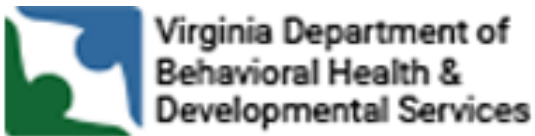




# Program Standards



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## OVERVIEW:

The Department of Behavioral Health and Developmental Services (DBHDS) set a goal to develop a statewide crisis system of care that serves individuals diagnosed with a developmental disability (DD). The REACH (Regional Education Assessment Crisis Services Habilitation) program was established to meet this expectation. Initially this program built upon the then existing components of the community crisis system to create a more comprehensive Developmental Disability Crisis Response System. This statewide system is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing crisis events which put them at risk for homelessness, incarceration, hospitalization, and/or danger to self or others. REACH programs offer an additional layer of support to Emergency Services, the state hospital system, and caregivers who work the most closely with individuals with a developmental disability (DD).

The mission statement of the REACH program reads as follows:

*Individuals with developmental disabilities shall be supported with services that allow the individual to live the most inclusive life possible in his/her community which includes access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services when indicated.*

REACH serves a target population of children and adults with co-occurring diagnoses of developmental disability and behavioral health needs in addition to those presenting with challenging behavior. REACH services enhance local capacity and provide collaborative, cost-effective support to individuals and their families through exemplary clinical services, education, accessing/linking supports, mentoring, and training. REACH programs are collaborative with other agencies and families and are committed to finding a way to serve *all* individuals with DD who are at risk for a behavioral or mental health crisis. When standard services are not appropriate, REACH staff are committed to developing interventions to support the system. At times, this will mean supporting the individual through locating other services, working with DBHDS to secure additional resources, or assisting with the psychiatric hospitalization process and providing transition and step-down services. All services are provided within a context of on-going attention to service outcomes.

The first and perhaps most important way to handle a crisis is to avoid an occurrence whenever possible. The use of crisis services most often follows severe challenging behaviors on the part of the individual (e.g., assault, property destruction, or serious self-injury). Crisis education prevention and planning can provide a long-term strategy to assist an individual and the people who provide support to better cope in times of difficulty. The REACH programs offer crisis prevention services in concert with crisis response. The crisis services promote a mentor based approach to increase the skills of those that support the individual. Additionally, to increase the skills of those who support individuals with developmental disabilities, the program offers training on various topics in many locations throughout the state.

The REACH program shall be trauma informed while meeting the following objectives:

- Provide timely crisis interventions to individuals who are experiencing a crisis event of a behavioral and/or psychiatric nature, as well as supports to families and other care providers.
- Provide mobile community-based crisis assessment and direct crisis services designed to address and resolve the immediate stressors so that the risk of the individual losing their current living arrangement is eliminated or mitigated. Additional prevention services will be developed to help mitigate future events. Crisis services shall be available twenty-four hours a day, seven days a week.

- Provide crisis supports in a residential setting for stabilization. DBHDS has determined that it is best practice to provide supports where the crisis occurs whenever possible. The residential component shall be used when community based crisis services or supports are not effective or clinically inappropriate.
- Provide information and training on the program such that REACH services are contacted early in the escalation period while the individual is still in home with the goal of diverting out of home placement.
- Provide measureable qualitative and quantitative performance outcomes for review of services.
- Modify strategies and performance objectives to meet ongoing system and program goals.

## DEFINITIONS:

The term "developmental disabilities" is a lifelong disability that can encompass intellectual and/or physical impairments.

The Commonwealth of Virginia has adopted the following definitions as part of Code of Virginia: § 37.2-100. Definitions.

*"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life."*

[Note: The Diagnostic and Statistical Manual Of Mental Disorders, Fifth Edition refers to DD and ID under the heading of "Neurodevelopmental Disorders". Intellectual Disability is referred to as "Intellectual Developmental Disorder" under this heading.]

- *"Behavioral health authority" or "authority" means a public body and a body corporate and politic organized in accordance with the provisions of Chapter 6 (§ 37.2-600 et seq.) that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, developmental, and substance abuse services. "Behavioral health authority" or "authority" also includes the organization that provides these services through its own staff or through contracts with other organizations and providers.*
- *"Community services board" means the public body established pursuant to § 37.2-501 that provides mental health, developmental, and substance abuse services within each city and county that established it; the term "community services board" shall include administrative policy community services boards,*

*operating community services boards, and local government departments with policy-advisory community services boards.*

DBHDS Developmental Services Regions are comprised of five regions encompassing the Commonwealth. The regions are referred to as Northern, Central, Southwestern, Western, and Eastern. *Refer to Appendix A for the breakdown of CSBs for each region.*

Advisory Council: The Advisory Council is made up of a group of regional community stakeholders who review the REACH outcomes and challenges while representing the needs and values of the community and service recipients. A regional council may have responsibility for both the adult and children's programs if regional representation is encompassing both children and adult services and supports, equally.

Advocacy Definitions as per "Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services"

- *"Human Rights Advocate": Human rights advocate" means a person employed by the commissioner of DBHDS upon recommendation of the State Human Rights Director to help individuals receiving services exercise their rights.*
- *"Protection and advocacy agency" means the state agency designated under the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI) and the Developmental Disabilities Assistance and Bill of Rights Act (DD). The protection and advocacy agency is the disAbility Law Center of Virginia (dLCV).*

Crisis Education and Prevention Plan (CEPP): The CEPP is an individualized, client-specific written document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the circle of support to assist the individual in addressing and deescalating problems in a healthy way and provide teaching skills that the individual can apply independently. For the purpose of REACH crisis services, the CEPP functions as the person centered individual service plan.

## **PROGRAM OVERSIGHT/OPERATION/LICENSURE:**

DBHDS is responsible for oversight of the REACH program. Each of Virginia's five DD Regions operates an Adult and Child REACH Program through a designated lead Community Service Board (CSB) or a Behavioral Health Authority (BHA).

REACH programs are licensed by the Department of Behavioral Health and Developmental Services to provide an array of services. The licenses are as follows:

- 07-007: "Outpatient Services/Crisis Stabilization – REACH": A non-residential crisis stabilization REACH service for children, adolescent, and/or adults with co-occurring diagnosis of developmental disability and behavioral health needs.

- 01-004: “Group Home Service- REACH”: A residential group home with crisis stabilization REACH service for adults with co-occurring diagnosis of developmental disability and behavioral health needs.
- 14-059: “REACH Children’s Residential Service”: A residential group home with crisis stabilization REACH service for children and adolescents with co-occurring diagnosis of developmental disability and behavioral health needs.

## **REACH STAFFING AND SERVICES:**

REACH Coordinators (license eligible) are the primary point of entry into each REACH program, and they serve as a liaison between the components of the person’s system of care. They work to facilitate cooperative communication by bringing all partners to the table to discuss the individual’s plan of care. The Coordinator is also responsible for completing crisis assessments, developing Crisis Education and Prevention Plans (CEPPs), and training care providers in how to implement the CEPP. They provide emergency assessments and evaluation for REACH services during crisis situations. They work to strengthen the system by coordinating the input of the entire team into assessments and interventions, developing plans to teach coping skills, and linking the individual to on-going services and supports

REACH staff roles also includes a REACH Program Director, a Crisis Therapeutic Home (CTH) Manager, Clinical Director/Oversight, Medical Director/Oversight, Hospital Liaison, Nursing, Medication Technician (CTH only), Mobile Support Workers, QHMPs/QDDPs, Recreation/Activities Oversight (Child CTH) and direct support providers. All staff will be cross-trained in the provision of services to individuals diagnosed with DD with co-occurring mental health or behavioral issues. For further information on staff qualifications and required training, refer to section “Staff Qualifications” later in this document.

## **PROGRAM SERVICES DESCRIPTION:**

### Admission Criteria:

All individuals receiving Adult REACH services must be aged 18 or older, and have a diagnosis of a Developmental Disability, with co-occurring mental illness and/or significant behavioral challenges that are active or cyclical in nature. For Children’s REACH services, the child may receive services up until their 18<sup>th</sup> birthday at which time they will be transitioned into the adult program if needed. The child must also have a diagnosis of Developmental Disability, with co-occurring mental illness and/or significant behavioral challenges that are active or cyclical in nature.

As noted earlier, having been diagnosed as DD is not the sole criteria for admission to the REACH program. Individuals must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric or behavioral nature that puts the individual at risk of psychiatric hospitalization or disruption to their residential stability. This can include difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, homelessness or isolation from social supports; difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, managing finances or recognizing basic safety risks to such a degree that health or safety is jeopardized. In addition, any behavior that is not appropriate to such a degree that immediate intervention by mental health, social services, or the judicial system is necessary suggests the need for REACH services. An individual diagnosed with a traumatic brain injury would only qualify for admission if the injury

occurred such that the person meets all the requirements for being diagnosed DD (including age of onset) and demonstrate MI and/or significant behavioral challenges.

REACH services are available to individuals at all times who meet eligibility requirements for the program. No qualifying individual will be turned away if unable to pay. The goal of REACH is to provide services to individuals for a period of at least 3-12 months, with the potential for a longer period of support when indicated. Additionally, cases may be easily reactivated as needed.

There may be instances when an individual transitions across Regions for community based services as well as for receipt of residential crisis services in an out of region/regional Crisis Therapeutic Home (CTH). Guidelines have been set forth in the “REACH Cross Region Transfers Guide” for processing the transition of services while maintaining consistency across the statewide system of care.

The REACH program does not serve individuals who are actively abusing substances or requiring medically managed detox treatment. The residential component of the program, Crisis Therapeutic Home (CTH), is not intended to be a long term residence or respite. REACH is unable to accept individuals into the CTH who have met criteria for a TDO by an Emergency Service certified pre-screener. REACH personnel do not pre-screen individuals for inpatient admission.

