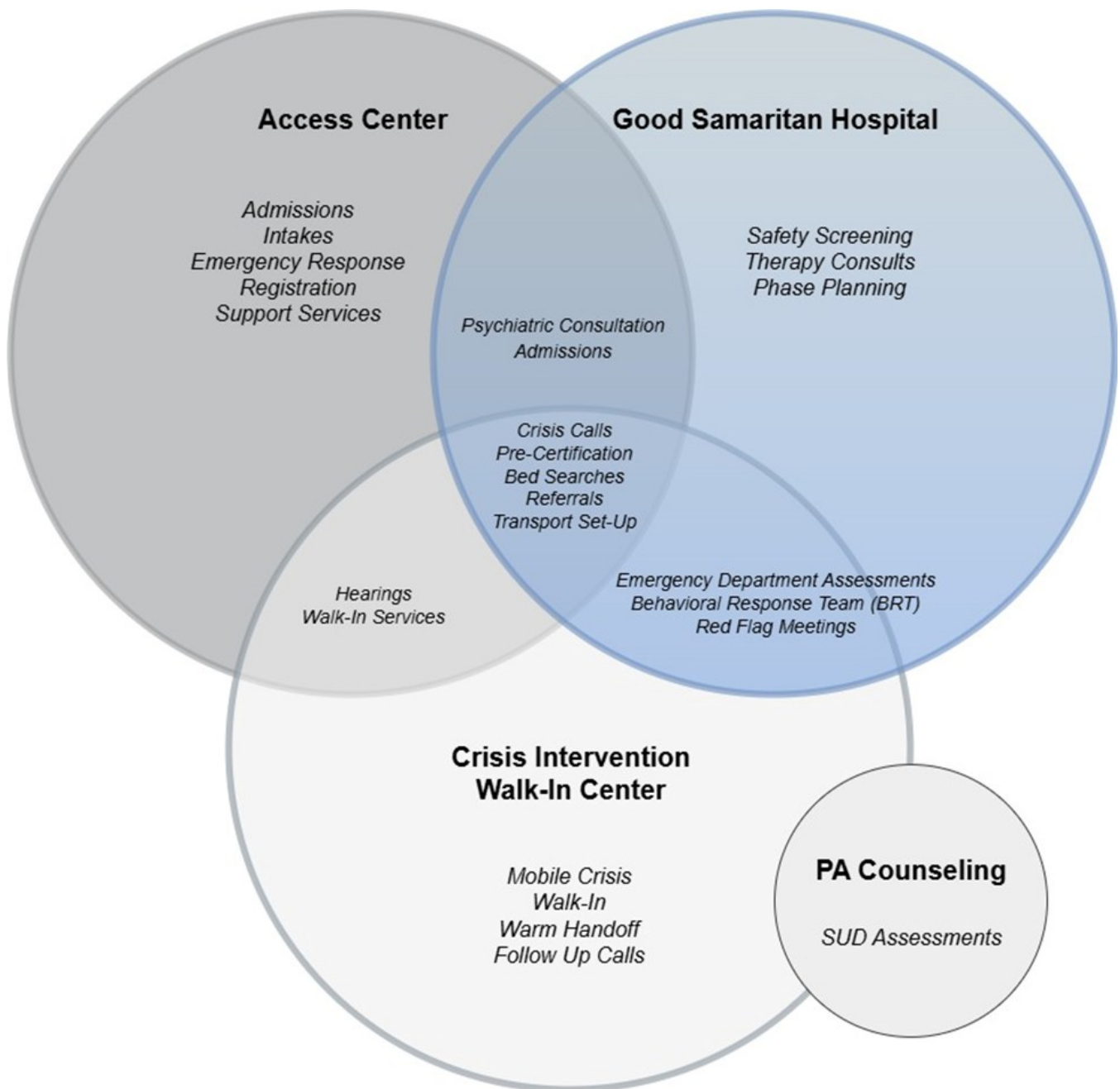
Lebanon County MH/ID/EI (Enhancement Plan Sponsors) along with TPG Consultants met with Senior Leadership of WellSpan Philhaven (WSP) and WellSpan Good Samaritan Hospital Emergency Department (ED) and reviewed the current workflow process provided by ED, and walked through each of the 4 Table-Top Exercise Scenarios. Each scenario was designed to highlight particular challenges

Several issues of interest were highlighted in the discussion:

- WellSpan Philhaven's ability to bill for services rendered in the ED; working through issues with Capital Area Behavioral Health Collaborative (CABHC) and PerformCare to utilize the appropriate codes to bill HealthChoices or Commercial Payers for these services in the ED. (*\*At the time of the release of this report, the billing of HealthChoices has been resolved. Commercial Payers have not.*)
- For substance use disorder, WSP Crisis Counselors provide warm handoff to community treatment when the Service Coordination Agency's (SCA) vendor is unavailable. WellSpan Philhaven (WSP) discussed exploring the benefit to have staff receive American Society of Addiction Medicine (ASAM) training and become certified. WSP will be working with the local SCA, Lebanon County Commission on Drug & Alcohol Abuse, to discuss how WSP can become ASAM Certified. Having WSP be certified to provide ASAM assessments would streamline workflow.
- The ability to have continuity for Psychiatric Consultation in the ED.
- The ability to become Trauma-Informed Certified in the ED.

As part of the table-top exercise, WSP provided a diagram that shows the organizational structure and interrelatedness of Crisis Intervention Staff in the WellSpan network, and the service each area provides.

*See WSP organizational diagram on the following page.*



## Law Enforcement Survey

In May 2024, TPG developed a survey to request responses from each of the municipal police departments in Lebanon County. The survey was intended to be very brief to not be a time burden on the officers. The purpose of the survey was to collect information to assess the degree of time and effort placed upon the officers who must respond to calls that may involve crisis intervention.

The survey was endorsed and supported by both Holly A. Leahy, Administrator, Lebanon County MH/ID/EI, and Pier Hess-Graf, Lebanon County District Attorney. The initial notice was provided on May 28, 2024, with additional reminders sent in the subsequent weeks, the last of which was on June 14, 2024, to the following police departments:

- Annville Township Police Department
- Cleona Borough Police Department
- Cornwall Borough Police Department
- Fort Indiantown Gap Police Department
- Lebanon City Police Department
- Millcreek Township Police Department
- North Cornwall Township Police Department
- North Lebanon Township Police Department
- North Londonderry Township Police Department
- Palmyra Borough Police Department
- South Annville Township Police Department
- South Lebanon Township Police Department
- South Londonderry Township Police Department
- Pennsylvania State Police

At the time of the survey, the Pennsylvania Department of Community & Economic Development, Municipal Statistics reported 114 full time police officers in Lebanon County. Participation in the survey was 18 respondents, or 13.8%.<sup>(4)</sup>

Based on the survey respondents, police are responding to crisis intervention calls an average of 1 to 3 times per week. These calls appear to be evenly distributed in supporting or meeting crisis staff on location and assessing and serving 302 involuntary commitments. Most telling were the responses related to Crisis Intervention Training (CIT), and Mental Health First Aid Training (MHFA). Only approximately 50% of the respondents indicated that they have received these trainings. A more complete evaluation of the training programs and participation of the local law enforcement departments should be considered.

## Roadmap to the Ideal Crisis System – Measurable Criteria

The National Council for Behavioral Health published The Roadmap to the Ideal Crisis System, Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response (hereafter referred to as The Roadmap) in March 2021. The Roadmap introduction describes:

*In most American communities today, the behavioral health crisis system isn't really a system at all, but a combination of services provided by law enforcement and hospital emergency rooms that are typically not designed to meet the needs of individuals in the midst of behavioral health crises. Often the only treatment options for individuals in behavioral health crises are in settings that do not adequately meet their needs*

*despite being extremely costly, such as emergency rooms and inpatient psychiatric units. Further, lack of appropriate and accessible behavioral health crisis response too frequently results in law enforcement being the only available first responders, which may lead to an increase in unnecessary arrest and incarceration for people with acute behavioral health needs.<sup>(5)</sup>*

The core requirements that Lebanon County crisis intervention project sponsors outlined in the development of a Enhancement Plan were the following:

- Providing an overview of the existing crisis services delivered by Lebanon County Crisis Intervention.
- Examining each crisis system modality recommended in SAMHSA 's National Guidelines for Behavioral Health Crisis Case Best Practice Toolkit and developing concrete actions steps toward implementing recommendations.
- Providing a complete financial analysis of Lebanon County's current crisis service system and recommendations around the implementation and sustainability of the best practice recommendations that include enhancement of current crisis services, Mobile Crisis Response Team, and a Crisis Walk-In Center.
- Analyzing the potential for regional partnerships with surrounding counties.
- Utilizing inclusive planning approaches through a survey of diverse local consumers and local stakeholders.
- Providing additional recommendations for Crisis Intervention as they serve a growing diverse population.

The Roadmap provided an operational resource that was built upon the SAMHSA National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit of 2020 and as updated in 2025 (hereafter referred as Toolkit) that allowed a more comprehensive analysis of all areas of the crisis intervention system continuum of services.

TPG designed and utilized an analysis model for this engagement in the Enhancement Plan based upon the Roadmap measurable indicators by section, to assess and provide a baseline evaluation of the Lebanon County crisis intervention system. Our guiding principles were to utilize the Roadmap definitions of what is the “optimal” or “ideal” crisis intervention system, and then assess what is feasible, given the operational constraints of Lebanon County being a rural class 5 County, as the foundation for the observations and recommendations made in this report.

“Optimal or Ideal” does not mean perfect, nor does it assume unlimited resources. It refers to a set of recommendations or criteria that Lebanon County can use to determine how to invest resources to achieve the best overall outcomes and to incorporate best practice processes, programs and practices that would contribute to the achieving the best possible results, as effectively, and efficiently as possible.<sup>(6)</sup>

Here is a general outline of the process TPG used to build the assessment model from the Roadmap:

- We built a data model that identified all of the measurable criteria referenced in the Roadmap document (459 measurable criteria in total).

- The measurable criteria were a more granular elaboration of the scoring categories contained in the Roadmap Report Card (64 summarized scoring types) [See Appendix 3 – Roadmap Report Card Measures](#)
- TPG then scored each measurable criteria using the Report Card Anchors provided by the Roadmap on a 1-5 Scale (outlined below). We followed the guidance from the Roadmap that scoring was based on the results of our stakeholder interviews and professional judgement. *Note: Scoring relied upon professional judgement, as not all items evaluated fit neatly with specific anchors. Our assessment averaged scoring results to resolve differences larger than 1. The results provided in this report are to be used as a baseline assessment as a guide to focus Enhancement Plan Sponsors on future program development.*

| Score | Description   |
|-------|---|
| 1     | Just getting started – <i>Not started and/or not on our radar and/or If interest does exist in moving on this, barriers seen as too overwhelming to make it worthwhile to put any energy into moving forward.</i> |
| 2     | Making initial progress – <i>At least some awareness of this as a desirable goal within our system, and/or initial efforts to explore implementation, but no actual movement or specific plans yet.</i>           |
| 3     | About half-way there – <i>Active steps that are beginning the process toward implementation; early stages of implementation.</i>  |
| 4     | Substantial progress – <i>Active steps being taken toward full implementation, but still incomplete, with intent to implement further.</i>  |
| 5     | Nearly completed or completed – <i>Implemented in our system in a manner that is functioning well.</i>  |

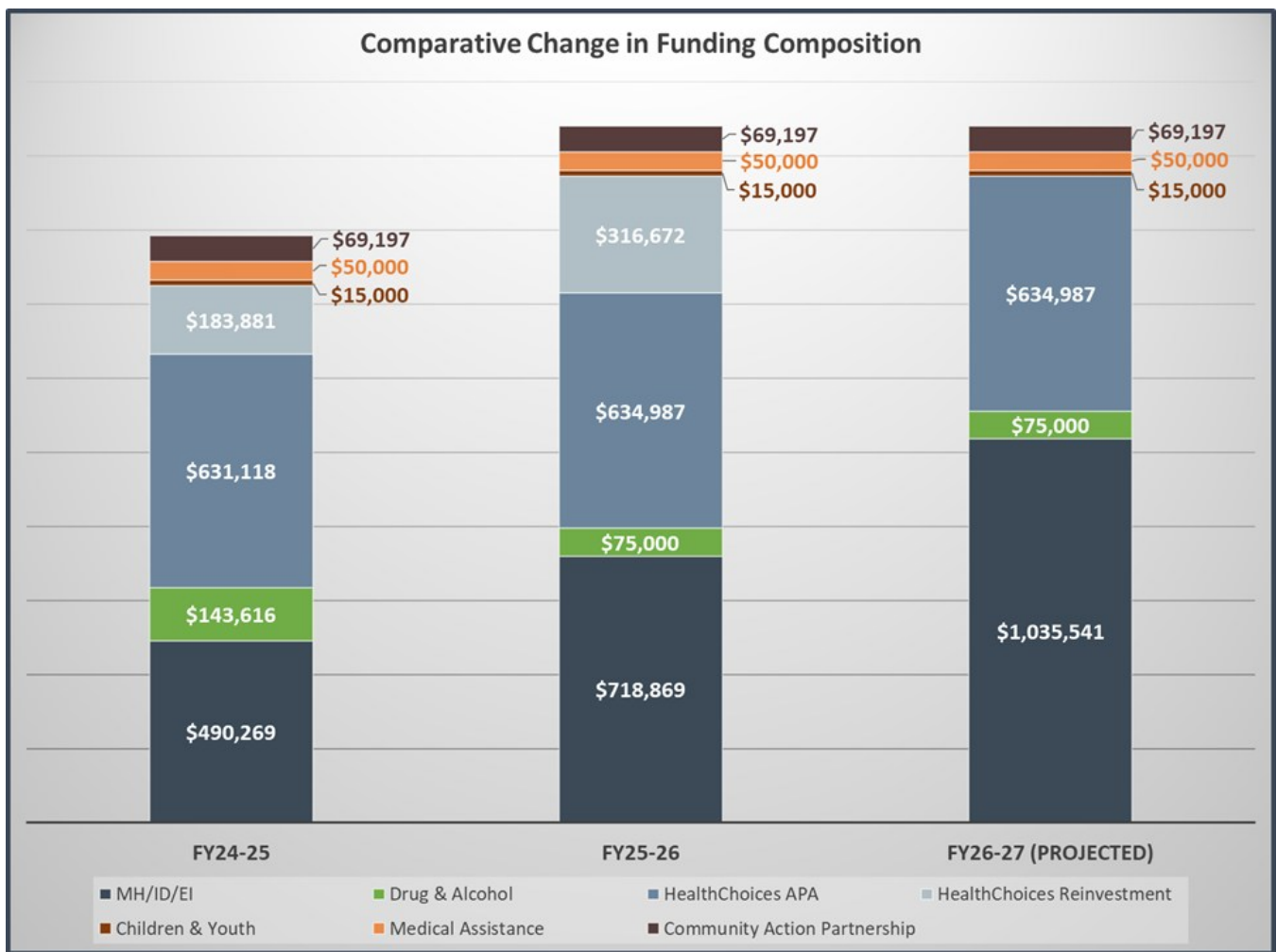
- We then normalized<sup>(7)</sup> the scoring results. For further analysis, we ranked them in two ways, described below:
  - First, we grouped the Report Card results by major categories as outlined in the Roadmap: Accountability and Finance; Crisis Continuum, Capacity and Services; and Best Clinical Practice. This sort allowed us to measure level of completion by major categories. .
  - Secondly, we grouped them in normalized order overall (from high to low) to outline level of completion on the Roadmap Scale above. This sort ordering helped to provide insight into establishing prioritization for the emerging themes discovered in the Enhancement Plan field work and helped to form a basis for observations and recommendations. [See Appendix 4 – Roadmap Group Scores \(Normalized\)](#)
- The results of the scoring of the National Council’s Roadmap Report Card and mapping stakeholder response results provided the context and supporting background for providing an overview of the existing crisis services delivered by Lebanon County Crisis Intervention.
- Examination of each crisis system modality recommended in SAMHSA 's Toolkit and the related National Council’s Roadmap enabled us to develop concrete actions steps toward implementing recommendations.

- As noted earlier in Enhancement Plan report, Lebanon County MH/ID/EI had initiated crisis intervention system improvements during the analysis period (January 2024 through December 2024) which may not be reflected in some score results.

## Analysis of Current Budget and Utilization

The funding composition for Lebanon County Crisis Intervention Services has changed significantly over the past several years, and as projected for the future. The data graphic and corresponding budget table provided below shows the crisis intervention services operating budget for the previous fiscal year (FY24-25), the current fiscal year (FY25-26), and as projected for FY26-27.

Lebanon County Crisis Intervention Comparative Budgets:



# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

| Funding                      | FY24-25             | FY25-26             | FY26-27 (Projected) |
|------------------------------|---------------------|---------------------|---------------------|
| MH/ID/EI                     | \$ 490,269          | \$ 718,869          | \$ 1,035,541        |
| Drug & Alcohol               | 143,616             | 75,000              | 75,000              |
| HealthChoices APA            | 631,118             | 634,987             | 634,987             |
| HealthChoices Reinvestment   | 183,881             | 316,672             |                     |
| Children & Youth             | 15,000              | 15,000              | 15,000              |
| Medical Assistance           | 50,000              | 50,000              | 50,000              |
| Community Action Partnership | 69,197              | 69,197              | 69,197              |
| <b>Total</b>                 | <b>\$ 1,583,081</b> | <b>\$ 1,879,725</b> | <b>\$ 1,879,725</b> |

Budgeted costs for service delivery, with the full implementation of the new crisis walk-in center facility, implementation of mobile crisis services, and the addition of peer support counselors are reflected in the usage of HealthChoices Reinvestment funding throughout FY24-25 and FY25-26. The intended purpose of Reinvestment funding was to support start-up and implementation costs for the improved crisis intervention services delivery system. Reinvestment funds will not be part of the projected funding composition for FY26-27.

In addition, Lebanon County Commission on Drug and Alcohol (LCD&A) has decreased funding to crisis intervention services by 47.8% from FY24-25 funded at \$143,616 to FY25-26 funded at \$75,000. The impact of the reduction of this prior financial sustaining commitment is significant.

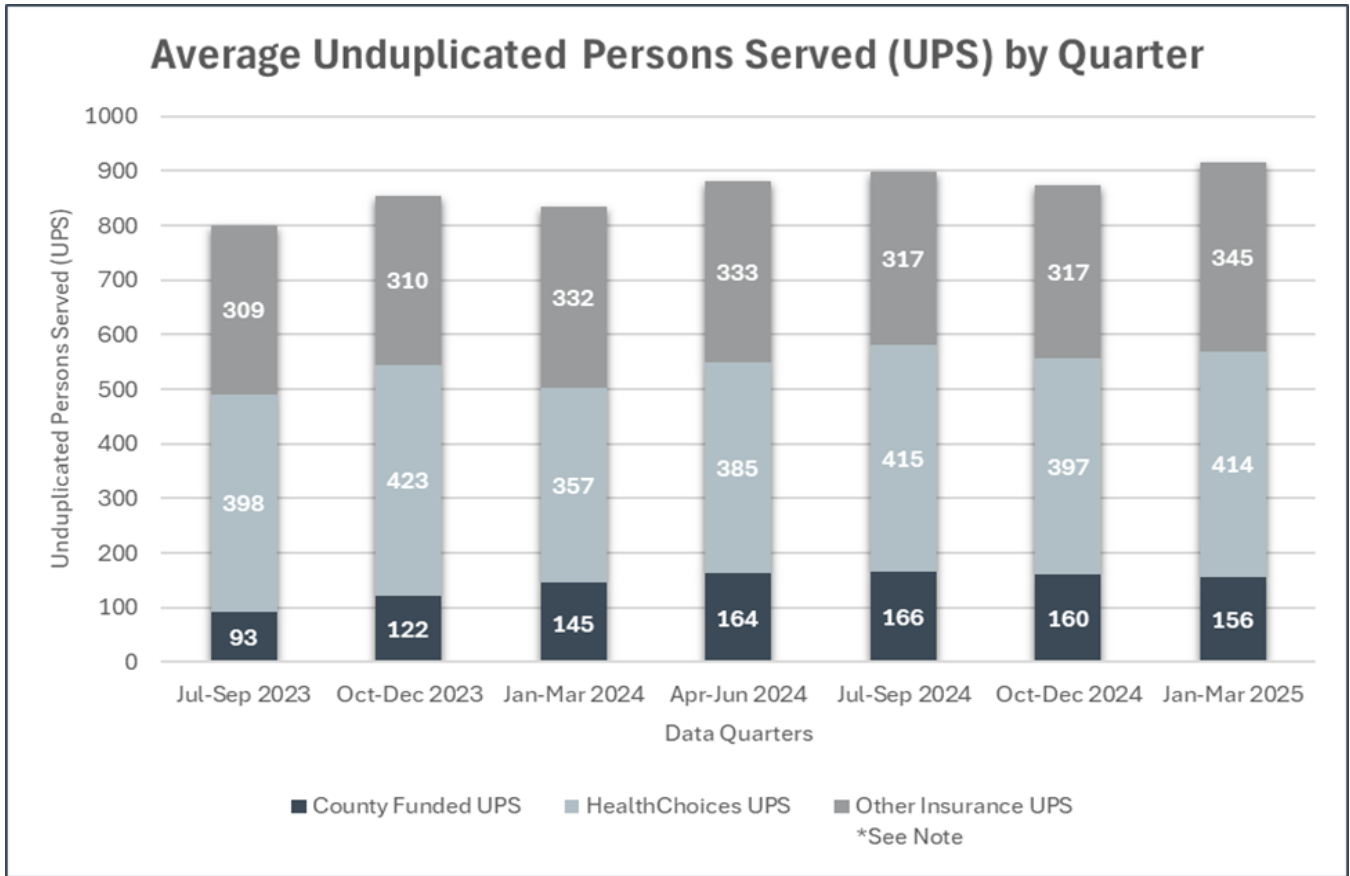
Other funding sources from Medicaid, Lebanon County Children and Youth Service, and the Lebanon County Community Action Partnership have remained relatively flat with no anticipated change in funding levels.

The overall impact of the reduction of funds from HealthChoices Reinvestment and LCD&A has caused the significant financial costs to shift to Lebanon County MH/ID/EI. The impact for FY25-26 is an increase of 46.6% over FY24-25, and a projected additional increase of 44.1% for FY26-27. It is unclear if state mental health funding will make up the difference.

While changes in the funding mix has presented challenges to the effective delivery of crisis intervention services, utilization data for the period of July 2023 through March 2025 shows a consistent level of unduplicated persons served, as reported by WellSpan Philhaven (WSP).

The tables on the following page shows the quarterly average number of unduplicated persons served:

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan



## Unduplicated Persons Served (UPS) by Quarter:

| Measure             | Jul-Sep 2023 | Oct-Dec 2023 | Jan-Mar 2024 | Apr-Jun 2024 | Jul-Sep 2024 | Oct-Dec 2024 | Jan-Mar 2025 |
|---------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| County Funded UPS   | 93           | 122          | 145          | 164          | 166          | 160          | 156          |
| HealthChoices UPS   | 398          | 423          | 357          | 385          | 415          | 397          | 414          |
| Other Insurance UPS |              |              |              |              |              |              |              |
| <b>*See Note</b>    | 309          | 310          | 332          | 333          | 317          | 317          | 345          |
| <b>Total UPS</b>    | <b>800</b>   | <b>855</b>   | <b>834</b>   | <b>882</b>   | <b>898</b>   | <b>874</b>   | <b>915</b>   |

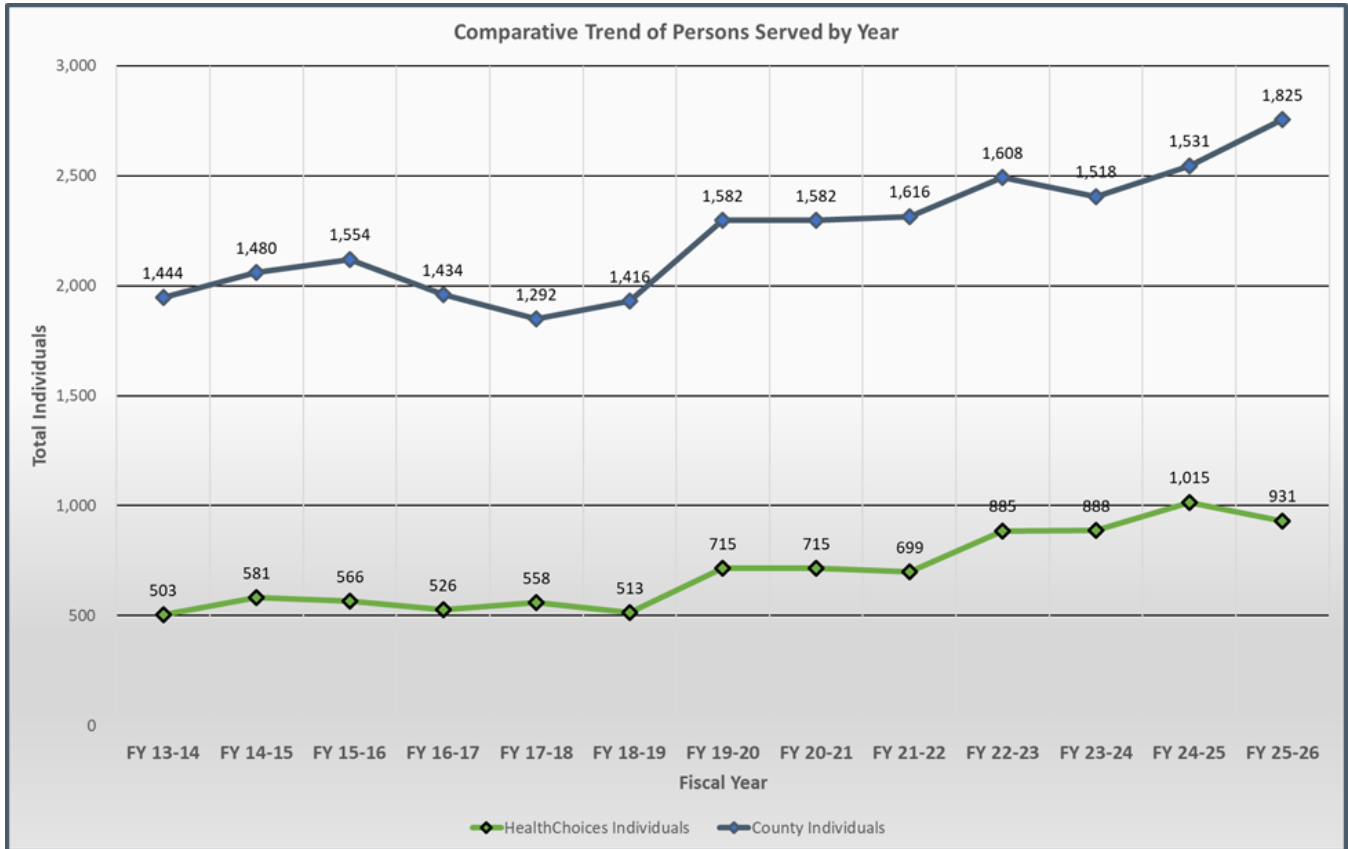
## Percentage Distribution of UPS by Quarter:

| Measure             | Jul-Sep 2023 | Oct-Dec 2023 | Jan-Mar 2024 | Apr-Jun 2024 | Jul-Sep 2024 | Oct-Dec 2024 | Jan-Mar 2025 |
|---------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| County Funded UPS   | 12%          | 14%          | 17%          | 19%          | 18%          | 18%          | 17%          |
| HealthChoices UPS   | 50%          | 49%          | 43%          | 44%          | 46%          | 45%          | 45%          |
| Other Insurance UPS |              |              |              |              |              |              |              |
| <b>*See Note</b>    | 39%          | 36%          | 40%          | 38%          | 35%          | 36%          | 38%          |
| <b>Total UPS</b>    | <b>100%</b>  | <b>100%</b>  | <b>100%</b>  | <b>100%</b>  | <b>100%</b>  | <b>100%</b>  | <b>100%</b>  |

**\*Other Insurance NOTE:** The tables provided above reflect the category “Other Insurance” which includes persons whose services are not directly funded by Medicaid through the HealthChoices Behavioral Health Program, or as directly funded by Lebanon County (approximately 35-40% of the persons served). Currently, because crisis intervention services are not a covered service through commercial insurance plans, Lebanon County must bear the costs for the “Other Insurance” category. Medical services provided by WellSpan, such as for Behavioral Health Therapists (BHTs) or Psychiatry may be billable by WellSpan, but do not offset costs for crisis intervention borne by Lebanon County.

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

Utilization data on Medicaid funded crisis intervention levels of service under the HealthChoices Behavioral Health Managed Care Program has also been provided by Capital Area Behavioral Health Collaborative (CABHC) to compare with base program data provided by WellSpan Philhaven (WSP). HealthChoices funds are provided to Lebanon County through a Special Payment Arrangement (SPA) based upon actual HealthChoices members served as a percentage of the total unplaced persons served by Crisis Intervention for the prior completed fiscal year. The two lines in the graph depicted below show the total number of HealthChoices members, and County Funded clients served for each of the respective fiscal years.



Crisis Intervention service trends projected for FY25-26 show a decrease of estimated HealthChoices funded members coupled with a projected increase of County funded clients. The projected change in the funding mix of persons served, if realized, will place an additional financial burden upon Lebanon County.

The county crisis intervention system is comprised of a wide array of contributing parts not all of which are within the operational control of Lebanon County MH/ID/EI. So it is very difficult to draw direct lines of cause and effect within the overall crisis intervention system. The participating organizations operating independently include each of the individual law enforcement departments, school districts, community hospitals and emergency medical responders, other county human services offices, the behavioral health managed care system, and a vast array of community service providers. Operational and financial challenges encountered by any of these participating organizations have a direct impact on crisis intervention and are felt throughout the overall system.

Equally true is that each part of the overall system plays a participating role in maintaining and improving the overall crisis intervention system within the county. In some instances, costs and benefits do not directly align. Investment costs in establishing improved efficiencies within the crisis intervention services system may produce offsetting cost savings in the broader system, such as with the emergency department, physical healthcare, or with the costs associated with community law enforcement.

A key cultural mindset shift for key crisis intervention system stakeholders must move from “what will benefit one part of the system” to “what will benefit the overall system?” A crisis system is more than a collection of services. It involves prevention, early intervention, response, and post-vention with the necessary peer transition support.<sup>(8)</sup> Improved behavioral health crisis intervention services may actually drive cost savings in physical health due to ED boarding, or inpatient admissions that may have been able to be diverted, or with law enforcement or the criminal justice system. We offer one example on behavioral health’s impact on physical health costs:

- National research has shown that individuals with behavioral health conditions face substantially higher healthcare costs. A study found that their annual healthcare expenditures are, on average, 3.5 times higher than those of individuals without behavioral health conditions. Despite representing just 27% of the population, people with behavioral health conditions account for a staggering 56.5% of total healthcare costs. Only 7.9% of these costs are actually attributed to behavioral health services. The vast majority, 92.1%, is directed toward physical health care, often addressing conditions exacerbated by untreated or poorly managed behavioral health issues.<sup>(9)</sup>

The National Association of State Mental Health Program Directors (NASMHPD) in conjunction with their Crisis Now partners report that establishing crisis intervention options can reduce costs by more than half.<sup>(10)</sup> The trend is comparable when reviewing annual behavioral health acute inpatient and crisis care system costs for the State of Pennsylvania, as well as within Lebanon County.

Connections Health Solutions, a nationally recognized provider of Crisis Stabilization Services, recently opened an Emergency Behavioral Health Walk-In Center in Harrisburg, serving Cumberland, Dauphin, and Perry Counties. Connections have reported that an accountable entity with a significant national market share in 2023 saw the average length of stay for inpatient hospitalization exceed eight days. The per diem averaged between \$950 and \$1000 daily, and the typical cost per inpatient stay was between \$7,500 and \$9,000.<sup>(11)</sup>

These statistics are comparable to Lebanon County data showing that acute psychiatric inpatient days can range from \$900 to \$1,500 per day, with lengths of stay from 16 to 21 days, with episodes of care averaging \$13,000. By contrast, deploying mobile crisis intervention services that divert crisis intervention users from costly inpatient acute psychiatric care, costs approximately \$295 per episode.

## Examination of Regional / State-Wide Environmental Factors

Resource limitations of small rural counties like Lebanon County require leaders to think regionally, to identify specialized service resources that may exist beyond county borders. Our examination of service resources involved meeting with stakeholders from the surrounding counties, as well as representatives from across the State.

We sought to collect lessons learned from leaders and subject matter experts who have had experience in building out innovative crisis intervention systems and supporting community services. Our analysis included Primary Contractor representatives throughout the State who have managed their respective Behavioral HealthChoices programs since behavioral health managed care began in 1997. We also spoke with experienced Mental Health and Substance Abuse Service leaders at the County level, from both small rural counties to very large urban counties. We found many of the core challenges are present in all.

The result of the broad net approach was that we were able to collect valuable input and guidance from experts who have many years of experience in facing the challenges and “thinking through” obstacles to design service delivery programs that meet the needs of service users and their families and communities.

## Development of Recommendations and Plans

Throughout the field work and analysis conducted from approximately January 2024 through June 2025 for the development of the Enhancement Plan, TPG consultants compiled source documentation and project notes that have been referenced and summarized to draw clear observations, highlighting conditions and constraints, and forming recommendations to build a comprehensive strategic plan that will provide guidance for Lebanon County program managers.

This report provides a comprehensive list of observations and recommendations in the sections that follow. Not every recommendation may be possible in the short term (i.e. within the next year). The information contained in this strategic plan will enable Lebanon County Project Sponsors and other County and Community leaders to think forward to overcome operational challenges and continue to prioritize what can be done while keeping focus on what is optimal as conditions and capabilities evolve.

## Limitations to Analysis

Since the beginning of the project, Lebanon County MH/ID/EI Project Sponsors placed no limitations on the design and execution of the project consulting engagement. We had continual discussion and project status update meetings to seek guidance and permission to proceed with the field research and stakeholder input. Our interviews were candid and confidential, and we found the generous sharing of knowledge to be enlightening.

As with all research, inquiry, description, and the recommendations that follow, not all will agree with the conclusions we have drawn. Our hope is that with persistent optimism, as the many experts who have shared their experiences and guidance as the basis for this strategic plan, will continue to refine and expand upon our conclusions in productive ways that improve the Lebanon County Crisis Intervention System.

# OVERVIEW OF THE EXISTING CRISIS INTERVENTION SYSTEM

- ◆ Crisis Intervention System Partners
- ◆ System Strengths and Accomplishments
  - ◇ **Expanded Staffing**
  - ◇ **Improved Location**
  - ◇ **Improved Community Awareness / Culture**
  - ◇ **Implement Certified Peer Specialists**
  - ◇ **Crisis System Coordination**
  - ◇ **Community Relationship Building**
  - ◇ **Development of Crisis System Dynamic Enhancement Plan**
  - ◇ **Implementation of Communication Technology**
- ◆ Operational Framework Assessment
  - ◇ **10 Steps for Communities, System Leaders, and Advocates**



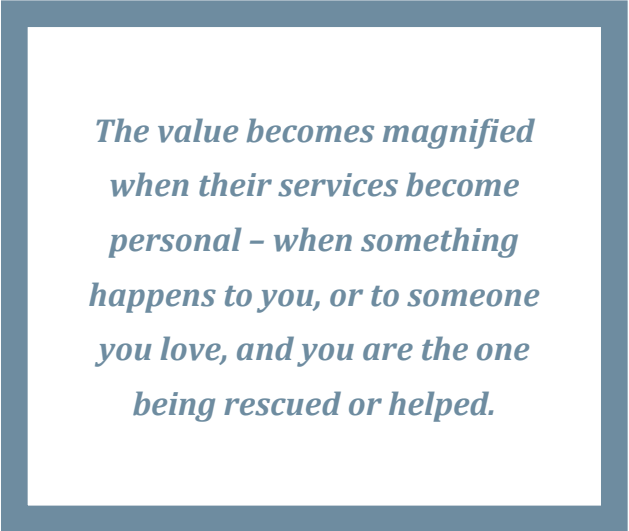
## Overview of Existing Crisis Intervention System

### Crisis Intervention System Partners

An optimal behavioral health crisis intervention system is a necessary community service, just like police, fire, and emergency medical services (EMS). Communities value and depend on having first responders available, highly trained and skilled when they are called upon to respond to a crisis. The value becomes magnified when their services become personal – when something happens to you, or to someone you love, and you are the one being rescued or helped.

Lebanon County is to be commended on their desire to identify what an optimal behavioral health crisis intervention system looks like, and to build towards that model with all the resources available to meet the needs of its citizens. While “optimal” is the goal, there are very real limitations facing a small, rural Pennsylvania County like Lebanon County.

Limitations or barriers are common throughout most of Pennsylvania – with limited funding, skilled human resources, housing, and community service capacity. Lebanon County has been vigilant in their desire to develop an Enhancement Plan to explore what can be done (i.e. what is possible) in the pursuit of what is optimal.

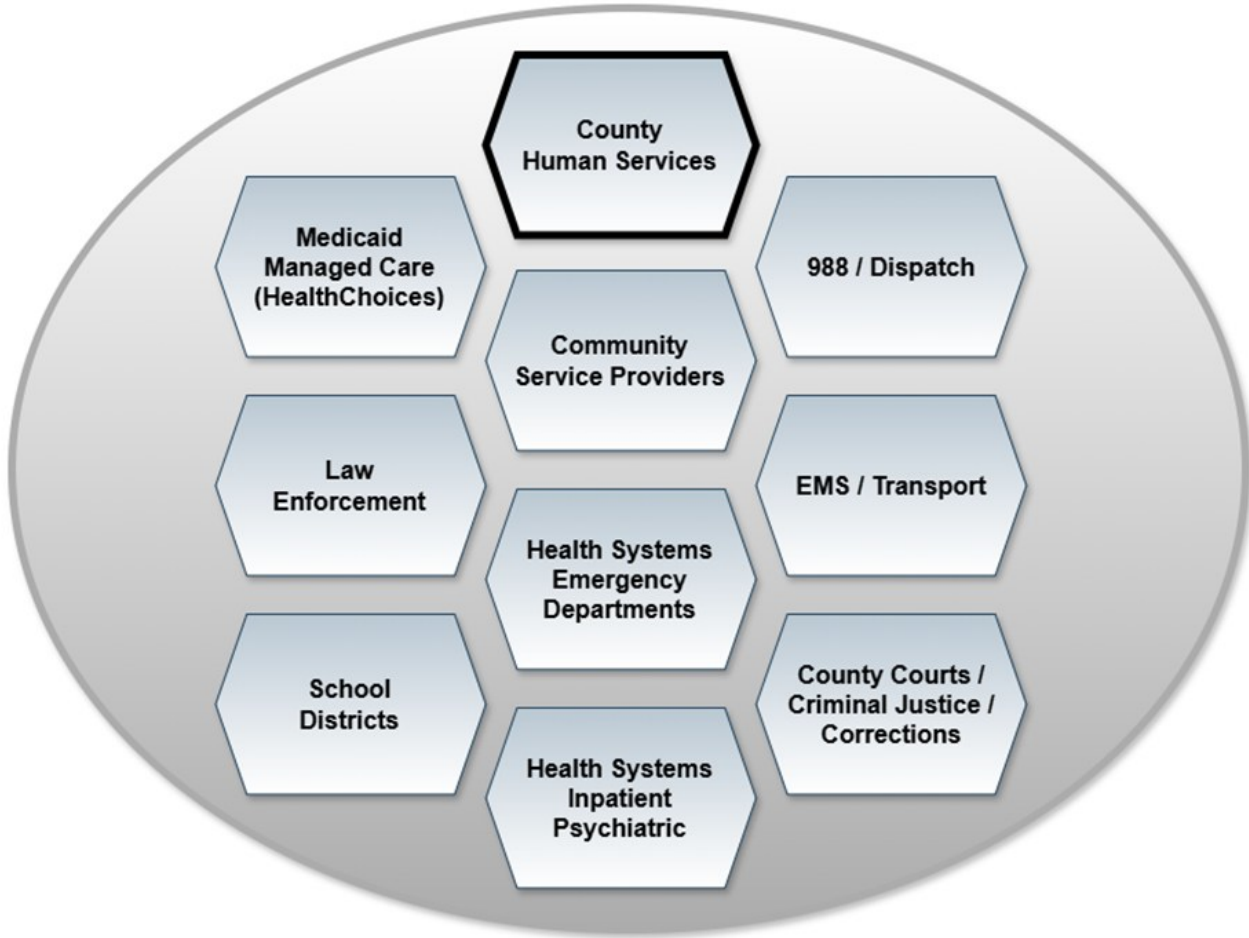


*The value becomes magnified when their services become personal – when something happens to you, or to someone you love, and you are the one being rescued or helped.*

A behavioral health crisis system is part of the much larger ecosystem of community health care and human services, cutting across many governmental bodies and jurisdictions, and in all categories of life (culture, income levels, education, etc.). It is more than just a single program. Rather it is a dynamic organized set of structures, processes, and services that must work together to meet all types of urgent and emergent crises quickly, safely, and successfully.

Each organizational system shown in the diagram below has its own mission, functional requirements and constraints. However, they all must perform together as a unified body when it comes to the delivery of crisis intervention services. Points of contact, communication, cooperation and involvement differ with each crisis intervention event.

So, it is essential that coordination between the respective parts is continually monitored with the goal of constant quality improvement. The SAMHSA Toolkit states “Agency-to-agency collaboration is essential and may manifest through personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols or more advanced high-tech solutions...”<sup>(12)</sup>



The operational parts of the crisis intervention system fit within the much larger ecosystem of processes that interact within Lebanon County (outlined above). The graphic below shows the current essential parts of the crisis intervention system within Lebanon County. The boxes in blue are the parts that are currently part of their crisis service delivery continuum. The boxes in gray are not part of the current crisis system.



Lebanon County is part of a regional 988 Call Center in Lancaster County established as part of the 988 Suicide & Crisis Lifeline. There are 12 regional 988 call centers in Pennsylvania. Lebanon County also operates a local 911 dispatch that coordinates with the regional 988 call center.

Lebanon County MH/ID/EI subcontracts with WellSpan Philhaven as their subcontracted provider delivering Crisis Intervention Services.

In 2024, MH/ID/EI established a new crisis walk-in center in close proximity to the local Emergency Department (ED) at WellSpan Good Samaritan Hospital. The new walk-in center location has improved access and amenities to improve the walk in experience as well as house the crisis call center and support the expansion of the mobile crisis team, including peer support staff. Lebanon County has psychiatric inpatient capacity provided by WellSpan Philhaven as well as the Lebanon County Veterans Administration Medical Center.

In addition to the service delivery providers mentioned above, Lebanon County MH/ID/EI has a close relationship with Capital Area Behavioral Health Collaborative (CABHC). CABHC is a private, not-for-profit company that manages the Behavioral HealthChoices Managed Care (Behavioral HealthChoices) contract with the State of Pennsylvania for Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties.

CABHC subcontracts to PerformCare as their behavioral health managed care organization.

In the most current state fiscal years, approximately 30 to 40% of the crisis intervention services provided in Lebanon County were to members of Behavioral HealthChoices. Behavioral HealthChoices provides funding to MH/ID/EI through an special payment arrangement (SPA) that is calculated for each fiscal year.

## System Strengths and Accomplishments

### Expanded Staffing

Lebanon County MH/ID/EI has developed, in collaboration with WellSpan Philhaven and CABHC, a community based mobile crisis service to provide face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis. Staffing levels and locations at the time of field work and analysis are outlined below:

| Positions                                      | FTE           | Location  | Funding                            |
|--|---------------|---|------------------------------------|
| Program Manager                                | 1.0           | Crisis Intervention Walk-In Center; and Mobile Crisis Services; 209 Hathaway Park, Lebanon, PA 17042  | MH/ID/EI and CABHC (HealthChoices) |
| Counselors                                     | 13.2          |   |                                    |
| Certified Peer Specialists (CPS)               | 2.0           |   |                                    |
| Mental Health Delegates                        | 5.0           | MH/ID/EI staff are available as needed; 220 East Lehman Street, Lebanon, PA 17046   |                                    |
| Behavioral Health Therapists (BHT)             | 17.0          | WellSpan Philhaven; located at WellSpan Good Samaritan Hospital Emergency Department; 252 South 4 <sup>th</sup> and Walnut Streets, Lebanon, PA 17042 | WellSpan Philhaven                 |
| Certified Registered Nurse Practitioner (CRNP) | 1.0           |   |                                    |
| Psychiatric Consultation                       | As needed     |   |                                    |
| Security Staff                                 | 3.0           |   |                                    |
| Director Level Support                         | 1.0           | WellSpan Access Center; 283 South Butler Road, Lebanon, PA 17042  |                                    |
| Indirect Crisis Staffing                       |               |   |                                    |
| Backup Support for Telephone / On-Call         | Coverage 24/7 |   |                                    |
| Senior Director                                | 1.0           | WellSpan Philhaven; 283 South Butler Road, Lebanon, PA 17042  |                                    |
| Administrative Support                         |               |   |                                    |
| Backup and Support for Administrator           | On-Call; 24/7 |   |                                    |

### Improved Location

During the early phases of the development of the Enhancement Plan, Lebanon County MH/ID/EI moved the Crisis Intervention Office to a new and improved location, across the street from WellSpan Good Samaritan Hospital. The new space provided improved access to walk-in services to provide individuals with appropriate care without an unnecessary visit to the Emergency Department (ED).

Although the previous walk-in center was close by, it was not well utilized because of limited space and inconvenient handicap accessibility. Determination during internal planning meetings prompted the need for a new location to leverage accessibility and space capacity improvements to be more appealing and inviting to clients. The move to the new location was made in September 2023.

To promote community awareness, MH/ID/EI provided a community open house in January 2024 to invite community stakeholders to tour the new program location and to launch efforts for community awareness. Special times were reserved for both local law enforcement and school districts to promote coordination and education. Tours were given and information was distributed about how to access crisis intervention. The desired outcome was that the number of people presenting directly to the ED would decrease in correlation with an increase in mobile crisis community visits.

## **Improved Community Awareness / Culture**

Historically in Lebanon County, providers, system partners, first responders and educators directed or sent individuals who needed mental health help at the WellSpan Good Samaritan Emergency Department. The ED would contact Crisis Intervention, and the crisis services were delivered in the ED. To move crisis service delivery from the ED to crisis intervention, MH/ID/EI funded a “community liaison” position to educate the service system, first responders, educators, and other county entities. The community liaison met with stakeholders, attended existing committee meetings and worked in the community to help direct those in need to the crisis intervention walk-in center, call center and to utilize mobile crisis in the community as much as possible.

## **Implement Certified Peer Specialists**

In November 2023 a Whitepaper was published by the Emergency Department Boarding Workgroup, a statewide body of experts from Counties, Behavioral Health Managed Care Organizations, Providers and HealthChoices Management / Collaboratives. The Whitepaper was entitled, “System Analysis and Recommendations to Reduce Psychiatric Boarding and to Support Persons in Emergency Departments”. The focus of the workgroup (in-part) was to address adverse outcomes caused by ED boarding and develop strategies that could be adopted by Primary Contractors (PCs), their Behavioral Health Managed Care Organizations (MCOs) and network hospitals. Throughout their findings and recommendations, the usage of Peer Supports is an essential part of the crisis intervention service delivery system.

At roughly the same time (March 2023) as the Whitepaper was being developed, Lebanon County was working with CABHC on two HealthChoices Reinvestment Projects for the development of mental health professionals within mobile crisis intervention services, and for embedding peer support specialists with mobile crisis intervention services. In 2023, crisis intervention hired a new Program Manager to implement expanded programming. And, early in 2025, two certified peer specialists (CPS) joined the crisis team. Service expansion is in the early stages of activity, and the crisis team is working to integrate the peer support resources.

## **Crisis System Coordination**

A key initiative that began in November 2023 was the establishment of a collaborative forum to review and address the continued development and improvement of the crisis intervention system. The Mobile Crisis Collaboration Team (MCCT) has become the administrative body to assess and continue the development of the County crisis intervention system.

What began as a collaboration to bring key stakeholders together to establish Lebanon County Crisis Intervention as a dispatchable entity with first responders or independently, has become a coordinated body. The MCCT now meets quarterly (or sooner as needed) and has grown to

incorporate local law enforcement and emergency medical services / ambulance to join in the collaboration and planning. Expansion plans for future meetings will include participants from the local school systems within Lebanon County.

Currently the MCCT is comprised of the following community leaders / stakeholders:

- Lebanon County MH/ID/EI Administrator
- Lebanon County MH/ID/EI Deputy Administrator
- Lebanon County MH/ID/EI Director of Mental Health Services
- Lebanon County Crisis Intervention Program Director (WellSpan Philhaven)
- WellSpan Philhaven Senior Director of Operations
- Lebanon County DES Deputy Director
- First Aid and Safety Patrol
- West Lebanon Regional Police Department Chief
- Lebanon City Police Department Chief
- James Biever Police Community Alliance

The MCCT goals are:

- Clear communication between all entities regarding laws and expectations.
- Identify and remove barriers to full collaboration in the community between all entities.
- Education and engagement of stakeholders with crisis.
- Identification of training needs and funding resources to provide requested training.
- Review and monitoring of dispatch reports / data.
- Ensure safety of all entities through appropriate technology.
- Implementation of Crisis automatic deployment.
- Creation and distribution of informational resources to the community.
- Other areas as identified by the team.

## **Community Relationship Building**

The crisis intervention Director, in conjunction with the County MH/ID/EI staff have made significant effort to meet with representatives of the courts, law enforcement leaders, the County Department of Emergency Services (DES), including 911, as well as other first responders such as EMS and Fire.

The combined efforts in this first year have been remarkable, with much progress made. Coordination has been made between 911 services and DES to help bring crisis intervention on scene to support law enforcement and other first responders.

## **Development of Crisis System Dynamic Enhancement Plan**

In April 2023, MH/ID/EI published a request for proposals (RFP) for the selection of consulting services to develop a Crisis System Dynamic Enhancement Plan for Lebanon County. The Panto Group, LLC was selected and engaged to conduct research and analysis, and to write the Strategic Enhancement Plan.

The Enhancement Plan will afford Lebanon County and the related community crisis intervention services stakeholders to have a comprehensive overview of current (“as-is”) conditions of the crisis system, mapping to best practices as contained in SAMHSA’s national guidelines (2022, and 2025), as well as an assessment of areas of growth and improvement using the National Council for Behavioral Health’s Roadmap to the Ideal Crisis System measured criteria and Report Card.

The Enhancement Plan is designed to not only provide a baseline for measurements but is forward-looking for further development using the Roadmap recommendations for action (see operational framework, below) over the next 5 years should current financial and operational barriers be able to be overcome.

## **Implementation of Communication Technology**

Recently in 2025, the DES provided crisis intervention with mobile technology to increase safety in the community and monitor community location using global monitoring.

Crisis intervention staff have used radios in communication with the Lebanon County DES that notify 911 dispatch of their location and deployment to a crisis in the community. Crisis staff could press a button, and 911 dispatch would be notified to send police back-up. The communication system also enabled DES to do safety checks on crisis staff when they are out in the community. DES expects to replace the old radio units with new radios sometime in 2026.

In addition, Crisis had 2 designated mobile phones for crisis staff to share, or they were permitted to use their personal phone when in the community. The MCCT determined that 2 mobile phones were insufficient to ensure the safety of crisis workers in the community due to the increased mobile crisis intervention. As of July 2025, crisis intervention staff now have 10 mobile phones (deployed to each staff person per shift) through DES that are directly connected to the DES computer aided dispatch (CAD) system and geolocation services.

Crisis staff log into the CAD system with their individualized credentials and phone assignment number which enables DES to identify the crisis worker and their location. CAD capabilities allow crisis staff to “self-dispatch” without having to call and provide information about their identity and location, streamlining system efficiency. Other crisis staff are also able to see where crisis workers are located in the field. The capabilities of the new mobile technology enable mobile crisis to be automatically deployed versus being deployed by request. The DES Medical Director has approved the development of automatic deployment and is awaiting full implementation of GPS mobile phone technology. Automatic deployment is projected to begin in early 2026.

## Operation Framework Assessment

The National Council for Behavioral Health has provided guidance in their Roadmap to the Ideal Crisis System (Roadmap) in March 2021.<sup>(13)</sup>

Provided in the sections below is a summary outline of the current Lebanon County crisis intervention system as examined in during the field work and analysis phase of the development of the Enhancement Plan (January 2024 through June 2025). Advancements are noted where Lebanon County MH/ID/EI has initiated system improvements during that same time period.

Roadmap steps for communities and for system leaders are restated with the current conditions observed with action steps in progress, and the continued work recommended.

### **10 Steps for Communities, System Leaders, and Advocates**

#### **Identify and Convene Community Partners (Step 1)**

*Identify community stakeholders and potential partners who are interested in, or have a stake in, behavioral health crisis services within your community and develop a voluntary ad-hoc group for initial discussions. Remember to engage stakeholders and funding partners that represent the whole community, not just those who are indigent or funded by Medicaid. Behavioral health crisis systems are an essential community service for everyone.*

##### Current Condition

Lebanon County MH/ID/EI is the administrative accountable entity with the responsibility to provide for the delivery of crisis intervention services. MH/ID/EI contracts with WellSpan Philhaven for the delivery of crisis intervention services.