The intent of the REACH program is to support all individuals who are eligible for REACH services; however in some **rare** instances an individual may be denied services by the REACH program. Prior to denying services to an eligible individual, REACH will contact the Department to discuss the reasons that the program feels they cannot address the person’s needs. Should a service denial be determined, the REACH Crisis Services will work in concert with the individual, the individual’s team of stakeholders, and the Department to link the individual to appropriate services.

#### Responsibility of Family/Provider/CSB Support Coordinator:

Once the individual accepts REACH services, it is expected the Family/Provider/CSB Support Coordinator will:

1. actively be involved throughout the duration of REACH services,
2. participate and collaborate in ongoing team meetings, and
3. actively participate in discharge planning.

#### Referrals and Response Time:

REACH receives both emergent and non-emergent referrals from a variety of sources, including community providers and case managers. Referrals are to be made to the program either in writing or through the “Crisis Line” staffed by each regional program 24 hours a day, seven days a week. *Refer to Appendix A. for regional program service areas and related contact information.* The program has a standardized “Program Referral Form” (*see appendix B*) for referral of an individual to any REACH program. All referrals are documented upon receipt.

For a non-crisis referral, referral sources are contacted by REACH Crisis Team Members when the referral is received and follow-up is initiated within 24 hours or on the next business day. Further follow-up is as follows:



- Intakes into the REACH program are scheduled within 10 business days of the initial contact with the referring party. When they occur, exceptions to the 10-day rule are made to accommodate the referring party. If an exception occurs, information must be documented in the individual's record as to reasons for the delay in meeting the deadline and any related attempts to eliminate the reason for a delay.
- In the event that a referral source does not respond after an initial contact in which they previously indicated interest in the program, the program will attempt two follow-up phone calls to schedule an in-person intake assessment. If there is no response to the calls, a letter will be sent thirty days after initial referral date to the referral source indicating closure of the referral. This letter will also include contact information for the crisis line should the person need support in the future.

For a referral that comes into the 24/7 crisis line, the on-call staff triages the call in the following manner:

- by initially providing support;
- obtain information to complete documentation on form;
- determine if the caller is in need of emergent or non-emergent services;
- if a crisis, dispatch on call staff for a face to face assessment; and
- enter call on call log.

If referral is determined to be crisis in nature, the REACH staff will respond, in person

- within 1 hour in urban areas, and
- 2 hours in rural areas.

Note: The REACH regional programs are designated:

- Urban: Region IV and Region II (Alexandria; Fairfax-Falls Church; Loudoun, Arlington, Rappahannock Area, and Prince William CSBs)
- Rural: Regions I, III, V, and II (Northwestern, and Rappahannock-Rapidan CSBs)

All referrals related to individuals must be documented in the REACH data store, Electronic Health Record (EHR) and billing portal within 24 hours.

### Community Based Mobile Supports:

Mobile Crisis Supports: As noted previously, once the person is determined to be in crisis the REACH staff will respond in person. Upon arrival, the REACH staff will:

- assess the situation to offer suggestions for de-escalation of immediate crisis and safety strategies based on observation to stabilize the person in the immediate situation,
- evaluate the need for mobile supports or other intensive community supports,
- collaborate with ES/ED staff to assess need for hospitalization (if clinically applicable),
- explain what REACH services can offer,
- determine eligibility
  - DD diagnosis
  - presenting issues
  - review least restrictive options
- obtain consent for treatment,
- obtain releases of information and copies of pertinent documents, if available and possible,
- complete documentation which must include:



- demographics of the individual;
- detailed summary of the current crisis event, including both immediate and remote antecedents, as well as the response to crisis behavior by those in the individual's environment;
- information regarding mental status;
- psychiatric and medication history;
- active medical problems, both chronic and acute;
- recent stressors;
- strengths;
- interventions;
- disposition; and
- schedule follow-up appointments.

If the REACH Crisis Team Member feels there is imminent danger they should immediately call 911 or instruct the caller to contact 911. REACH staff will present to the site of the call as soon as possible to assist in supporting the individual, assisting other responders with information or consultation, and ensuring that there is communication with the point of final disposition.

A REACH (Crisis) Stabilization Service Plan will be completed within 72 hours using the standardized form for anyone receiving crisis services post assessment.

A more formal intake and assessment process occurs after the immediate crisis has passed so that all documentation can be obtained and questions can be answered. Intakes are conducted through a face-to-face meeting that includes REACH staff, the individual, case manager, and as many other members of the individual's support team as possible. To supplement the elements noted above, additional clinical assessment procedures, gathering of medical records and previous psychological evaluations, and information regarding psychiatric history are obtained during the intake process. The intake/admissions process allows for active collaboration between the individual and his/her team of providers, and should include as many members of the individual's care network as possible.

It is the intent that REACH be notified early in the crisis to prevent the need for the support network to seek law enforcement or emergency service involvement. However, when emergency services is conducting a hospitalization assessment, REACH should be contacted as early in the process as is possible so that collaboration takes place between ES, hospital staff, REACH, the individual, and family to formulate the best treatment outcome. REACH staff will be physically present for all psychiatric pre-screenings to:

- determine if REACH services can sufficiently mitigate the immediate crisis or prevent hospitalization,
- ensure that REACH services are fully activated, and
- provide initial crisis stabilization efforts through the prescreening process.

Whenever possible, if an ECO or TDO is issued, REACH staff will remain with the individual until an appropriate bed is located or the individual is stabilized within the emergency room setting. If TDO is issued, REACH hospital liaison will have weekly contact for the purpose of offering supports to the team and individual, and to participate in coordination of discharge plans and follow-up services. When a REACH program is notified that an individual has been voluntarily hospitalized or made known to the program after commitment, the hospital liaison will contact the respective hospital and/or family to offer REACH services.

Should an in-person response be clinically contraindicated, this rationale will be clearly documented on the call log and in the individual's EHR if they have been admitted to the REACH program. However, follow up to ensure that the clinical issue is appropriately addressed is required as is timely communication with DBHDS to ensure follow up has been effective. Dependent upon reason for clinical contraindication, a plan will be developed to mitigate any future contraindication of future REACH in-person response.

REACH teams provide crisis supports based on the location of the crisis; thus REACH regional programs will work in collaboration with one another as needed (e.g. if a person resides in one catchment area but receives day services in another). If an individual is active in a region but then moves into another region's area, the regional program where the residence is located has the primary responsibility for services.

When a call comes into the crisis line and the REACH staff determines the caller is **not** requesting an in-person response, the staff will offer supports for resolution of the situation. The following supports offered are typical of these types of calls:

- implementation of the individual's crisis education and prevention plan (CEPP) or any individualized protocols,
- provide information to linkage of other support networks,
- direct caller to other REACH staff for information, and
- prevention calls.

Prevention Calls: Often times calls will come into the crisis line that are not crisis in nature. Rather, they reflect the daily challenges and stressors that individuals will experience as they navigate their social environment. At these times, REACH staff can intervene to assist the person with problem solving, providing reassurance, or coaching them through the application of a coping skill that they are working to develop. These types of responses are vital to building independence and personal self-efficacy. They also provide natural opportunities to practice implementing coping skills in response to real stressors. These calls are preventive in nature, both because they focus on skill building and because they help the person address the immediate situation before it escalates.

Mobile supports are provided in the individual's home and community setting. REACH staff work directly with the individual and their current support provider or family. Techniques and strategies are provided via mentoring, coaching, teaching, modeling, role-playing, problem solving, or direct assistance. Examples of supports provided are assisting with skills building such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, emotion recognition/regulation and monitoring of medication compliance through daily check-ins.

When providing mobile supports, the goal is to attain the mutually agreed upon objectives of the individual, the support provider/family, and REACH staff to achieve stability and implement future prevention strategies. This is accomplished through developing rapport, implementing therapy strategies, and mentoring the support care giver(s) of the individual. REACH staff are not acting as a substitute caregiver/staff during the mobile sessions. In the mentoring process, all providers/family members and REACH staff should have a working understanding of the agreed upon goals of the mobile supports so that the intervention, training, and modeling will be effective to help the individual achieve stabilization. The mentoring process also includes joint planning, observation of the care giver interacting with the individual, practicing new strategies, feedback on what is working and what adjustments needs to be made to existing strategies, and addressing new areas of concern.

Mobile Supports typically include:

- responding to a crisis line call;
- stabilizing the immediate situation;
- providing coaching and mentoring in therapeutic strategies
- assessment and determining eligibility;
- obtaining authorization requirements;
- entering information into EHR;
- developing Provisional CEPP;
- training and mentoring;
- updating the CEPP;
- linking to service supports;
- updating and training on prevention strategies; and
- scheduling future appointments;

Mobile crisis supports are tailored to the individual's needs and his/her environment, provided for up to 15 days, and average 2.0 hours per session. Contact by REACH staff for the purpose of prevention and continued stabilization will be offered at least once a week during the first month post crisis event, and subsequently offered monthly until the individual has been stabilized for 90 days. The frequency of contact by REACH staff will be adjusted if clinical assessment of consumer needs indicates an augmented frequency of delivery. All supports are provided by staff in accordance with professional licensing regulations and service provisions. *Refer to Appendix C for "Service Descriptions" for service types and related provider credentials.*

All REACH Mobile Crisis Team members are trained in recognizing, preventing, intervening and de-escalating aggressive behaviors and receive updates annually. However, physical restraints are not part of the supports provided by the mobile team except in situations of immediate danger to the person and the REACH mobile worker.

#### Provisional/Updated Crisis Education and Prevention Plan (CEPP)

From the collaboration that occurred during the intake and assessment, a provisional CEPP is developed commonly referred to as the "crisis plan". This form has been standardized and used by all regional programs (*See Appendix D for example and training instructions*). Staff will train people supporting the individual on the procedures included in this plan initially and after any changes that would affect implementation of supports.