Lebanon County also maintains other groups of stakeholders focusing on crisis intervention services including:

- Lebanon County Mobile Crisis Collaboration Team (MCCT), including the participation of MH/ID/EI, DES, First Aid and Safety Patrol (FASP), and local law enforcement.
- Lebanon County Criminal Justice Advisory Board (CJAB) – The ongoing mission of the Lebanon County Criminal Justice Advisory Board is to identify the strengths, weaknesses, and needs of the local criminal justice system, and by means of communication, cooperation, and collaboration, enhance and improve the system and services in the most effective, efficient, and cost-effective manner possible.
- Lebanon County Suicide Prevention Task Force - The Lebanon County Suicide Prevention Task Force is a collaboration of community members, providers, and schools working together for the prevention of suicide. The mission of the Task Force is to develop strategies to reduce the risk of suicide and provide education to the community of Lebanon County through the collaborative efforts of service providers and agencies.

- MH/ID/EI Quality Management Team (QMT) – The QMT is tasked with the review of the current mental health services to determine what, if any, changes should be made to improve the services. The team reviews / develops components of the County Mental Health Plan, reviews the Consumer Satisfaction Services (CSS) surveys, discusses issues related to HealthChoices (PerformCare) and state initiatives for improvement and quality of care.
- Lebanon County Behavioral Health Action Team – As a result of the AOPC Behavioral Health Summit, President Judge Tylwalk has developed the Lebanon County Behavioral Health Action Team which will focus on the following goals: a) The need for early identification and intervention process to provide services in a timely fashion to lessen involvement in the criminal justice system for those with behavioral health issues; b) The development and implementation of a mental health court to provide a systemic way to shepherd cases through the court system while providing necessary supportive services for those involved; and, c) Address the housing dilemma faced by many individuals with mental health issues who find themselves incarcerated with no readily available ability to re-enter into society due to the lack of appropriate housing. The team continues to convene several times a year, with sub-committees meeting more frequently to establish goals and priorities.
- Team MISA (Mental Illness and Substance Abuse) – Team MISA was implemented to divert low risk individuals with mental illness and other special needs from prison in the very early stages of incarceration. Each representative has a strong interest in improving the Criminal Justice System’s handling of persons with mental illness and other special needs while having the authority to influence change within their respective departments. Each Team MISA meeting focuses on developing effective working relationships and processes between the systems, reducing jail time for individuals with mental illness as well as other special needs, expanding community treatment options, educating team members about mental illness, special needs and substance use disorder and increasing early diversion for D&A and MH/ID defendants.
- In addition, under the Behavioral HealthChoices Managed Care Program, Lebanon County is part of an intergovernmental cooperation agreement identifying Capital Area Behavioral Health Collaborative (CABHC) as the contracting entity with OMHSAS for the delivery of the Behavioral HealthChoices Program. CABHC maintains committees including Clinical, Consumer / Family Focus, Fiscal, and Provider Relations.

## Continued Work Recommendations

Lebanon County MH/ID/EI is encouraged to continue to develop participation and collaboration with an expanding group of community stakeholders under the established Mobile Crisis Collaboration Team (MCCT). This group could be instrumental for the establishment of strategic assessment and planning for continued development initiatives for the crisis intervention system.

## Read and Process Relevant Sections of the Report (Step 2)

*Share the report with your stakeholders and ask them all to read the Introduction. Then, have the stakeholders identify aspects of the report most relevant to them over a few sessions and have them present sections of the report to the group as a whole.*

### Current Condition

TPG used national guidelines to conduct and organize fieldwork and analysis to make observations and recommendations for the Enhancement Plan development. The guidelines included:

- National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit; SAMHSA, (2020 and updated 2025)
- National Guidelines for Child and Youth Behavioral Health Crisis Care; SAMHSA, (2022)
- Roadmap to the Ideal Crisis System; National Council for Behavioral Health, (March 2021)
- Stakeholder interviews collected baseline perceptions of strengths and weaknesses of the existing system to establish a baseline and identify potential areas for development aligned with national guidelines. Results were subsequently mapped to measured criteria for scoring.

### Continued Work Recommendations

The national guidelines referenced above have formed the basis to define the optimal crisis intervention system, and have been used and referenced in the Enhancement Plan. These should be used as resources to aid MH/ID/EI in their strategic planning process internally, and with community service partners.

## Develop a Local Vision / Disseminate the Vision <sup>A</sup> (Steps 3 and 4)

*National Council Roadmap Recommendation(s) for Action:*

*Have the stakeholders develop an initial vision for an ideal behavioral health crisis system in your community. Do not be discouraged if you are far from that goal right now. Every community with an improved behavioral health crisis system had to start at the beginning and make progress over time. Write down this vision with some initial action steps and actively share it with others.*

**Note A:** *Cross referenced with Step 1/10 for System Leaders and Advocates - The core of this vision is that behavioral health crisis systems are an essential community service that should be designed to be at least on par with the responsiveness of emergency and urgent medical care: Every person gets the right response every time. Incorporate core values in the vision: welcoming, hopeful, trauma-informed, recovery-affirming, integrated and designed with the goal of eliminating disparities in response for those who are most vulnerable and marginalized.*

## Current Condition

Lebanon County MH/ID/EI has established the following program enhancements aligned with their vision for overall crisis intervention system improvement. They worked in conjunction with CABHC and WellSpan Philhaven for the implementation of approved HealthChoices Reinvestment Plans. Program expansions implemented include:

- Enhancements to the mobile crisis team to expand delivery of services within WellSpan Good Samaritan Hospital Emergency Department to establishing a mobile crisis intervention team for the delivery of services in the community. This initiative involved the hiring of staff, and re-assigning roles to establish a community liaison.
- MH/ID/EI also established a new location for a crisis walk-in center that was more conducive and engaging to users of crisis intervention services.
- Hired Certified Peer Specialists to work with the mobile crisis team.
- Develop a comprehensive Enhancement Plan to produce observations and recommendations to drive action steps for continued program strategic development.

## Continued Work Recommendations

The broader team of stakeholders participating on the Mobile Crisis Collaboration Team (MCCT) should review the observations and recommendations in the Enhancement Plan to plan for future actions within the crisis intervention system.

A consistent challenge is managing the constant balance of what an “ideal” system looks like versus what is possible, given current operating constraints. Updated crisis intervention regulations are still pending and State and Federal financial resources do not match the local needs. This places program leaders in a difficult position to secure and braid limited funding to build necessary new and innovative services.

## **Accountable Entity <sup>B</sup> (Step 5)**

*National Council Roadmap Recommendation(s) for Action:*

*Identify one or more entities that may serve as the accountable entity within your community. It could be county leadership, city leadership, a managed care organization or an existing community collaborative addressing jail diversion or suicide prevention.*

***Note B:** Cross referenced with Step 7/10 for System Leaders and Advocates – Identify mechanisms for regional and local accountability for crisis system performance. These could be based on regional intermediary system structures and/or on existing templates for delineating community accountability for EMS.*

## Current Condition

Lebanon County MH/ID/EI is the accountable entity with responsibility for the overall crisis intervention system as the County MH Administrator. MH/ID/EI contracts with WellSpan Philhaven for the delivery of crisis intervention services

MH/ID/EI has taken the leadership to create a framework as the accountable entity to identify mechanisms for regional and local accountability for crisis intervention system performance. The MCCT is evolving as the collaborative mechanism that incorporates participation from a group of community stakeholders to outline areas of accountability and performance. While many key community stakeholders now participate on the MCCT, MH/ID/EI seeks to improve stakeholder participation, accountability, cooperation, and coordination with community stakeholders who have not yet participated.

## Continued Work Recommendations

Lebanon County MH/ID/EI serves as an effective accountable entity for crisis intervention services. No additional recommendations.

## **Planning and Implementation Team<sup>C,D,E,F</sup> (Step 6)**

*National Council Roadmap Recommendation(s) for Action:*

*Identify a team of people to meet regularly on an ongoing basis to begin to plan the ideal behavioral health crisis system. This could be a new group under the accountable entity or a component of an existing collaboration. Do not hesitate to seek consultation or outside facilitation if needed at this step or any other step along the way.*

**Note C:** *Cross referenced with Step 2/10 for System Leaders and Advocates – As part of the vision, articulate a 10-year plan for working collaboratively with all system intermediaries, funders and communities to make step-by-step progress toward achieving universal progress. Remember that implementing universal 911 response systems took a decade or more.*

**Note D:** *Cross referenced with Step 3/10 for System Leaders and Advocates – Highlight the essential elements of the system and encourage the development of a system wide conversation to adopt the vision. Essential elements that might be highlighted for purposes of conversation include local accountability (accountable entities), all-payer financing, system performance metrics, crisis continuum (call center, mobile crisis, urgent care, crisis center, various types of crisis residential programs, intensive community crisis intervention), response to all ages and population groups, clinical/medical leadership, peer support and best practices for crisis intervention.*

**Note E:** *Cross referenced with Step 5/10 for System Leaders and Advocates – Using this report, convene system stakeholders to identify the most important quality metrics for behavioral health crisis system performance that all system intermediaries should be accountable to achieve.*

**Note F:** *Cross referenced with Step 10/10 for System Leaders and Advocates – This report provides guidance for those regulations, addressing items such as no force first, advance directives, medical screening, integrated response to individuals with co-occurring mental health/SUD and behavioral health/IDD, and so on.*

## Current Condition

As mentioned earlier under crisis system coordination, the County MH/ID/EI leaders have assembled the Mobile Crisis Collaboration Team (MCCT) as the administrative body to assess and develop the County crisis intervention system.

The MCCT meets as a coordinated body every 3 months and has incorporated local law enforcement and emergency medical services / ambulance to join in the collaboration and planning.

Currently the MCCT is comprised of key County Human Services Officials from MH/ID/EI, WellSpan Philhaven Crisis Intervention, Lebanon County Department of Emergency Services (DES), First Aid Safety Patrol (FASP), and representatives from several local Police Departments.

Implemented in November 2023 as a solution to facilitate collaboration, the MCCT was organized to foster clear communication between all participating groups regarding laws and expectations. The purpose was to pursue full participation and collaboration with all related entities in the community, provide community education and awareness of crisis intervention services and to identify training needs and opportunities.

Over the time period of the development of this Enhancement Plan, the MCCT has continued to establish plans and procedures for monitoring dispatch reports and the related data, to ensure safety processes within the crisis system through the expanded use of appropriate technology, and to develop the process for crisis intervention automatic deployment.

## Continued Work Recommendations

Lebanon County MH/ID/EI is encouraged to continue the growth and expansion of the MCCT participating members to include:

- The County District Attorney's Office
- Lebanon County Commission on Drug & Alcohol Abuse (LCCDAA)
- Full participation from all local Police Departments
- Full participation from all local School Districts
- Lebanon City and other local Municipal Leaders.
- Other engaged and enthusiastic community stakeholders (as may be helpful for short term participation and support).

MCCT areas of action for future consideration and development should include:

- Review and operationalize the Enhancement Plan, to identify feasibility, goal setting, scope, schedule, cost, responsible parties, responsibilities, establish governance, documentation, monitoring, assessing success, managing risk, maintaining documentation and lessons learned.
- Develop an implementation plan: As part of the vision, articulate a 5-year plan for working collaboratively with all system intermediaries, funders and communities to make step-by-step progress toward achieving universal progress.

- Highlight the essential elements of the system and encourage development of a system-wide conversation to adopt the vision.
- Identifying barriers, root causes, and brainstorming possible solutions and strategies.
- Identify performance metrics: Using the Enhancement Plan, convene system stakeholders to identify the most important quality metrics for behavioral health crisis system performance that all system intermediaries should be accountable to achieve.
- Incorporate best practice standards into system regulations: The Enhancement Plan provides guidance for regulations that address items such as no force first, advanced directives, medical screening, integrated response to individuals with co-occurring mental health/substance use disorder and behavioral health/intellectual and developmental disabilities and so on.

## Baseline Self-Assessment <sup>6</sup> (Step 7)

*National Council Roadmap Recommendation(s) for Action:*

*Using the measurable criteria in the report, rating each item from 1-5, have the planning team rate the current status of your behavioral health crisis system. No matter what you find, give yourselves a round of applause. See the Report Card in the Appendix to help you organize this step. Use the Report Card as well to track your progress over time.*

***Note G:** Cross referenced with Step 4/10 for System Leaders and Advocates – Encourage communities to come together to perform a systemwide baseline assessment of the current behavioral health crisis system, using the enclosed Report Card. Use the report card to track progress across the system over the course of the 10-year plan.*

### Current Condition

TPG has conducted a systemwide baseline assessment of the current behavioral health crisis system using the Report Card provided in the National Council's Roadmap to provide an initial baseline for Lebanon County MH/ID/EI to review. Please refer to:

- [Appendix 3 – Roadmap Report Card Measures](#)
- [Appendix 4 – Roadmap Group Scores \(by Section; Normalized\)](#)

TPG used measurable criteria contained in the Roadmap and summarized the compiled results at the Report Card level. We used the rating criteria provided and normalized the results for comparison.

### Continued Work Recommendations

The baseline assessment conducted as part of the fieldwork for the Enhancement Plan should be conducted with a broader stakeholder group, incorporating more participants at regular intervals in the future (i.e. annually at first, and then at 2-3 year intervals) to be able to identify status (growth, development, regress).

## Early Wins (Step 8)

*Identify 3-5 improvement opportunities that the team can address early on, within available capacity and resources. Develop and implement a collaborative plan to begin to make progress in small steps on each item. Give yourselves another round of applause for making progress.*

### Current Condition

Early wins include:

- Establishment of new Crisis Walk-In Center.
- Staff recruitment for mobile crisis intervention
- Incorporation of Peer Support staff into the crisis intervention system
- Establishment of the Mobile Crisis Collaboration Team (MCCT)
- Enhanced technology communication improvements as provided by LC DES for crisis intervention workers
- Development of the Crisis System Dynamic Enhancement Plan (Enhancement Plan), as a comprehensive assessment of the current crisis intervention system, and guidance for continued strategic growth and development.

### Continued Work Recommendations

Lebanon County MH/ID/EI has encountered many challenges common to innovative crisis intervention service development for a small, rural Pennsylvania County. Limited Federal and State resources have not deterred MH/ID/EI Leaders from continued work on system development. HealthChoices Reinvestment financial resources have enabled necessary structural changes to the crisis system, and the inclusion of Peer Support services.

MH/ID/EI has also continued to coordinate local county and community stakeholders to build out a collaborative team of local experts. Strategic planning continues using National guidance of the optimal crisis intervention system, to scale and implement creative local solutions that are feasible.

## Data and Financing <sup>H,I,J</sup> (Step 9)

*National Council Roadmap Recommendation(s) for Action:*

*At the same time, members of the planning team begin to gather clinical and cost data on current system performance and identify potential local, state and federal funding opportunities. Do not worry that your initial data are not perfect or that you do not find all the funding you will eventually need. Every community makes progress in steps, with slow improvement of data and using initial seed funds to attract further funding as the vision of the crisis system takes shape.*

**Note H:** *Cross referenced with Step 6/10 for System Leaders and Advocates – Develop a process to award community crisis collaboratives grants, possibly matching grants, for planning and implementation. This can begin with a few pilot communities and slowly be disseminated to the whole system. Continually measure progress in all communities across the system, rewarding small steps forward over time.*

*Note I: Cross referenced with Step 8/10 for System Leaders and Advocates – All private and public behavioral health funders should be required to contribute appropriately to the funding of the community behavioral health crisis system that serves the people covered by or affected by their funding. This includes all types of insurance plans.*

*Note J: Cross referenced with Step 9/10 for System Leaders and Advocates – Identify clear definitions of the various components and services in the behavioral health crisis continuum and require that Medicaid and other funders reimburse for those services (e.g., urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention) at rates that at least cover costs. Note that medical urgent care and emergency services do not operate at a loss; neither should commensurate behavioral health crisis services.*

## Current Condition

Possibly the most significant areas for meaningful growth in scope, quality, and efficiency is the development of a more robust data warehouse. Currently monthly utilization data is provided by WellSpan Philhaven from their internal electronic medical record. Opportunities exist for further growth and development of more robust data analysis but would require establishing a data warehouse. Data sets need to be identified for their usefulness and inclusion in an overall data warehouse.

Results of our field work identified that various stakeholder groups maintain structured data (i.e. manual excel based data and individual systems such as those with DES, law enforcement, or schools). However, this data is not collected and incorporated into a centralized warehouse to be used for measurement and analysis.

A second very significant area is to be able to compile a system wide operating budget to facilitate a broader system business plan. Each respective stakeholder group incurs costs associated with individuals who are involved with crisis intervention. An initial step would be to start to compile a comprehensive cost study by including actual or estimated costs borne by each group. By compiling this budget information, we can begin to establish overall cost and start to isolate areas where efficiencies may drive cost savings, or quality improvements.

## Continued Work Recommendations

Lebanon County is primarily dependent upon funding provided by the Commonwealth of Pennsylvania Department of Human Services (PA DHS), and the Behavioral Health Choices Program for crisis intervention services. Annual State Budget allocations and the pattern of HealthChoices Medicaid member utilization drive the financial capabilities to deliver crisis intervention services.

Unlike other community services which are funded by their respective municipalities to guarantee capacity (such as law enforcement, fire departments, and emergency medical services), crisis intervention services are the responsibility MH/ID/EI and Medicaid Behavioral Managed Care. Changes within the PA DHS or Federal Medicaid Programs have a direct impact on the scale and capabilities of local County crisis intervention service systems. Shortfalls in funding become the responsibility of the local County to assure crisis intervention services are available.

Leaders have begun to look for new and creative ways to identify costs and potential efficiencies in crisis intervention service delivery.

Areas of inquiry include:

- Are there efficiencies that can be provided to local law enforcement by the development of a more robust crisis intervention system to reduce repetitive wellness checks done by officers? Would these operational efficiencies produce value to the overall crisis intervention system?
- Are there alternate financial resources in the form of grants or in-kind support from local industry or the business community?
- Are there philanthropic opportunities from regional employers that could support specified initiatives (such as information system development, or additional human resources)?
- Continue to explore all-funder participation, seeking to develop all private and public behavioral health funders to contribute appropriately to the funding of the community behavioral health crisis system that serves the people covered by or affected by their funding. This includes all types of insurance plans.
- Continue to participate and support the development of adequate rates for all elements of the crisis continuum.

## **Comprehensive Plan (Step 10)**

*Keep meeting and working together. Over a period of time, using the data you have gathered with consultation (if needed), use this report for guidance to develop a comprehensive, collaborative plan for the design of an ideal behavioral health crisis system for your community. Identify a step-by-step approach for multiple partners to begin to work together to make progress over a period of years.*

### Current Condition

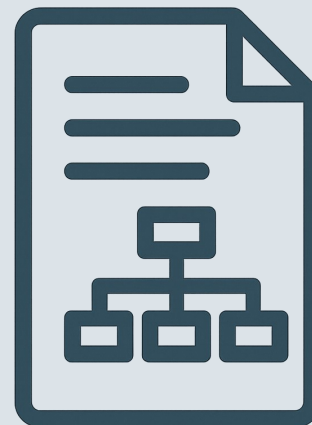
The Lebanon County MH/ID/EI, in establishing the Mobile Crisis Collaboration Team (MCCT) has provided a strategic forum for continued assessment, analysis, and crisis intervention program development as a collaborative effort of local participant stakeholders and community leaders.

### Continued Work Recommendations

Lebanon County is encouraged to support and promote the efforts of the MCCT and to build a larger body of participating stakeholders, and to use this forum for continued evaluation and strategic planning for the delivery of local crisis intervention services.

# PRESENTATION FORMAT FOR AREAS OF ANALYSIS

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Format Outline of the Remaining Sections

The remainder of the Crisis System Dynamic Enhancement Plan (Enhancement Plan) in the following sections is organized using the following outline:

- Environmental Conditions
- National Guidelines (for Reference)
- Observations from Field Work
- Recommendations for Further Action

Each section will outline the environmental conditions impacting the respective area of analysis and then cite applicable National Guideline references as taken from the National Council Roadmap, showing the section and page of the reference.

Observations are provided from the field work and analysis conducted during development of the Enhancement Plan, and where applicable are cross-referenced with scoring categories from the Roadmap Report Card.

Finally, each section closes with detailed recommendations for action or consideration by the Lebanon County Office of MH/ID/EI and their collaborative stakeholder partners.

## ANALYSIS AREA 1:

# FUNDING STRATEGIES

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Funding Strategies

### Environmental Condition

The "MH MR Act of 1966" (MH/MR Act) renamed in 2011 to the "Mental Health and Intellectual Disabilities Act of 1966", (MH/ID Act; 50 P.S. § 4201 et seq.), is the state law that established a framework for mental health and intellectual disability services within Pennsylvania. The act outlines the responsibilities of both the state and counties in providing prevention, diagnosis, treatment, and rehabilitation for individuals with mental disabilities and intellectual disabilities, and the act was later amended to replace the term "mental retardation" with "intellectual disability".

A key provision of the MH/ID Act is Section 201 – General Powers and Duties of the Department; item (7): [that it is the Commonwealth’s responsibility to] “make grants, pay subsidies, purchase service and provide reimbursement for mental health and intellectual disability services in accordance with this act.” Lebanon County interprets this to mean that the Commonwealth is responsible to provide funding for the mandated services.

Crisis intervention services provided in Pennsylvania currently operate under guidelines published by the Office of Mental Health and Substance Abuse Services (OMHSAS) in July 1993. These were provided to Mental Health Administrators prior to the publication of final regulations (55 PA Code Chapter 5240; Mental Health Crisis Intervention Services). Mental Health Administrators struggle with growing expectations prompted by National behavioral health crisis care guidance, as provided by SAMHSA’s National Guidelines for a Behavioral Health Coordinated System of Crisis Care (January 2025, updating their original Guidelines from 2020), to develop a comprehensive modern crisis intervention system. National guidance now recognizes the U.S. transition to the 988 Suicide & Crisis Lifeline, implemented in 2022, and encourages the creation and maintenance of an effective crisis continuum of services.

With outdated regulations and no specifically identified crisis intervention funding, coupled with the needs of modern programmatic expectations, Lebanon County (as with all other Pennsylvania Counties) is forced to do what it can under difficult conditions. While all Pennsylvania Counties, regardless of their size and resources, face the same programmatic expectations, the burden to find solutions is even more difficult for small rural counties like Lebanon County. In practical terms, it is a challenge for Lebanon County to simply maintain the delivery of basic services with existing financial and community resources.

### National Guideline for Reference

*National Council Roadmap, Section 1, Pg. 42 – Accountability and Finance: Financing - A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community in the same way that police, fire, EMS and emergent/urgent medical care are essential community services. For this reason, there must be adequate financing for that continuum of services to achieve appropriate community response, just as is the case for other safety-net services. Aligning multiple funding streams to support a single crisis system, rather than each funder developing its own system is likely to be more efficient, effective and accessible to customers.*

## Observations

### Multiple payers contribute to financing services and capacity in the continuum. (Measure 1E)

- The Lebanon County crisis intervention system is funded by braiding several categorical funding sources together to provide services to all populations and comorbidities (interventions for youth, adults and older adults, as well as individuals with mental health, SUD and cognitive disabilities in any combination). Current and future funding projections have been provided earlier in this report.

### Multiple payers contribute to financing services and capacity in the continuum. Shared resource contribution (Measure 1E)

- Once global crisis intervention system costs can be measured, each system can assess if any efficiencies can be found in collaborative solutions or funding strategies. Evaluate how the overall system can be improved with the addition of crisis worker resources to provide support to law enforcement or the local school systems.
- The Roadmap provides a worthy concept for consideration in that the behavioral health crisis system is a shared system capacity. All involved are accountable over time to contribute resources to core capacity. Funding for a “global” crisis financing budget is defined in each community as a collaboration between public payers (states, counties, cities/towns), public and private insurers and accountable health systems. Proportional contribution is based on historical utilization and potential value added.
- While shared resource contributions may not be practical in the short-term, the larger system of stakeholders involved in crisis intervention service delivery must assess total cost, level of effort, and collaborate on innovative solutions. Improvement in incremental parts of the system improves the system overall.

### Accountable entity coordinates financing. (Measure 1F)

- Lebanon County MH/ID/EI is the accountable entity responsible for producing the annual operating budget for crisis intervention services. Each state fiscal year MH/ID/EI requires budget information from their crisis intervention subcontractor to negotiate an annual operating budget. MH/ID/EI identifies staffing and service changes proposed by their subcontractor, compiles a funding source budget, and approves an annual contract for operations. Part of the process to braid funding sources is to work with CABHC to determine the annual funding for crisis intervention services through a HealthChoices alternative payment arrangement (APA). Over the past several years the funding composition (i.e. sources of funding) has remained unchanged, while the proportions have fluctuated with crisis system user mix or availability of funding.
- While MH/ID/EI is responsible for an annual crisis intervention operating budget, the impact of the overall crisis intervention system of services involves areas outside of MH/ID/EI control or responsibility. The Roadmap identifies that “the accountable entity is responsible for producing a global budget for the ideal crisis continuum. This budget is initially based on historical utilization data of all components and all payers of community behavioral health crisis response and has projections for future utilization based on movement toward an ideal system.” The overall crisis intervention “system” in the County involves human and financial resources from many other independent

systems, such as the ED, law enforcement, medical emergency responders, and community providers. Each of these other related systems incur hidden costs associated with the delivery of crisis intervention services. Some of these costs are funded through other sources, such as the delivery of billable services in the ED. However, unless costs in other systems are investigated and quantified, these costs will remain hidden. Quantifying how much time, effort, and cost are incurred by related community services is unclear unless they can be measured for the purpose of system improvement. The notion of producing a “global budget” for the crisis intervention system has merit for consideration. First steps involve gap analysis seeking to identify time and effort metrics from the related systems to move toward the calculation of a global budget.

All services in the crisis system function as safety-net support partners for behavioral health system programs. (Measure 1Q)

- During the Enhancement Plan field work and data analysis, we did not discover evidence of any needing individual or family who had gone unserved by the crisis intervention system. The current financing mechanisms designed are functioning as the necessary safety net for the entire delivery system. However, future funding projections may necessitate the allocation of local county funding to assure maintenance of effort.

## Recommendations

The constraints of limited resources require heightened attention and collaboration of those involved. The practical solution is in how the process is managed, the accountability and collaboration of the stakeholders, and a persistently optimistic mindset. While more funding is an answer, it is not the only answer necessary to drive system improvement.

The recommendations we offer below are not bound by current constraints nor are they in order of priority but are provided as an objective for consideration in making positive impact on the current crisis intervention system.