The CEPP serves as the foundational document that explains the rationale for various interventions and describes those interventions operationally so that they can be implemented effectively by the system of care. Every individual who is accepted and utilizes services from REACH will receive a CEPP. Ideally, meetings are scheduled within 7 days of receiving the initial referral and are conducted as soon as possible thereafter. These meetings are scheduled so as to include as many of the individual's support network as possible. Team members should include the REACH coordinator, the individual, supported decision maker (guardian or authorized rep, if applicable) members of the mental health service team, members of the developmental disabilities service team, the case manager, and as many of the individual's family and friends as possible. The purpose of the meeting is to gather information, discuss goals, and begin to develop a plan to assist the individual and his or her caregivers during times of difficulty. Following the initial

meeting, REACH staff will complete additional assessments, interview informants, and do behavioral observations within the individual's primary settings.

It is expected that a provisional crisis education and prevention plan (CEPP) be completed within 15 days of admission to the REACH program. While it is understood that the provisional plan will not be as comprehensive as is optimally desired, it will be sufficient to provide timely support to the system while additional information gathering and discussions are occurring. Although all CEPP's are considered to be working documents that will evolve over time, it is expected that an "updated" plan will be available to the support team within 30 days after provisional plan completion (45 days from admission to REACH program) or prior to initial discharge from the CTH. For the youth who is being admitted to a REACH Child CTH who resides outside of the catchment area of that operating REACH Child CTH and is unknown to REACH, the referring/home region REACH coordinator is responsible for penning the CEPP in collaboration with the CTH clinical/leadership staff.

The updated plan will include all the elements of the provisional CEPP and the following:

- Enhancement of the crisis intervention steps including;
  - Refined definition of behavior (those that would be associated with a mental health presentation and those exclusive of);
  - Refined description of these presenting behaviors at baseline, during escalation, crisis, and post-crisis (cool down);
  - Description of environmental triggers/setting events;
  - Description of antecedents to presenting behaviors (before escalation and crisis);
  - Refined support/intervention strategies (including alternate skill building procedures); and
  - Who and when to call for help/support.
- Description of debriefing protocol for individual and staff;
- Linkages/Coordination Needed;
- Training Signatures for both plans; and
- Updated Staff and Individual's signature.

### Crisis Therapeutic Homes (CTH)

As noted earlier, the residential component of the program, Crisis Therapeutic Home (CTH), is not intended to be a long term residence or respite. REACH programs admit persons to the CTH for stabilization of a crisis, a planned prevention, or as a step-down from a state hospital/ training center/jail. The therapeutic techniques utilized at the CTH are designed to support individuals in crisis or post crisis (prevention and step-down) and thus the CTH environment is designed around these supports rather than an environment associated with a long term residence. Lack of a discharge disposition will not be a barrier to admission to the CTH. Crisis admissions are prioritized over those individuals being admitted for planned prevention or step-down admission. However if a step-down admission is imminent, this person may take priority over the person requesting a crisis admission. The CTH can provide in depth assessments, a change in setting to allow for stabilization, and a highly structured and supportive environment to improve coping skills and work on other goals that aide in stabilizing the current crisis or prevent future occurrence. REACH therapeutic homes are coeducational and have a capacity for 6 individuals. The CTHs supporting adults 18 years of age and older are located in each of the five DBHDS Developmental Services Regions of the state. There are two CTHs that support youth up until their 18<sup>th</sup> birthday. One home operated by the Northern REACH Program supports the Northern and Western DD Regions while the second home operated by the Central REACH Program, supports the Central, Eastern, and Southwestern DD Regions.

The intent of the CTH is to support all individuals who are eligible for services; however in some rare instances an individual may be denied services by the CTH. Prior to denying services to an eligible individual, REACH will contact the Department to discuss the reasons that the program feels they cannot address the person's needs. Should a service denial be determined, the REACH Crisis Services will work in concert with the individual, the individual's team of stakeholders, and the Department to link the individual to appropriate services.

Information requested for admission is standardized throughout the state wide program. Refer to section "*Types of Admissions*" for admission responsibilities and required paperwork.

Since the children's CTH supports individuals from more than one REACH regional program, a small team will be responsible for processing an admission request. This team will consist of the CTH manager and the Regional REACH Director or designee from each of the Regional REACH programs that are supported by the CTH. This group will be responsible for prioritizing admissions if there are competing requests given bed availability. The ultimate decision lies with the Regional Operator Program Director in consultation with DBHDS if a decision on an admission or prioritization of an admission cannot be reached by the group. Children admitted to the CTH who have not reached their 14<sup>th</sup> birthday shall be accepted only after a written agreement with the legal guardian. Children 14 years of age and older who are accepted to the CTH must sign for consent for treatment along with the legal guardian. To ensure choice, the decision to consent for treatment must be made based on an understanding of the REACH program's mission and guidelines and other options available for treatment outside of the REACH Program. Children cannot be court ordered to the REACH CTH. If the legal guardian who consented to a minor's admission or if a minor 14 or older objects at any time to further treatment, the minor shall be discharged from the CTH within 48 hours with supports offered by the REACH program.

Admission to an adult CTH is the responsibility of the local Regional REACH Programs. Prior to denying services to an eligible individual, the program will contact the Department and review the reasons that the program feels they cannot address the person's needs.

Once all information is received, the accepting Director or designee will make a decision within two hours of receipt of all paperwork.

Admissions to the CTH adhere to all state licensing standards including, but not limited to, the following medical documentation: Physician's review/medical clearance (in part to ensure crisis is not medically related), standing orders, TB Screen signed, and copies of current medication orders. While admission may not occur until medical clearance is obtained, REACH staff actively and systematically work to obtain other needed documentation as quickly as possible such as identification cards and the REACH signed CTH program guidelines/house rules.

REACH staff provide direct therapeutic care to individuals admitted to the Crisis Therapeutic Home. All admissions to the CTH must be guided by a treatment plan, crisis stabilization plan, which has been developed specifically for the CTH stay; the information from this plan is updated during the stay to include strategies that are to be implemented once discharged and formulate either in the provisional/updated CEPP. The treatment plan will detail specific outcomes that are measurable and observable through objectives that support the overarching outcome. Staff members assist with skill building in areas such as self-care, communication strategies, and effective coping skills. They monitor medication compliance and conduct daily therapeutic groups and activities (i.e. self-esteem building, wellness groups, appropriate self-

expression, problem solving, coping skills/relaxation strategies, and recreational, social, and leisure activities). Although both the adult and child CTH have core curriculums to assist staff in the aforementioned skill building/support groups, the curriculum applications are tailored to the needs of the individuals in residence. The parent is responsible for notification to the local school system of the admission to the REACH short term Crisis residential program (CTH) to arrange for any related supports that will be provided by the youth's school system during stay at the program. In addition, the parent is also responsible for notification to the school of the date of discharge from the CTH.

When supporting the children at the CTH in taking care of their personal needs, staff with the same gender as the youth will be assigned during this time. In the event that it is necessary for staff to supervise children of the opposite gender, care will be taken to assure for the privacy of the youth.

### **Types of CTH Admissions:**

- a) Crisis Stabilization Admission: Crisis Stabilization supports are provided to individuals admitted to the CTH to assist them through an acute crisis event. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from reaching stability within their home setting. Examples of when an individual may be appropriate for a crisis stabilization admission are:
- When experiencing behavioral challenges or increased mental health issues that puts their current placement and/or systems of support at risk.
  - When caregivers are unable to support the person at the time due to behavior that is aggressive, excessively risky, or beyond what the home can manage.
  - When interpersonal conflict within the setting suggests the need to provide a period of separation and an opportunity to revise treatment strategies to address the root of the disagreement.

Admission to the CTH must stem from a current face to face assessment conducted by REACH staff. This assessment typically originates as a result of the crisis call. Admission is based on bed availability. CTH procedures include:

- Obtaining authorizations/releases;
- Obtaining Medical Clearance and physician's orders;
- Develop a transportation plan;
- Complete intake;
- Develop staffing plan;
- Develop safety plan;
- Enter data into EHR and Billing services;
- Convene admissions meeting within 72 hours of admission;
- Development/Update provisional CEPP within 72 hours of admission to the home;
- Complete training of provisional CEPP and safety plan with CTH staff;
- Convene weekly discharge planning meetings inclusive of case management;
- Weekly updates regarding the status of those individuals with "no dispositions" to DBHDS Director of Community Support Services;
- Medication reviews (including any p.r.n. administration) and side effect monitoring
- Update CEPP and train provider on information in this document prior to discharge; and
- Finalize discharge and follow-up.



A crisis stabilization admission to the Crisis Therapeutic Home is meant to be short-term, and therefore may be approved for up to 15 consecutive days per crisis event with the possibility for one 15 day reassessment (maximum of 30 days). *Refer to “Discharge Planning” section of this document for more details on the discharge process.*

Responsibilities regarding a crisis admission to the CTH in respect to the REACH program, Provider/Family and CSB are as follows:

**REACH responsibilities (required prior to admission):**

- Triage with CTH Team
- Face to face crisis assessment
- Release of information (if out of region referral)
- Signed Stabilization Service Plan
- Signed CTH Program Guidelines/House Rules
- Provisional Crisis Plan (or Full CEPP) if known to REACH
- If out of region referral, home region coordinates call with accepting region and CSB for hand off

**Provider/family responsibilities (required prior to admission):**

- Appropriate labeled/bottled medications or prescriptions (minimum of 2 week supply)---*to include medications for both **physical** and **mental** health needs*
- Coordinate transportation needs with REACH
- Sign Parent Agreement (for Child CTH)
- Notification to school system by family for child admission

**CSB Support Coordinator (required prior to admission):**

- REACH Medical Orders Form (signed physician orders)
- REACH Medical Screening Form (signed medical clearance by healthcare professional)
- If out of region referral, participate in call with accepting and home region
- Transportation coordination (if provider/family are unable to transport)
- If previously unknown to REACH
  - Program referral form
  - Consent for treatment
  - ROIs
  - Provider choice

**Additional requests (may occur subsequent to admission):**

- If billing Waiver (H2011-Center based crisis supports), request ISAR to be opened by SC



- Admission/Discharge planning calls scheduled with all available team members
- Copy of ID (SC)
- Copy of insurance card (SC)
- Verification of guardianship (SC)

- b) Crisis Prevention Admission: Crisis prevention admissions will be provided to individuals who are receiving ongoing REACH services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. At a minimum, individuals must be enrolled in and willing to accept ongoing REACH services to be eligible for a prevention admission. If a crisis prevention admission is approved but the challenges requested to be addressed are not part of the last CEPP, CTH staff are to be informed prior to admission of the goals of the admission.