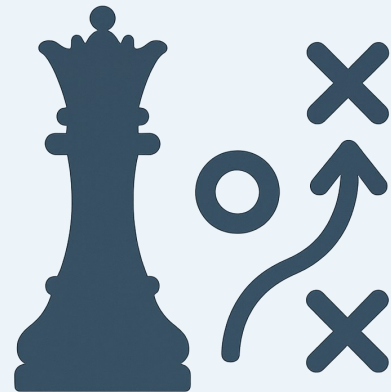
- Continuing efforts through legislative channels. Educate and influence state legislators on the completion of Pennsylvania crisis intervention regulations that would establish associated levels of funding for the currently unfunded mandates. Once regulations are established, to work with commercial insurance and the Pennsylvania Department of Insurance (DOI).
- Continuing efforts to contract with commercial payers to cover crisis intervention services as billable.
- Seeking grant funding for the crisis intervention system in collaboration with system partners. Possible areas of investigation for securing grant funding as they become available would include:
  - Pennsylvania Commission on Crime and Delinquency (PCCD) – eGrants
  - National Association of Counties (NACo) – Grant Resources
  - Substance Abuse and Mental Health Services (SAMHSA) – Grants Dashboard
  - Department of Justice (DOJ) – JUSTgrants; Office of Community Oriented Policing Services (COPS) – including the Law Enforcement Mental Health and Wellness Act Program (LEMHWA); Office of Justice Programs (OJP); and the Office of Violence Against Women (OVW)

- Department of Education (DOE); local school system grants for mental health and substance abuse services.
  - Health Resources and Services Administration (HRSA)
  - Opioid Settlement Funds
  - Grants.gov
  - Philanthropy – seek engagement with local large employers (WellSpan, Bell & Evans, The Hershey Company, Lebanon Valley College) for financial or in-kind support.
- Identify service expansion where the usage of HealthChoices Reinvestment funds may be appropriate.
  - Participation of Lebanon County in The Stepping Up initiative, which supports local jurisdictions in establishing and reaching measurable goals that demonstrate reduced prevalence of mental illness across the justice system. Participation would provide resources, technical assistance and potential grant funding to address local conditions. Currently Berks, Bucks, Chester, Cumberland, Dauphin, Montgomery, Philadelphia, and York Counties are participating Innovator Counties.
  - Establishing a means for the exchange of data across the crisis intervention system as a foundation for identifying performance measures. Currently the data supporting crisis intervention is provided by WellSpan Philhaven for basic crisis intervention utilization. Expansion of additional forms of data (such as from local law enforcement, 988 / 911 emergency dispatch, or CABHC for HealthChoices utilization) in an established data warehouse would be a good first step for quality analysis as well as a resource for making application for grant funding.
  - Establish a funding partnership / shared ownership with other parts of the crisis intervention system. Start by having the different systems share their operating budgets and goals to enable cross-system analysis and to design cross-system budgets. This would provide a first step in being able to see the whole functional picture and identify if there are any inefficiencies or redundancy. It would also afford a basis for discussion and strategic planning for joint efforts.

ANALYSIS AREA 2:

# ACCOUNTABLE ENTITY STRATEGIC PLANNING

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Accountable Entity Strategic Planning

### Environmental Condition

The engagement of TPG to develop a Crisis System Dynamic Enhancement Plan (Enhancement Plan) for Lebanon County marks a significant action step by MH/ID/EI to develop the County crisis intervention system as included in their recent strategic plans:

- Lebanon County Human Services Plan for Fiscal Year 2024-2025 – Improve and expand the county crisis intervention system services through the awarded grant funding through the Community Mental Health Services Block Grant (CMHSBG) funding under the American Rescue Plan Act (ARPA) of 2021.
- Lebanon County Criminal Justice Advisory Board (CJAB) Strategic Plan for 2023-2024; Updated Report – applied for CMHSBG funding to prepare a comprehensive Crisis System Plan for the County. This entails examination of the existing system and implementing a full spectrum of enhanced crisis services including mobile response teams and a crisis walk-in center.
- CJAB Strategic Plan for 2024-2025 – In December 2022, MH/ID/EI was awarded a grant under the American Rescue Plan to prepare a comprehensive Crisis System Plan for the county. Transforming Crisis Intervention is a State mandate. In response to this mandate, MH/ID/EI issued an RFP in April 2023; the County Commissioners awarded a consultant contract to TPG in August 2023 to begin the project.

MH/ID/EI, as the accountable entity for crisis intervention services, has worked over the past several years to change the culture to utilize crisis intervention services prior to or as a diversion from services in the ED. Previously, the customary crisis response was for crisis intervention staff to engage and treat needy individuals once in the hospital ED. With the implementation of the national 988 Suicide and Crisis Lifeline in 2020, greater emphasis was placed on the delivery of mobile crisis intervention in the community, as a strategy for diversion from the ED as both a quality enhancement and cost saving strategy.

In March 2023, MH/ID/EI was awarded two HealthChoices Reinvestment Plan allocations for the development of mental health professionals and embedding peer support specialists within mobile crisis intervention services. The financial resources enabled MH/ID/EI to begin the transformation of the County crisis intervention system.

At the time of the engagement of TPG to prepare the Enhancement Plan, MH/ID/EI had already begun working with WellSpan Philhaven (their subcontracted crisis intervention services provider) to enhance staffing and to begin the recruitment of peer support specialists. In addition, the priority to begin more actively promoting mobile crisis in the community was initiated. A new, more suitable and engaging location was also chosen as the crisis walk-in center in close proximity to the WellSpan Good Samaritan Hospital Emergency Department.

The next necessary step was to develop the Enhancement Plan to identify strengths and opportunities in the current system, as well as to highlight weaknesses and potential threats to be addressed.

## National Guideline for Reference

*National Council Roadmap, Section 1, Pg. 39 – Accountability and Finance: Structure for Coordination, Collaboration, and Accountability – A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. To operationalize such an ideal system, it is not adequate to simply have an array of discrete programs and providers. It is essential that all the payers and providers within the system work collaboratively to ensure that the various components work effectively together and are accountable for excellent crisis response and continuous improvement of crisis response to community members. Effective coordination and quality improvement require commitment as well to sharing both aggregate performance data and personal health information (PHI) systematically between all points of service.*

## Observations

### Accountable entity identified and established. (Measure 1A)

- Lebanon County MH/ID/EI is the accountable entity responsible for oversight, contracting and quality monitoring. MH/ID/EI subcontracts and works closely with WellSpan Philhaven for the delivery of crisis intervention services. Combined, they provide a formal crisis collaboration structure and process with an identified crisis coordinator provided by WellSpan Philhaven.

### Behavioral health crisis system coordinator identified. (Measure 1B)

- WellSpan Philhaven has a clearly identified crisis program manager. The crisis program manager is accountable directly to WellSpan Philhaven supervision but also takes instruction and guidance from MH/ID/EI as the accountable entity.
- The new crisis program manager as well as the operational changes implemented within the past two years (the relocation of the crisis walk-in center, additional staffing, and the recruitment of peer support specialists) have been a valuable improvement to the crisis system and provide a strong foundation for growth. The establishment of coordinated quality metrics, system policies, procedures, and protocols and services that govern how the individual elements of the crisis system work together are continually reviewed and updated to address operational changes.
- MH/ID/EI currently manages system collaboration and quality improvement plans as part of their contract monitoring and oversight. Quarterly Quality Management Team (QMT) meetings are conducted. The QMT is tasked with the review of the current mental health services to determine what changes should be made to improve the services. The team reviews and develops components of the county Mental Health Plan, reviews the Consumer Satisfaction Services (CSS) surveys, discuss issues related to Behavioral HealthChoices (PerformCare) state initiatives for improvement and quality of care issues.

### Community behavioral health crisis system collaborative meets. (Measure 1C)

- The Roadmap recommends the accountable entity and crisis coordinator hold a regular crisis coordination meeting at least monthly for each geographic area, attended by representatives of first responders, crisis continuum providers, human service agencies, ambulatory service providers, housing providers, funders and advocates.

- MH/ID/EI has established the Mobile Crisis Collaboration Team (MCCT) as discussed earlier (see section on Planning and Implementation Team, above). A more complete discussion is provided in the following section on continued development of the MCCT.

Data is collected and used collaboratively for customer oriented continuous improvement.  
(Measure 1K)

- WellSpan Philhaven provided that they maintain a robust database on their patients and services within their electronic medical record. They provide MH/ID/EI monthly utilization reports that show categorical service user by referral source and presenting need. As data needs may evolve, the data maintained by WellSpan Philhaven will have the capacity to provide summarized data for analysis. MH/ID/EI requires that data reporting / sharing that is not de-identified must comply with the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2.
- WellSpan Philhaven reported that their crisis intervention quality improvement unit routinely reviews data metrics and goals using Lean Six Sigma methods (Concern, Cause, Countermeasure, Confirm). They also conduct a safety meeting every day to review metrics.

## Recommendations

The Roadmap offers steps for communities and leaders to establish a collaborative body such as the MCCT to advance the recommendations of the Enhancement Plan. The process would use the baseline findings by each measured criteria to conduct follow-up assessments over time, to chart progress.

Areas of attention would include the following action steps:

- Identify additional community stakeholders and potential partners who are interested in, or have a stake in, behavioral health crisis services within the community and further develop the participation in the MCCT. The goal would be to have as broad representation as possible to establish accountability and buy-in.
- Share the guidance and recommendations with the MCCT, asking them to read and identify what is most relevant to them.
- Continue to assemble the MCCT to meet regularly on an ongoing basis, under the direction of the accountable entity, or a component of an existing collaboration.
- Use the baseline results from the Enhancement Plan using the measurable criteria provided in the Roadmap, rating each item from 1-5 as a starting point.
- Gather clinical and cost data on the current system performance and identify any areas for improvement or for system funding opportunities.
- Identify the most important quality metrics for the behavioral health crisis system performance that all system partners can be accountable to achieve.
- Create a comprehensive operational plan for concrete actions to be taken, schedule for completion, associated costs to the system and how they will be funded, and metrics to measure success using national guidelines identifying a step-by-step approach for multiple system partners to make progress over a period of years.

ANALYSIS AREA 3:

# MOBILE CRISIS COLLABORATION TEAM

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Mobile Crisis Collaboration Team

### Environmental Condition

With the implementation of the 988 Lifeline and Guidance provided by SAMHSA and the National Council for Behavioral Health, each County within the State of Pennsylvania is working to establish or strengthen their community crisis intervention systems. The development of crisis stabilization services has been a challenge at the County level due to the lack of modernized crisis intervention regulations and the necessary funding required to implement enhanced systems of care.

SAMHSA draws the analogy comparing crisis intervention services to other community services that are funded at the municipal level in what they describe as the “Firehouse Model” – citing how each municipality must have comprehensive fire, police, and emergency medical services. They describe how crisis services are essential and may be needed by anyone in the community, the need is predictable over time (but timing of individual crisis events is not), and effective crisis response is lifesaving and much less expensive than the consequences of inadequate care. (SAMHSA Guidelines 2020, p. 36-37).

The Firehouse Model provides a conceptual basis for local discussion while each County and community work to find the right-fit solution that provides the best services possible, given local resource constraints.

Lebanon County MH/ID/EI has worked in collaboration with the Capital Area Behavioral Health Collaborative and PerformCare (the local Behavioral HealthChoices Primary Contractor to the State of Pennsylvania, and their subcontracted behavioral health managed care provider), as well as WellSpan Philhaven (their subcontracted crisis intervention service provider), to produce an effective crisis intervention service delivery system for Lebanon County. Financial sustainability has recently become a challenge given most recent budget year projections, placing a heavier burden on MH/ID/EI program funding. Potential shortfalls may need to be underwritten by Lebanon County tax dollars if sustainable alternatives cannot be found.

The need exists for establishing greater coordination of all of the respective stakeholders and to build an effective ongoing working structure to bring all the parties together in closer involvement. The recommendations below outline a strategy to promote the continued participation and development of the MCCT.

### National Guideline for Reference

*National Council Roadmap, Section 1, Pg. 30 – Guiding Principles and System Values – Ideal behavioral health crisis systems have the expectation that systems, populations and individuals in crisis are complex. Complexity refers to the overlap between mental health and substance use issues, as well as between behavioral health and health issues, cognitive disabilities and all types of human service needs. An ideal behavioral health crisis system has to be able to design services based on the expectation of complexity (i.e., co-occurring mental health and substance use issues, combined with other health and human service needs) in all settings and be aware that successful performance*

*involves partnership with multiple collaborative systems, as well as attention to behavioral health issues for people whose major connection to service may be in a non-behavioral health service setting and for whom under-attention to behavioral health issues may lead to high costs in other domains.*

*SAMHSA Guidelines 2025, p. 60 – Coordination and Integration – Effective coordination among crisis system partners (e.g., EMS, law enforcement, hospitals/EDs, social services, schools, child welfare) across the state or local area is crucial to improve integration of services and systems, including improved data sharing, resource connectivity, and avoiding duplication of effort. Accountable entities should collaborate with systems that serve children and youth, adults, and older adults as well as individuals with I/DD to increase access to and quality of crisis services and improved outcomes for all.*

*SAMHSA Guidelines 2025, p. 60 – System Flow, Continuity and Throughput – Accountable entities are responsible for understanding how an individual is able to flow through the system, including entry and exit points. This can be accomplished through comprehensive system mapping. They should have a process and mechanism for identifying where individuals are in the behavioral health coordinated system of crisis care (BHCSCC) and the involvement of partner systems (e.g., law enforcement, EMS, social services, crisis-related services, other behavioral health services, and social services) in their care. Accountable entities can then use mapping to inform system gaps, service needs, and areas for improvement. Additionally, accountable entities should develop and maintain a well-structured emergency plan to ensure that there is no disruption of services during large scale emergencies, such as a natural disaster or mass casualty event. These emergencies may also indicate the need for additional crisis support due to the unique behavioral health needs that may arise due to the nature of the event. These emergency plans should include specific protocols and procedures for collaborating with Incident Command Systems (ICS) and working alongside federal agencies that might be involved such as the Federal Emergency Management Agency (FEMA) and/or SAMHSA, as well as state emergency management organizations and local disaster response teams.*

*SAMHSA Guidelines 2025, p. 61 – Data, Evaluation, and Quality Improvement – Accountable entities are responsible for data collection, tracking, and sharing as well as evaluation of a behavioral health coordinated system of care (BHCSCC) and their services. In this role, accountable entities can:*

- Develop process and outcome metrics for services and system components.*
- Develop and implement processes for data collection systems, track data over time, data sharing, data use, and linking administrative data.*
- Develop and implement a standard about how to use data for continuous quality improvement for services and the system.*
- Disseminate data and results to the public through dashboards and/or other visual tools to improve system transparency, celebrate successes, and raise awareness regarding system barriers.*

*National Council Roadmap, Section 3, Pg. 173 – Basic Clinical Practice-Collaboration, Coordination and Continuity of Care-Coordination of Care with Community Systems – The accountable entity responsible for oversight, contracting and quality monitoring expects all contracted crisis providers to document and implement the following clinical practice guidelines for program and staff collaboration with community human service systems through training, supervision and human resource evaluation*

*(Collaborative human service systems include the following: law enforcement, criminal justice [including specialty courts, probation and parole], housing/homeless services, child protection, elder protection, aging/disability, school systems, visiting nurses, intellectual/developmental disability, brain injury services, nursing homes, rehabilitation centers and other long-term care, social services [e.g., benefits, refugee services], veteran's services, office of conservator/public guardianship, domestic violence and vocational rehabilitation):*

## Observations

Lebanon County has demonstrated clear interest and has taken concrete action to commission the development of the Crisis Intervention Dynamic Enhancement Plan to identify ways to enhance their current crisis system delivery system. Each of the constituent system stakeholders who participated in the research all had deep desire to understand the current system better, and interest in doing what they can to help to make improvements overall.

A significant issue was repeated by many stakeholders during the fieldwork phase of the project in that there should be better participation, coordination, and communication between the various parts of the overall crisis intervention system. The condition present has been summarized by the guidance provided in the SAMHSA Guidelines (2020) regarding crisis system coordination (emphasis in bold added):

*Crisis services should not be viewed as stand-alone resources operating independent of the local community mental health and hospital systems but rather an integrated part of a coordinated continuum of care. Services needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode. This is not easily achieved given the complex dynamics that are in play in many communities throughout the country that have complex health ecosystems influencing the care delivery system. **Given the understanding that pieces of a continuum of care will not typically align and partner fully without a purposeful intent, regular communication between crisis services, local hospital and outpatient service leaderships must be coordinated in a thoughtful manner that focuses on the needs of the community served. Agency-to-agency collaboration is essential and may manifest through personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols or more advanced high-tech solutions such as real-time bed registries, shared GPS-enabled communication to support dispatch and outpatient appointment setting through the call center hub.** (SAMHSA Guidelines 2020, p. 25).*

Some of the guidelines offered by SAMHSA may not be feasible to incorporate into the crisis intervention service delivery system currently due to present state and local constraints (i.e. the presence of human and financial resources, state regulation for crisis intervention services). However, many of the conditions voiced for better participation, coordination, and communication are very attainable with the investment of time and attention by the participating operational groups of stakeholders.

When groups of stakeholders can invest their time and attention to find solutions in collaborative meetings that are well structured, efficiently run, where all are accountable, and the greatest effort is given to maximize the valuable time commitment with discussion that produces concrete action, great creative solutions will emerge. As an added value, the

opportunity for spin-off solutions in other systems more than just crisis intervention are made possible to further the achievement of other clear community missions such as public safety, education, and population health.

## Recommendations – Overview

Aligned with the previous recommendation to perform ongoing evaluation using the baseline assessment in the Enhancement Plan, expansion and continued development of the MCCT will improve system-wide coordination. While the MH/ID/EI performs as the accountable entity, it has been difficult to draw the broader group of key stakeholders together.

Beyond the responsibility and operational control of MH/ID/EI there are a number of key community stakeholders who each have a significant role in the design and performance of an effective crisis intervention service delivery system. MH/ID/EI can and does work closely with WellSpan Philhaven, WellSpan Good Samaritan Hospital, Capital Area Behavioral Health Collaborative (CABHC) for the administration of the Behavioral Health Choices Program, and a number of community service providers throughout the mental health and intellectual disabilities service continuum. As the accountable entity, MH/ID/EI has direct influence over and collaboration with these stakeholders.

Independent of the stakeholders mentioned above (where there are high levels of involvement around a common mission) there are other equally important stakeholders where levels of crisis intervention system involvement are less simply because their core mission is focused on other important community responsibilities.

For example, law enforcement, the courts, school districts and information technology departments do not have crisis intervention as their core mission. Each has many other areas of responsibility demanding their attention. However, each provides a critical piece of support contributing to the overall performance of the crisis intervention system in the County. Increased attention and participation from these stakeholders will improve and enhance quality, efficiency, and cost effectiveness of the overall system.

A key area for improvement is to establish improved communication, and collaboration from the Lebanon County Commission on Drug & Alcohol Abuse (LCCDAA). Within the organizational structure of Lebanon County Human Services, MH/ID/EI must depend upon the participation and assistance of the LCCDAA office for being a creative partner and funding source for the effective delivery of crisis intervention services. Both agencies have working relationships with the other agencies involved in the delivery of crisis intervention services (as stated above). However, improved coordination between MH/ID/EI and LCCDAA will promote efficient and cost-effective systems improvement. As stated in the Current Budget and Utilization section earlier in this report, funding for crisis intervention services from the LC D&A has been significantly reduced by 47.8% from FY24-25, placing additional financial challenges upon the crisis intervention system.

We realize this is not easy to build this collaborative body into the newly established MCCT, but responses from stakeholders throughout the system observed during our field work indicated that system-wide coordination was needed for improvement.

The MCCT, performing as an advisory board body of stakeholders, could be tasked to:

- Review the published Crisis Intervention Dynamic Enhancement Plan and to operationalize recommendations for action.
- Identify additional stakeholders, and provide outreach to additional participants to join the MCCT. Current and potential participating agencies may include:
  - Lebanon County Government Representation
    - Mental Health / Intellectual Disabilities / Early Intervention (MH/ID/EI)
    - Drug & Alcohol Commission (D&A)
    - Area Agency on Aging (AAA)
    - Children and Youth Services (CYS)
    - Information Technology
    - Veterans Affairs
    - District Attorney
    - County Court System
    - Corrections
    - Probation / Parole
    - County Department of Emergency Services
  - WellSpan Philhaven
  - WellSpan Good Samaritan Hospital
  - Peer Support Specialist(s) / Certified Recovery Specialist(s)
  - Capital Area Behavioral Health Collaborative (CABHC)
  - County Law Enforcement Departments
  - County School Districts and Intermediate Unit 13
  - County Emergency Responders
  - MH Quality Management Team
  - Other Identified Community Champions

Provided below is a listing of development topics that have been documented during the fieldwork phase to produce the Enhancement Plan. The list is not prioritized in weight of criticality. It is provided as a starter-set of findings and recommendations as the outcome of the development of the dynamic enhancement plan that can be used by the Task Force to identify areas of collaborative action. It is likely that in the review of these topics, others will emerge as well that may be outside of the direct mission of crisis intervention services. These spin-off areas should be considered a value-add produced by this body of community experts and could become the fuel for other areas of investigation and improvement.

## Recommendations – Specific Areas of Investigation by MCCT:

### **Establish Memorandums of Understanding (MOU)**

Identify where needed and appropriate to document responsibilities and expectations in memorandums of understanding (MOU) to define what actions are to be taken, who the responsible parties for the delivery of work products, timeframes and resource support. The deliberate process to establish MOUs will define parameters of operation, interaction, coordination, and communication and become the basis of accountability in the overall system.

MOUs are helpful working documents to outline relationships and responsibilities centered around the delivery of crisis intervention services. They can be used to establish and memorialize agreements and accountability for performance amongst participating organizations within, or outside of the County.

Currently, WellSpan Philhaven (WSP) Crisis Intervention has been working to standardize processes with each of the Lebanon County school districts. The WSP Community Liaison is making progress to establish working relationships and MOUs with the respective school districts to outline their participation. Similar work is being done with each of the Lebanon County police departments to create workflows that can also be incorporated into MOU documents.

The formalization of these relationships help to define terms, set measurable goals, and establish accountability for collaboration and quality improvement.

MH/ID/EI would benefit from implementing an MOU process that documents and outlines working responsibilities and accountability with each of the other internal County Offices.

### **Re-Assess Condition Status using Roadmap Report Card Baseline Scores**

Determine a time interval possibly 1 to 2 years in the future where the measured criteria provided in the Roadmap to the Ideal Crisis System would be reassessed and scored to compare to the baseline provided in the Crisis Intervention Dynamic Enhancement Plan. Identified changes would be examined to determine areas of improvement as well as areas that have declined.

### **Expand Coordination, Collaboration and Channels of Communication**

Frequently mentioned by crisis system stakeholders interviewed as part of the Enhancement Plan field work was the need for improved coordination, collaboration, and communication throughout the system.

With the implementation of the MCCT, MH/ID/EI has initiated system changes in an effort to overcome operational silos and to determine how to coordinate county and community stakeholders together to get everyone on the same page.

The most frequently referenced barrier to collaborative efforts by system stakeholders is there are no or limited financial resources to expand programming. As a result, participation in planning wanes, as well as consistent participation, coordinated strategic effort, and communication. In the broader stakeholder system, it is very difficult to keep crisis

intervention system development in the center of stakeholder group attention. MH/ID/EI needs to continue to communicate the need and value of a coordinated crisis intervention strategy, and to provide outreach to stakeholder groups that have not participated in crisis intervention system collaboration.

### **Assist Law Enforcement**

Examination of specific police department's performance metrics (i.e. wellness check volumes) was not collected as part of the field work for development of the Enhancement Plan. It would be valuable to collect views and opinions from local law enforcement as to what they need to improve their work processes that could be remedied by MH/ID/EI to develop and provide preventative services that would result in a reduction of wellness checks performed on individuals with behavioral health issues. Data metrics would need to be identified to perform measurement of frequency and volume. As with diversion of an individual in crisis from an emergency department, prevention efforts for reduction of the frequency of wellness checks or crisis interventions would be less costly and more beneficial to the whole system, especially the individual in need.

Establishing law enforcement as a preferred customer, how could crisis intervention systems of coordination benefit local law enforcement? Topics may include (as an example):

- Promote and facilitate ways in which crisis intervention staff and local police get to know one another, and gain familiarity with each other's perception of one another.
- Develop informal ways to break down lines of separation and develop common understanding of the needs and expectations of each system.
- Establish channels of communication to promote cross training and identify system improvements.
- Identify work processes that improve and strengthen performance where crisis intervention and law enforcement are jointly involved.
- Development of information exchange feasibility and strategies to address what information could be provided to law enforcement prior to responding to a crisis call. Is there acceptable information that can be made available to first responders, and how could that be done appropriately?
- Develop joint-training opportunities between crisis intervention and law enforcement officers and do establish a process to assure full participation in necessary training and skill development for all officers, including crisis intervention training, trauma-informed care, suicide, and mental health first aid.

### **Development of a Mental Health Treatment Court**

The Criminal Justice Advisory Board Strategic Plan for SFY2024-2025 identifies the goal for Lebanon County is to develop and implement a Mental Health Treatment Court, accredited by the Administration Office of Pennsylvania Courts (AOPC). Mental health courts partner key justice system officials with leaders in the mental health system to divert offenders with severe mental illness into a judicially supervised program and includes community-based treatment.

The number of defendants with serious untreated mental illnesses in the criminal justice system has drastically increased in recent years, but traditional court processes prove to be unsuccessful in changing the outcomes for many of these defendants.

Mental health courts provide a team of court staff and mental health professionals that work together to screen and assess defendants, develop treatment plans and supervise offenders. These courts offer defendants the opportunity to avoid incarceration by complying with community supervision and mandated treatment.

The Sequential Intercept Model should be used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others. Employed as a strategic planning tool, the model shows how people with mental and substance use disorders flow through the criminal justice system along six distinct intercept points: <sup>(14)</sup>

- Community Services
- Law Enforcement
- Initial Detention and Initial Court Hearings
- Jails and Courts
- Reentry, and
- Community Corrections

The MCCT can provide valuable support and technical assistance to the Criminal Justice Advisory Board in the development of a Mental Health Treatment Court.

### **Enroll in the Stepping Up Initiative**

The Stepping Up Initiative is a data-driven framework that assists counties through training, resources, and support that are tailored to local needs. It is a partnership of The Council of State Governments (CSG) Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation. At the local level, these jurisdictions are applying collaborative, cross-system approaches guided by data to understand the scale of the problem, employ high-impact strategies, and drive countywide system change.

Examples of such strategies include implementing programs to divert people from jail, as well as using assessments to identify people with SMI upon incarceration and connect them to appropriate treatment and services, reducing their likelihood of future incarcerations and hospitalizations. Additionally, Stepping Up counties strengthen their data collection and tracking to better understand the extent of their problem and their progress, leading to targeted action plans with system-wide impacts. <sup>(15)</sup>

The Stepping Up Initiative identifies actions anchored in research and best practices that are directly aligned with the needs present in Lebanon County:

Strengthen and formalize cross-system collaboration – Policies that bring state and local leaders across multiple systems (criminal justice, behavioral health/health, housing, etc.) together to understand local challenges, establish shared goals, and identify opportunities for states to support local collaborative responses.

Improve local capacity to collect data and share information – Policies that equip states and

localities to examine the impact of investments and target resources toward the most effective strategies.