Discharge from a REACH Crisis Prevention Admission is pre-determined and scheduled at the time of admission. Recommended length of stay is 3-5 days per admission. Discharge meetings are required at the conclusion of the stay and are intended to consolidate skills learned, inform care providers of progress made, and discuss ways to generalize skills to the home environment.

No more than one crisis prevention stay per month is recommended. Crisis Prevention Admissions should not exceed 5 consecutive days per stay unless warranted by clinical presentation and the individual's need. A crisis prevention admission will be re-scheduled if a person needing a crisis stabilization admission occurs in the interim.

- c) Step- Down Prevention Admission: CTH can also be utilized as a step-down from, psychiatric hospitals, a training center (adults), jails, or Crisis Stabilization Units as part of a structured transition between placements.

As a part of this service, REACH staff will:

- Attend the person's hearing (if under a Temporary Detention Order)
- Establish contact with the Hospital/Training Center Social Worker
- Participate in team meetings at the treating facilities and will maintain weekly contact with the individual while they are preparing for discharge. Visits to the treating facility are intended to provide support and connection to the individual as well as on the spot education and training to facility staff.
- Complete a consultation note at the conclusion of each visit to an outside treatment setting. A copy of this note will be provided to nursing staff for inclusion in the individual's medical record according to the protocol for the treating facility. This note will document the visit and provide written recommendations as needed.
- Complete an intake and assessment while individual at the hospital/training center/jail.
- Work with individual, family, hospital treatment team, and provider on discharge planning from both the hospital and CTH.

Responsibilities regarding a Prevention or Step-Down Admission to the CTH in respect to the REACH program, Provider/Family, CSB, and Hospital or Training Center are as follows:

**REACH responsibilities (required prior to Prevention or Step Down admission):**

- Triage with CTH Team

- Face to face assessment to ensure stability 24-72 hours beforehand (may be accomplished via discharge/planning meeting for step downs; completed by home region if out of region referral)
- Release of information (if out of region referral)
- Signed Stabilization Service Plan
- Signed CTH Program Guidelines
- Provisional Crisis Plan (or Full CEPP) if known to REACH
- If out of region referral, home region coordinates call with accepting region and CSB for hand off

**Provider/family responsibilities (required prior to Prevention or Step-down admission):**

- Appropriate labeled/bottled medications or prescriptions (minimum of 2 week supply)---*to include medications for both **physical** and **mental** health needs*
- Coordinate transportation needs with REACH
- Sign Parent Agreement (for Child CTH)
- Notification to school system by family for child admission

**CSB Support Coordinator responsibilities (required prior to Prevention or Step Down admission):**

- REACH Medical Orders Form (signed physician orders)
- REACH Medical Screening Form (signed medical clearance by healthcare professional)
- If out of region referral, participate in call with accepting and home region
- If previously unknown to REACH
  - Program referral form
  - Consent for treatment
  - ROIs
  - Provider choice
- Transportation coordination (if provider/family are unable to transport)

**Hospital or training center responsibilities (required prior to Step Down admission)**

- Progress notes from hospital (at least previous 24-48 hours)
- Current labs within past quarter
- History and physical
- MARs for last 2 weeks
- Appropriate labeled/bottled medications or prescriptions (minimum of 2 week supply or enough supply until next scheduled medical/psychiatric appointment)---*to include medications for both **physical** and **mental** health needs*

**Additional requests (may occur subsequent to admission):**

- If billing Waiver (H2011-Center based crisis supports), request ISAR to be opened by CSB support coordinator (SC)

- Admission/Discharge planning calls scheduled with all available team members
- Copy of ID (family/SC)
- Copy of insurance card (family/SC)
- Verification of guardianship (guardian/SC)

### **Responsibility for Appointments, Obtaining Personal Supplies, and Contact during the Stay at CTH:**

It is the intent of the REACH program that the individual keep scheduled critical appointments such as medical, psychiatric, clinical, and business appointments (e.g. Social Security) during their stay at the CTH. The primary responsibility for arranging and providing transportation to these appointments falls with the individual's family/provider. The case manager would serve as the back up to the family/provider. In the event that the person does not have a case manager, REACH staff will coordinate with family/provider to ensure that this person attends his/her appointments as scheduled.

The family/provider is responsible for ensuring that the individual has clothing and any necessary medical supplies (such as cane, walker, CPAP) that are needed for the duration of their stay.

During the individual's stay at the CTH, the case manager and provider will keep in regular contact (at least weekly) with the REACH CTH staff and be an active participant in scheduled treatment meetings so that everyone is able to support the individual throughout their stay at the CTH.

**Extensions to the 30 Day Admission Rule:** There will be circumstances when the need for a crisis stabilization stay will exceed 30 days. When clinically indicated, extensions may be granted. The procedure for requesting an extension of the therapeutic stay beyond the 30-day time frame is summarized below:

1. On or before the 25<sup>th</sup> day of stay at a regional Crisis Therapeutic Home, the Regional REACH Director will submit a request to the Office of Developmental Services for a 15-day extension. This is a written request which may be submitted through encrypted email or secure fax (804-692-0077).
2. Requests for further extensions will be made by updating the original request and resubmitting it 5 days prior to the extension end date. **REQUESTS WILL INCLUDE:**
  - Client name
  - Region
  - Date of admission
  - Reason for extended stay
  - Length of extension requested
3. Within 24 hours of receiving a request for an extension of a Crisis Therapeutic admission, DBHDS, shall inform the Regional REACH Director whether the individual is eligible for continued stay.

**No Case Manager/No Disposition:** When a person is admitted to the CTH without a Case Manager or without a place to return to upon discharge from the program, the REACH director for the program will immediately:

- contact the DBHDS Director of Community Support Services or designee;
- contact a Regional Community Resource Consultant;
- initiate a RST referral; and
- contact the local CSB or Waitlist CM for Case Management services.

As noted previously, the REACH programs will send weekly updates regarding the status of those individuals with “no dispositions” to DBHDS Director of Community Support Services.

## **ON-GOING FOLLOW-UP BY REACH:**

Staff meetings are held regularly to update staff on referrals, calls coming into the crisis line, transfers, individuals in the CTH, and those awaiting step-down or prevention admissions/services.

Triage Meetings: All REACH teams meet every business day morning for a triage call meeting. This will occur with members present either in-person or on a conference call. Agendas and minutes are maintained. The meeting will review:

- on-call updates;
- crisis plans, discharges, and any jail, or psychiatric discharges or step downs staffed;
- individual’s updates;
- new referrals, including transfers from another Region,
- transition requests, and
- CTH updates.

Multidisciplinary/Clinical Team Meetings: This meeting is held at least monthly but may occur more frequently as some regional programs split meetings according to location within the region and then convene for a group meeting. This meeting incorporates an in depth processing of the status of some individuals, brief trainings, updates on operations, troubleshooting of staffing, and reviews of admission and discharge status of individuals.

CTH Meetings: In addition to the updates given in the daily triage meetings, The CTH Director will chair a monthly face to face meeting with CTH staff, including the REACH program director and clinical manager, to complete a more in depth review of those residing in the CTH, review prevention or step-down admissions pending, and to review coordination for those being discharged. This meeting will also be a place to address any concerns that have arisen in the home and a time for brief training to be completed.

## **PROCEDURE TO REFER INDIVIDUALS FROM ONE REACH PROGRAM TO ANOTHER (OTHER THAN CTH REFERRALS):**

The REACH programs are operated by separate providers, regionally distributed according to DBHDS Developmental Services Regions. Nonetheless, REACH programs work together to ensure that appropriate services are available at all times and to all individuals regardless of geographic location. Therefore, an individual may receive services from a REACH program outside of their residential area if they move to a new Region. In these cases, transfers from one REACH service to another will be facilitated from one REACH Director to the other REACH Director or designee. The individual and/or guardian must sign an Authorization to Release PHI in order to permit information from one REACH program to be provided to another REACH Program.

All referrals are to be documented by both the sending and receiving program to facilitate transfers. Phone calls should be made between programs to follow-up on referral paperwork as well as training of the new coordinator and provider by the previous coordinator.

## **DISCHARGE PLANNING:**

**Mobile Supports:** Discharge planning will occur as part of the supports offered. As part of the ending of mobile sessions, the CEPP will again be reviewed with individual/family/provider to update and finalize. An individual will be discharged from mobile supports 90 days after stabilization. A written discharge report will be completed within five business days of discharge.

**CTH:** Discharge planning will occur during the admission process for crisis stabilization admissions and prior to admissions for those stepping down or admitted for prevention. For individuals who have no disposition upon admission or have had a provider change during the stay, the discharge planning must include an assessment of the person's needs, environmental assessment, and visits with the provider and the residence. The team must then reconvene with enough time to process the individual's choice and complete the logistics of the transition with all service providers. All discharge meetings will include at a minimum the individual, and their post stay support system (family, providers, etc. (as appropriate)), CSB support coordinator (if they have one), REACH coordinator, REACH CTH manager, and CTH support staff. The meetings will be documented on a discharge plan and discharge summary will be completed within five business days of discharge.

Individuals will be discharged from REACH support services upon their request (refuse/decline services), their guardian's or authorized representative's request, if they move to another state or out the catchment area, or if they have not had contact with their REACH Coordinator within the past 30 days despite Coordinator's attempts. Their case can be transferred to another REACH Program if they relocate within Virginia.