Reduce avoidable justice system contact – Policies that focus on building opportunities to (1) respond to people in mental health crisis prior to and upon law enforcement contact, (2) divert people with behavioral health needs who don't pose a public safety risk to appropriate community-based services and supports (and supervision, if applicable), (3) ensure timely movement/processing (e.g., case processing, etc.) for people in the system, and (4) reduce the likelihood of return to the system (through reentry, community supervision strategies).

Strengthen community-based care and services – Policies that focus on ensuring that (1) sufficient capacity and access exists in the community to address people's unmet behavioral health and social service needs and (2) available services and care are accessible and include effective responses to people in the criminal justice system.

The MCCT can provide valuable support to pursue Lebanon County enrollment as a Stepping Up participating County. Currently there are 8 Innovator Counties in Pennsylvania – Berks, Bucks, Chester, Cumberland, Dauphin, Montgomery, Philadelphia, and York.

### **Explore the Feasibility of The Hub Model / Situation Table**

A model for crime prevention used by the Government of Canada – The Hub Model (also known as the Community Mobilization Prince Albert approach and Situation Tables in other jurisdictions) consists of a multi-agency team focused on addressing specific situations where the probability of experiencing harm is imminent. This model is not a service delivery mechanism, but rather a way of utilizing and mobilizing the systems and resources already in place in different, unified, and dynamic ways to address specific situations of elevated risk, for which an integrated approach is required.

- Professionals from a variety of human service backgrounds sit at Hub / Situation Tables. Police officers, teachers, social workers and youth workers are just a few examples of the kinds of professionals that might participate. During a meeting, participants work together to review situations of acutely elevated risk to determine if an individual or family meets the criteria for imminent risk of harm and/or victimization. Following their review, the Hub / Situation Table team will co-ordinate interventions as necessary.
- When situations are brought to the table, the situation is discussed using a four-filter process to determine whether a collaborative intervention is necessary and serves to minimize the risk of unnecessary sharing of information. The four filter process, which may vary slightly in each jurisdiction, is as follows: <sup>(16)</sup>
  - Filter 1: Home Agency Screening – Agencies identify situations that may benefit from contact with a Hub Table ensuring the criteria for acutely elevated risk is met
  - Filter 2: De-Identified Discussion – The initial discussion at the Hub Table is limited to de-identified information
  - Filter 3: Identifiable Discussion – Limited personal information is shared to help determine if other agencies are involved with the individual or family

- Filter 4: Intervention Planning – Only three or four agencies typically remain at this level of the discussion; other agencies will be eliminated if they do not have a relevant role
- The Hub model is currently being used in Montgomery County, PA in 4-5 locations. Our discussion with local stakeholders shared that police feel these table discussions are a benefit, a collaboration that helps the community. Local social services receive referrals from police (they call the referrals “the bridge”). The Hub assesses risk and shares information within HIPAA constraints. Mobile crisis then works on the case and do follow-up.
- The concept of the Hub model described above may have applicability or provide guidance to Lebanon County.

### **Social Work Resource Feasibility**

Examine the potential use of shared social worker resources throughout the system. Currently several school districts utilize social workers to facilitate navigation and community education for preventative services with individuals and families. In some instances, where a social work resource was used by a local police departments, there were favorable results. Opportunities exist to assess the feasibility of securing grant funding to support the development of social work resources as connective tissue between the service systems, and to facilitate communication and follow-through.

### **Forensic Diversion Specialist Resource Feasibility**

The Forensic Diversion Specialist is a licensed clinician who will meet with individuals to determine if they meet the criteria to receive services: the individual has a mental illness diagnosis, current criminal justice involvement, and reduced imminent risk to the community. If an individual is deemed appropriate for a diversion plan, the Forensic Diversion Specialist will make recommendations to the Courts as to specific conditions to reduce and / or eliminate charges. Some conditions may include stipulated treatment compliance, compliance with medication management, participation in assigned community wellness programs, and oversight with mental health case management support.

Most commonly, these stipulations are regulated with unsecured bail conditions, which are then monitored through pretrial services. Clients are supported through case management and by the Forensic Diversion team. If conditions are not followed and the person is not engaged in services, bail can be revoked, and further criminal charges can be pursued.

The Forensic Diversion Program using a Diversion Specialist has been operational in Berks County, Pennsylvania in January 2012 through a collaboration between Berks Connections / Pre-Trial Services and the Berks County MH/DD Program as part of a comprehensive county jail diversion program for individuals with mental illness. The Diversion Specialist is instrumental in the delivery of a system which includes a number of initiatives such as Stepping Up, CCAP Comprehensive Behavioral Health Task Force, Cross-Systems Mapping (Intercepts 1-5), Crisis Services, Forensic Blended Case Management, Law Enforcement, and a Data Driven Justice Initiative. <sup>(17)</sup>

The MCCT is encouraged to explore the service model established in Berks County to gain valuable insight into establishing further collaboration and leveraging resources of the Lebanon County Court System.

### **Continue 988 / 911 Dispatch Coordination; and Development of Peer-Operated Warmline Capabilities**

Examine the current interaction between call systems to identify if there are potential improvements that can be built upon the advances made between local 911 Dispatch and the Regional 988 call centers. Examination of existing data points provided by the Lebanon County Department of Emergency Services (DES) showing distinct dispatch calls by type, EMS type, primary unit response by type, and secondary unit location.

Expanded capabilities and data analysis is necessary to summarize data metrics for evaluation and quality improvement. In addition, a valuable enhancement to the current service delivery would be to establish a peer-operated warmline. Solutions may be available with regional resources already present in surrounding Counties.

### **Initiate the Development of a Data Warehouse**

Currently, data for utilization analysis is not maintained in a centralized data warehouse repository. Structured data from various sources should be identified for usefulness and ease of production and exchange into an integrated data warehouse.

Cost / benefit analysis should be conducted to determine if there is capacity to house an integrated data warehouse (i.e. a secure environment for building a database home for the collection of system data). Establishing a data warehouse would be the first step to begin utilization analysis, evaluation, and quality improvement processes.

### **Discuss Feasibility and Interest to Develop an Emergency Psychiatric Assessment, Treatment, and Healing (EMPATH) Unit at WellSpan Good Samaritan Hospital**

EMPATH is a model for psychiatric emergency care. The model is based on the premise that the majority of psychiatric emergencies can be resolved in less than 24 hours with prompt, appropriate intervention. However, evidence shows that the environment of standard emergency departments may, in fact, exacerbate the symptoms of a psychiatric crisis. EMPATH units are hospital-based outpatient programs which can promptly accept all medically appropriate patients in a psychiatric crisis, even those on involuntary psychiatric detention. Generally, an EMPATH unit is either part of the emergency department or is located nearby on the hospital's campus .

Statistics cited in System Analysis and Recommendations to Reduce Psychiatric Boarding and to Support Persons in Emergency Departments, a Whitepaper produced by the Emergency Department Boarding Workgroup in 2023 show promising results when implementing an EMPATH Unit for psychiatric emergency care: <sup>(18)</sup>

- Hospitalizations for patients with acute psychiatric needs have dropped 70-80 percent.
- Boarding for this patient population in the emergency department has dropped by 90 percent.
- Average length of stay for patients with acute psychiatric needs has dropped to 16 hours.
- Recidivism rates for this patient population have dropped significantly.

- At one institution, nearly \$1 million was added to the emergency department's finances by the addition of an EMPATH unit, making ER beds available for other patients presenting with physical ailments and traumas.

MCCT should engage in exploratory discussion with WellSpan Good Samaritan Hospital to determine if there is any interest and potential cost / benefit to explore the development of expanded crisis intervention capacity in the form of an EMPATH Unit. While the establishment of a complete crisis stabilization solution may not be feasible, the expansion of service capabilities within, or in proximity to the ED within the hospital may be possible.

### **Coordination with key Lebanon County Health and Human Services Offices**

Crisis intervention services are provided to individuals who may already be involved with the Office of Children & Youth (C&Y), the Area Agency on Aging (AAA), or the Commission on Drug & Alcohol (D&A). Other involvements include Veterans Affairs (VA), or the Department of Emergency Services (DES). Several areas where additional development of inter-office coordination and communication include:

- Care coordination with C&Y working with the Emergency Department Behavioral Health Therapists (BHTs) for children in placement or at risk of placement to improve outcomes.
- Enhance coordination and communication between Crisis Intervention with the AAA to improve awareness of their procedures, and to improve follow-up communication.
- Coordination with D&A to identify stable funding and strategy for the delivery of assessments by American Society of Addiction Medicine (ASAM) certified staff. Fieldwork identified D&A was desirous of streamlining their contractual agreements for the delivery of assessments and SUD warm handoffs. Assessments could potentially be provided by ASAM trained staff to streamline D&A administrative overhead. MH/ID/EI currently has experienced a reduction in D&A funding support of 48% from SFY24-25 to SFY25-26. Examination of the use of additional D&A resources (such as Opioid Settlement Funding) may be a solution to make up current funding reductions.

### **Identify Emergency Department Training Needs and Implement Monitoring Process**

The crisis intervention system in Lebanon County has implemented several changes to their operational processes to expand the usage of mobile crisis intervention in the community, and the usage of peer support staff. In addition, the behavioral health therapy staff within the local Emergency Department (ED) has also gone through operational changes including staff recruitment and development.

Crisis intervention services are delivered to a person in need requires the fluid interaction of many parts performing with a high level of coordination and precision. Each part of the service delivery system (i.e. police officers, crisis intervention staff, ED medical staff, BHTs and psychiatric consult staff, and community service providers) has requirements and operational expectations of how they should work with the other parts. Without a consistent syllabus of training requirements and monitoring training participation, system coordination will deteriorate over time.

Lebanon County MH/ID/EI has offered and held extensive training throughout the years. However, they have indicated that there has been very poor participation in the trainings offered. A root cause is that MH/ID/EI is unable to require participation from outside organizations. Where MH/ID/EI has control through contracted provider relationships, crisis intervention staff are required to participate in mandated training.

Areas of improvement to address training issues include:

- Establish uniform procedures that are agreed upon by organizations outside of the administrative control of MH/ID/EI to create accountability for training participation.
- Offer training to ED, BHT and crisis staff on managing older adult presentation including running necessary tests to rule out physical issues especially for those presenting for the first time. Providing training to educate staff on identification of dementia.
- Cross-training of crisis intervention staff with ED staff and BHTs to improve understanding of policy for treatment, and clear understanding of roles of responsibility and interaction. Training should also include a clear understanding of safety procedures and the role of ED Security Personnel.
- Offer training to ED, BHT and crisis staff on individuals who have intellectual disabilities (ID). The training program should include on-going training for persons who are dually diagnosed for MH and ID. Training should extend to ED Physicians and Psychiatrists.
- Offering training on policies and procedures for the patient receiving crisis intervention services and their family members who are accompanying the individual in the ED.
- Offer and Monitor Participation in Trauma-Informed Care Training in the ED – Development and monitoring of a trauma-informed approach in the ED setting will ease patient discomfort by creating safe and empowering environments. Trauma-Informed Care (TIC) promotes enhanced communication between client and provider to improve screening and assessment, treatment planning, and service delivery while decreasing the risk for re-traumatization. The establishment of a trauma-informed training program aligns with the CJAB Strategic Plan for SFY24-25:
  - Recommend that service providers apply culturally competent and generationally focused approaches in evidence-based policies, practices, and programs to improve the delivery of services.
  - Improve the ability of the county systems to identify, implement, and monitor impacts of effective trauma-informed strategies to improve outcomes.
  - Improve the capacity of systems to blend funding streams to sustain the implementation of evidence-based, trauma-informed practices.
- Offer and Monitor Participation in Zero Suicide / Suicide Safer Care Training – Establish a training protocol for suicide risk screening, assessment and planning into crisis intervention practices, and employee orientation.

### **Improve Process of Notification Upon Discharge**

Communication of clear instructions to individuals and their families when the individual is discharged from an ED a part of normal procedure. Structured communication to notify involved community providers, managed care behavioral health managed care organizations (PerformCare) is not consistent. It is very important for community providers who will be treating the discharged individual to know their conditions and if there are any medication changes. Community stakeholders had indicated the need for improvement of consistent communication as part of the discharge process.

The MCCT is encouraged to review possible solutions to create clear communication channels and procedures for informing the community stakeholders of appropriate notice of discharge.

### **Explore the Use of Internships for Psychiatric Consultation**

Development of psychiatric consultation with local medical schools (i.e. Hershey Medical School) for medical resource capacity for mobile crisis intervention staff. In addition, establishing a working relationship with The Pennsylvania Psychiatric Leadership Council (PPLC) may be beneficial to explore opportunities.

The PPLC is a neutral forum for exploring complex cross system issues which impact public service mental health services and its recipients. It is a partnership of groups which otherwise do not meet regularly. Clinicians, providers, managed care companies, state and county government representatives, academia, families and individuals in treatment, all joining together around common goals. The PPLC serves as a consultant to state and local health care agencies and continues to present pertinent issues around the topics of community based behavioral health care to its membership. <sup>(19)</sup>

Opportunities may exist for psychiatrists and interns to make time available for on-call consultation to mobile crisis, or for consultation during the day shift for consultation in the ED.

### **Leveraging Early Successes with Local School Districts**

Lebanon County MH/ID/EI, through the efforts of their Crisis Community Liaison, is currently working to establish communication channels with each of the County school districts. Comments received during the field work phase of the development of the Enhancement Plan indicated that there was need for more consistent communication and coordination with the local school districts within Lebanon County. The remedy to establish consistent communication was the implementation of the Crisis Community Liaison staff position.

Through the Behavioral HealthChoices Program every school district in Lebanon County has school-based outpatient services offered. While the implementation of the Crisis Community Liaison role is new, there is significant results communicating and collaborating with the County school districts.

MH/ID/EI is encouraged to build upon the positive results achieved, and to assess opportunities for expanded service capabilities leveraging the resources of the local school districts.

## **Develop Consistent Model of Community Education**

Local school districts who have social worker staff resources have engaged in community outreach and education. School stakeholders have indicated that it is very difficult to educate families on the value and use of crisis intervention services. They are very resistant due to trust and cultural constraints. Stakeholders had also expressed that they would be very receptive and appreciative for crisis intervention to come out and provide community presentations in the schools to staff and parents and highlight prevention measures.

Another potential community resource for community and family education would be in coordination with the Intermediate Unit 13 (IU13) Education Center for Adults. This may provide a venue for additional community education and awareness of crisis intervention services and crisis prevention. The IU13 can also be a resource to support cultural competency and overcoming cultural barriers through community education.

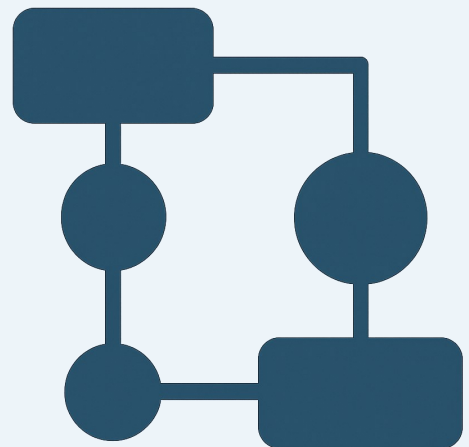
Expansion of current forms of community education in collaboration with the National Alliance on Mental Health (NAMI) of Central Pennsylvania may also add to a portfolio of training opportunities.

MH/ID/EI has indicated that they have engaged the services with Mental Health America of Lancaster County to provide education, community awareness and advocacy.

## ANALYSIS AREA 4:

# MAPPING WORKFLOWS

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Mapping Workflows

### Environmental Condition

The current crisis intervention system of care is not fully documented with clearly defined workflow maps showing action steps, decision points, resulting actions, and participants in the service delivery system, and descriptions of roles and responsibilities. A current process map workflow is provided in Appendix 6 from WellSpan Good Samaritan Hospital, Emergency Department (ED) as a sample illustration as reference for the observations and recommendations made below. [See Appendix 5 – WellSpan Good Samaritan Hospital Emergency Department Workflow.](#)

The implementation of new and enhanced services in the crisis intervention system (a new walk-in center location, changes with mobile crisis, and the addition of peer supports staff) has been the focus of MH/ID/EI and WellSpan Philhaven crisis intervention directors. Recruitment and hiring of new staff to fill all vacancies and refining operational policies and procedures has been an ongoing effort.

During the field work phase of the Enhancement Plan, stakeholders had identified areas where better collaboration, coordination, and understanding of the operational workflow processes guiding each part of the service delivery system is needed. Having a comprehensive system mapping (using detailed workflow diagramming) would help identify areas where coordination is required, or where system gaps, redundancies, or other inefficiencies may exist. Process mapping would also have a long-term benefit in its utility for monitoring and staff orientation and training.

### National Guideline for Reference

*SAMHSA Guidelines 2025, p. 60 – System Flow, Continuity and Throughput: Accountable entities are responsible for understanding how an individual is able to flow through the system, including entry and exit points. This can be accomplished through comprehensive system mapping. Accountable entities can then use mapping to inform system gaps, service needs, and areas for improvement.*

*National Council Roadmap, Section 1, Pg. 57 – Flow and Throughput: Processes must be in place to both respond in real-time to fluctuations in demand and barriers to flow and periodically review whether the system has the adequate capacity and operational processes to meet community needs. Quality methods involving formal application of quality improvement technology (e.g., LEAN, Plan-do-check-act cycles) are designed to improve process efficiencies and throughput while maximizing the value to and experience of customers and stakeholders.*

### Observations

System metrics include attention to how clients flow through the continuum timely/successfully. (Measure 1M).

Flow metrics are currently being collected at various stages of the crisis intervention service continuum. WellSpan Philhaven utilizes information provided by WellSpan's electronic medical record to produce data reports to MH/ID/EI for utilization review. The Lebanon County Department of Emergency Services (911 Dispatch) also has recently provided sample reports for review by MH/ID/EI staff.

While a good foundation for measuring operations is present, continued development of an integrated workflow and supporting data metrics would enable more detailed analysis and monitoring to assess if and where there are areas needing attention for improvement.

### Continuity of Care and Seamless Vertical and Horizontal Flow

Mapping the movement of an individual through the crisis intervention service delivery system is not a discrete linear set of steps, but more often is comprised of fluid cycles of repetitive actions. The individual receiving crisis intervention services will frequently move through cycles of distress or agitation, as trained police officers, crisis intervention, or emergency department staff will work to de-escalate the person's condition.

Many individuals in crisis, their families and supports experience multiple disjunctions and transitions in care during the crisis episode at a time when they are most vulnerable and distressed. These transitions are often associated with multiple repetitive assessments, changes in diagnosis and variations in treatment plan from one day to the next or one program to the next. This lack of continuity through the crisis episode results in the diminished experience of care for primary customers. Seamless process flow is even more challenging with individuals with co-occurring conditions (such as with mental health and substance use disorders, or for individuals with intellectual disabilities).

### Continuity of Care – Timeframes and Workflows within the Crisis Continuum (Measure 3V)

It is critical that crisis services provide immediate care to those who need it most. To achieve this goal, established methods for measuring and improving throughput should be employed. Quality improvement methods (including but not limited to "Lean") are well-suited for maximizing workflow processes and quality improvement in crisis services. An important focus of Lean is waste reduction, which is defined as anything that is non-value added to the customer, such as time spent waiting.

Because crisis service delivery may occur very quickly and move from law enforcement or crisis intervention worker to medical service provider, to behavioral health service provider, it is very important for all the service staff involved to completely understand the overall workflow and have clear instructions for what is being done from engagement through assessment, and intervention. Who does what, when, and how quickly is important for all service providers throughout the crisis service continuum.

Therefore, it is very important for MH/ID/EI and WellSpan Philhaven to take the lead in a collaboration of all the other community stakeholders to establish clearly defined workflows for each part of the crisis continuum, and detailed guidelines and quality improvement processes for workflow and throughput in all levels of the crisis system.

These established workflows and functional instructions need to remain continually fresh and up to date and translated into clinical practice instructions that can be used as the basis for monitoring and quality assessment. Well defined workflows and staff roles and responsibilities will enable all staff to know how and when to act without inefficient overlap or duplication of effort. The whole team will be able to clearly understand the process map and can be a resource to identify bottlenecks and barriers to service flow and develop solutions.

### Sample Workflow – WellSpan Good Samaritan Hospital, Emergency Department (ED)

The workflow diagram in Appendix 5 – WellSpan Good Samaritan Hospital Emergency Department Workflow shows the process currently in operation that maps an individual who arrives in the ED with a crisis intervention encounter. The process clearly outlines steps in sequence or cycles of actions, and what medical or behavioral provider is responsible. We provide this as a sample of one part of the overall crisis intervention continuum of services. Other similar diagrams could be produced to outline the involvement, responsibilities and operational action steps for law enforcement, crisis intervention, school systems, the judicial system / courts / corrections, 988 / 911 coordinated dispatch, and the referral process to community service providers. This is an important step necessary to overcome coordination issues is to understand the workflow processes in the current system.

## Recommendations

Establishing a process map for each of the respective parts of the crisis intervention service delivery system will aid MH/ID/EI and other key stakeholders better understand the workflow of action steps involved in serving an individual who needs crisis intervention services. The process workflow provided above from WellSpan Good Samaritan Hospital's Emergency Department provides insight as to the movement of an individual through emergency room services, providers involved in care, decision points requiring action, and subsequent steps (either discharged to community services or to inpatient psychiatric care).

Workflows detailing actions and decision points for 911 Emergency Dispatch and Regional 988 Suicide & Crisis Lifeline would also be very helpful to highlight the steps and areas requiring coordination between systems at the outset of a crisis event.

Workflows detailing response actions and decision points for WellSpan Philhaven (Crisis Intervention), from the point of notification from 911 or 988, would highlight the action steps taken by crisis intervention staff. Actions and decision points for the engagement of mobile crisis as well as peer support would be outlined for interaction and coordination with law enforcement prior to arrival, on site, and in the ED. Coordination of crisis intervention staff with ED physicians, behavioral health therapists, medical staff, and behavioral health psychiatric consultants could show detailed interactions and dependencies.

Ideally, it would be very helpful to be able to map related workflows from as many law enforcement departments as possible or practical. The purpose of this exercise would be to gain an understanding of action steps for officers who are called for a crisis intervention response, or for a wellness check that progresses into a crisis intervention encounter. Stakeholders had indicated that there is a need for law enforcement officers to better understand the processes and decision points of the crisis intervention system.

Conversely, stakeholders also indicated that there is an equal need for crisis intervention workers to better understand the processes and decision points of law enforcement officers. Building out detailed workflows, with detailed descriptions of actions and response would not only become a valuable assessment tool to examine the current “as-is” state of the overall crisis intervention system but also provide the ability to focus on specific areas where the system may not be performing as it should, or as efficiently and effectively as possible.

The development and documentation of process flows is not an exercise that can be accomplished in the short term. As with many tactical objectives, they are grown and developed over time. As each process map is shared, it can be examined to see how it fits within the current policies and procedures and quality improvement activities involved in the crisis service delivery system.

Process workflows, action steps and decision points should be reviewed annually for modification and can become part of the overall crisis intervention policies and procedures documentation, as well as part of new staff orientation training or crisis intervention training for law enforcement officers.

## ANALYSIS AREA 5:

# LAW ENFORCEMENT ENGAGEMENT

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Law Enforcement Engagement

### Environmental Condition

#### Financial Cost Estimates

Nationally, SAMHSA reported in the National Guidelines for Behavioral Health Crisis Care (2020) that according to the 2019 Treatment Advocacy Center published Road Runner study, more than \$17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness. If extrapolated to law enforcement agencies nationwide, this number is approximately \$918 million or 10% of law enforcement’s annual operating budget. <sup>(20)</sup>

A question immediately emerges as to what is the level of effort, time, attention, and resource cost (human and financial) invested in providing public safety in response to prevention and delivery of crisis intervention services by local law enforcement officers? How would we start to investigate the answer to this question?

Further investigation could be conducted to measure how often police officers are called for welfare check requests to the same persons with behavioral health issues multiple times per month would enable the County to quantify assumptions with measurable data maintained by each police department. In addition, the measurement and extrapolation of time and cost that is required to make welfare visits to frequent callers would highlight the dimensions of scope. Would we find the same results as referenced in the financial cost estimates of 10% of annual operating budgets?

City and State, a news organization that dedicates its coverage to Pennsylvania’s state and local government has published the following on March 31, 2025 (excerpt below, bold emphasis added):

*Pennsylvania stands alone when it comes to policing: The commonwealth has more local police departments than any state in the country. As municipalities and boroughs around Pennsylvania grapple with financial burdens and police departments struggle to recruit and retain officers, more localities are opting to join forces in an effort to regionalize their services. There are 2,560 municipalities in Pennsylvania; 1,304 of them have state police coverage only. Another 887 municipalities have their own departments. Of the remaining municipalities, 143 comprise the 41 regional police departments, and 226 municipalities contract services from a municipal or regional police department for their police coverage. **The average per capita cost for a municipal police department in 2023 was \$285, the cost for a regional police department was \$204 – a nearly 30% savings per capita.*** <sup>(21)</sup>

Examination of Lebanon County, prompted by the reported per-capita costs provided in the article above, and based on Pennsylvania Department of Community & Economic Development (DCED) Municipal Statistics for Lebanon County Police Departments, public safety (estimated overall costs for law enforcement) in Lebanon County is approximately \$36M, covering a population of 143,257, at a per-capita cost of \$252 per person, per year in CY2023.

Applying the estimate from the Road Runner study that 10% of law enforcement's annual operating budget is spent serving people with mental illness as a barometer and apply it to the costs shown in the DECED information above, we get a possible cost estimate of \$3.6M County wide.

SAMHSA National Guidelines provide the cost effectiveness of the development of a mobile crisis intervention service delivery system with the following study results:

*Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was \$1,520 for mobile crisis program services, which included program costs and psychiatric hospitalization. For regular police intervention, the average cost per case was \$1,963, which consisted of police services and psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. <sup>(23)</sup>*

We provide these estimates only to underscore the possible scope of hidden costs that may be currently borne by law enforcement in the form of time and effort that could be more effectively be directed elsewhere to serve the broader interests of the community. Efforts to support and improve the crisis intervention system in Lebanon County by all community stakeholders will provide a clear cost and quality benefit to the community.

### **Crisis Intervention Service Culture Changes**

In March 2022, a Lieutenant with the Lebanon City Police Department was killed in the line of duty while responding to a domestic disturbance and burglary. Two other officers were also injured , undergoing emergency surgery. The tragic nature of this event was felt by the entire Lebanon County community. Lieutenant Lebo had served the Lebanon City Police Department for over 40 years and was scheduled to retire only 30 days later. His tragic death still has a very powerful legacy impacting the culture of law enforcement, the Lebanon County community and the State of Pennsylvania to this day.