## **FOLLOW-UP POST DISCHARGE:**

Follow up is an integral part of REACH services, and is provided to all individuals who have received crisis stabilization/intervention services. Follow up benefits both the individual and their systems of care, allowing residual problems to be addressed at their lowest level of intensity. REACH staff is in frequent contact with service providers and individuals to ensure that they remain stable and continue to receive effective services. Follow up activities include home visits, phone contacts, in person consultation with the individual, family, day support and residential providers, and attendance at team meetings to remain in-touch and aware of emergent issues as they arise. All active cases receive at least monthly phone contact to check in and ensure that the individual continues to do well until discharge from the program.

## **TRAINING AND OUTREACH:**

In addition to training related to specific individuals, the REACH programs offer outreach and training to all community partners, including people with disabilities, families, hospitals, law enforcement, CSB staff, providers, or other agencies that provide services to the DD community. The REACH programs will offer trainings to community partners at least quarterly and more often, if necessary to meet training requests from the community. These trainings may be conducted by REACH staff or sponsored by the REACH program in cases where other professionals are providing expert training. For each training session, a training log that includes the date, duration, and title of the training, along with attendees' name, role, and agency affiliation must be completed.

Finally, REACH staff members are able to develop trainings on specific topics of interest to the field. Topic specific trainings may be requested by community stakeholders or may be offered by REACH to address

regional trends observed in the clinical population being served. As with required trainings, documentation of attendance, training title, and date, time and duration of the training is required.

## **EMERGENCIES AND USE OF RESTRAINTS:**

Each regional REACH Mobile Crisis Team maintains a plan of action for appropriate staff response to psychiatric, behavioral, medical and/or other emergencies that place individuals in imminent danger of harm. Regional REACH teams have policy and procedures that are related to use of restraints and behavioral interventions and supports. As noted earlier, physical restraints are not part of the supports provided by the mobile crisis team except in situations of immediate danger to the person and the REACH mobile worker and are used only as a last resort in the CTH. Mechanical restraints are prohibited in all REACH programs.

In general, all REACH programs discourage the use of physical restraint except in emergent situations when there is imminent risk of harm to an individual or others and any application is considered a last resort. In these situations, only techniques supported by the programs' regional crisis intervention training may be used. The use of the restraint must be documented in the person's electronic health record, in the DBHDS CHRIS System, and will have an internal review by the program's QM staff. Legal Guardian's will be notified of any use of restraints.

For any use of physical restraint, a debriefing must occur with the staff and individual as soon as clinically appropriate, but no later than 24 hours post discontinuation of the restraint. The debriefings must be documented in the individual's electronic health record.

All staff must complete the regional program's crisis training which incorporates restraint and management of behavior within forty-five days of hire. This training program has been approved by DBHDS. Staff must also be retrained annually according to the specifications of each program.

The rare use of physical restraint as per REACH procedures are in compliance with the Department of Behavioral Health and Developmental Disabilities "*Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Disabilities*". All program related restrictions incorporated as part of the CTH environment are written in the CTH House rules for each Region's CTH and are in compliance with the Human Rights regulation and in accordance with treatment appropriate with a short term crisis program. Individual restrictions follow all applicable Human Rights Regulations for review.

## **STAFF QUALIFICATIONS:**

The REACH Mobile Crisis Teams consist of qualified staff that are educated and trained to provide services to individuals with DD. REACH Mobile Crisis Team Members are qualified to provide:

- Crisis assessment, stabilization & intervention;
- Symptom assessment & management;
- Consultation and training to consumers, families, and other service providers;
- System linkages;
- Social, interpersonal, and leisure time activity services; and
- Support services or direct assistance to ensure consumers obtain the basic necessities of daily life.



The REACH Director is responsible for ensuring that all REACH staff members comply with minimum experiential (licensure, credentialing, etc.) guidelines and demonstrate core competencies as related to crisis services, mental health disorders, and developmental disabilities. To facilitate this, DBHDS in conjunction with REACH leadership have developed a set of core training curriculum in conjunction with competencies developed by DBHDS to ensure that a well-informed and knowledgeable workforce responds to crisis situations and is available to provide effective treatment and follow up care. All newly hired REACH staff must complete a structured training and mentoring program to ensure that they are sufficiently trained to meet the service standards listed above. While additional training related to general operating procedures, agency-specific practices, and documentation is included in the orientation of REACH staff, structured training is provided in the following areas according to the timelines specified (*it should be noted that training topics are updated as indicated by emerging clinical information in the field as it relates to best practices for supporting individuals with DD as well as based on data gathered from the program on emerging trends in support needs what is noted below is not an exhaustive list of all training topics covered*):

1. To be completed within 15 days of hire

- Introduction to the REACH program, including history, mission and philosophy of the program, roles within the team, documentation requirements, and orientation to the CTH, including engaging at the home for blocks of time as scheduled by the REACH Director or designee. In addition the employee should receive all agency required training as part of an employee's orientation as outlined in the licensing regulations.

2. To be completed within 180 days of hire

- Introduction to waiver services and the different waivers available
- Orientation to DD/ID
- Mental Health Disorders and DD Comorbidity
- Introduction to Autism and ASD Characteristics
- Sexuality and ASD
- Employment, Guardianship, and Transition to Adulthood
- Assessing and evaluating symptoms and behaviors
- Social competence
- Trauma informed care
- Medication and medical causes of behavior
- Behavioral assessment and interventions, including overviews of Positive Behavior Support, Applied Behavior Analysis
- Completion of all DBHDS DSP and advanced competencies (medical, behavioral, and autism)

To demonstrate competency of didactic trainings received, staff must complete and pass an objective comprehension test. While formalized didactic training serves as the minimum necessary to prepare staff to provide crisis and prevention services, ongoing supervision and mentoring of staff both in and outside the provision of crisis services is critical for employee development. Therefore, in addition to the tasks outlined above, incoming REACH staff must complete a process of supervision and mentoring. This process must include at a minimum:

- Weekly individual supervision for the first 180 days of service
- Group supervision twice per month for the first 180 days of hire
- For CTH staff, regularly scheduled shadowing and supervision of staff within the CTH within the first 180 days of hire; for community staff, regularly scheduled shadowing and supervision in the CTH for the first 30 days of hire



- For community staff, shadowing of at least 6 in person crisis responses, with three of these being purely observational and three being handled as a team
- For all staff, observation of at least two trainings conducted by REACH staff and delivered to family, provider staff, or other community partner.
- For all staff, completion of one training provided to family, group home staff or other community partner that is observed by licensed clinician or supervisory staff
- For all staff, development of a formal case presentation, prepared under the direct supervision of a licensed clinician, and delivered to the larger REACH team for peer feedback
- Review and feedback on all Crisis Education and Prevention Plans by licensed or licensed eligible staff for the first 180 days of service

The above activities must be completed and documented in the employee's personnel record. The trainings and supervision practices as described in these standards ensure that competencies are grown over time. However, just as important as developing competencies is establishing that staff members retain high levels of competency and engage in ongoing professional development throughout their service to the program. Therefore, after completing their first year of satisfactory service, All REACH staff will continue their professional development through the following activities.

- Each year by the anniversary of their hire date, all staff members will complete at least 12 hours of continuing education in topics related to mental health, trauma informed care, intellectual disability, developmental disability, applied behavior analysis, positive behaviors supports, and/or related topics. All training should be commensurate with the level of expertise of the receiving staff.
- REACH Leadership must observe clinical service delivery and provide feedback at least once annually and more often if warranted for REACH coordinators and other clinical staff. At the discretion of the REACH Director, this requirement may be made less stringent for those staff with a proven track record of success within the program.
- All staff will receive review of written work (CEPP's, progress notes, crisis assessments, etc.) at least yearly with written feedback provided of all reviews.

## **MONITORING AND EVALUATION OF SERVICE QUALITY:**

The REACH monitoring and evaluating service quality policy shall comply with all Federal and State laws including *Commonwealth of Virginia, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Development Services*, 12 VAC 35-105. These regulations can be found online at the Department of Behavioral Health and Development Services website. All revisions to this policy shall be submitted for review and comment to the Local Human Rights Committee prior to implementation. The goals and objectives of the REACH program are consistent with requirements of DBHDS, guidelines for federal block grants, and all applicable laws and administrative rules.

### **A. Quality Monitoring and Evaluation**

The REACH programs fully participate in the evaluation and quality assurance activities mandated by DBHDS and/or other funding sources. REACH Program's planning and evaluation system is oriented to the mission and purpose of the program and gives primary emphasis to services and outcomes, priorities, needs, and constituencies (consumers and communities). Planning and evaluation is characterized by a long-term perspective and ongoing analysis. The planning and evaluation system is also designed to encourage participation, awareness, and review by Advisory Council members, staff and volunteers, consumers, and the general public. Results of evaluation are used for planning, and for modification of REACH activities when necessary. It is essential that all REACH programs continue to evaluate service

needs and outcomes through the continuous process of data collection and evaluation, both for reporting purposes and to improve service effectiveness over time.

### **B. REACH Crisis Services Quarterly Qualitative Review Process:**

The purpose of the review process is to have information that contributes to the understanding of how the services offered by the REACH programs are impacting the lives of the individuals in crisis as well as allow DBHDS to increase consistency and continuity of care. The information, both qualitative and quantitative data, should allow for DBHDS staff to revisit the existing processes so that future changes will enhance services and allow individuals to remain in their home setting while also ensuring that regardless of where the individual resides in the state they have access to qualified and competent intervenors.

The review process will be initiated in the first quarter of the state fiscal year and the information reviewed will be from the prior quarter. The reviews will be completed by the DBHDS Regional Crisis Systems Managers and subsequent report reviewed by the DBHDS Director of Community Support Services. The quarterly reviews will consist of the following:

- Conference Call which includes:
  - a data review of the respective Regional REACH Program's Quarterly Report;
  - review of compliance with REACH Program Standards (1<sup>st</sup> and 3<sup>rd</sup> quarters only);
  - and
  - review of compliance with Performance Contract (2<sup>nd</sup> and 4<sup>th</sup> quarters only)
- A chart review of two cases per program (adult/child)
  - One hospitalized during the quarter
  - One not hospitalized
- Review of corrective action plan from previous reporting periods as appropriate
- An in-person review of designated topics centering on service provisions and/or clinical improvement.