Though not directly related, the loss of Lieutenant Lebo provides background context and emphasis on system enhancement initiatives that were underway. In 2023, MH/ID/EI sought to make significant crisis intervention system changes to re-establish an improved culture of service delivery. Prior to 2023, crisis intervention services were delivered primarily within the local Emergency Department (ED), which was the destination for local law enforcement to bring individuals in crisis. The process was part of a long-standing standard operating procedure. The result was that potentially unnecessary ED encounters resulting in ED boarding drove up costs and did not most effectively serve the individual in crisis.

Currently, with the collaboration of WellSpan Philhaven, the crisis intervention process has moved to provide mobile crisis intervention which serves to divert and reduce individuals being brought by law enforcement to the local ED. Mobile crisis also incorporates the services of peer support staff who, in conjunction with the crisis worker, can effectively de-escalate critical encounters. Each of these developed interventions has shown promising results as they have worked closely with law enforcement to establish coordinated operational standards.

## National Guideline for Reference

As first responders, law enforcement is often the principal point of entry into emergency mental health services for individuals experiencing a mental health or substance use crisis. Police officers are a critical part of the crisis response system to provide public safety.

Strong relationships with law enforcement and first responders, as well as clear policies that outline roles of interaction between police and crisis intervention clinical staff is an essential part of a successful delivery system.

*SAMHSA Guidelines 2020 Toolkit, p. 34 – Guidelines indicate: Specialized police responses involve police training by mental health professionals in order to provide crisis intervention and act as liaisons to the mental health system. Consistent with the findings above, Crisis Intervention Training (CIT) necessitates a strong partnership and close collaboration between the police officers and mental health programs. Crisis programs should engage in ongoing dialog with local law enforcement agencies to support continuous quality improvement and collaborative problem-solving. Top crisis systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations. Strong partnerships between crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care, justice system diversion and the elimination of psychiatric boarding in emergency departments.*

*Implementation Guidance:*

- *Have local crisis providers actively participate in CIT training or related mental health crisis management training sessions.*
- *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
- *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
- *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

## Observations

First responders are priority customers (Measure 2E)

National guidance describes law enforcement officers are to be treated as priority customers when they describe the process for dropping off individuals to a crisis stabilization center. While Lebanon County does not have a crisis stabilization center, the concept of considering law enforcement as a preferred or priority customer in the continued development of the local crisis intervention system of care is crucial.

The officers we had the privilege to speak to were extremely helpful and energized to provide their expert perspective and candid guidance and support in both the development of the Enhancement Plan, as well as willingness to participate as a stakeholder contributor in the future.

More work can be done, however, to perform outreach to each department to bring together representatives who can provide meaningful guidance to community pressures facing law enforcement officers who interact with individuals with mental health or substance abuse issues in crisis. Their front-line experience and analysis would be a major contribution to the crisis intervention quality improvement process being developed.

Both stakeholders from law enforcement as well as from the County and crisis intervention expressed the desire to build stronger working relationships, channels of consistent communication, and willingness to work collaboratively to continue to develop the crisis intervention service delivery system.

#### Crisis-trained first responders deployed. (Measure 2R)

A survey of the Lebanon County law enforcement departments showed that 47% of respondents had indicated they have not been trained on Crisis Intervention Team (CIT), and 56% of the respondents had indicated they had not been trained on Mental Health First Aid (MHFA). [See Appendix 6 – Law Enforcement Survey Results.](#)

The National Council Roadmap highlights that it is very important for collaborative planning and cooperation among community stakeholders including: the District Attorney's Office, the Public Defender's Office, the County Department of Corrections and Rehabilitation, the County Human Services Offices, the local behavioral health authority, the Social Security Administration, public and private community mental health providers, law enforcement agencies, local school systems, colleges and universities, emergency medical technicians, family members and mental health consumers.

An essential part of an effective and successful crisis intervention service delivery system is to have adequate numbers of CIT trained officers. All officers should have basic exposure to an introductory curriculum on behavioral health such as MHFA for Public Safety. CIT officers receive more intensive training, including 40 hours of specialized training in: psychiatric diagnoses, suicide intervention, substance use disorders, behavioral de-escalation techniques, trauma, the role of the family in the care of a person with mental illness, mental health and substance use disorder laws and local resources for those in crisis.

Guidance suggests that a CIT coordinator should be selected outside of local law enforcement departments as part of the accountable behavioral health entity function. This could possibly be a role assigned to Crisis Intervention on behalf of MH/ID/EI. The coordinator would be responsible for planning, coordinating and implementing all CIT-related classes, including the 40-hour CIT class, roll call training, recurring training, 911 call-taker training and executive training for the law enforcement leaders.

#### A clear set of instructions (operations uniform practice standards)

Under ideal conditions, the primary responder to a mental health crisis will often be a law enforcement officer or other first responder. While changes are being implemented in Lebanon County for the continued development of their mobile crisis model, the development of uniform operation standards and procedures continue to be

under review for quality and effectiveness of the system. It is very important that uniform practice standards are created and applied to provide clear guidance to law enforcement officers as well as mobile crisis intervention staff. Stakeholders had indicated that a coordinated system would be benefitted by having a clear set of instructions for engagement and procedure.

### The Police School (Montgomery County Model)

Community behavioral health leaders in Montgomery County, Pennsylvania have established, in collaboration with a community provider, a police school to learn about behavioral health, de-escalation skills, and to learn about mobile crisis intervention from mental health staff presenters. This model has received national recognition for training law enforcement officers as well as corrections staff.

Montgomery County Emergency Services, Inc. (MCES) has established “The Police School” (see [CrisisInterventionSpecialistTrifold.pdf](#)) as a school for Continuing Law Enforcement Education (CLEE) accreditation through a 3-day Crisis Intervention Specialist (CIS) course. (CIS is approved for Continuing Law Enforcement Education (CLEE) credit by the Municipal Police Education and Training Commission (MPOETC) and for EMS Continuing Education by the Pennsylvania Department of Health.)<sup>(24)</sup>

The CIS School is designed to:

- Train law enforcement and criminal justice personnel on how to assess and interact with individuals in a behavioral health crisis, emphasizing interventions that are empathetic, and trauma informed.
- Assist law enforcement and criminal justice personnel in understanding and dealing more effectively with individuals who are in crisis and suffering from a behavioral health problem (mental illness, developmental disability, substance abuse, etc.)
- Focus on crisis intervention and harm reduction via education, demonstrations, role plays, virtual reality simulations, along with interviews and training with Mental Health America of Lancaster and Certified Peer Specialists.
- Address mental health law (civil, criminal and competency to stand trial), mental health disorders, developmental disabilities, substance abuse, suicide, medications and terminology.
- The school has been functioning over a period of approximately 30 years, has grown to incorporate 24 police departments in Montgomery County, and nearly all departments have 100% of their police officers trained. County behavioral health leaders have shared that the long-term goal has been fantastic.

## Recommendations

Recommendations referenced in earlier sections outlined the need for improved overall system coordination. Law enforcement is very closely aligned with crisis intervention services and may be the most significant and impactful partner with WellSpan Philhaven staff in the delivery of crisis intervention services.

In accordance with the current conditions, guidelines, and observations provided above, are the following recommendations:

- Continue to pursue methods to establish strong relationships between law enforcement and crisis intervention staff. Opportunities would include establishing regular meetings for information, identification of barriers, and possible resolution strategies, between law enforcement, 911 dispatch, and crisis intervention staff to review the condition of current operating standards and to identify if there are any areas requiring improvement. The overriding goal would be in the pursuit of zero intercept solutions (as identified in the Sequential Intercept Model).
- Promote the concept that the police must be viewed as “priority customers” to the crisis intervention system. As policies and procedures are created and modified going forward, crisis intervention services should assess their collaboration with law enforcement to consider how the crisis intervention operations can mutually benefit (i.e. add value and efficiency) to the law enforcement departments overall.
- Immediately convene when a partnered intervention does not go as planned. The Crisis Program Manager and police contact should review the incident, compare against procedure and work through a plan of correction.
- Develop methods of accountability to strive for 100% participation and completion in identified (required) training, including, but not limited to, Crisis Intervention Training (CIT), Mental Health First Aid (MHFA), Trauma-Informed Care (TIC).
- Establish a clear set of uniform practice standards of operation, as a guidebook or manual for the interactions and service delivery of law enforcement and the crisis intervention system. Practice standards would align with individual policies and procedures and could be expanded to incorporate Emergency Department (ED) practice standards as well.
- Examine the available data maintained in each respective system (law enforcement, crisis intervention) and determine appropriate data metrics (key performance indicators) for monitoring and analysis. Once identified, determine how appropriate information exchange can be developed to begin the building blocks of a more robust crisis intervention data information warehouse.
- Establish participation from each respective law enforcement department on the newly formed Task Force as referenced in the Task Force recommendations earlier. The Task Force would be a new community collaborative body to oversee the crisis intervention operational plan of action.
- Explore the feasibility and participation of the Hub Model / Situation Table, as referenced in the Task Force recommendation earlier.
- Examine feasibility of co-responder model, interest and value by law enforcement and crisis intervention stakeholders.
- Examine feasibility / interest in participation in Police School, where Lebanon County Officers would be permitted to attend specialized training for certification.
- Identify / assign a CIT Coordinator Role within the crisis intervention system to facilitate scheduling and tracking of trainings offered and participants from local law enforcement departments.

## ANALYSIS AREA 6:

# SCHOOL DISTRICT ENGAGEMENT

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## School District Engagement

### Environmental Condition

Lebanon County has 6 public school districts in a predominantly rural setting. Stakeholders from each of the school districts interviewed had limited interaction with crisis intervention services. However, their experience and candid recommendations for system-wide improvements were very informative and helpful.

School stakeholders were very interested in exploring collaborative solutions with Lebanon County MH/ID/EI, as well as to interact more frequently with crisis intervention staff as elaborated further in the recommendations provided below.

### National Guideline (Reference)

*SAMHSA Guidelines 2025, p. 5 – Systems that should be part of a Behavioral Health Coordinated System of Crisis Care (BHCSCC) include, but are not limited to, healthcare settings, including EDs; schools; social service and child welfare agencies; domestic violence, sexual assault, and human trafficking programs; housing providers; public safety-first responders; and adult and juvenile justice systems, among others.*

*SAMHSA Guidelines 2025, p. 64 – School systems are a valuable resource for community engagement – Community engagement is a process of developing relationships that enable partners to work together to address crisis-related issues and promote mental well-being to achieve positive health impact and outcomes. Community engagement enables changes in behavior, policies, programs, and practices within communities. Community engagement can assist with creating communication plans that appeal to different cultural and demographic communities, shape needs assessments and inform quality improvement efforts to continue to enhance efficient and effective crisis practices.*

### Observations

Similar to what has been found with other key stakeholder groups, coordination efforts between school systems and crisis intervention are typically event based (i.e. prompted by some event of issue that causes more intensive interaction). However, stakeholders consistently expressed the desire for opportunities for information sharing and collaboration.

School districts had shared the value of hiring social work resources to provide system coordination and support to help educate children and families. Social work staff interviewed expressed interest in establishing more frequent forms of information sharing and cross-training with crisis intervention to identify areas of concern. A pervasive area identified was the stigma associated with behavioral health and the use of crisis intervention services. Children and families are resistant to use the services available. Efforts to educate families is ongoing, but attitudes and cultural barriers are difficult to overcome.

Other creative strategies for community education and engagement was to perform outreach in places of worship, and places where people are sleeping and eating in the community (in reference to community housing and meal services). These are potential entry points for parent education.

School staff have expressed enthusiasm for collaboration on possible solutions, and may be a resource for collaborative champions.

As described earlier in this report, Lebanon County MH/ID/EI, through the efforts of their Crisis Community Liaison has initiated system improvements to establish communication channels with each of the County school districts.

## Recommendations

- Crisis intervention services should continue to reach out to the local school districts to leverage the capabilities and resources of both systems to develop effective forms of community education and family support. Efforts in this area will facilitate greater communication and planning on ways to develop and implement preventative services. Focus should be aligned with National Guidelines provided below, (Excerpt: SAMHSA Guidelines 2025, p. 64):
  - Strategies for community engagement for the establishment of an operational collaborative plan could include surveys, listening sessions, information sessions, and lectures. Strategies can be organized in partnership with other local entities and may include attending pre-established community events to gather information in locations such as schools, places of worship, or community centers .
  - The Center for Rural Pennsylvania provides the following steps to guide the development of a community engagement plan:<sup>151</sup>
    - Step 1: Define the issue.
    - Step 2: Identify the purpose and degree of citizen engagement.
    - Step 3: Identify tools for engaging citizens.
    - Step 4: Identify individuals and groups that need to be involved.
    - Step 5: Develop a plan for recruiting and retaining participants.
    - Step 6: Create a positive environment for citizen engagement.
    - Step 7: Develop evaluation criteria and decide next steps; and
    - Step 8: Maintain open lines of communication.
  - A routine evaluation of the community engagement plan (annually, or at a cadence that is decided upon by the organizing entity and collaborative partners) ensures that the plan continues to engage the community effectively. This effort should involve collaboration with the organizations involved in developing the plan. A routine evaluation allows for quality improvement, transparency / accountability, and sustainability of the engagement plan.
- Explore the development of cross training school district and crisis intervention staff. The purpose of cross training would be to establish service awareness and channels of communication / coordination. School staff expressed interest in having presentations on services from crisis intervention representatives.
- Establish coordination / information sharing with school-based outpatient services operating within the schools and discuss any emerging issues, or related policies and procedures. Other secondary areas of discussion would include enrollment in Behavioral HealthChoices, as well as identification if there are any services delivered in the school setting by community providers, and billable to commercial payers.

ANALYSIS AREA 7:

# INFORMATION SYSTEMS AND TECHNOLOGY

- ◆ Environmental Conditions
- ◆ National Guidelines (for Reference)
- ◆ Observations from Field Work
- ◆ Recommendations for Further Action



## Information Systems and Technology

### Environmental Condition

Data is essential to any growing and successful human services enterprise. It fuels informed decision-making, enhances operational efficiency, strengthens internal and external customer / client relationships, and enables the ability to identify risks and measure quality. Data provides factual basis in contrast to the anecdotal “I think, I feel, I believe” that fuel intuition and guesswork. With a forward mindset, data reveals gaps in unmet needs and provides valuable insight into opportunities for program growth and innovation.

The Lebanon County crisis intervention system has some very strong building blocks to build a specialized crisis intervention data warehouse. Capital Area Behavioral Health Collaborative (CABHC) has established a very robust data warehouse of Behavioral HealthChoices data for several decades since the program began. WellSpan Philhaven and Good Samaritan Hospital utilize EPIC as their electronic medical record. Lebanon County Department of Emergency Services (DES) maintains a state of the art 911 computer-aided dispatch (CAD) system that can identify the location of the caller, provide pre-arrival instructions, logs relevant information, and notifies first responders.

These data systems are highly specialized, effective, and secure. They have grown independently over many years in a continually evolving process following program growth and development.

Other systems beyond those mentioned, are those maintained by many of the other categorical human services offices within Lebanon County, as well as those used by court administration, parole, probation, and corrections. Local law enforcement departments, school districts, and community service providers also have specialized information systems collecting and warehousing necessary information to manage their operations.

These systems, many of which are designed using the latest technologies and data infrastructure are highly configurable with the capacity for information exchange.

From the many disparate sets of information contained in the separate data repositories of the agencies and services listed above, great opportunities exist for the identification and design of essential data elements (metrics) that could be used as key performance indicators (KPI) for the future growth of the crisis intervention system in Lebanon County.

### National Guideline

*SAMHSA Guidelines 2025, p. 67 – Evaluation and Data Collection – Data collection and evaluation of behavioral health crisis services is essential to developing and maintaining a coordinated system of crisis care that is responsive to the unique and evolving needs of the community.*

*Data Governance – Data governance refers to the necessary frameworks, policies, and protocols developed by an agency or organization to manage all aspects of data collection. Evaluation of data collection should be anchored by a detailed data governance plan that should account for the following aspects:*

- *Data Quality: Processes to ensure data is collected in an accurate and uniform manner.*
- *Data Security: Protocols in place to ensure data will be protected and only accessed by authorized individuals, including the handling of protected health information (PHI).*
- *Data Sharing / Transparency: List of audiences for each type of data and necessary considerations for each, processes and mechanisms for data sharing and data access, as well as routine measures in place to ensure data collection efforts are known and accessible to all relevant partners/community members. This may include data type, standards, and access/reuse considerations.*
- *Data Integration: List of any external data sources and processes for data aggregation and usability.*
- *Compliance: List of any legal / regulatory requirements pertinent to data collection, storage, and sharing, and the measures taken to meet these requirements.*

*By maintaining an effective data governance plan, the coordinated system of crisis care can ensure transparent, effective, and safe data collection, sharing, and storage.*

*SAMHSA Guidelines 2025, p.70 – Optimizing Crisis Systems Through Technology – Technology enhances communication and coordination in the delivery of behavioral health crisis services. Technology, such as GPS-enabled mobile team services, real-time bed registry and coordination, centralized outpatient appointment scheduling, electronic health record integration with partner services and health information exchange networks, and the use of artificial intelligence in responder training and evaluation, all play an important role in expanding access to high-quality crisis care*

*Technology to Facilitate Data Collection – States that have used technology to consolidate their data between 988 and their other crisis services—from mobile dispatch to law enforcement collaboration—have been able to be transparent with their data and launch interactive dashboards to the public to visualize growth and outcomes throughout the crisis continuum. There are a number of technology providers which have supported data collection and sharing. This includes opportunities for referral management and linkage. Data standardization and automation can help improve the care delivery process.*

*SAMHSA Guidelines 2025, p. 76 – Technology to Enhance Access to Care Through Telehealth – One benefit of telehealth that has long been recognized is the ability to reach individuals in underserved locations, including rural remote areas. This allows the individual to receive help without having to spend hours and possibly money on transportation to a health facility outside of their community and away from their support network. It is important to note that broadband access can be a barrier to the utilization of this modality in some communities as well as other potential technological hurdles. These concerns offer the opportunity for problem-solving and advocacy to ensure that this resource is available as broadly as possible.*

*SAMHSA Guidelines 2025, p. 77 – Cybersecurity Considerations – Behavioral health providers should increase their focus on cybersecurity throughout the coordinated system of crisis care, especially as systems are being linked and connected in new ways, which puts personal data more at risk with increased vulnerable entry points. Everyone working on related systems and platforms should ensure cybersecurity standards and protections are in place that will protect crisis-related infrastructure and user information. Policymakers and providers should ensure that they collect only the data necessary, anonymize them whenever possible, and implement security measures.*

## Observations

The crisis system has data and capability to keep track of client progress through the continuum. (Measure 1N)

Currently client information can be tracked only through the capabilities of WellSpan Philhaven through their electronic medical record (EPIC) for clients within the WellSpan system. There are no current capabilities to track individuals through an integrated system throughout the span of a crisis intervention event. Nor is there any current ability to identify bed capacity in the community.

Stakeholders indicated the need for improvement to be able to track movements of individuals, especially at discharge. The cause of concern was due to individuals discharged on prescribed medications. This information is very important to community providers who may be serving the individual.

Law enforcement stakeholders voiced the same concerns. However there are significantly more barriers for protected health information that can be released to law enforcement.

MH/ID/EI identified there are barriers and levels of complexity in the coordination of the regional 988 Lifeline, and the local 911 systems. Coordination efforts continue to establish appropriate response algorithms being used in the 911 system, and the capability to identify meaningful data metrics and produce utilization reports.

Currently there is a memorandum of understanding (MOU) between Lebanon County Department of Emergency Services (911) and Lancaster County Behavioral Health & Developmental Disabilities (BHDS) Regional Call Center (988). Call volumes are being measured to evaluate performance capabilities.

Data is collected and used collaboratively for customer oriented continuous improvement. (Measure 1K)

To the degree that structured data is available within the WellSpan Health System, the crisis intervention director expressed that they have the resources to perform data collection and analysis for continuous quality improvement functions. Integrated information from other related systems in the crisis continuum is not currently available.

### Community behavioral health crisis system collaborative meets. (Measure 1C)

Currently, MH/ID/EI is responsible for quality improvement and monitoring of the crisis intervention system through monthly meetings directly related to the delivery of crisis intervention services.

In an earlier recommendation an opportunity to create a larger community behavioral health crisis system collaborative (termed earlier as a “Task Force” with defined participation, timeframes and scope) could be a broader body of stakeholders tasked to assemble as a collaborative, to address continuous quality improvement goals and objectives.

## Recommendations

Development of an integrated data repository for crisis intervention services, built upon the current capabilities (i.e. data elements and infrastructure) of the existing systems outlined in the environmental conditions above. At the most basic level, the establishment of a data platform (infrastructure, database, and business intelligence) to contain a crisis system data warehouse is achievable.

Often times, the notion of building a data repository is daunting because of the absence of structured (“clean”) data, or the capability to build necessary infrastructure (hardware, or virtual hardware), as well as the database itself and the business intelligence tier that would sit on top for reporting. These challenges often keep leaders and system stakeholders from taking any preparatory steps. Valuable opportunities exist to take the preparatory steps to provide movement toward more elaborate solutions.

Outlined below are some preliminary steps for consideration. Working with each respective entity, identification of data elements that could be used to establish meaningful key performance indicators would be a reasonable first step:

- Is there stakeholder interest and buy-in to proceed? Each of the respective initial stakeholders, as well as those who may be added in the future must assess that value would be worth the effort. These stakeholders would authorize the charter to continue to the next action steps in the development process.

Once stakeholder interest determines a “go / no go” at this stage, with a go, the following two steps could be done to continue to evaluate before action would be authorized to proceed:

- Conduct / research to identify specific data sets and their contributing owners. For instance, foundational data could be provided by the existing well-established data systems managed by CABHC, WellSpan, and DES.
  - What data is available?
  - What data is appropriate to produce meaningful measures?
  - What data is possible to maintain confidentiality?
  - Is this data exportable from its existing home in a structured format?
  - Can this data be integrated (i.e. do keys exist, or can they be created)?

- Once data is defined as available and appropriate, create specifications for a new data platform for the creation of a new data repository, specifically serving crisis intervention services. The action steps to resolve at this stage would include the following:
- Research the best architecture and software to establish a virtual data platform, as a home for a new crisis intervention services database. Industry standard options could be designed to use open-source software solutions to control cost to establish the database. Typically, the owner of the data warehouse would apply their current architecture, software, and security standards to the design considerations.
- Once architecture is resolved, create appropriately detailed technical and functional specifications (i.e. What is the virtual hardware / software design and how will it be built? What are the security measures? How will it be maintained and supported?)
- Define rules for extract, transform, and load (ETL) process. Data from different places must be integrated into a meaningful body and may require some transformation from their original state. The ETL process defines, using a shipping analogy, how it is packaged in its home port, how it is shipped via a definite path, how it arrives at its new port in the same pristine condition, and then how it is transformed to its final destination and use.
- Specify a desired business intelligence / reporting tier. There are a variety of industry standard products that could be used. The owner of the data warehouse may already be using a business intelligence product.

Assuming favorable buy-in to proceed, the four specification steps above (data, architecture, and ETL, reporting tier) are exploratory. At this stage estimations of project scope, schedule, and cost could be determined with relative accuracy to determine the feasibility and value development to production.

Described above is a process to assess development of information system capacity. Any advancements made to building information systems or the usage of technology to advance the capability and quality of service delivery adds value to the whole, and manifests in unmeasured capabilities in the future. Having more robust information systems as the foundation for service delivery, and the expanded usage of mobile technology (as is being used in the delivery of telehealth services) offers enhanced capabilities that can be brought to remote locations and used by all involved in each crisis encounter.

# APPENDICES

- ◆ Appendix 1—Crisis System Dynamic Enhancement Plan Contributors / Stakeholders
- ◆ Appendix 2—Table-top Exercise
- ◆ Appendix 3—Roadmap Report Card Measures
- ◆ Appendix 4—Roadmap Group Scores (Normalized)
- ◆ Appendix 5—WellSpan Good Samaritan Hospital Emergency Department Workflow
- ◆ Appendix 6—Law Enforcement Survey Results

## Appendix 1 – Crisis System Dynamic Enhancement Plan Contributors / Stakeholders

The following contributors have been grouped by categories and listed in alphabetical order by last name within each group. We wish to thank each for their time and generous contribution of their expertise in the development of this strategic plan.

### Lebanon County Crisis System Dynamic Enhancement Plan Sponsors

- Holly A. Leahy, Administrator, Lebanon County MH / ID / EI
- Melissa Herr, Deputy Administrator , Lebanon County MH / ID / EI
- Kasey E. Felty, Director of Mental Health Services, Lebanon County MH / ID / EI

### Lebanon County Officers

- Stephanie Axarlis, Court Administrator, Lebanon County Court System
- Susan Christner, Deputy Director - Juvenile Unit, Lebanon County Probation Services (Juvenile)
- Rebecca Davis, Deputy Warden of Treatment, Lebanon County Correctional Facility
- Brian Diederick, Deputy District Attorney, Lebanon County District Attorney
- James R. Donmoyer, Jr., Director, Lebanon County Commission on Drug and Alcohol Abuse
- Bob Dowd, Director, Lebanon County Department of Emergency Services
- Kathleen Dugan, Aging Care Management Supervisor, Lebanon County Area Agency on Aging
- Horace Ehrgood, Hearing Team - Public Defender, Lebanon County Public Defender
- Sue Emerich, Program Specialist, Lebanon County Office of Children & Youth Services
- Audrey Fortna, Director of Probation Services, Lebanon County Probation Services (Adult)
- Sharon Gassert, Deputy Director, Lebanon County Office of Children & Youth Services
- Pier Hess-Graf, District Attorney, Lebanon County District Attorney
- Christine Heibel, Director of ID & EI Services, Lebanon County MH / ID / EI
- Keith Kilgore, Hearing Team - Review Officer, Lebanon County Mental Health Review Officer
- Adrian Layser, Administrator, Lebanon County Area Agency on Aging
- Tina Litz, Warden, Lebanon County Correctional Facility
- Tom Long, Hearing Team - Assistant Solicitor, Lebanon County Solicitor
- Erin Moyer, Executive Director, Lebanon County Office of Children & Youth Services
- John C. Tylwalk, President Judge, Court of Common Pleas, Lebanon County Court System

## WellSpan Philhaven

- Kate Barlup, Clinical Operations Manager, WellSpan Philhaven - ACT / New Start Program
- Dale J. Brickley, Ph.D., Director of Program Development, WellSpan Philhaven - Crisis Intervention
- Tracy Dugan, Program Manager, WellSpan Philhaven - Crisis Intervention
- William Fisher, BHT Supervisor / Licensed Therapist , WellSpan Philhaven
- Jessica Grier , Director of Behavioral Health Community Based Services, WellSpan Philhaven - Crisis Intervention
- Janine Malin, Director, WellSpan Philhaven - ACT Team Leader
- Rick Metzger, Supported Housing Counselor, WellSpan Philhaven - Housing Counselor
- Jessica Podcasy, Access Center Director, WellSpan Philhaven - Crisis Intervention
- Brian Shumante, Weekend Staff, WellSpan Philhaven - Crisis Intervention
- Kelly Sinico, 2nd Shift Manager, WellSpan Philhaven - Crisis Intervention
- Brenda Startoni, Community Liaison, WellSpan Philhaven - Crisis Intervention

## WellSpan Good Samaritan Hospital Emergency Department

- Nicole Baker, Charge Nurse, WellSpan Good Samaritan Hospital
- Quinn Grimes, Assistant Medical Director of the Emergency Department, WellSpan Good Samaritan Hospital
- Kathleen Hogan Flinn, Medical Staff, WellSpan Good Samaritan Hospital
- Nora Leidy, Medical Staff, WellSpan Good Samaritan Hospital
- Daniel P. McIntyre, MD, Medical Director of the Emergency Department, WellSpan Good Samaritan Hospital

## Community Providers

- Brenda Berkheiser, Regional Director - Lebanon/Schuylkill/Dauphin/Berks Counties, Supportive Concepts for Families, Inc.
- Jill Beveridge , Director of FFS Programming (Blended Case Mgmt), Service Access and Management, Inc.
- Laura Dadswell, Behavioral Health Coordinator, Advocacy Alliance (South Central PA Health Care Quality Unit [HCQU])
- Skyler Deitrick, Psychiatric Rehabilitation Director, Community Services Group
- Keona Dilworth, Program Manager, Keystone Enhanced Personal Care Home
- Tiffany Dreher, Executive Director of Outpatient, PA Counseling Services
- Jessica Fenchel, Chief Operating Officer, Access Services
- Carrie Ann Frolio, VP of Integration and Business Development, Family First (FQHC)
- Linda Groff, Vice President of Mental Health Services, Threshold Rehabilitation
- Christine Hartman, Executive Director, Community Action Partnership
- Heather Hoffman, Practice Manager, Family First (FQHC)
- Joanna Katherman, Health contractor to Lebanon County Correctional Facility, PrimeCare Medical, Inc.
- Stephani Lawson, Regional Director for South Central Region, Service Access and

Management, Inc.

- Jennifer Longenecker, ID Supports Coordinator Supervisor, Center for Community Resources
- Edward B. Michalik, Psy.D., Chief Executive Officer, Threshold Rehabilitation Services, Inc.
- Matt Miller, Chief Growth & Development Officer, Connections Health Solutions
- Jessica Paul, Executive Director, Consumer Satisfaction Services (CSS)
- Karen Raugh, Executive Director, Housing Authority / Redevelopment Authority
- James Reichenbach, Chief Community Impact Officer, Union Community Care (FQHC)
- Abby Robinson, Consumer / Family Satisfaction Team Manager, Consumer Satisfaction Services (CSS)
- Michael Rodriguez, Engagement Manager, Service Access and Management, Inc.
- Bryan Smith, Executive Director, Lebanon County Christian Ministries
- Rebecca Snavelly, Psychiatric Rehabilitation Associate, Community Services Group
- Kara Summers, Chief of Operations, First Aid Safety Patrol (Crisis Transportation)
- Martha Thompson, Owner/Coordinator, Empower the Mind (Student Assistance Program)

## Municipal Police Departments

- Scott Dierwechter, Installation Police Officer, Fort Indiantown Gap Police Department
- William Reigle, II, Chief of Police, South Londonderry Township
- Jeremy Richard, Chief of Police, Lebanon Veterans Administration Medical Center
- Eric Sims, Captain, Lebanon City Police

## School Districts

- Amber Abreau, Director of Student Services, Lebanon School District
- Kelly Bastek-Jones, Director of Pupil Services, Northern Lebanon School District
- Kimberly Briggs, Social Worker, Lebanon School District
- Serena Gergenti, K-6 Social Worker, Annville Cleona School District
- Danielle Heisler, Asst to Superintendent, Annville Cleona School District
- Karl Liedtka, Lead Counselor / Coordinator, Lebanon School District
- Kate Long, Director of Human Services, Cornwall Lebanon School District
- Nichole McCullough, Guidance Counselor, Eastern Lebanon County School District
- Josh McManness, Program Manager, Lancaster-Lebanon Intermediate Unit 13 (IU13)
- Clare Missmer, Guidance Counselor, Palmyra School District
- Amanda Musser, Social Worker, Palmyra School District
- Kara Rhoads, Social Worker, Northern Lebanon School District
- Carolyn Richards, Director of Student Services, Annville Cleona School District
- Katie Scott, Annville District Social Worker, Annville Cleona School District
- Kathy Setlock, Director of Pupil Services, Palmyra School District
- Amy Shoemaker, Director of Pupil Services, Eastern Lebanon County School District
- Kelly Smith, School Social Worker, Eastern Lebanon County School District

## Behavioral Health Choices and County Administrators

- Catherine Arbogast, Administrator, MH / ID / EI and D&A, Centre County
- Tina Clymer, Administrator, Carbon-Monroe-Pike MH / DD
- Daniel Eisenhauer, Director of Operations (retired 6/1/2025), PerformCare
- Jeffrey George, Regional Director, Community Care Behavioral Health Organization (CCBHO)
- Jeffrey Hartzell, Administrator, Carbon-Monroe-Pike HealthChoices
- David McAdoo, Chief Executive Officer, Southwest Behavioral Health Management (SBMH)
- LeeAnn Moyer, Director, Montgomery County Managed Care Solutions
- Pamela Seaman, Administrator, Berks County Department of Mental Health and Developmental Disabilities
- Scott Suhring, Chief Executive Officer, Capital Area Behavioral Health Collaborative (CABHC)
- Sally Walker, Chief Executive Officer, Behavioral Health Alliance of Rural Pennsylvania (BHARP)
- Jennifer Williams, MH Deputy Administrator, Carbon-Monroe-Pike HealthChoices

## Appendix 2 – Table-Top Exercise

| WellSpan Tabletop Exercise for Crisis Intervention Process  |  |   |  |
|---|--|---|--|
| Scenario 1  | Scenario 2   | Scenario 3  | Scenario 4   |
| Male, Age 32; living in community setting.  | Female, Age 74; living in community setting.   | Gender and Age unknown; living in community setting.  | Male, Age 15; Middle-School, 8 <sup>th</sup> grade; lives with mother and 3 siblings.  |
| Known to the Mental Health (MH) and Intellectual Developmental Disabilities (IDD)   | Known to the Area Agency on Aging (AAA)  | Not known to Mental Health (MH) or Commission on Drug and Alcohol Abuse (CDAA)  | Known to the Crisis Intervention / Hospital System, as well as Juvenile Probation (JPO)  |
| Geographic Location: Rural Community  | Geographic Location: Downtown in Lebanon City  | Geographic Location: Housing / apartment complex; near community park / busy public area.   | Geographic Location: Rural School District   |
| <p><b>Condition:</b> Living with family with in-home support. Off medication and refusing to attend program, became aggressive toward home staff and family, crisis called.</p> <p>Situation unsafe, police contacted, caregiver injured. Male now hurting himself (striking himself); EMS contacted to transport to ED with police assist. Male continues to act out in ED, trying to injure himself and others.</p> | <p><b>Condition:</b> found wandering in a local park, disheveled and talking to herself, reported to police by another person in the park.</p> <p>Police transport to ED.</p> <p>Becomes agitated and disoriented once in the ED.</p> <p>ED has several medical events requiring more intensive staff involvement.</p> | <p><b>Condition:</b> Appears violent, outside the home (porch); throwing furniture; yelling, threatening behavior; don't know if they have a weapon. There is another person who seems to be the target of the threats in the home. Appears to be impaired, intoxicated or under effects of drugs.</p> <p>Police determine no weapon; after short talk the person begins to sob and reports they want to kill themselves. Police call crisis.</p> | <p><b>Condition:</b> Student lives with single mother and 3 younger siblings. Has been involved with JPO for previous incident. The student is unmanaged diabetic.</p> <p>Involved in an aggressive incident (fight) in school earlier in the week, resulting in disciplinary action. This is the second incident, and he is suspended.</p> <p>Less than a month ago, Crisis had been called, resulting in ED evaluation. He was discharged with a referral to a day treatment program which has not started.</p> <p>The student returns to school and makes threatening comments to other students at the beginning of the school day. Another student reports threats to the Office. Tells Principal he wants to harm himself.</p> |
| <b>Step 1:</b> Crisis Intervention was called.  | <b>Step 1:</b> local Police were called; transported to ED.  | <b>Step 1:</b> local Police call Crisis Intervention.   | <b>Step 1:</b> School Principal calls Crisis and parent of student.  |

**General Response Questions:**

1. What impedes Mobile Crisis response times?
2. What was described as done very well (by overall Crisis response)?
3. What was identified as a problem, or could have been done better (by overall Crisis Response)?

**General ED Response Questions**

1. Who is responsible for the crisis response in the ED?
2. What treatment occurs in the ED (i.e. administration of medications, chemical restraint)
3. How are services integrated with Crisis Intervention staff, Police, EMS, hospital providers, MCO (if applicable), and community service providers?
4. When / how do lines of responsibility transfer in the crisis response in the ED?
5. What services are conducted by the hospital Behavioral Health Clinician (BHC)?
6. How do the BHC's and the Crisis Intervention staff respond to crisis events? Individually, with transition; or collaboratively / jointly?
7. How is security handled? When / how does security engage?
8. How does the hospital perform discharge planning (i.e. to find a community resource for discharge)?
9. What is the average length of stay in the ED for a crisis response? What is the average length of stay for ED boarding?

**General School Response Questions**

1. Who takes charge of the crisis response in the school setting?
2. What is the process to call parents, police, crisis, EMS? What determines priority?
3. How do parents typically respond when Crisis Intervention services are recommended?
4. What if parents refuse Crisis Intervention services; what is the process?
5. How are school staff used in a crisis response? (i.e. how has Crisis Intervention been involved with school staff)?
6. How is Juvenile Probation involved or accessed in a crisis event?
7. Who / how are community resources accessed (anticipating discharge planning)?

## Appendix 3 – Roadmap Report Card Measures

### Report Card - Sec1 - Accountability and Finance

- 1A Accountable entity identified and established.
- 1B Behavioral health crisis system coordinator identified.
- 1C Community behavioral health crisis system collaborative meets.
- 1D All services are accountable for system values.
- 1E Multiple payers contribute to financing services and capacity in the continuum.
- 1F Accountable entity coordinates financing.
- 1G Financing is adequate for population need.
- 1H Everyone is eligible, regardless of insurance.
- 1I The crisis continuum meets standards for capacity and geographic access for the population.
- 1J Quality metrics are established and measured for each service and the crisis continuum as a whole.
- 1K Data is collected and used collaboratively for customer oriented continuous improvement.
- 1L Provider contracts include incentives for performance in line with values and metrics.
- 1M System metrics include attention to how clients flow through the continuum timely/successfully.
- 1N The crisis system has data and capability to keep track of client progress through the continuum.
- 1O Satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) measured/improved.
- 1P Consistent level of care determination and utilization management criteria throughout the system.
- 1Q All services in the crisis system function as safety-net support partners for behavioral health system programs.
- 1R Standards define how the crisis systems works collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection).
- 1S Standards define how community systems work collaboratively with the behavioral health crisis system.

### Report Card - Sec2 - Crisis Continuum; Capacity and Services

- 2A Safe, welcoming, values-based services throughout the continuum.
- 2B Services address the continuum of crisis experience from pre-crisis to post-crisis.
- 2C Spaces and security practices are safe, warm, welcoming, therapeutic.

- 2D Families and collaterals are partners/customers.
- 2E First responders are priority customers
- 2F The service continuum responds to all ages
- 2G Continuum of capacity for people with co-occurring needs: mental health/ substance use disorder (MH/SUD), behavioral health/ intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ).
- 2H Cultural/linguistic/immigrant capacity.
- 2I Continuum of services described operationally.
- 2J Capacity for seamless flow and continuity of care.
- 2K Client information sharing thru the continuum.
- 2L Clients are kept track of through the continuum.
- 2M Family/collateral outreach and engagement.
- 2N Outreach/consultation with community providers.
- 2O Telehealth utilized effectively throughout the continuum.
- 2P Crisis hub secure access and urgent care center(s).
- 2Q Crisis call/text/chat center (911/non-911).
- 2R Crisis-trained first responders deployed.
- 2S Available, low barrier, medical screening/triage.
- 2T Mobile crisis for all ages, to homes, schools, etc.
- 2U 23-hour observation.
- 2V Residential crisis services: high and low medical.
- 2W Peer respite/Living Rooms.
- 2X Detox and sobering support center capacities.
- 2Y Psychiatrically capable emergency room services.
- 2Z Psychiatric inpatient capacity: all ages, both general units and specialized units.
- 2AA Continuity of crisis intervention: home and office.
- 2BB Emergency and non-emergency transport.
- 2CC Adequately staffed multidisciplinary teams in all settings.
- 2DD Clinical, nursing, medical leadership.
- 2EE Access to specialty consultation.
- 2FF Peer support throughout the continuum.

## Report Card - Sec3 - Basic Clinical Practice

- 3A Crisis system framework for practice improvement and competency development.
- 3B Universal competencies: welcoming, hopeful, safe, trauma- informed, culturally affirming.
- 3C Engaging families and other natural supports.

- 3D Competency in information sharing.
- 3E Using crisis plans and advance directives.
- 3F Basic core competencies for call center staff and first responders.
- 3G Basic core competencies for behavioral health crisis staff.
- 3H No force first: maximizing trust and minimizing restraint.
- 3I Suicide risk screening and intervention.
- 3J Violence risk screening/threat assessment.
- 3K Medical triage and screening.
- 3L Substance use disorder triage and screening.
- 3M Application of civil commitment (inpatient/output).
- 3N Practice guidelines: multidisciplinary crisis teamwork, including role of peers.
- 3O Practice guidelines: non-medical crisis intervention.
- 3P Practice guidelines: crisis psychopharmacology.
- 3Q Practice guidelines: co-occurring substance use disorder/ medication-assisted treatment startup.
- 3R Practice guidelines: co-occurring medical illness.
- 3S Practice guidelines for youth/families/guardians.
- 3T Practice guidelines for older adults/caregivers.
- 3U Practice guidelines for cognitive disabilities.
- 3V Workflows within the crisis continuum.
- 3W Post-crisis continuity, critical time intervention.
- 3X Pre-/post-crisis planning with community providers.
- 3Y Coordination of Care with Community Systems

## Appendix 4 – Roadmap Group Scores (by Section)

| Seq | Row | Label   | Average of Combined Scores | Average of Normalized Scores |
|-----|-----|---|----------------------------|------------------------------|
| 1   | 1P  | Consistent level of care determination and utilization management criteria throughout the system.   | 4.33                       | 1.00                         |
| 2   | 2B  | Services address the continuum of crisis experience from pre-crisis to post-crisis.   | 3.67                       | 0.80                         |
| 3   | 1H  | Everyone is eligible, regardless of insurance.  | 4.33                       | 0.77                         |
| 4   | 1D  | All services are accountable for system values.   | 3.00                       | 0.77                         |
| 5   | 2D  | Families and collaterals are partners/customers.  | 3.50                       | 0.75                         |
| 6   | 2I  | Continuum of services described operationally.  | 3.75                       | 0.72                         |
| 7   | 2J  | Capacity for seamless flow and continuity of care.  | 3.17                       | 0.72                         |
| 8   | 1R  | Standards define how the crisis systems works collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection). | 3.75                       | 0.71                         |
| 9   | 1S  | Standards define how community systems work collaboratively with the behavioral health crisis system.   | 3.00                       | 0.71                         |
| 10  | 1I  | The crisis continuum meets standards for capacity and geographic access for the population.   | 3.42                       | 0.70                         |
| 11  | 2Q  | Crisis call/text/chat center (911/non-911).   | 3.25                       | 0.68                         |
| 12  | 3N  | Practice guidelines: multidisciplinary crisis teamwork, including role of peers.  | 3.25                       | 0.68                         |
| 13  | 2EE | Access to specialty consultation.   | 3.25                       | 0.68                         |
| 14  | 3D  | Competency in information sharing.  | 3.50                       | 0.64                         |
| 15  | 2Z  | Psychiatric inpatient capacity: all ages, both general units and specialized units.   | 3.50                       | 0.64                         |

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

| Seq | Row | Label  | Average of Combined Scores | Average of Normalized Scores |
|-----|-----|--|----------------------------|------------------------------|
| 16  | 2AA | Continuity of crisis intervention: home and office.  | 2.17                       | 0.64                         |
| 17  | 2Y  | Psychiatrically capable emergency room services.   | 1.83                       | 0.64                         |
| 18  | 3K  | Medical triage and screening.  | 3.13                       | 0.64                         |
| 19  | 1K  | Data is collected and used collaboratively for customer oriented continuous improvement.                                     | 2.50                       | 0.63                         |
| 20  | 1O  | Satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) measured/improved. | 2.88                       | 0.63                         |
| 21  | 1F  | Accountable entity coordinates financing.  | 3.38                       | 0.62                         |
| 22  | 3G  | Basic core competencies for behavioral health crisis staff.  | 3.05                       | 0.62                         |
| 23  | 3C  | Engaging families and other natural supports.  | 2.96                       | 0.60                         |
| 24  | 3W  | Post-crisis continuity, critical time intervention.  | 3.00                       | 0.60                         |
| 25  | 1M  | System metrics include attention to how clients flow through the continuum timely/successfully.                              | 3.00                       | 0.60                         |
| 26  | 3E  | Using crisis plans and advance directives.   | 3.00                       | 0.60                         |
| 27  | 3J  | Violence risk screening/threat assessment.   | 3.00                       | 0.60                         |
| 28  | 3X  | Pre-/post-crisis planning with community providers.  | 3.00                       | 0.60                         |
| 29  | 2P  | Crisis hub secure access and urgent care center (s).   | 3.00                       | 0.60                         |
| 30  | 3I  | Suicide risk screening and intervention.   | 3.00                       | 0.60                         |
| 31  | 1J  | Quality metrics are established and measured for each service and the crisis continuum as a whole.                           | 2.94                       | 0.58                         |

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

| Seq | Row | Label  | Average of Combined Scores | Average of Normalized Scores |
|-----|-----|--|----------------------------|------------------------------|
| 32  | 2G  | Continuum of capacity for people with co-occurring needs: mental health/substance use disorder (MH/SUD), behavioral health/intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ). | 2.91                       | 0.57                         |
| 33  | 1E  | Multiple payers contribute to financing services and capacity in the continuum.  | 2.50                       | 0.57                         |
| 34  | 1B  | Behavioral health crisis system coordinator identified.  | 4.00                       | 0.56                         |
| 35  | 1A  | Accountable entity identified and established.   | 3.50                       | 0.56                         |
| 36  | 1C  | Community behavioral health crisis system collaborative meets.   | 2.17                       | 0.56                         |
| 37  | 2F  | The service continuum responds to all ages   | 2.88                       | 0.56                         |
| 38  | 2A  | Safe, welcoming, values-based services throughout the continuum.   | 2.88                       | 0.56                         |
| 39  | 3F  | Basic core competencies for call center staff and first responders.  | 2.83                       | 0.55                         |
| 40  | 2CC | Adequately staffed multidisciplinary teams in all settings.  | 2.86                       | 0.54                         |
| 41  | 2DD | Clinical, nursing, medical leadership.   | 2.50                       | 0.54                         |
| 42  | 2C  | Spaces and security practices are safe, warm, welcoming, therapeutic.  | 2.80                       | 0.54                         |
| 43  | 2E  | First responders are priority customers  | 2.64                       | 0.49                         |
| 44  | 3U  | Practice guidelines for cognitive disabilities.  | 2.64                       | 0.49                         |
| 45  | 2H  | Cultural/linguistic/immigrant capacity.  | 2.58                       | 0.48                         |
| 46  | 1Q  | All services in the crisis system function as safety-net support partners for behavioral health system programs.   | 3.50                       | 0.47                         |
| 47  | 1G  | Financing is adequate for population need.   | 1.83                       | 0.47                         |

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

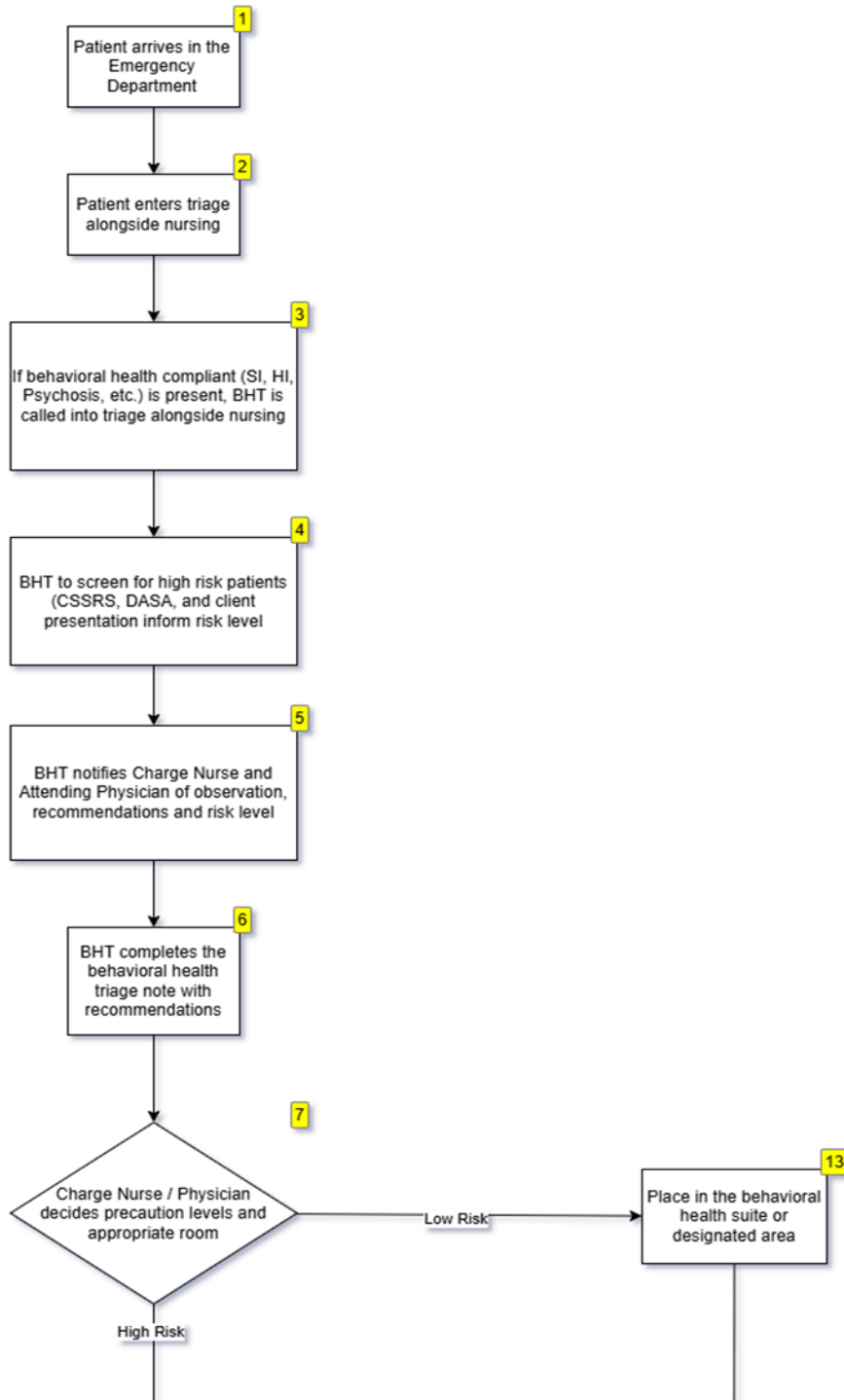
| Seq | Row | Label  | Average of Combined Scores | Average of Normalized Scores |
|-----|-----|--|----------------------------|------------------------------|
| 48  | 3A  | Crisis system framework for practice improvement and competency development.                     | 2.83                       | 0.45                         |
| 49  | 3V  | Workflows within the crisis continuum.   | 2.40                       | 0.42                         |
| 50  | 3T  | Practice guidelines for older adults/caregivers.   | 2.40                       | 0.42                         |
| 51  | 2FF | Peer support throughout the continuum.   | 2.40                       | 0.42                         |
| 52  | 3B  | Universal competencies: welcoming, hopeful, safe, trauma- informed, culturally affirming.        | 2.20                       | 0.42                         |
| 53  | 2T  | Mobile crisis for all ages, to homes, schools, etc.  | 2.36                       | 0.41                         |
| 54  | 3L  | Substance use disorder triage and screening.   | 2.30                       | 0.39                         |
| 55  | 2N  | Outreach/consultation with community providers.  | 2.30                       | 0.39                         |
| 56  | 3H  | No force first: maximizing trust and minimizing restraint.                                       | 2.25                       | 0.38                         |
| 57  | 2M  | Family/collateral outreach and engagement.   | 2.25                       | 0.38                         |
| 58  | 3Q  | Practice guidelines: co-occurring substance use disorder/ medication-assisted treatment startup. | 2.17                       | 0.35                         |
| 59  | 1L  | Provider contracts include incentives for performance in line with values and metrics.           | 1.95                       | 0.32                         |
| 60  | 3Y  | Coordination of Care with Community Systems  | 2.00                       | 0.30                         |
| 61  | 2K  | Client information sharing thru the continuum.   | 1.93                       | 0.28                         |
| 62  | 2S  | Available, low barrier, medical screening/triage.  | 1.88                       | 0.26                         |
| 63  | 2O  | Telehealth utilized effectively throughout the continuum.  | 1.88                       | 0.26                         |