### **C. REACH Crisis Services Annual Qualitative Review Process:**

The annual review process is an on-site review of the application of the REACH standards by DBHDS staff. The intent of this process is to observe how the program staff apply the practices and supports provided by the REACH programs through shadowing of the staff and to interact with all levels of staff to obtain an understanding of their roles in supporting individuals and related systems of support. It also allows for both group and individual interaction between DBHDS staff and REACH staff throughout all programs to promote goals achieved and process barriers that staff have incurred while providing supports.

### **D. Data Collection:**

All data will be entered into and maintained in the statewide REACH Data Store. Each Region will receive at least two licenses to facilitate efficient data entry. Data elements relevant to assessing the quality and effectiveness of the REACH programs will be documented in the REACH Data Store, with reports built from this source available at the Department's request. Additionally, each Regional Program will track trends in the use of crisis services and gather information about the population served (i.e. age, nature of disability, geographic area, etc.) in their respective Region. In addition to establishing needed clinical information, the data will be useful in service and financial planning. Data elements related to crisis response will be entered into the REACH Data Store within 3 business days of the crisis event. Requests by DBHDS for additional data will be honored and responded to promptly.

### **E. Advisory Council**

Regional Advisory Councils meet at least twice annually to provide support and review the progress of the program. They also have a role in outlining future directions. Regional Advisory Councils enhance our capacity to remain accountable to everyone involved. Based on regional needs, Regional Advisory Councils may meet more frequently.

### **COMPLAINT PROCESS:**

All REACH programs are committed to providing the best possible quality of service. To maintain this commitment, each program has a process for investigating and resolving complaints. Following are expectations for the complaint process:

1. Each Region will develop a complaint form that is offered to any stakeholder of family member who is expressing a significant concern.
2. Complaint forms must include space for the nature of the complaint, what was done to resolve it (if applicable) and the name and contact information of the person making the complaint.
3. Completed complaint forms will go to the Fiscal Agent of the program or designee. A copy should be submitted electronically to DBHDS. DBHDS will not respond to complaints at this level but will use the information for tracking purposes.
4. Anonymous complaints may be used for information purposes by the Fiscal Agent if desired but do not need to be submitted to DBHDS unless special circumstances are evident.
5. Upon receipt of the written complaint, the Fiscal Agent or designee will make contact with the agency, provider, or family making the complaint. This initial contact should be made within 48 hours of the complaint being received. Next steps should be determined and documented on the complaint form.
6. Within 10 days from the point of initial contact a resolution should be presented to the complaining party. If this is accepted, the case is closed. If no resolution is garnered, the complaint should be forwarded to the Director of Community Support Services or designee.

### **MOU AGREEMENTS:**

REACH develops relationships with community partners in order to bridge service gaps and improve service outcomes. Formal Memorandums of Understandings (MOU) are important to defining those partnerships. These agreements link the REACH program with mental health and medical providers, inpatient mental health units, developmental disabilities providers, residential providers, vocational and day services providers, state agencies, dentists, neurologists, experts in the field, etc. Affiliates are partners with signed MOUs that the REACH programs maintain frequent and ongoing collaboration with as part of the infrastructure.

Further, REACH has numerous partners providing services in the community; partners are defined as those agencies with which REACH does not have a formal MOU, but with whom they work in collaboration. This approach is adaptable to the changing needs of the people and systems supported.

One of the most critical MOU functions is to develop a crisis support continuum. This includes development of agreements and collaboration with mobile crisis teams and first responders for increased diversion and collaboration with hospitals regarding admittance and discharge planning and transition.

## REFERENCES:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Code of Virginia. 12VAC35-115. Department of Behavioral Health. *Rules and Regulations to Assure Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services*.

Department of Behavioral Health and Developmental Services Division of Developmental Services. (October 2017, 6<sup>th</sup> Edition). *Navigating the Developmental Disability Waivers: A guide for Individuals, Families and Support Partners*

## **Appendix A**

### **REACH CONTACT INFORMATION**

#### **Region I (Western):**

##### **ADULT** REACH Program:

672 Berkmar Circle  
Charlottesville, VA 22901

**24/7 Crisis line #: 855-917-8278**

##### **CHILD** REACH Program Director: Amanda Cunningham

2305 Landsdown Place,  
Lynchburg VA 24501

**24/7 Crisis line #: 888-908-0486**

#### Areas Served:

- **Allegheny Highlands CSB:** Alleghany, Covington, Clifton Forge City
- **Harrisonburg-Rockingham CSB:** Harrisonburg, Bergton, Bridgewater, Broadway, Dayton, Elkton, Grottoes, Keezletown, Massanutten, McGaheysville, Mt. Crawford, Mt. Solon, Penn Laird, Port Republic, Rockingham, Timberville
- **Horizon BH:** Clifford, Elon, Lowesville, Madison Heights, Monroe, Sweet Briar, Amherst, Pamplin, Spout Spring, Appomattox, Bedford City, Bedford, Big Island, Forest, Goode, Goodview, Hardy, Huddleston, Moneta, Montvale, Thaxton, Alta Vista, Brookneal, Campbell, Concord, Lynch Station, Rustburg, Lynchburg
- **Region 10 CSB:** Crozet, Earlysville, Esmont, Greenwood, Keswick, North Garden, Scottsville, White Hall, Charlottesville, Fluvanna, Kents Store, Palmyra, Dyke, Graves Mill, Greene, Ruckersville, Arrington, Stanardsville, Bumpass, Louisa, Mineral, Trevilians, Afton, Colleen, Faber, Gladstone, Love, Lovingston, Massies Mill, Montebello, Nellysford, Nelson, Piney River, Roseland, Schuyler, Shipman, Tyro, Wingina, Wintergreen
- **Rockbridge Area CS:** Bath, Hot Springs, Millboro, Virginia, Warm Springs, Buena Vista, Lexington, Brownsburg, Fairfield, Glasgow, Goshen, Natural Bridge, Raphine, Rockbridge Baths, Rockbridge, Steeles Tavern, Vesuvius
- **Valley CSB:** Augusta, Augusta Springs, Fishersville, Ft. Defiance, Lyndhurst, Middlebrook, Mount Solon, Staunton, Stuarts Draft, Swoope, Verona, Weyer's Cave, Blue Grass, McDowell, Monterey, Waynesboro, Highland, Hightown

#### **Region II (Northern):**

##### Adult and Child REACH Director: Liv O'Neal

3460 Commission Court Suite 300  
Lakeridge, VA 22192

**24/7 Crisis Line: 855-897-8278**

#### Areas Served:

- **Alexandria CSB:** City of Alexandria
- **Arlington County CSB:** Arlington
- **Fairfax Falls Church CSB:** Annandale, Burke, Centreville, Clifton, Fairfax City, Fairfax , Fairfax Station, Falls Church, Great Falls, Herndon, Springfield, Vienna
- **Loudoun CSB:** Aldie, Ashburn, Bluemont, Chantilly, Dulles, Hamilton, Hillsboro, Lansdowne, Leesburg, Lincoln, Loudoun, Lovettsville, Middleburg, Neersville, Paeonian Springs, Philimott, Purcellville, Round Hill, South Riding, Sterling, Waterford, The Plains
- **Northwestern CS:** Winchester, Clarke, Berryville, Boyce, Millwood, White Post, Clearbrook, Cross Junction, Frederick, Gainesboro, Gore, Stephens City, Luray, Page, Rileyville, Stanley, Basye, Edinburg, Fishers Hill, Fort Valley, Maurertown, Mt. Jackson, New Market, Orkney Springs, Quicksburg, Shenandoah, Strasburg, Toms Brook, Woodstock, Middletown, Bentonville, Front Royal, Linden, Warren
- **Prince William County CSB:** Manassas, Manassas Park, Bristow, Dale City, Dumfries, Gainesville, Haymarket, Montclair, Nokesville, Occoquan, Prince William, Quantico, Triangle, Woodbridge
- **Rappahannock Area CSB:** Bowling Green, Carmel Church, Caroline , Ladysmith, Milford, Port Royal, Rappahannock Academy, Ruther Glen, Woodford, Fredericksburg, Dahlgren, King George, Lake Anna, Spotsylvania, Thornburg, Falmouth, Stafford
- **Rappahannock-Rapidan CSB:** Amissville, Brandy Station, Culpeper, Elkwood, Fauquier, Griffinsburg, Jeffersonston, Reva, Richardsville, Stevensburg, Broad Run, Casanova, Catlett, Delaplane, Goldvein, Hume, Madison, Markham, Marshall, Midland, New Baltimore, Paris, Remington, Sumerduck, The Plains, Upperville, Warrenton, Brightwood, Crigslerville, Hood, Leon, Locust Dale, Madison, Pratts, Rochelle, Syria, Wolftown, Barboursville, Gordonsville, Locust Grove, Montpelier Station, Orange, Somerset, Bealton, Boston, Castleton, Flint Hill, Huntly, Rappahannock, Scrabble, Sperryville, Viewtown, Washington, Viewtown

#### Region III (Southwest):

Adult and Child REACH Director: Denise Hall  
824 West Main Street  
Radford, VA 24141  
**24/7 Crisis Line: 855-887-8278**

#### Areas Served:

- **Blue Ridge BH:** Botetourt, Buchanan Town, Daleville, Eagle Rock, Fincastle, Oriskany, Roanoke City, Troutville, Arcadia, Catawba, Craig, New Castle, Newport, Paint Bank, Bent Mountain, Roanoke , Vinton, Salem, Vinton
- **Cumberland Mt CSB:** Big Rock, Buchanan , Grundy, Pilgrims Knot, Vansant, Castlewood, Cleveland, Dante, Honaker, Lebanon, Rosedale, Russell, Tazewell
- **Danville-Pittsylvania CSB:** Danville, Blairs, Callands, Chatham, Gretna, Pittsylvania, Ringgold, Sandy Level
- **Dickenson County BHS:** Birchleaf, Breaks, Clinchco, Clintwood, Dickenson , Haysi
- **Highland CS:** Washington County, Abingdon, Clarksville, Damascus, Emory, Glade Spring, Meadowview and City of Bristol, Virginia



- **Mt. Rogers CSB:** Bastian, Bland , Rocky Gap, Carroll , Atkins, Ceres, Chilhowie, Elk Creek, Fires, Galax, Grayson, Groseclose, Hillsville, Independence, Mouth of Wilson, Smyth, Sugar Grove, Troutdale, Whitetop, Saltville, Marion, Barren Springs, Crockett, Fort Chiswell, Foster Falls, Ivanhoe, Max Meadows, Wythe, Wytheville, Rural Retreat
- **New River Valley CS:** Radford, Willis, Copper Hill, Floyd, Giles, Narrows, Pearisburg, Rich Creek, Staffordsville, Blacksburg, Christiansburg, Claudville, Montgomery, Riner, Shawsville, Pilot, Allisonia, Draper, Dublin, Hiwassee, New Bern, Pulaski , Pembroke, Meadows of Dan
- **Piedmont CS:** Martinsville, Boones Mill, Burnt Chimney, Callaway, Ferrum, Franklin , Glade Hill, Penhook, Rocky Mount, Smith Mountain Lake, Union Hall, Wirtz, Axton, Bassett, Collinsville, Fieldale, Henry, Ridgeway, Spencer, Stanleytown, Patrick
- **Planning District One BHS:** Dryden, Ewing, Jonesville, Lee, Middlesboro, Pennington Gap, Rose Hill, Stickleysville, Norton, Clinchport, Duffield, Dungannon, Gate City, Hiltons, Nickelsville, Scott, Weber City, Appalachia, Big Stone Gap, Coeburn, Pound, St. Paul, Wise

#### Region IV (Central):

Adult and Child REACH Director: Autumn Richardson

3700 Festival Park Plaza 2<sup>nd</sup> Floor

Chester, VA 23831

**24/7 Crisis Line: 855-282-1006**

Areas Served:

- **Richmond BHA:** Richmond City
- **Chesterfield CSB:** Chester, Chesterfield , Ettrick, Matoaca, Midlothian, Mosely
- **Crossroads CSB:** Amelia, Jetersville, Buckingham, Charlotte, Charlotte Court House, Drakes Branch, Keysville, Randolph , Red Oak, Cartersville, Cumberland , Dundas, Kenbridge, Lunenburg, Meherrin, Prince Edward, Victoria, Blackstone, Crewe, Nottoway, Farmville, Green Bay, Rice
- **District 19 CSB:** Hopewell, Dinwiddie, McKenney, Emporia, Greensville, Skippers, Disputanta, Fort Lee, Prince George, Claremont, Spring Grove, Surry, Wakefield, Jarrat, Stony Creek, Sussex, Wakefield, Waverly, Colonial Heights, Petersburg
- **Goochland/Powhatan CS:** Crozier, Goochland, Gum Spring, Hadensville, Maidens, Manakin-Sabot, Oilville, Powhatan
- **Hanover County CSB:** Ashland, Beaverdam, Doswell, Hanover, Mechanicsville, Montpelier, Rockville
- **Henrico Area MHDS:** Charles City, Red House, Glen Allen, Henrico, Highland Springs, Sandston, Lanexa, New Kent , Providence Forge, Quinton
- **Southside CSB:** Warfield, Alberta, Brunswick , Gasburg, Lawrenceville, Rawlings, Alaton, Boydton, Buffalo Junction, Chase City, Clarksville, Clover, Halifax, Mecklenburg, Nathalie, Scottsburg, Skipwith, South Boston, South Hill, Sutherlin, Virgilina, Bracey



## Region V (Eastern):

Adult and Child REACH Director: Brandon Rodgers

7025 Harbourview Blvd., Suite 119,

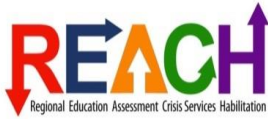
Suffolk, VA 23435

**24/7 Crisis Line: 888-255-2989**

Areas Served:

- **Chesapeake CSB:** City of Chesapeake
- **Colonial BH:** James City, Jamestown, Toano, Poquoson, Williamsburg, Grafton, York, Yorktown
- **Eastern Shore CSB:** Wachapreague, Accomac City, Accomack , Belle Haven, Bloxom, Chincoteague, Grasonville, Hallwood, Harborton, Keller, Melfa, New Church, Onancock, Onley, Painter, Parksley, Pungoteague, Quinby, Sanford, Tangier, Tasley, Wachapreague, Wallops Island, Cape Charles, Capeville, Cheriton, Eastville, Exmore, Hacks Neck, Jamesville, Machipongo, Nassawadox, Northampton, Oyster, Townsend, Willis Wharf
- **Hampton Newport News CSB:** Newport News, Hampton
- **Middle Peninsula Northern Neck CSB:** Wake, Saluda, Essex , Tappahannock, Dutton, Gloucester, Gloucester Point, Hayes, King and Queen, Aylett, King William, West Point, Irvington, Weems, White Stone, Burkeville, Church View, Cobbs Creek, Deltaville, Grimstead, Gwynn's Island, Hallieford, Hardyville, Hartfield, Locust Hill, Mathews, Middlesex, Port Haywood, Topping, Urbanna, Wake, Burgess, Callao, Heathsville, Kilmarnock, Lottsburg, Northumberland, Ophelia, Reedville, Wicomico Church, Farnham, Naylor's Beach, Richmond , Warsaw, Coles Point, Colonial Beach, Kinsale, Montross, Oak Grove, Stratford, Westmoreland, Achilles, Lancaster, Morattico
- **Norfolk CSB:** City of Norfolk
- **Portsmouth BHS:** City of Portsmouth
- **Virginia Beach:** City of Virginia Beach
- **Western Tidewater CSB:** Suffolk, Isle of Wight, Boykins, Capron, Courtland, Drewryville, Franklin City, Ivor, Sedley, Southampton, Smithfield, Windsor

## Appendix B



# PROGRAM REFERRAL FORM

Individual's Name:

Date of Referral: [Click here to enter a date.](#)

Time of Referral:

Type of Referral: ☐ Crisis

☐ Non Crisis

If Crisis:

Departure Time:

Arrival Time:

ES Involved/Prescreened?: Yes ☐ No ☐

Crisis Response Location: [Choose an item.](#)

Primary Reason for Referral: [Choose an item.](#)

### Section I: Referral Source Information

Name of Person Making Referral:

Name of Agency and/or their Relation:

Source of Referral: [Choose an item.](#)

Referral Source Telephone/Email:

### Section II: Individual Information

Name of Individual Being Referred:

DOB:

Age:

SS# (Required):

Race/ethnicity:

[Choose an item.](#)

Sex: [Choose an](#)

[item.](#)

Address:

Zip Code:

City/County:

Type of Residence: [Choose an item.](#)

# of Residences Within the Past 5 years:

Phone #:

Alternate #:

### Section III: Diagnoses and Medical (Please list all)

Intellectual and/or Developmental Disability:

Mental Health:

Medical:

Allergies:

Medications: ☐ See attached medication list ☐ No Medications Prescribed

### Section IV: Guardian/Authorized Representative

Does Client Have a Guardian?: ☐ Yes ☐ No (If relevant please provide guardianship documents)

If Yes: Name:

Relationship:

Address/ Phone/ Email:

Does Client Have an AR?: ☐ Yes ☐ No

If Yes: Name:

Relationship:

Address/ Phone/ Email:

### Section V: Providers & Emergency Contact

Case Manager Name:		CSB: Choose an item.
Phone #:		Email:
Type:	<input type="checkbox"/> ID/DD CSB <input type="checkbox"/> MH <input type="checkbox"/> DD Private <input type="checkbox"/> DSS (Foster Care) <input type="checkbox"/> None	
Psychiatrist:	Phone #:	Email:
Behaviorist:	Phone #:	Email:
PCP name:	Phone #:	Email:
Other (specify: _____)	Phone #:	Email:
Other (specify: _____)	Phone #:	Email:
Emergency contact name:	Phone #:	Email:
Relationship to individual:		

### Section VI: Insurance (Check all)

Insurance Type:	<input type="checkbox"/> MCO Plan _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Private
	<input type="checkbox"/> None <input type="checkbox"/> DD Waiver <input type="checkbox"/> DD Waiver Waitlist
	<input type="checkbox"/> Other funding source: _____
Insurance ID #:	MCO #: _____ Medicaid # _____

### Section VII: Hospitalization and Residential History

Psychiatric Hospitalizations in last 3 years (start with most recent):

DATE OF ADMISSION/DISCHARGE	FACILITY	DISCHARGE DISPOSITION (location)

Medical Hospitalizations in last 3 years (start with most recent):

DATE OF ADMISSION/DISCHARGE	FACILITY	DISCHARGE DISPOSITION (location)

Residential Placements in last 3 years (start with most recent):

DATE OF ADMISSION/DISCHARGE	RESIDENTIAL PROVIDER NAME	DISCHARGE DISPOSITION (location)


### Section VIII: School/Vocational

Education Level: \_\_\_\_\_ Currently Enrolled in School: ☐ Yes ☐ No

Name of School: \_\_\_\_\_

Employed: ☐ Yes ☐ No Employer: \_\_\_\_\_ Employment Status: ☐ P/T ☐ F/T

Type: ☐ With Supports ☐ Without Supports

### Section IX: Documentation (Check documents that that can be provided at Intake)

☐ Face Sheet ☐ Psychological ☐ Neuropsychological ☐ Individualized Education Plan

☐ Physical ☐ PPD Test ☐ Medication List ☐ Guardianship/ Power of Attorney Documents

☐ Photo ID ☐ Insurance cards ☐ Other: \_\_\_\_\_

**Signature of Person Completing Referral/Credentials** (please write legibly):

\_\_\_\_\_

### Administrative Use Only:

**Disposition:**  
☐ Accepted for REACH Admission  
**Coordinator Assigned:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
☐ More information needed to determine if individual is eligible for REACH services  
☐ Individual not eligible for REACH  
☐ Individual/Legal Guardian declines on-going REACH services

**Reason for ineligibility:**  
☐ No diagnosis of DD ☐ SA/Not in full remission  
☐ Other: \_\_\_\_\_

<b>Staff Who Processed Referral:</b>	<b>REACH Program/Region Receiving Referral:</b>
<b>Date Received:</b>	<b>Date Opened in EHR:</b>
<b>Date of Follow up call:</b>	<b>Intake Date:</b>

## **Appendix C**

### **SERVICE TYPES AND DESCRIPTIONS:**

#### **1. Developmental Disability Waiver – Crisis Support Options:**

- **Center-based Crisis Supports:** Provide long-term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu. Services are provided through planned and emergency admissions. Planned admissions will be provided to individuals who are receiving ongoing crisis services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. Crisis stabilization admission will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from experiencing stability within their home setting. The allowable activities include but are not limited to:
  - Assessments and stabilization techniques
  - Medication management and monitoring
  - Behavior assessment and positive behavior support
  - Intensive care coordination
  - Training of other in Positive Behavior Supports
  - Assisting with skill-building as related to the behavior
  - Supervision of the individual in crisis to ensure safety

Applicable Waivers: Building Independence; Family and Individual; and Community Living.