# Lebanon County Crisis Intervention System Dynamic Enhancement Plan

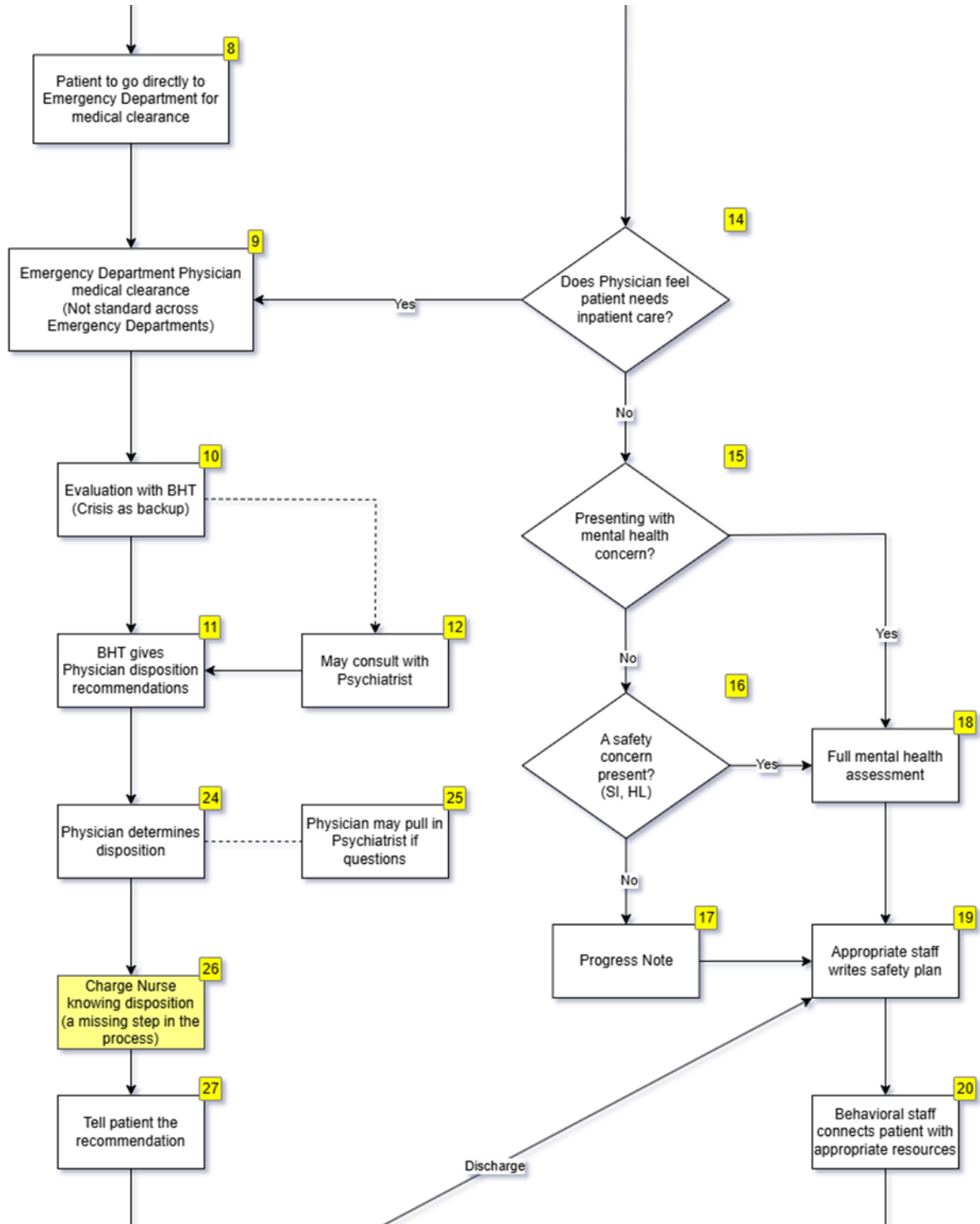
| Seq                | Row | Label   | Average of Combined Scores | Average of Normalized Scores |
|--------------------|-----|---|----------------------------|------------------------------|
| 64                 | 3P  | Practice guidelines: crisis psychopharmacology.   | 1.86                       | 0.26                         |
| 65                 | 3S  | Practice guidelines for youth/families/guardians.   | 1.80                       | 0.24                         |
| 66                 | 2R  | Crisis-trained first responders deployed.   | 1.75                       | 0.23                         |
| 67                 | 1N  | The crisis system has data and capability to keep track of client progress through the continuum. | 1.70                       | 0.21                         |
| 68                 | 2BB | Emergency and non-emergency transport.  | 1.58                       | 0.18                         |
| 69                 | 3R  | Practice guidelines: co-occurring medical illness.  | 1.56                       | 0.17                         |
| 70                 | 2V  | Residential crisis services: high and low medical.  | 1.43                       | 0.10                         |
| 71                 | 2X  | Detox and sobering support center capacities.   | 1.00                       | 0.10                         |
| 72                 | 2W  | Peer respite/Living Rooms.  | 1.00                       | 0.10                         |
| 73                 | 2L  | Clients are kept track of through the continuum.  | 1.28                       | 0.08                         |
| 74                 | 2U  | 23-hour observation.  | 1.14                       | 0.04                         |
| 75                 | 3M  | Application of civil commitment (inpatient/output).   | 1.06                       | 0.02                         |
| 76                 | 3O  | Practice guidelines: non-medical crisis intervention.   | 1.00                       | 0.00                         |
| <b>Grand Total</b> |     |   | <b>2.57</b>                |                              |

## Appendix 5 – WellSpan Good Samaritan Hospital Emergency Department Workflow

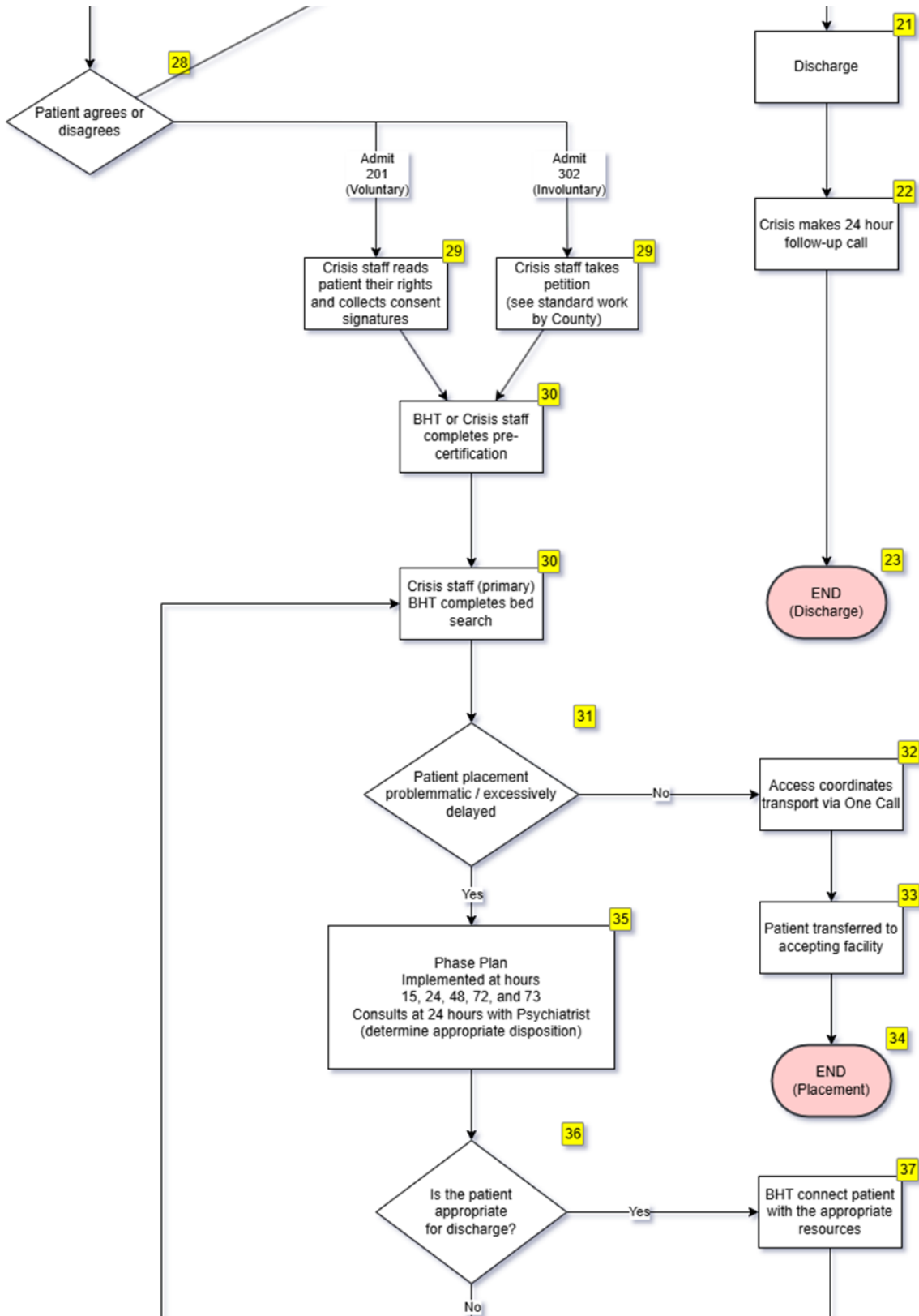
WellSpan Good Samaritan Hospital, Emergency Department (ED) – Crisis Intervention  
Workflow, Page 1 of 4.



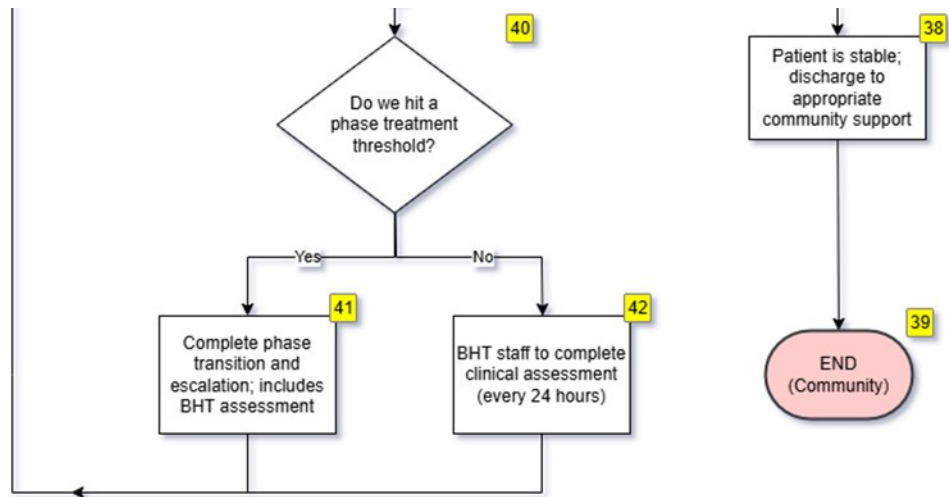
## WellSpan Good Samaritan Hospital, Emergency Department (ED) – Crisis Intervention Workflow, Page 2 of 4.



## WellSpan Good Samaritan Hospital, Emergency Department (ED) – Crisis Intervention Workflow, Page 3 of 4.

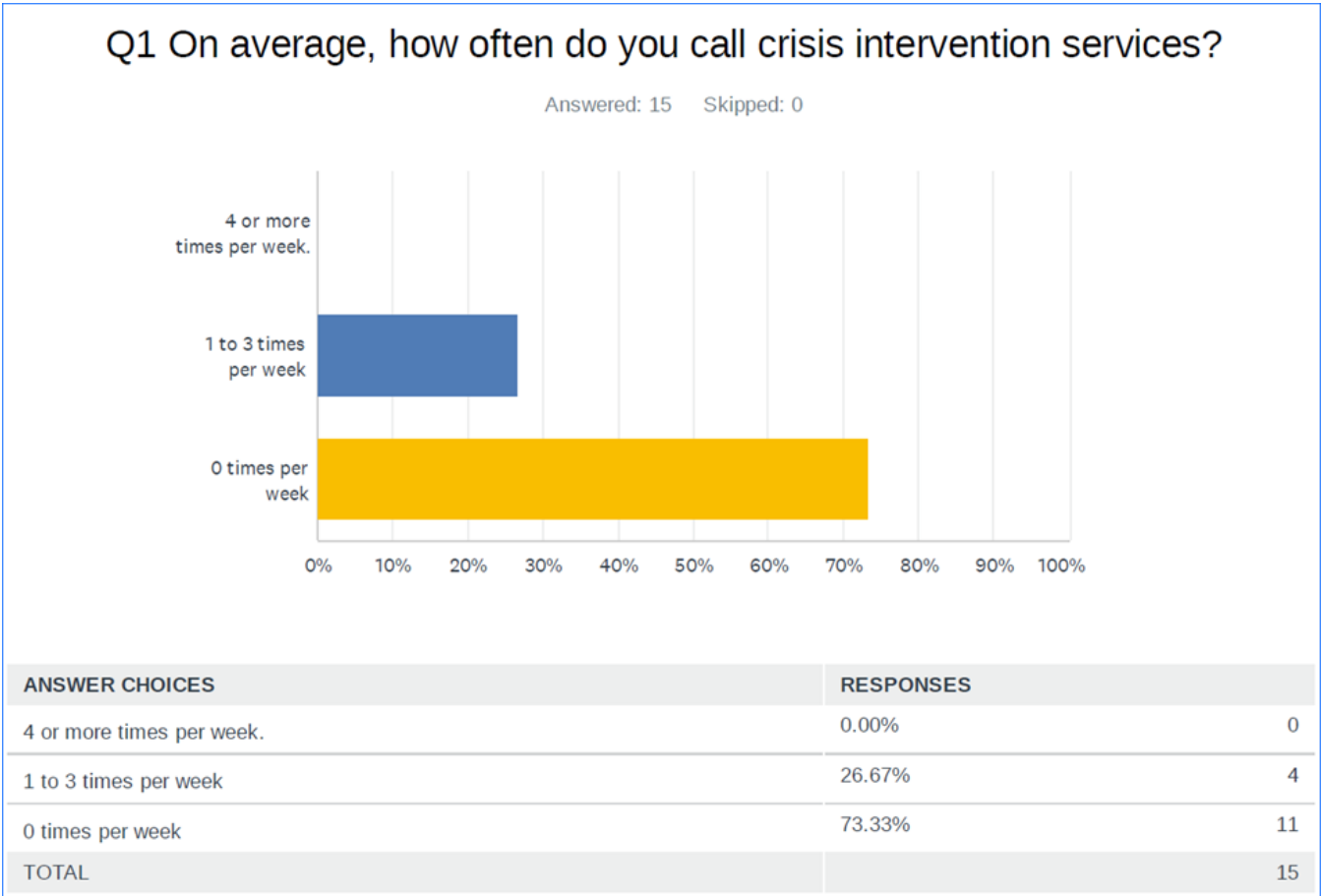


## WellSpan Good Samaritan Hospital, Emergency Department (ED) – Crisis Intervention Workflow, Page 4 of 4.



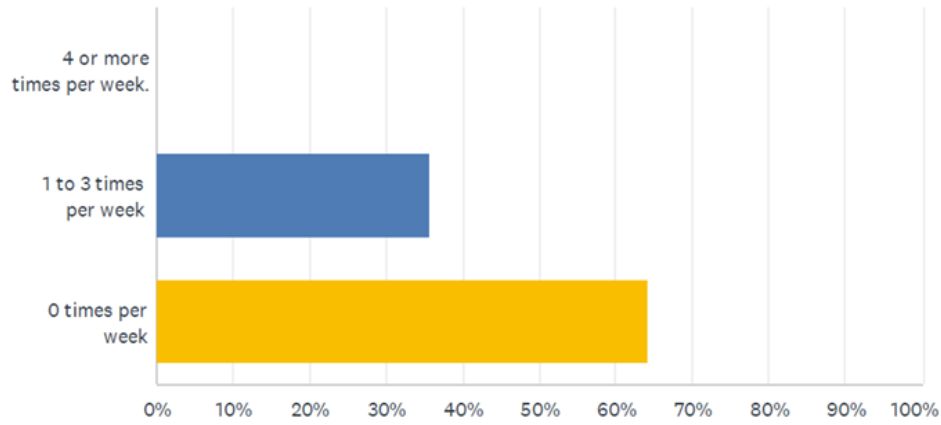
## Appendix 6 – Law Enforcement Survey Results

Provided below are the Police Department Crisis Intervention System Involvement Survey questions and survey responses:



Q2 On average, how often are you called by crisis intervention services?

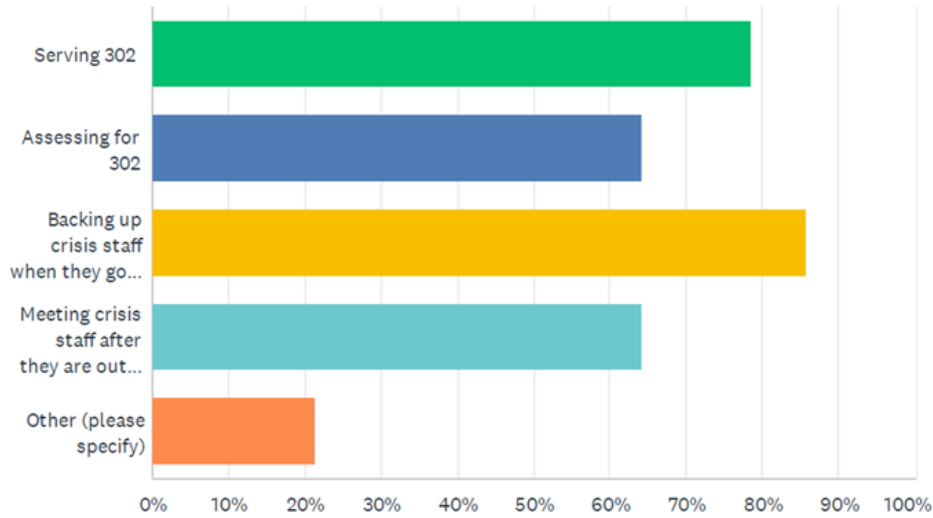
Answered: 14 Skipped: 1



| ANSWER CHOICES            | RESPONSES |    |
|---------------------------|-----------|----|
| 4 or more times per week. | 0.00%     | 0  |
| 1 to 3 times per week     | 35.71%    | 5  |
| 0 times per week          | 64.29%    | 9  |
| TOTAL                     |           | 14 |

### Q3 What types of calls do you respond to related to crisis intervention?

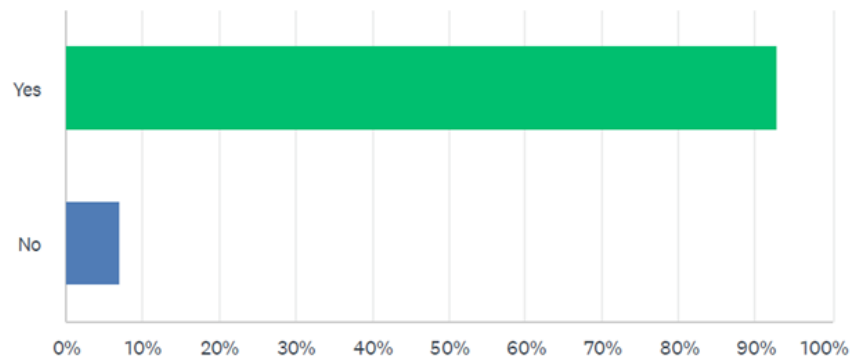
Answered: 14 Skipped: 1



| ANSWER CHOICES  | RESPONSES |    |
|---|-----------|----|
| Serving 302   | 78.57%    | 11 |
| Assessing for 302                                     | 64.29%    | 9  |
| Backing up crisis staff when they go out - planned    | 85.71%    | 12 |
| Meeting crisis staff after they are out – need assist | 64.29%    | 9  |
| Other (please specify)                                | 21.43%    | 3  |
| Total Respondents: 14                                 |           |    |

Q4 If individual calls 911, and Dispatch calls your Department as a first responder believing the caller may have Mental Health concerns, would you accept the recommendation of Dispatch for you to contact mobile crisis services?

Answered: 14 Skipped: 1



| ANSWER CHOICES | RESPONSES |    |
|----------------|-----------|----|
| Yes            | 92.86%    | 13 |
| No             | 7.14%     | 1  |
| TOTAL          |           | 14 |

Q5 – When working on a crisis response, what works well?

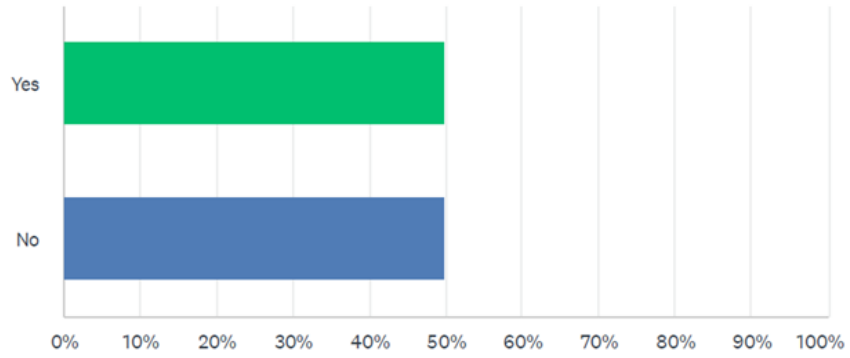
Q6 – When working on a crisis response, what does not work well?

Q7 – How can the crisis system help you better?

Q8 – In a perfect world, how would the crisis intervention system work best?

### Q9 Have you been trained in Crisis Intervention Techniques (CIT)?

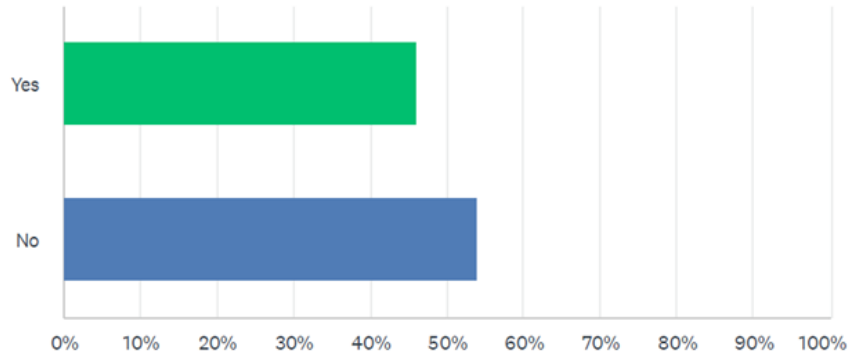
Answered: 14 Skipped: 1



| ANSWER CHOICES | RESPONSES |           |
|----------------|-----------|-----------|
| Yes            | 50.00%    | 7         |
| No             | 50.00%    | 7         |
| <b>TOTAL</b>   |           | <b>14</b> |

Q10 Have you been trained in Mental Health First Aid (MHFA)?

Answered: 13 Skipped: 2

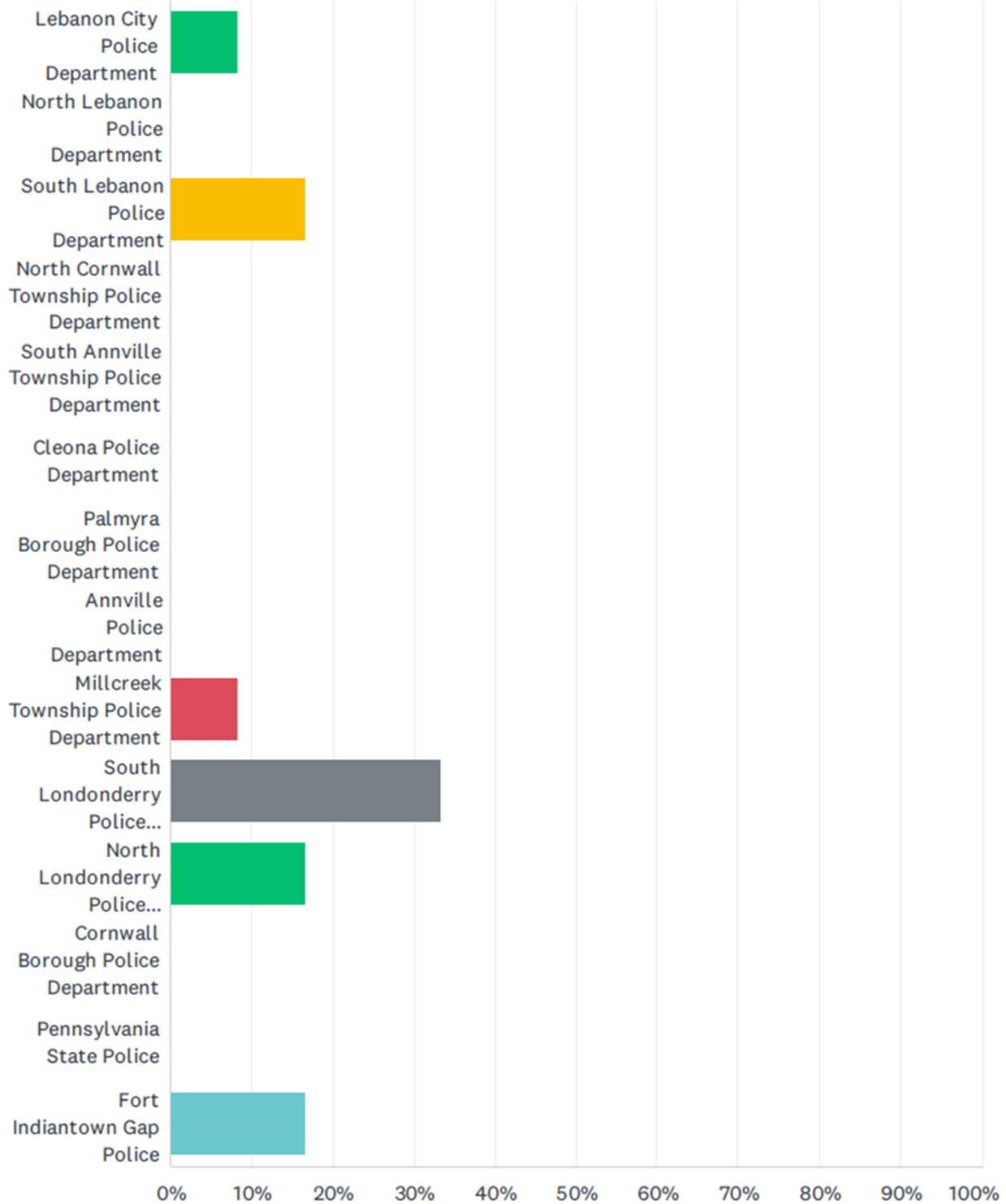


| ANSWER CHOICES | RESPONSES |    |
|----------------|-----------|----|
| Yes            | 46.15%    | 6  |
| No             | 53.85%    | 7  |
| TOTAL          |           | 13 |

Q11 – We value your input to help make the overall County Crisis Intervention System better. Please tell us what improvements can be made to the process.

### Q12 What Police Department are you with?

Answered: 12 Skipped: 3



## End Notes

- (1) U.S. Census Bureau. Lebanon County, Pennsylvania. U.S. Department of Commerce. Retrieved 05/21/2025 from [https://data.census.gov/profile/Lebanon\\_County,\\_Pennsylvania?g=050XX00US42075](https://data.census.gov/profile/Lebanon_County,_Pennsylvania?g=050XX00US42075).
- (2) Behavioral Health Commission. (2022). Special Report Recommendations to the Pennsylvania General Assembly. p. 7.
- (3) SAMHSA Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health (NSDUH). Retrieved 05/22/2025 from <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases>.
- (4) Pennsylvania Department of Community & Economic Development. Municipal Statistics. Retrieved 05/23/2025 from [https://apps.dced.pa.gov/munstats-public/ReportInformation2.aspx?report=MuniPolice\\_Excel](https://apps.dced.pa.gov/munstats-public/ReportInformation2.aspx?report=MuniPolice_Excel)
- (5) National Council for Behavioral Health. (March 2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response. p.11.
- (6) Ibid., p. 14.
- (7) Normalizing data means transforming the data results to a uniform scale, between 0 and 1 or a standard normal distribution (mean of 0, standard deviation of 1). This is useful for comparing values across different ranges or features, especially when making comparisons between variables that have different units or scales.
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