Unit: 1 day

Limits: Up to six months per year in 30 day increments

Center-Based Crisis Support Providers shall be licensed by DBHDS as providers of (MH) crisis stabilization services and group home residential services and either emergency services or residential crisis stabilization services. Center-Based crisis supports shall be provided by LMHP, a LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener; or, a QDDP or Direct Support Professional (DSP) under the supervision of one of the professionals listed above.

- **Community-based Crisis Supports:** Are ongoing supports to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing required due to mental health or behavioral concerns; and/or frequent setting changes. Supports are provided in the individual's home and community setting. Crisis staff work directly with and assist the individual and their current support provider or family. Techniques and strategies are provided via coaching, teaching, modeling, role-playing, problem solving, or direct assistance. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. The allowable activities include but are not limited to:
  - Assessments and stabilization techniques
  - Medication management and monitoring
  - Behavior assessment and positive behavior support
  - Intensive care coordination
  - Training of others in positive behavioral supports
  - Assist with skill building as related to the behavior

Applicable Waivers: Building Independence; Family and Individual; and Community Living.

Community-Based Crisis Supports is an hourly service unit and may be authorized for up to 24 hours per day if necessary in increments of no more than 15 days at a time. The anticipated annual limit is 1,080 hours without further medically necessary justification.

Community-Based Crisis Support services shall be provided by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener, or Qualified Developmental Disabilities Professional (QDDP).

- **Crisis Support Services:** Provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization to an individual who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize their current community living situation. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period. Crisis Support Services Includes:
    - Crisis Prevention Services - Provides ongoing assessment of an individual's medical, cognitive, and behavioral status as well as predictors of self-injurious, disruptive, or destructive behaviors, with the initiation of positive behavior supports to prevent occurrence of crisis situations.
    - Crisis Intervention Services – Used in the midst of the crisis to prevent the further escalation of the situation and to maintain the immediate personal safety of those involved.
    - Crisis Stabilization Services – Begin once the acuity of the situation has resolved and there is no longer an immediate threat to the health and safety of those involved. Geared toward gaining a full understanding of all of the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived.
- Applicable Waivers: Building Independence; Family and Individual; and Community Living.  
Unit: 1 day  
Limits: Limits up to 24 hours per day, if necessary, with the following limits
- Crisis Prevention: 60 days per ISP year
  - Crisis Intervention: No more than 15 days at a time for no more than 90 days per ISP year
  - Crisis Stabilization: No more than 15 days at a time for no more 60 days per ISP year

Providers shall employ or utilize QDDPs, LMHPs, or other qualified personnel licensed to provide clinical or behavioral interventions.

## **2. MH Crisis Stabilization:**

### **Service Definition:**

Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.



## **Medical Necessity Criteria**

The service-specific provider intake must document the need for crisis stabilization services. To qualify for this service, individuals must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.

Individuals must MEET at least TWO of the following criteria at the time of admission to the service:

1. Experiencing difficulty in establishing and maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization or homelessness or isolation from social supports.
2. Experiencing difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.
3. Exhibiting such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are or have been necessary.
4. Exhibiting difficulty in cognitive ability (such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior).

Individuals may not receive Crisis Stabilization when they meet the exclusion criteria below:

Exclusion Criteria: Service is neither appropriate nor reimbursed for:

### **MEET ONE**

- 1) Individuals with medical conditions which require hospital care;
- 2) Individuals with a primary diagnosis of substance abuse;
- 3) Individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to self or others

Crisis Stabilization providers must be licensed by DBHDS as a provider of Nonresidential Crisis Stabilization or Residential Crisis Stabilization. Crisis Stabilization services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a certified Pre-screener (must be signed off on by LMHP/S/R/RP)

## **3. MH Crisis Intervention:**

### **Service Definition**

Crisis intervention shall provide immediate mental health care, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention services must be available 24 hours a day, seven days per week.

### **Crisis Intervention Objectives**

- Prevent the exacerbation of a condition
- Prevent injury to the individual or others; and
- Provide treatment in the least restrictive setting.

## **Medical Necessity Criteria**

There must be documentation of an immediate mental health service need with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.

Crisis intervention services are provided following a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Individuals must MEET BOTH Criteria A and B to qualify for reimbursement.

- A. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.
- B. Individuals must MEET TWO of the following criteria at the time of admission to the service:
  - 1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;
  - 2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
  - 3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or
  - 4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

## **Service Credentials**

Crisis Intervention providers must be licensed as a provider of Emergency Services by DBHDS. Crisis intervention shall be provided only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified pre-screener.

**Crisis Education and Prevention Plan**  
**Provisional**

Initial Date: \_\_\_\_\_

Demographic Information	
Name:	
Address:	
DOB:	Telephone:
CSB:	
Guardian/AR Name:	
Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Living Situation (check one)	
<input type="checkbox"/> Own Home	<input type="checkbox"/> Group Home
<input type="checkbox"/> Family Home	<input type="checkbox"/> Sponsored Home
<input type="checkbox"/> ALF	<input type="checkbox"/> ICF
<input type="checkbox"/> Other:	
Diagnoses	
DD:	
MH:	
Medical:	

Dental:			
Medications:			
Name:	Dose:	Reason:	
Name:	Dose:	Reason:	
Other Important Information			
Communication Style:			
Language spoken/understood:			
Cultural/Heritage Considerations:			
Current/Previous Legal Involvement:			
APS/CPS/DSS Involvement:			
Attending School:			
Important People			
Name	Relationship	Address	Phone #

### Crisis Plan Section:

What is baseline? What does the person look like at their best? Please describe in observable terms:

Behavior:

Strengths:

Preferred Activities:

Preferred People:

Rapport Development:

What types of supports have been tried in crisis situations that have been HELPFUL?

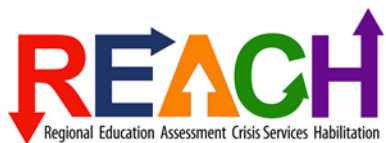
Previous Supports Offered	Why was this <u>HELPFUL</u> ?

What types of supports have been tried in crisis situations that were NOT HELPFUL?

Previous Supports Offered	Why was this <u>NOT HELPFUL</u> ?

**Mental Health Presentation** (When MH symptoms are increasing, what does this look like? If no specific MH diagnosis and/or symptoms, use this area to provide additional info on pre-crisis and/or crisis behaviors as applicable)

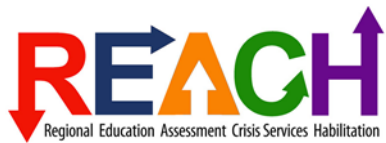




**Region specific information goes here**  
**(REACH Program, address, crisis**  
**line)**

**Crisis Intervention:**

Crisis Behavior	Any visible cues you see prior to the crisis behavior?	What is the person communicating through their behavior?	Hypothesized triggers/setting events	Support Strategies/interventions	Persons Involved- Who to Call
Pre-crisis:					



**Region specific information goes here**  
**(REACH Program, address, crisis**  
**line)**

Debriefing Protocol Post Crisis:

4.

5.

Linkages/Coordination Needed:

## Signature Page for Provisional Section of Plan

Name	Agency	Phone Number	Email Address	Signature
<b>Guardian</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Family/friend contact</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Residential Program</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Vocational/day Program</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Case manager/ Service Coordinator</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>REACH Coordinator</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Primary Physician</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Psychiatrist</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Therapist</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Neurologist</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>MH Case manager</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Other</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	

## Crisis Education and Prevention Plan Final

Dates of update: \_\_\_\_\_

Stressors (environmental, situational, internal) that lead to crises:

- 1.
- 2.
- 3.

Target Behavior	What to look for leading up to target behavior	Prosocial Behavior (Replacement Behavior)	Support Interventions	Crisis Criteria (whom to call and when)
Pre-crisis:				

Debriefing Protocol Post Crisis:

- 1.
- 2.

Action Plan for Crisis

- 1.
2. Call REACH crisis line for support
3. Call 911

Linkages/Coordination Recommended:

- 1.
- 2.
- 3.

## Signatures for Final Crisis Education and Prevention Plan

Name	Agency	Phone Number	Email Address	Signature
<b>Guardian</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Family/friend contact</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Residential Program</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Vocational/day Program</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Case manager/ Service Coordinator</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>REACH Coordinator</b>	Click here to enter agency.	Click here to enter phone number	Click here to enter address.	
<b>Primary Physician</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Psychiatrist</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Therapist</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Neurologist</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>MH Case manager</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	
<b>Other</b>	Click here to enter name.	Click here to enter phone number	Click here to enter address.	



